Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for the fiscal year.

	Is this information correct? Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Atlantic General Hospital Corporation	◉	○	
Your hospital's ID is: 210061	◉	○	
Your hospital is part of the hospital system called Atlantic General Hospital/Health System	◉	○	
The primary Narrative contact at your hospital is Bruce Todd	○	◉	Tina Simmons
The primary Narrative contact email address at your hospital is mtodd@atlanticgeneral.org	○	◉	tsimmons@atlanticgeneral.org
The primary Financial contact at your hospital is Bruce Todd	◉	○	
The primary Financial email at your hospital is mtodd@atlanticgeneral.org	◉	○	

Q4. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. Please select the community health statistics that your hospital uses in its community benefit efforts.

- [x] Median household income
- [x] Percentage below federal poverty line (FPL)
- [x] Percent uninsured
- [ ] Percent with public health insurance
- [x] Percent with Medicaid
- [ ] Mean travel time to work
- [ ] Percent speaking language other than English at home
- [x] Race: percent white
- [x] Race: percent black
- [x] Ethnicity: percent Hispanic or Latino
- [ ] Life expectancy
- [ ] Crude death rate
- [ ] Other

Q6. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

AGH FY19-21 CHNA, County Health Rankings, MD SHIP, Healthy People 2030, Worcester County Health Department Data, Community Survey, Healthy Communities Institute, US Census Bureau, CHSI, MHA Data, Vital Statistics

Q7. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q8. Section I - General Info Part 2 - Community Benefit Service Area

Q9. Please select the county or counties located in your hospital's CBSA.

☐ Allegany County	☐ Charles County	☐ Prince George's County
☐ Anne Arundel County	☐ Dorchester County	☐ Queen Anne's County
☐ Baltimore City	☐ Frederick County	☑ Somerset County
☐ Baltimore County	☐ Garrett County	☐ St. Mary's County
☐ Calvert County	☐ Harford County	☐ Talbot County
☐ Caroline County	☐ Howard County	☐ Washington County
☐ Carroll County	☐ Kent County	☑ Wicomico County
☐ Cecil County	☐ Montgomery County	☑ Worcester County

Q10. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all Somerset County ZIP codes located in your hospital's CBSA.

- [ ] 21817
- [ ] 21821
- [ ] 21822
- [ ] 21824
- [ ] 21836
- [ ] 21838
- [x] 21851
- [x] 21853
- [ ] 21857
- [ ] 21866
- [ ] 21867
- [x] 21871
- [ ] 21890

Q29. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q32. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

- [x] 21801
- [ ] 21802
- [ ] 21803
- [x] 21804
- [ ] 21810
- [ ] 21814
- [ ] 21822
- [ ] 21826
- [ ] 21830
- [ ] 21837
- [ ] 21840
- [ ] 21849
- [ ] 21850
- [ ] 21852
- [ ] 21856
- [ ] 21861
- [ ] 21865
- [ ] 21874
- [ ] 21875

Q33. Please check all Worcester County ZIP codes located in your hospital's CBSA.

- [ ] 21792
- [x] 21804
- [x] 21811
- [x] 21813
- [x] 21822
- [x] 21829
- [x] 21841
- [x] 21842
- [x] 21843
- [x] 21851
- [x] 21862
- [x] 21863
- [x] 21864
- [x] 21872

Q34. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.

- [x] Based on ZIP codes in your global budget revenue agreement. Please describe.

Appendix E: Definition of Hospital Service Area. The HSCRC will use zip codes and/or counties for market analysis.
The primary service area (PSA) of the hospital consists of the following zip codes (or counties): 21811, 21842, 19975, 19945, 21813

- [x] Based on patterns of utilization. Please describe.

ED and IP utilization targeted activities based upon diagnosis patient volumes

- [x] Other. Please describe.

Tri-county partnerships expand CBSA. Close proximity, rural community, and lack of transportation to Delaware expands CBSA to Sussex County and Accomack County, VA.

Q35. Provide a link to your hospital's mission statement.

https://www.atlanticgeneral.org/about-us/vision-and-mission/

Q36. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

AGH provides clinical site opportunities to various health occupations, i.e. rad tech, nursing, pharmacy interns, med student interns, etc., students/interns from local universities and colleges. Distance learners are provided local clinical site opportunities as well through their online studies and expanding partnerships with other universities in Maryland. AGH supports and provides high school mentoring opportunities to local tech school programs from Worcester, Wicomico, and Somerset counties and Project SEARCH.

Q37. Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

Q38.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (●) Yes
- ( ) No

Q39. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q40. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

05/12/2019

Q41. Please provide a link to your hospital's most recently completed CHNA.

https://www.atlanticgeneral.org/documents/AGH-9313-CHNA-Report-2019-21-booklet-form-050319.pdf

Q42. Please upload your hospital's most recently completed CHNA.

AGH-9313-CHNA-Report-2019-21-booklet-form-050319.pdf
18MB
application/pdf

Q43. Section II - CHNAs and Stakeholder Involvement Part 2 - Internal CHNA Partners

Q44. Please use the table below to tell us about the internal partners involved in your most recent CHNA development.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☑	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Physician(s)	☐	☐	☑	☑	☐	☐	☑	☑	☐	☐	
Nurse(s)	☐	☐	☑	☑	☐	☐	☑	☑	☐	☐	
Social Workers	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hospital Advisory Board	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Other (specify)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

Q46. Please use the table below to tell us about the internal partners involved in your community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☑	☐	☑	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☐	☐	☑	☑	☑	☑	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q47. Section II - CHNAs and Stakeholder Involvement Part 4 - Meaningful Engagement

Q48. Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. Please use the table below to tell us about the external partners involved in your most recent CHNA. In the first column, select and describe the external participants. In the second column, select the level of community engagement for each participant. In the third column, select the recommended practices that each stakeholder was engaged in. The Maryland Hospital Association worked with the HSCRC to develop this list of eight recommended practices for engaging patients and communities in the CHNA process.

Refer to the FY 2021 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is optional for FY 2021, but will be mandatory for FY 2022.

	Level of Community Engagement	Recommended Practices

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here: Tidal Health (including Nanticoke and McCready)	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
Local Health Department -- Please list the Local Health Departments here: Worcester, Wicomico, Somerset	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
Local Health Improvement Coalition -- Please list the LHICs here: Worcester LHIC, Tricounty Health Planning	☑	☑	☑	☑	☐	☐	☑	☑	☐	☑	☐	☑	☐	☑
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other State Agencies -- Please list the agencies here: MD Dept of Environment, MD Dept of Transportation, MD Dept of Education, WorCOA, MAC	☑	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐
Local Govt. Organizations -- Please list the organizations here: Worcester County Government	☑	☑	☑	☐	☐	☐	☐	☑	☐	☑	☐	☐	☑	☑

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Faith-Based Organizations	☑	☑	☑	☑	☐	☐	☑	☑	☐	☐	☐	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here: WCPS	☑	☑	☑	☐	☐	☐	☑	☑	☐	☐	☐	☐	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here: SU, UMES, DelTech, DE Univ, Ches College, Frostburg, South Hills, Oakwood, Lynchburg, Wilm U	☑	☑	☐	☐	☐	☐	☑	☑	☐	☐	☐	☐	☑	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here: LBHA, Local Drug & Alcohol Coalition, WoWAOA, Shep Pratt, Hudson Health, SUN, WCHD	☑	☑	☐	☐	☐	☐	☑	☐	☐	☐	☐	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here: GOLD, Cricket Center, MD Food Bank, local food pantries/shelters	☑	☑	☐	☐	☐	☐	☑	☑	☐	☐	☐	☑	☑	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here: Worcester Warriors AOA, Atlantic Club, WorcGOLD, Worcester Goes Purple, Worcester Youth & Family	☑	☑	☑	☐	☐	☐	☑	☑	☐	☐	☐	☑	☑	☑
Consumer/Public Advocacy Organizations -- Please list the organizations here: Komen, March of Dimes, Red Cross, local chambers	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑
Other -- If any other people or organizations were involved, please list them here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

Q50. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q51. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

11/07/2019

Q52. Please provide a link to your hospital's CHNA implementation strategy.

https://www.atlanticgeneral.org/community-health-wellness/community-health-needs-assessments/

Q222. Please upload your hospital's CHNA implementation strategy.

Implementation-Plan-CHNA-2019-21-FINAL-Revised-10.1.2019 (1).doc

566KB
application/msword

Q53. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q54. Please select the CHNA Priority Area Categories most relevant to your most recent CHNA. The list of categories is based on the Healthy People 2030 objectives available here. This list is not exhaustive. Please select "other" and describe any CHNA Priority Area Categories that are not captured by this list. Select all that apply even if a need was not addressed by a reported initiative.

☑ Health Conditions - Addiction	☑ Health Behaviors - Drug and Alcohol Use	☐ Populations - Women
☑ Health Conditions - Arthritis	☐ Health Behaviors - Emergency Preparedness	☐ Populations - Workforce
☐ Health Conditions - Blood Disorders	☐ Health Behaviors - Family Planning	☐ Settings and Systems - Community
☑ Health Conditions - Cancer	☐ Health Behaviors - Health Communication	☐ Settings and Systems - Environmental Health
☐ Health Conditions - Chronic Kidney Disease	☑ Health Behaviors - Injury Prevention	☐ Settings and Systems - Global Health
☑ Health Conditions - Chronic Pain	☑ Health Behaviors - Nutrition and Healthy Eating	☑ Settings and Systems - Health Care
☐ Health Conditions - Dementias	☑ Health Behaviors - Physical Activity	☑ Settings and Systems - Health Insurance
☑ Health Conditions - Diabetes	☐ Health Behaviors - Preventive Care	☑ Settings and Systems - Health IT
☐ Health Conditions - Foodborne Illness	☐ Health Behaviors - Safe Food Handling	☐ Settings and Systems - Health Policy
☐ Health Conditions - Health Care-Associated Infections	☐ Health Behaviors - Sleep	☐ Settings and Systems - Hospital and Emergency Services
☑ Health Conditions - Heart Disease and Stroke	☑ Health Behaviors - Tobacco Use	☐ Settings and Systems - Housing and Homes
☑ Health Conditions - Infectious Disease	☐ Health Behaviors - Vaccination	☐ Settings and Systems - Public Health Infrastructure
☑ Health Conditions - Mental Health and Mental Disorders	☑ Health Behaviors - Violence Prevention	☐ Settings and Systems - Schools
☑ Health Conditions - Oral Conditions	☐ Populations - Adolescents	☐ Settings and Systems - Transportation
☑ Health Conditions - Osteoporosis	☐ Populations - Children	☐ Settings and Systems - Workplace
☑ Health Conditions - Overweight and Obesity	☐ Populations - Infants	☐ Social Determinants of Health - Economic Stability
☐ Health Conditions - Pregnancy and Childbirth	☐ Populations – LGBT	☐ Social Determinants of Health - Education Access and Quality
☑ Health Conditions - Respiratory Disease	☐ Populations - Men	☑ Social Determinants of Health - Health Care Access and Quality
☐ Health Conditions - Sensory or Communication Disorders	☐ Populations - Older Adults	☐ Social Determinants of Health - Neighborhood and Built Environment
☑ Health Conditions - Sexually Transmitted Infections	☐ Populations - Parents or Caregivers	☐ Social Determinants of Health - Social and Community Context
☐ Health Behaviors - Child and Adolescent Development	☐ Populations - People with Disabilities	☑ Other (specify) HIV, Telehealth, Access to Health Services-Insurance, Access to Health Services-Practicing PCP's

Q56. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

FY19-21 CHNA Identified health needs: #1Cancer, #2 Diabetes/Sugar, #3Overweight/Obesity, #4Smoking,drug or alcohol use, #5 Heart disease, #6 Mental health, #7 High blood pressure/stroke, #8 Access to Healthcare/No Health Insurance, #9 Dental Health, #10 Asthma/Lung Disease, #11 Injuries, #12 Sexually transmitted diseases & HIV

Q57. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q58. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q59. Please use the questions below to provide details regarding the initiatives to address the CHNA Priority Area Categories selected in the previous question.

For those hospitals completing the ***optional*** CHNA financial reporting in FY 2021, please ensure that these tie directly to line item initiatives in the financial reporting template.

For those hospitals **not** completing the ***optional*** CHNA financial template, please provide this information for as many initiatives as you deem feasible.

Please note that hospitals will be required to report on each CHNA-related initiative in FY 2022.

Q163. Please describe the initiative(s) addressing Health Conditions - Addiction.

	Health Conditions - Addiction Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q182. Please describe the initiative(s) addressing Health Conditions - Arthritis.

	Health Conditions - Arthritis Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q183. Please describe the initiative(s) addressing Health Conditions - Blood Disorders.

This question was not displayed to the respondent.

Q184. Please describe the initiative(s) addressing Health Conditions - Cancer.

	Health Conditions - Cancer Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Decrease the incidence of advanced breast, lung, colon, and skin cancer in the community	Increase awareness of importance of prevention, and early detection and reduce health disparities	1586 encounters in FY20. Due to Covid all health fairs, screening events etc. werer cancelled in FY21. We did launch a CHAMP initiave with our faith-based partners in June 21.	Health People 2030, MD SHIP, AGH databases, AGH CHNA, Vital statistics
Initiative B	Decrease the incidence of advanced breast, lung, colon, and skin cancer in the community	Increase provider services in community to provide for cancer related treatment	No additional oncology providers recruited in FY21	Track provider recruitment
Initiative C	Decrease the incidence of advanced breast, lung, colon, and skin cancer in the community	Improve access and referrals to community resources resulting in better outcomes	No new grant or program opportunities in FY21, but we did implement CHAMP program at the beginning of FY22	track grant opportunities and formal partnerships
Initiative D	Decrease the incidence of advanced breast, lung, colon, and skin cancer in the community	Increase support to patients and caregivers	Due to Covid, support groups and educational opportunities decreased in FY21	track community education opportunities and support group meetings
Initiative E	Decrease the incidence of advanced breast, lung, colon, and skin cancer in the community	Increase participation in community cancer screenings, especially at risk and vulnerable pop	Due to Covid, no health fairs or community screening events were held in FY21	Track community screening events that occur during the FY21
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				

All Other Initiatives				

Q185. Please describe the initiative(s) addressing Health Conditions - Chronic Kidney Disease.

This question was not displayed to the respondent.

Q186. Please describe the initiative(s) addressing Health Conditions - Chronic Pain.

	Health Conditions - Chronic Pain Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q187. Please describe the initiative(s) addressing Health Conditions - Dementias.

This question was not displayed to the respondent.

Q188. Please describe the initiative(s) addressing Health Conditions - Diabetes.

	Health Conditions - Diabetes Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Decrease incidence of Diabetes in the community	Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions	Diabetes ED visits and IP visits increased from FY20 and FY21	Track Ed visits and hospital admissions for FY 21
Initiative B	Decrease incidence of Diabetes in the community	Increase awareness around importance of prevention of diabetes and early detection	Due to Covid, all community education events, screening events and support groups were cancelled in FY21	Track diabetes community education events, screening events and support groups for FY21
Initiative C	Decrease incidence of Diabetes in the community	Increase patient engagement in self-management of chronic conditions	Due to Covid, all DSMP wellness workshops were cancelled in FY21	Track DSMP wellness workshops for FY21
Initiative D	Decrease incidence of Diabetes in the community	Increase provider services in the community to provide for diabetes-related treatment	3 patients were enrolled in Diabetes education via telehealth in FY21, attempts were made to hold Diabetes education support groups virtually, but this was not well received by thetarget patient population	Track diabetes education telehealth opportunities in FY21
Initiative E	Decrease incidence of Diabetes in the community	Increase community capacity and collaboration for shared responsibilty to address unmet health needs	A mini-grant was awarded in June 21 for implementation in FY22	Track partnerships with local health agencies in FY21
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q189. Please describe the initiative(s) addressing Health Conditions - Foodborne Illness.

This question was not displayed to the respondent.

Q190. Please describe the initiative(s) addressing Health Conditions - Health Care-Associated Infections.

This question was not displayed to the respondent.

Q191. Please describe the initiative(s) addressing Health Conditions - Heart Disease and Stroke.

	Health Conditions - Heart Disease and Stroke Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q192. Please describe the initiative(s) addressing Health Conditions - Infectious Disease.

	Health Conditions - Infectious Disease Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q193. Please describe the initiative(s) addressing Health Conditions - Mental Health and Mental Disorders.

	Health Conditions - Mental Health and Mental Disorders Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q194. Please describe the initiative(s) addressing Health Conditions - Oral Conditions.

	Health Conditions - Oral Conditions Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				

Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q195. Please describe the initiative(s) addressing Health Conditions - Osteoporosis.

	Health Conditions - Osteoporosis Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q196. Please describe the initiative(s) addressing Health Conditions - Overweight and Obesity.

	Health Conditions - Overweight and Obesity Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q197. Please describe the initiative(s) addressing Health Conditions - Pregnancy and Childbirth.

This question was not displayed to the respondent.

Q198. Please describe the initiative(s) addressing Health Conditions - Respiratory Disease.

	Health Conditions - Respiratory Disease Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				

Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q199. Please describe the initiative(s) addressing Health Conditions - Sensory or Communication Disorders.

This question was not displayed to the respondent.

Q200. Please describe the initiative(s) addressing Health Conditions - Sexually Transmitted Infections.

	Health Conditions - Sexually Transmitted Infections Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q201. Please describe the initiative(s) addressing Health Behaviors - Child and Adolescent Development.

This question was not displayed to the respondent.

Q202. Please describe the initiative(s) addressing Health Behaviors - Drug and Alcohol Use.

	Health Behaviors - Drug and Alcohol Use Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q203. Please describe the initiative(s) addressing Health Behaviors - Emergency Preparedness.

This question was not displayed to the respondent.

Q204. Please describe the initiative(s) addressing Health Behaviors - Family Planning.

This question was not displayed to the respondent.

Q205. Please describe the initiative(s) addressing Health Behaviors - Health Communication.

This question was not displayed to the respondent.

Q206. Please describe the initiative(s) addressing Health Behaviors - Injury Prevention.

	Health Behaviors - Injury Prevention Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q207. Please describe the initiative(s) addressing Health Behaviors - Nutrition and Healthy Eating.

	Health Behaviors - Nutrition and Healthy Eating Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q208. Please describe the initiative(s) addressing Health Behaviors - Physical Activity.

	Health Behaviors - Physical Activity Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q209. Please describe the initiative(s) addressing Health Behaviors - Preventive Care.

This question was not displayed to the respondent.

Q210. Please describe the initiative(s) addressing Health Behaviors - Safe Food Handling.

This question was not displayed to the respondent.

Q211. Please describe the initiative(s) addressing Health Behaviors - Sleep.

This question was not displayed to the respondent.

Q212. Please describe the initiative(s) addressing Health Behaviors - Tobacco Use.

	Health Behaviors - Tobacco Use Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q213. Please describe the initiative(s) addressing Health Behaviors - Vaccination.

This question was not displayed to the respondent.

Q214. Please describe the initiative(s) addressing Health Behaviors - Violence Prevention.

	Health Behaviors - Violence Prevention Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q215. Please describe the initiative(s) addressing Populations - Adolescents.

This question was not displayed to the respondent.

Q216. Please describe the initiative(s) addressing Populations - Children.

This question was not displayed to the respondent.

Q217. Please describe the initiative(s) addressing Populations - Infants.

This question was not displayed to the respondent.

Q218. Please describe the initiative(s) addressing Populations - LGBT.

This question was not displayed to the respondent.

Q219. Please describe the initiative(s) addressing Populations - Men.

This question was not displayed to the respondent.

Q220. Please describe the initiative(s) addressing Populations - Older Adults.

This question was not displayed to the respondent.

Q221. Please describe the initiative(s) addressing Populations - Parents or Caregivers.

This question was not displayed to the respondent.

Q222. Please describe the initiative(s) addressing Populations - People with Disabilities.

This question was not displayed to the respondent.

Q223. Please describe the initiative(s) addressing Populations - Women.

This question was not displayed to the respondent.

Q224. Please describe the initiative(s) addressing Populations - Workforce.

This question was not displayed to the respondent.

Q225. Please describe the initiative(s) addressing Settings and Systems - Community.

This question was not displayed to the respondent.

Q226. Please describe the initiative(s) addressing Settings and Systems - Environmental Health.

This question was not displayed to the respondent.

Q227. Please describe the initiative(s) addressing Settings and Systems - Global Health.

This question was not displayed to the respondent.

Q228. Please describe the initiative(s) addressing Settings and Systems - Health Care.

	Settings and Systems - Health Care Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q229. Please describe the initiative(s) addressing Settings and Systems - Health Insurance.

	Settings and Systems - Health Insurance Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				

Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q230. Please describe the initiative(s) addressing Settings and Systems - Health IT.

	Settings and Systems - Health IT Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q231. Please describe the initiative(s) addressing Settings and Systems - Health Policy.

This question was not displayed to the respondent.

Q232. Please describe the initiative(s) addressing Settings and Systems - Hospital and Emergency Services.

This question was not displayed to the respondent.

Q233. Please describe the initiative(s) addressing Settings and Systems - Housing and Homes.

This question was not displayed to the respondent.

Q234. Please describe the initiative(s) addressing Settings and Systems - Public Health Infrastructure.

This question was not displayed to the respondent.

Q235. Please describe the initiative(s) addressing Settings and Systems - Schools.

This question was not displayed to the respondent.

Q236. Please describe the initiative(s) addressing Settings and Systems - Transportation.

This question was not displayed to the respondent.

Q237. Please describe the initiative(s) addressing Settings and Systems - Workplace.

This question was not displayed to the respondent.

Q238. Please describe the initiative(s) addressing Social Determinants of Health - Economic Stability.

This question was not displayed to the respondent.

Q239. Please describe the initiative(s) addressing Social Determinants of Health - Education Access and Quality.

This question was not displayed to the respondent.

Q240. Please describe the initiative(s) addressing Social Determinants of Health - Health Care Access and Quality.

	Social Determinants of Health - Health Care Access and Quality Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A	Increase community access to comprehensive, quality health care services	Reduce unnecessary healthcare costs and reduction in hospital admissions and readmissions	There was a significant increase in ED visits and admissions for patients with Diabetes in the top three codes for visit in FY21. Some of this is attributed to Covid impact on preventative and early intervention care	Track hospital ED visits and admissions in FY21
Initiative B	Increase community access to comprehensive, quality health care services	Increase in awareness and self-management of chronic disease during FY21	Due to Covid, all health fairs and community education events, wellness workshops were cancelled	Track community education events, health fairs, and wellness workshops but due to covid all were cancelled for FY21
Initiative C	Increase community access to comprehensive, quality health care services	Reduce health disparities during FY21	Due to Covid, all events were cancelled, school-based telehealth program was postponed until FY22, health fairs all cancelled	AGH database, track community events, health fairs and committee participation and partnerships in FY21.
Initiative D	Increase community access to comprehensive, quality health care services	Increase community capacity and collaboration for shared responsibilty to address unmet needs in FY 21	Due to Covid, all events were cancelled and many committee meetings were cancelled, but some meetings still occurred to continue planning for FY22	track committee participation and partnerships for FY 21
Initiative E	Increase community access to comprehensive, quality health care services	Increase number of practicing primary care providers in the community during FY21	While we added several providers in FY21, we also had resignation of several providers in FY21, impact was neutral	Track provider recruitment FY 21
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q241. Please describe the initiative(s) addressing Social Determinants of Health - Neighborhood and Built Environment.

This question was not displayed to the respondent.

Q242. Please describe the initiative(s) addressing Social Determinants of Health - Social and Community Context.

This question was not displayed to the respondent.

Q243. Please describe the initiative(s) addressing other priorities.

	Other Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q130. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q131.

In your most recently completed CHNA, the following community health needs were identified:
Health Conditions - Addiction, Health Conditions - Arthritis, Health Conditions - Cancer, Health Conditions - Chronic Pain, Health Conditions - Diabetes, Health Conditions - Heart Disease and Stroke, Health Conditions - Infectious Disease, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Oral Conditions, Health Conditions - Osteoporosis, Health Conditions - Overweight and Obesity, Health Conditions - Respiratory Disease, Health Conditions - Sexually Transmitted Infections, Health Behaviors - Drug and Alcohol Use, Health Behaviors - Injury Prevention, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Physical Activity, Health Behaviors - Tobacco Use, Health Behaviors - Violence Prevention, Settings and Systems - Health Care, Settings and Systems - Health Insurance, Settings and Systems - Health IT, Social Determinants of Health - Health Care Access and Quality, Other (specify)
Other: HIV, Telehealth, Access to Health Services-Insurance, Access to Health Services-Practicing PCP's

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q132. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

We have an organizational health equity team that is focused on looking at health disparities in our community and in our patient population. During the Covid-19 pandemic, we partnered with our faith-based partners to stand up vaccine clinics and do outreach in underserved areas of the county and provide vaccines in populations impacted by health disparities. We are partnering with St. Paul to develop a Social Determinants of Health report (developed in FY22). We are also developing a Social Determinants screening tool that will be implemented in both inpatient and ambulatory areas in FY 22.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [x] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [x] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q129. If you wish, you may upload a document describing your community benefit initiatives in more detail.

CB_TableIIINarrative 1 Strategic Priorities-Access to Care, Diabetes, Cancer FY21-Final.docx
777.8KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q60. Section III - CB Administration

Q61. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [x] Yes, by the hospital's staff
- [ ] Yes, by the hospital system's staff
- [ ] Yes, by a third-party auditor
- [ ] No

Q246. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q62. Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

Q63. Please describe the community benefit narrative audit process.

The community benefit narrative is completed by the director of population health, with input from the director of finance. The report is reviewed by the VP Patient Care Services and the VP of Planning and Operations prior to submission.

Q64. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (●) Yes
- ( ) No

Q65. Please explain:

This question was not displayed to the respondent.

Q66. Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

Q67. Please explain:

This question was not displayed to the respondent.

Q68. Does your hospital include community benefit planning and investments in its internal strategic plan?

- ( ) Yes
- (●) No

Q69. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

This question was not displayed to the respondent.

Q70. If available, please provide a link to your hospital's strategic plan.

This question was not displayed to the respondent.

Q133. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents
- [x] Opioid Use Disorder - Improve overdose mortality
- [ ] Maternal and Child Health - Reduce severe maternal morbidity rate
- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

Q134. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q135. Section IV - Physician Gaps & Subsidies

Q223. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- (●) No
- ( ) Yes

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

This question was not displayed to the respondent.

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

This question was not displayed to the respondent.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

This question was not displayed to the respondent.

Q140. Section VI - Financial Assistance Policy (FAP)

Q141. Upload a copy of your hospital's financial assistance policy.

Financial Assistance Policy-Final.pdf
383.8KB
application/pdf

Q220. Provide the link to your hospital's financial assistance policy.

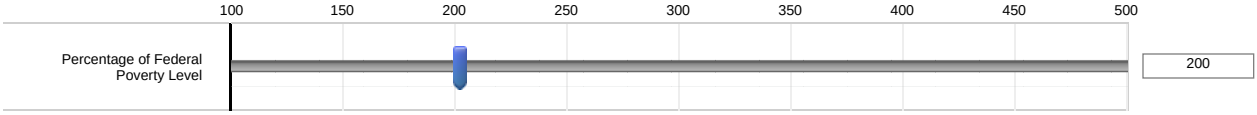
https://www.atlanticgeneral.org/documents/financial assistnce/Financial-Assistance-Policy-Approved-by-Board-02-05-2021.pdf

Q147. Has your FAP changed within the last year? If so, please describe the change.

- (●) No, the FAP has not changed.
- ( ) Yes, the FAP has changed. Please describe:

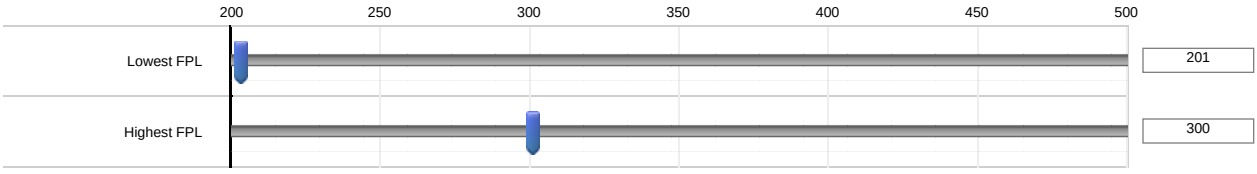
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

Please select the percentage of FPL below which your hospital's FAP offers free care.



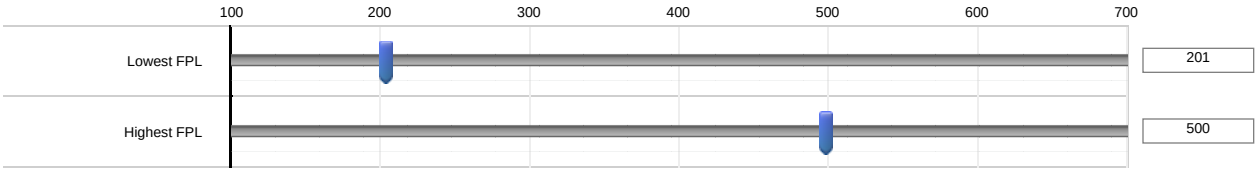
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.



Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.



Q146. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.

Debt as Percentage of Income		25

Q221. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding tax able year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [ ] Local property tax (real and personal)
- [x] Other (Describe) we have some property tax exemptions depending on usage, but not all local property taxes

Q150. Summary & Report Submission

Q151.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

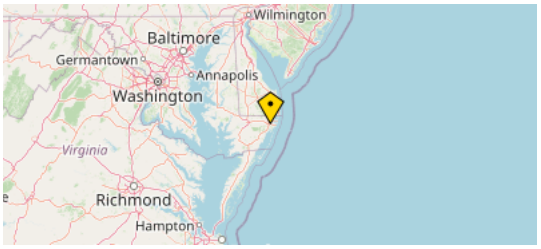
We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (38.345993041992, -75.183296203613)

Source: GeoIP Estimation



Atlantic General Hospital

Community Health Needs Assessment

2019-2021

ATLANTIC GENERAL HOSPITAL

care.givers

Approved by the Atlantic General Hospital Board of Trustees 5/2/19

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Atlantic General Hospital

Community Health Needs Assessment

2019 - 2021

Background and Purpose

The Atlantic General Hospital Corporation (AGH) is an independent, not-for-profit, full service, acute care, inpatient and outpatient facility located in the city of Berlin, Maryland, providing 24-hour emergency services, inpatient and outpatient diagnostic and surgical services, and intensive care services. Since opening our doors in May of 1993, Atlantic General has remained steadfast in serving the healthcare needs of our region's residents and visitors. Our hospital values and recognizes all the communities it serves. We combine the latest medical treatments with personalized attention in a caring environment.

The Patient Protection and Affordable Care Act (ACA) of March 23, 2010, includes requirements for nonprofit hospitals to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. The regulations include a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy to address those needs every three years. A community health needs assessment provides an overview of the health needs and priorities of the community. The CHNA must be made publicly available.

This CHNA represents the third time that Atlantic General Hospital has collaborated and completed the Community Health Needs Assessment process. A Community Health Needs Assessment is intended to provide information that helps hospitals and other community organizations to identify opportunities to improve the health of the community. The CHNA process identifies factors that influence the health of a population and determine the availability of resources that adequately address health concerns.

With the information provided in this report, hospital leaders and partners develop plans to address community health priorities and build upon the capacity, resources and partnerships of existing programs. AGH participates closely with Worcester County Health Department, Wicomico County Health Department, Somerset County Health Department, and Peninsula Regional Medical Center to provide Community Health Assessment data, surveys and programs. Worcester County Health Department document links are used extensively throughout the CHNA. (Appendix A)

A community health needs assessment provides an overview of the health needs and priorities of the community.

Atlantic General Hospital Overview

Atlantic General Hospital was built with the support of a dedicated community. Since opening our doors in May of 1993, Atlantic General has remained steadfast in serving the healthcare needs of our region's residents and visitors, which grows from 30,000 to 300,000 during the summer months. Our not-for-profit hospital is independently owned, and managed by a local board of trustees. That are active and involved members of the community.

Located in the city of Berlin, Worcester County, Maryland, AGH is the only hospital located in Worcester County, which is a federally-designated medically underserved area primary care, dental health and mental health. We serve Maryland, Virginia and Delaware residents and visitors.

AGH is a full service, acute care, inpatient and outpatient facility providing 24-hour emergency services, inpatient and outpatient diagnostic and surgical services, and intensive care services. It is Joint Commission accredited, a member of the American Hospital Association and the Maryland Hospital Association, and is consistently recognized as one of the most efficient hospitals in the State of Maryland. Our patients can expect individualized standards of care. We combine the latest medical treatments with personalized attention. Our Centers of Excellence at AGH include the Atlantic Endoscopy Center, Center for Joint Surgery, Bariatric services, Emergency Services, Eunice Q. Sorin Women's Diagnostic Center, Outpatient Infusion Center, Regional Cancer Care, Sleep Disorders Diagnostic Center, Stroke Center, Women's Health Center and Wound Care Center. AGH also provides Diabetes Outpatient Education Program, Full Service Imaging, Occupational Health Services, and a Pain Management Clinic.

In addition to the acute care and specialty services we provide at our main campus in Berlin, MD, we have more than several family physicians, internists, and specialists with offices in locations throughout the region that comprise Atlantic General Health System and Atlantic ImmediCare, which provides walk-in primary care and urgent care.

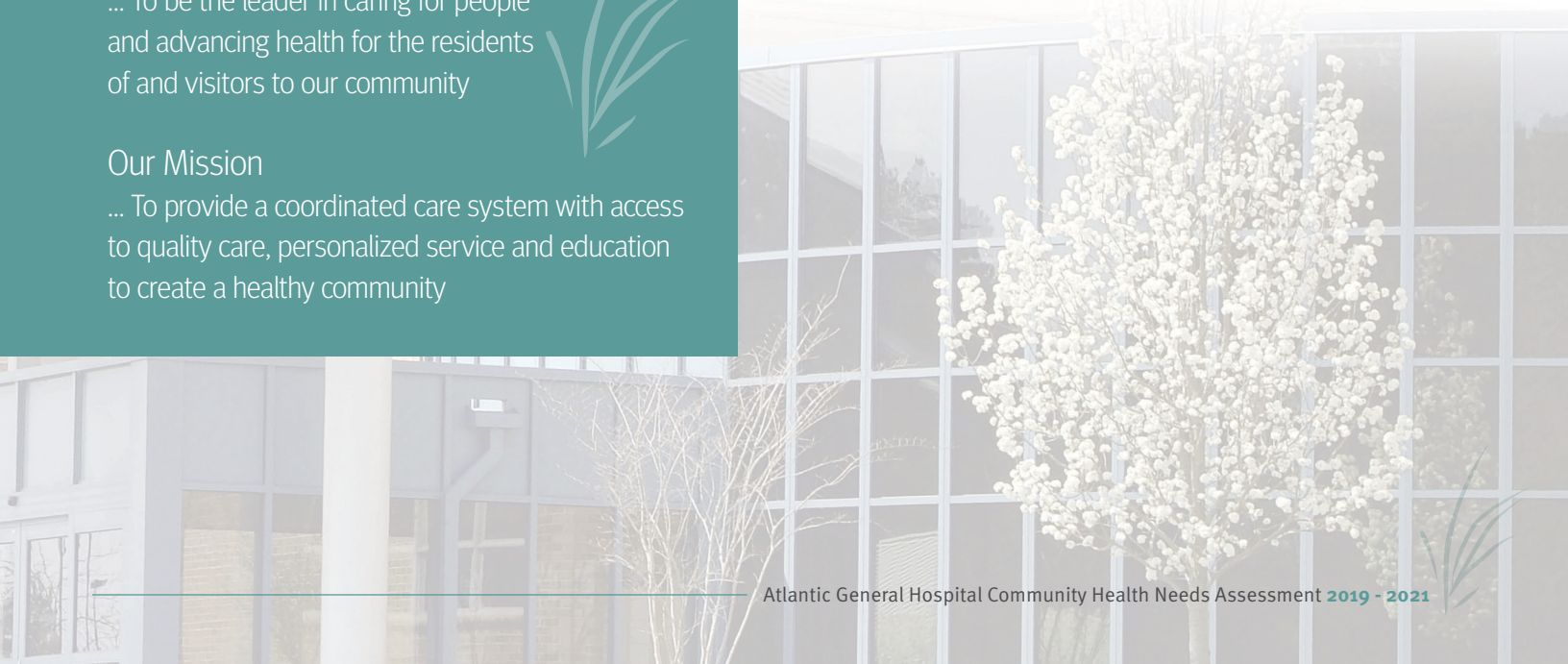
AGH employs over 860 year-round full- and part-time associates with annual payroll and benefits exceeding $66.7 million, making AGH the second largest employer in Worcester County. Our staff is here to counsel you in making the right choices for your health and quality of life. Even more valuable than our excellent, award-winning programs is the genuine warmth and concern our staff exudes in caring for each and every patient on a personal level.

Our Vision

... To be the leader in caring for people and advancing health for the residents of and visitors to our community

Our Mission

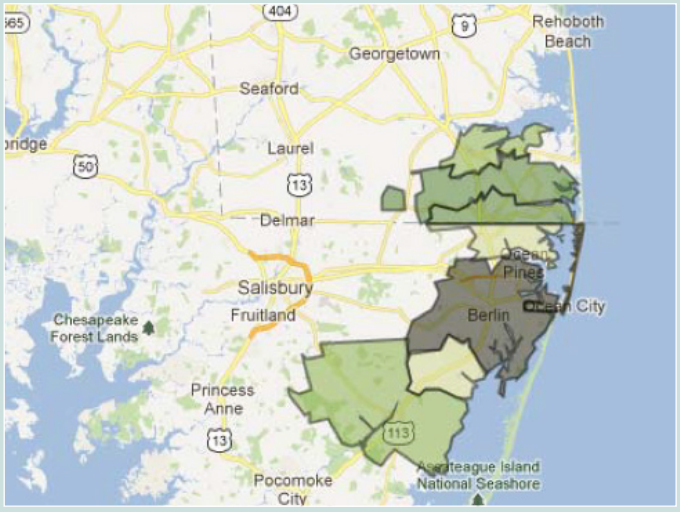
... To provide a coordinated care system with access to quality care, personalized service and education to create a healthy community



The Community Description

Atlantic General Hospital's primary service area is defined as those zip codes that total 90% of patient admissions, emergency or outpatient visits from the residents and/or there is a contiguous geographic relationship. Worcester and Sussex counties are underserved areas. There is a lack of public transportation making geographic location a factor in defining primary market.

Primary Service Area



Primary Market

Zip Code	City	County	State
19939	Dagsboro	Sussex County	DE
19945	Frankford	Sussex County	DE
19975	Selbyville	Sussex County	DE
21811	Berlin	Worcester County	MD
21813	Bishopville	Worcester County	MD
21841	Newark	Worcester County	MD
21842	Ocean City	Worcester County	MD
21843	Ocean City	Worcester County	MD
21862	Showell	Worcester County	MD
21872	Whaleyville	Worcester County	MD
21874	Willards	Worcester County	MD

Population Statistics

The population of the Worcester County resort destination, Ocean City, increases to near 300,000 during the tourist season. Lower Sussex County has similar characteristics of seasonality and retirees. Frankford and Dagsboro, DE have similar demographic profiles as Worcester County, MD. Selbyville, DE has some differing characteristics.

Population by Race	County: Worcester, MD		State: Maryland	
	Persons	% of Population	Persons	% of Population
White	42,342	81.76%	3,326,265	54.54%
Black/African American	6,694	12.93%	1,842,763	30.22%
American Indian/Alaskan Native	158	0.31%	23,550	0.39%
Asian	780	1.51%	413,172	6.78%
Native Hawaiian/Pacific Islander	20	0.04%	3,973	0.07%
Some Other Race	719	1.39%	276,169	4.53%
2+ Races	1,072	2.07%	212,528	3.48%

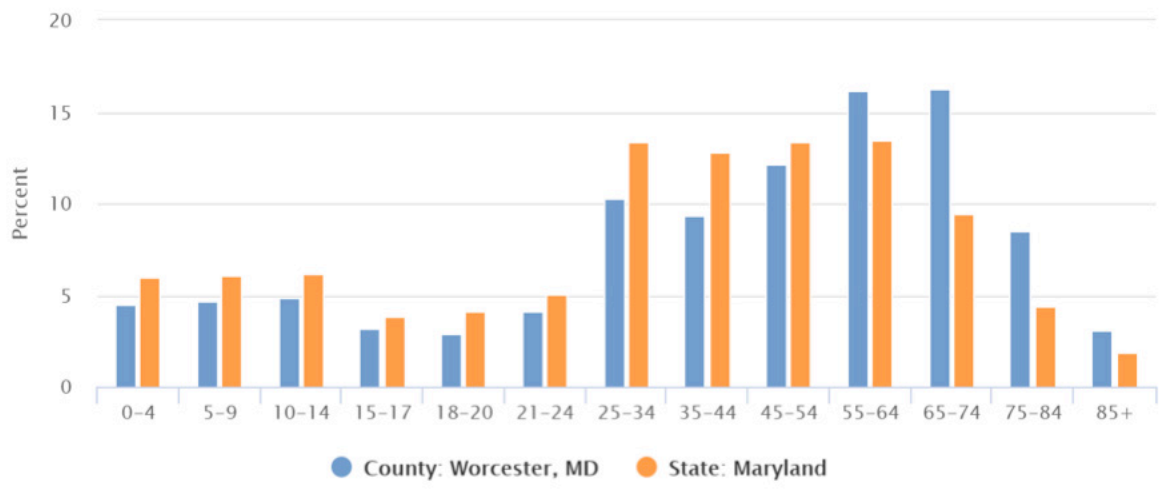
Population by Ethnicity	County: Worcester, MD		State: Maryland	
	Persons	% of Population	Persons	% of Population
Hispanic/Latino	1,876	3.62%	639,709	10.49%
Non-Hispanic/Latino	49,909	96.38%	5,458,711	89.51%

Population by Race	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
White	8,131	84.41%	181,858	78.30%	642,569	65.87%
Black/African American	638	6.62%	28,459	12.25%	217,440	22.29%
American Indian/Alaskan Native	79	0.82%	1,831	0.79%	4,751	0.49%
Asian	135	1.40%	2,980	1.28%	40,188	4.12%
Native Hawaiian/Pacific Islander	0	0.00%	196	0.08%	589	0.06%
Some Other Race	455	4.72%	10,810	4.65%	38,822	3.98%
2+ Races	195	2.02%	6,114	2.63%	31,133	3.19%

Population by Ethnicity	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
Hispanic/Latino	1,163	12.07%	22,540	9.71%	94,055	9.64%
Non-Hispanic/Latino	8,470	87.93%	209,708	90.29%	881,437	90.36%

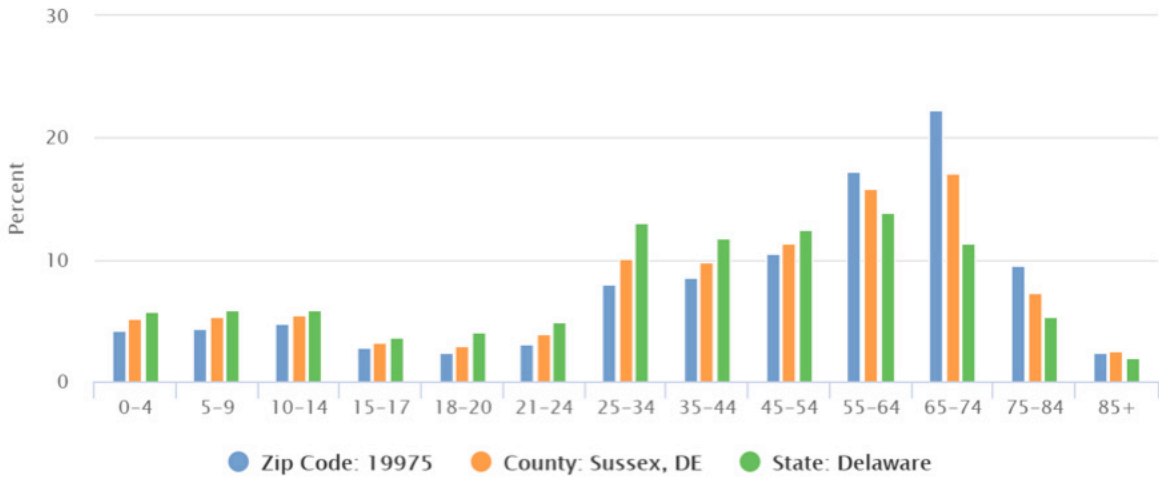
Population by Age Group

County: Worcester, MD



Population by Age Group

Zip Code: 19975



Median Age

County: Worcester, MD

50.1 Years

State: Maryland 39.2 Years

Median Age

Zip Code: 19975

55.9 Years

County: Sussex, DE
48.7 Years

State: Delaware
40.7 Years

Population Age 5+ by Language Spoken at Home	County: Worcester, MD		State: Maryland	
	Persons	% of Population Age 5+	Persons	% of Population Age 5+
Speak Only English	46,862	94.77%	4,684,915	81.74%
Speak Spanish	905	1.83%	450,637	7.86%
Speak Asian/Pac Islander Lang	278	0.56%	215,250	3.76%
Speak Indo-European Lang	1,098	2.22%	255,992	4.47%
Speak Other Lang	305	0.62%	124,390	2.17%

Population Age 5+ by Language Spoken at Home	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population Age 5+	Persons	% of Population Age 5+	Persons	% of Population Age 5+
Speak Only English	7,940	85.99%	197,630	89.76%	801,688	87.18%
Speak Spanish	1,054	11.41%	16,823	7.64%	64,373	7.00%
Speak Asian/Pac Islander Lang	84	0.91%	1,576	0.72%	20,437	2.22%
Speak Indo-European Lang	156	1.69%	3,965	1.80%	24,202	2.63%
Speak Other Lang	0	0.00%	178	0.08%	8,872	0.96%

Population Age 15+ by Marital Status	County: Worcester, MD		State: Maryland	
	Persons	% of Population Age 15+	Persons	% of Population Age 15+
Never Married	12,165	27.34%	1,773,956	35.61%
Married, Spouse present	21,214	47.68%	2,168,599	43.54%
Married, Spouse absent	1,879	4.22%	259,604	5.21%
Divorced	5,135	11.54%	500,917	10.06%
Widowed	4,095	9.20%	277,891	5.58%

Population Age 15+ by Marital Status	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population Age 15+	Persons	% of Population Age 15+	Persons	% of Population Age 15+
Never Married	1,642	19.65%	51,453	26.35%	274,599	34.12%
Married, Spouse present	4,847	58.01%	98,382	50.38%	357,043	44.37%
Married, Spouse absent	293	3.51%	8,749	4.48%	32,614	4.05%
Divorced	827	9.90%	22,472	11.51%	91,453	11.36%
Widowed	747	8.94%	14,206	7.28%	49,050	6.09%

Community Healthcare Utilization

The decline in inpatient admissions and emergency department, demonstrates the work of our strategic plan 2020 Vision: The Right Path to Good Health. It reflects the continued efforts to make sure that people get the right care at the right time in the right setting. Hospital care that is unplanned can be prevented through improved care coordination, effective primary care and improved population health. Care coordination, which AGH has invested significant resources, involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe,

	Volumes			Growth
	FY16	FY17	FY18	FY16-FY17
AGH Inpatient Admissions	4,884	4,608	4,116	-15.72%
AGH Emergency Department Visits	37,599	38,186	37,506	-0.25%
Atlantic General Health System Visits	91,877	95,610	112,137	22.05%

The Right Path to Good Health

appropriate, and effective care to the patient. Residents in our primary service area were admitted to a Maryland Hospitals under the following medical specialties:

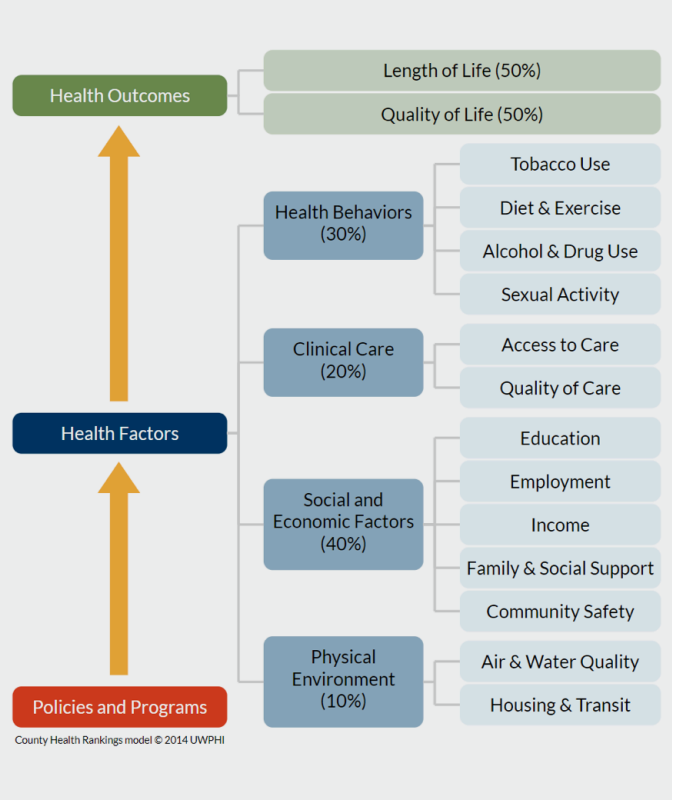
In a recent medical staff development plan completed by ECG Consultants, our community has or will have in the near future a shortage of full time providers in primary care (16.6), pulmonary (1.6), neurology (1), gastroenterology (1.8), general surgery (2) and nephrology (1).

Atlantic General Hospital is making important progress in addressing the region's physician shortage. However, without continued investment and policy changes, the growth in demand for health care services will continue to outstrip the supply.

Specialty	Utilization Ranking
Pulmonary	14.0%
Infectious Disease	12.7%
Orthopedic Surgery	11.7%
Neurology	11.7%
Cardiology	9.7%
Gastroenterology	9.7%
General Surgery	8.9%
Obstetrics/Delivery	8.4%
Normal Newborn	7.4%
Nephrology	5.7%

Key Demographic and Socioeconomic Characteristics

The factors affecting health is much more than access to healthcare. Using the illustration from the County Health Rankings, clinical care comprises about 20% of the total health picture with health behaviors (30%), social and economic factors (40%) and physical environment (10%). The environmental and social factors that affect the county residents helped shape our understanding of both primary and secondary data in the community health needs assessment.



Families Below Poverty

County: Worcester, MD

1,115 Families (7.60% of Families)

State: Maryland 100,209 Families (6.57% of Families)

Families Below Poverty with Children

County: Worcester, MD

605 Families (4.13% of Families)

State: Maryland 75,090 Families (4.92% of Families)

Families Below Poverty

Zip Code: 19975

192 Families (6.82% of Families)

County: Sussex, DE 5,127 Families (8.11% of Families)

State: Delaware 20,364 Families (8.12% of Families)

Families Below Poverty with Children

Zip Code: 19975

92 Families (3.27% of Families)

County: Sussex, DE 3,652 Families (5.78% of Families)

State: Delaware 14,629 Families (5.83% of Families)

Population 25+ by Educational Attainment	County: Worcester, MD		State: Maryland	
	Persons	% of Population Age 25+	Persons	% of Population Age 25+
Less than 9th Grade	1,140	2.90%	171,006	4.08%
Some High School, No Diploma	2,931	7.47%	249,912	5.96%
High School Grad	12,712	32.39%	1,063,834	25.39%
Some College, No Degree	8,197	20.89%	795,927	18.99%
Associate Degree	2,538	6.47%	273,055	6.52%
Bachelor's Degree	7,428	18.93%	875,274	20.89%
Master's Degree	3,136	7.99%	528,246	12.61%
Professional Degree	774	1.97%	127,529	3.04%
Doctorate Degree	391	1.00%	105,695	2.52%

Population 25+ by Educational Attainment	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population Age 25+	Persons	% of Population Age 25+	Persons	% of Population Age 25+
Less than 9th Grade	393	5.20%	7,274	4.23%	23,446	3.44%
Some High School, No Diploma	592	7.83%	16,293	9.47%	50,014	7.35%
High School Grad	2,326	30.77%	55,014	31.97%	214,778	31.55%
Some College, No Degree	1,677	22.19%	33,290	19.35%	128,302	18.85%
Associate Degree	666	8.81%	15,759	9.16%	53,893	7.92%
Bachelor's Degree	1,189	15.73%	26,691	15.51%	124,535	18.30%
Master's Degree	583	7.71%	13,074	7.60%	60,744	8.92%
Professional Degree	88	1.16%	2,942	1.71%	13,080	1.92%
Doctorate Degree	45	0.60%	1,738	1.01%	11,908	1.75%

Median Household Income by Race/Ethnicity	County: Worcester, MD	State: Maryland
	Value	Value
All	$62,944	$85,459
White	$66,780	$95,010
Black/African American	$34,406	$68,999
American Indian/Alaskan Native	$87,500	$64,946
Asian	$77,174	$107,407
Native Hawaiian/Pacific Islander	$147,917	$71,002
Some Other Race	$80,128	$66,601
2+ Races	$73,148	$79,780
Hispanic/Latino	$60,870	$72,659
Non-Hispanic/Latino	$62,980	$86,654

Worcester County has a higher graduation rate than Sussex County at 89.2% and 85.8%, respectively.

Average Household Income by Race/Ethnicity	Zip Code: 19975	County: Sussex, DE	State: Delaware
	Value	Value	Value
All	$92,308	$88,748	$88,168
White	$86,601	$86,061	$87,325
Black/African American	$58,359	$57,061	$66,371
American Indian/Alaskan Native	$66,667	$78,076	$71,303
Asian	$140,000	$114,496	$112,115
Native Hawaiian/Pacific Islander	$0	$63,305	$83,838
Some Other Race	$71,288	$68,378	$60,752
2+ Races	$42,692	$67,704	$65,033
Hispanic/Latino	$80,058	$68,917	$66,707
Non-Hispanic/Latino	$93,086	$89,847	$89,642

Major Employers [6.7] (2016)

Employer	Product/Service	Employments
Harrison Group*	Hotels and restaurants	1,170
Atlantic General Hospital	Medical services	860
Bayshore Development	Entertainment, recreation	520
O.C. Seacrets*	Hotels and restaurant	470
Dough Roller*	Restaurants	360
Carousel Resort Hotel & Condominiums*	Hotel and condominiums	340
Clarion Resort Fontainebleau*	Hotel and restaurant	340
Fager's Island	Hotel and restaurant	300
91st Street Join Venture/ Princess Royale*	Hotel and conference center	290
Phillips Seafood Restaurants*	Restaurants	290
Ocean Pines Association	Nonprofit civic organization	270
Trimper's Rides*	Entertainment, recreation	245
Ocean Enterprise 589/ Casino at Ocean Downs	Casino gaming	235
Berlin Nursing and Rehabilitation Center	Nursing care	195
Castle in the Sand*	Hotel and restaurant	185
Candy Kitchen	Candy products retail	150
Bel-Art Products	Plastics, lab equipment, chemicals	145

Excludes post offices, state and local governments, national retail and national foodservice; includes higher education
*Reflects summer employment levels.

** Statistics available through Health Communities Institute on www.atlanticgeneral.org*

Unemployment for Worcester County, is 7.65% while Selbyville is 2.43%. For 2018, Sussex and Worcester counties are at 7.3% and 8.9% respectively for uninsured patients, as stated by the US Census Bureau.

Health Factors and Status Indicators

The data and data sources can be viewed on the website www.atlanticgeneral.org. The data used on this website are continually updated as they become available, providing the community with a current overview of Worcester and Sussex counties. This data source is far better than traditional paper reports, which are static and often out of date soon after printing.

▶ Community Health Dashboards

The Robert Wood Johnson's county rankings are based on a model of population health and build on America's Health Rankings. These are summarized for Worcester and Sussex counties in Appendix D. Areas to explore for health improvement are adult smoking rates, adult obesity, alcohol impaired driving, and unemployment in Worcester County. Additionally in Sussex County, the areas of teen births, uninsured, and violent crimes stand out as areas below top US performers or the State.

Another source of community health indicators is found in the Maryland State Health Improvement Process (SHIP) indicators and goal attainment summarized in Appendix B. The goal of the State Health Improvement Process (SHIP) is to advance the health of Maryland residents. To achieve this goal, SHIP provides a framework for accountability, local action, and public engagement. Using 39 measures, SHIP highlights the health characteristics of Marylanders. These measures align with the Healthy People (HP) 2020 objectives established by the Department of Health and Human Services.

SHIP data primarily supports the development and strategic direction of Local Health Improvement Coalitions. These coalitions-- comprising of local health departments, nonprofit hospitals, community members, and other community-based organizations-- provide a forum to collectively analyze and prioritize community health needs based on SHIP data.

Resources Available to Address the Significant Health Needs

Resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report are listed in for Worcester County in a service directory. This listing is not exhaustive and is continually developing. It is located on an on-line reference called "Network of Care".

Network of Care

2-1-1 Maryland is partnership of four agencies working together to provide simple access to health and human services information. 2-1-1 is an easy to remember telephone number that connects people with important community services. Specially trained call specialists answer calls 24 hours a day, every day of the year.

www.211md.org

In Sussex County, resources are through State and Local Health Care Resources such as those listed with Division of Public Health – The Thurman Adams State Service Center, Division of State Service Centers (DSSC), Emergency Assistance Service (EAS), Division of Social Services (DSS), Division of Public Health (DPH)'s Sussex County Health Unit and Division of Substance Abuse and Mental Health (DSAMH). Beebe Medical Center services Dagsboro, Selbyville and Frankford with outpatient services.

La Esperanza – Community Center – This is the only bi-cultural and bilingual 501(c) (3) social services agency that provides free culturally appropriate programs and services in the areas of family development, immigration, victim services, and education to help Hispanic adults, children and families living in Sussex County. The Center currently serves approximately 10,000 individuals annually.

La Red Health Center – There are 3 locations available in Georgetown, Seaford and Milford. Services include: Adult and Senior, Behavioral Health, Customized Services for Small Businesses, Oral Health, Patient Enabling, Pediatric and Adolescent, Women's Health, Community Outreach, Medication, Delaware Marketplace, Medicaid Enrollment Assistance, Referrals for WIC, Screening for Life, The Community Healthcare Access program (CHAP), After Hours Coverage and Emergencies, Access to Transportation, Case Management for the Homeless Population, Laboratory Services, Gynecological Care Program. The center accepts: Uninsured, Underinsured, Private Insurance, Medicare, and Medicaid; all income levels accepted. Fees: Sliding scale available. Languages Spoken: English, Spanish.

Approach and Resources

CHNA Methodology

This 2019-2021 CHNA combines population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH uses Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (surveys) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes information gathered through ongoing key community groups.

Secondary Data Collection

AGH partners with surrounding hospitals, health departments and state agencies to bring to together a multitude of information. This Community Health Needs Assessment, a follow-up to a similar study conducted in 2012 and 2015, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area of Atlantic General Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

The information as well as other surveys, research and community data are used to identify issues of greatest concern and guide resource allocation to those areas, thereby making the greatest possible impact on community health status.

The needs assessment is a primary tool used by the Hospital to determine its community benefit priorities, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focuses on the health and social needs of our service area.

A sampling of resources utilized to complete the assessment is listed below. A comprehensive list is found under references.

- Community meetings with persons representing the broad interests of the community
- AGH Community Needs Survey
- Maryland State Health Improvement Process (SHIP) www.dhmh.maryland.gov/ship
- Tri-County Health Improvement Plan (T-CHIP)
- Healthy People 2020
- Worcester County Community Health Improvement Plan (CHIP) LHIC Local Health Improvement Coalition
- 2018 Medical Staff Development Plan
- Health Fairs
- Community Education Events
- 2018 County Health Outcomes & Roadmaps
- State of Delaware Health Needs Assessment www.dhss.delaware.gov/dhss/dph/files/shaship.pdf
- Delaware Health and Social Services through the Delaware Health Tracker www.delawarehealthtracker.com
- Beebe Medical Center Community Health Needs Assessment www.beebehealthcare.org/sites/default/files/1-CHNA%20FINAL%20DRAFT_0.pdf
- US Census Bureau

Who Was Involved in the Assessment?

Representatives from AGH participate on a number of community boards and attend a variety of community meetings, councils, and events to discuss and provide education on the health related needs and priorities of our common communities as well as discuss opportunities for collaboration. Likewise, diverse community members serve internally on hospital committees providing a forum to communicate the community health needs to the organization. Of particular importance is the CHNA completed by the Worcester County Health Department. Data and objectives are closely aligned. A master list of community involvement is located in Appendix C.

AGH Community Needs Survey (Appendix F)

The survey was designed to obtain feedback from the community about health related concerns. It was administered via paper at flu clinics, local community health fairs, churches, and other venues listed below. Through the Internet an electronic form of the survey was administered through a link that was prominently placed on AGH websites and other advertised community forums.

- Ocean City Health Fair in Ocean City, MD
- Hocker's in Bethany Beach, DE
- St. Peters Church in Ocean City, MD
- Year of the Woman Health Fair in Berlin, MD
- Medical Mondays in Millville, DE
- Spirit Kitchen in Berlin, MD
- Ocean City Senior Center in Ocean City, MD
- Rite Aid in Berlin, MD
- St. Peters Church in Ocean City, MD
- Apple Berlin in Berlin, MD
- Berlin Senior Center in Berlin, MD
- Healthy Happenings Meeting in Berlin, MD
- HOPE for Worcester Behavioral Health Fair in Ocean Pines, MD
- FBP CHNA Overview & Survey in Berlin, MD
- Ocean Pines Health Fair in Ocean Pines, MD
- Brandywine Senior Living in Selbyville, DE
- Ocean City AARP Meeting in Ocean City, MD
- MSEA Convention in Ocean City, MD
- Women of Faith Fair in Selbyville, DE
- Holy Savior Health Fair in Ocean City, MD
- Faith-Based Partnership in Ocean City, MD
- St. Mary's Health Fair in Pocomoke, MD
- Snow Hill High School Health Fair in Snow Hill, MD

Maryland State Health Improvement Process (SHIP) Plan

Maryland's State Health Improvement Plan (SHIP) provides a framework for continual progress toward a healthier Maryland. The SHIP includes 38 measures in six focus areas that represent what it means for Maryland to be healthy. Each measure has a data source and a target, and where possible, can be assessed at the county level. Detailed information is provided for each objective organized by Vision Areas, (healthy beginnings, healthy living, healthy communities, access to healthcare and quality preventive care)

2019 County Health Outcomes & Roadmaps

County Health Rankings measure and compare the health of counties/cities within a State. Four types of health factors are measured and compared: health behaviors, clinical care, social and economic, and physical environment factors. Health outcomes are used to rank the overall health of each county and city.

Tri-County Health Improvement Plan (T-CHIP)

The Tri-County Health Improvement Plan (T-CHIP) uses the State Health Improvement Plan (SHIP) and individual county community health assessments and health improvement plans to identify priorities to improve the health of residents of Somerset, Wicomico and Worcester counties by increasing accessibility, continuity and availability of quality of health services; optimizing cost-effectiveness of providing health services and preventing unnecessary duplication of health resources. Those priorities identified continue with reducing diabetes complications and reducing the proportion of children and adolescents who are considered obese.

Community Health Needs Assessment

The Community Health Needs Assessment survey was distributed by community outreach personnel and the Atlantic General Hospital website. Stakeholder interviews and focus groups were conducted by community outreach personnel. Community surveys represent information that is self-reported. Results from the paper surveys (286) and electronic versions (222) are found in Appendix G.

Top Health Concerns

The top health concerns among 2018 survey respondents were prioritized as listed:

- #1 Cancer
- #2 Diabetes/Sugar
- #3 Overweight/Obesity
- #4 Smoking, drug or alcohol use
- #5 Heart Disease
- #6 Mental Health
- #7 High Blood Pressure/Stroke
- #8 Access to Healthcare / No Health Insurance
- #9 Dental Health
- #10 Asthma / Lung Disease
- #11 Injuries
- #12 Sexually transmitted disease & HIV

Top Health Concern Priorities Over The (3) CHNA

	2012	2015	2018
Cancer	1	1	1
Diabetes/Sugar	4	3	2
Overweight/Obesity	3	2	3
Smoking, drug or alcohol use	5	5	4
Heart Disease	2	4	5
Mental Health	7	7	6
High Blood Pressure/Stroke	6	6	7
Access to Healthcare / No Health Insurance	8	8	8
Dental Health	10	10	9
Asthma / Lung Disease	9	9	10
Injuries	11	11	11
Sexually transmitted disease & HIV	12	12	12

Top Barriers to Healthcare

What do you think are the problems that keep you or other community members from getting healthcare they neeed?	
Too expensive/can't afford it	29.31%
No health insurance	23.53%
Couldn't get an appointment with my doctor	14.06%
No transportation	12.26%
Service is not available in our community	8.28%
Local doctors are not on my insurance plan	7.08%
Doctor is too far away from my home	5.48%

Top economic concerns creating barriers	
Access to affordable health care	23.16%
Living wages	21.05%
Access to affordable medicine	19.30%
Job opportunities	13.68%
Access to health insurance	10.70%
Access to affordable transportation	8.07%
Poverty	4.04%
Other:	
"access to quality healthcare"	
"physician accessibility"	

Top social concerns creating barriers	
Living wages	23.43%
Job opportunities	14.85%
Society attitudes	11.18%
Available transportation options	9.04%
Access to health foods such as fresh fruits and vegetables	8.12%
Educational opportunities	6.89%
Lack of social support, and social interactions	6.74%
Exposure to crime or violence	4.44%
Socioeconomic conditions, such as concentrated poverty	4.44%
Access to quality schools	3.22%
Poor or lack of public safety	3.06%
Social disorder, such as the presence of trash	2.30%
Lack of exposure to mass media and emerging technologies, such as the Internet or cell phones	2.30%
Other:	
"access to quality healthcare" "bad food is cheaper than good food"	
"lack of information of many basics by local doctors- need to drive to Baltimore to get referred"	
"locating quality doctors" "affordable housing" "Expensive Health Insurance"	
"things to do around community" "Not enough local agencies for health care"	

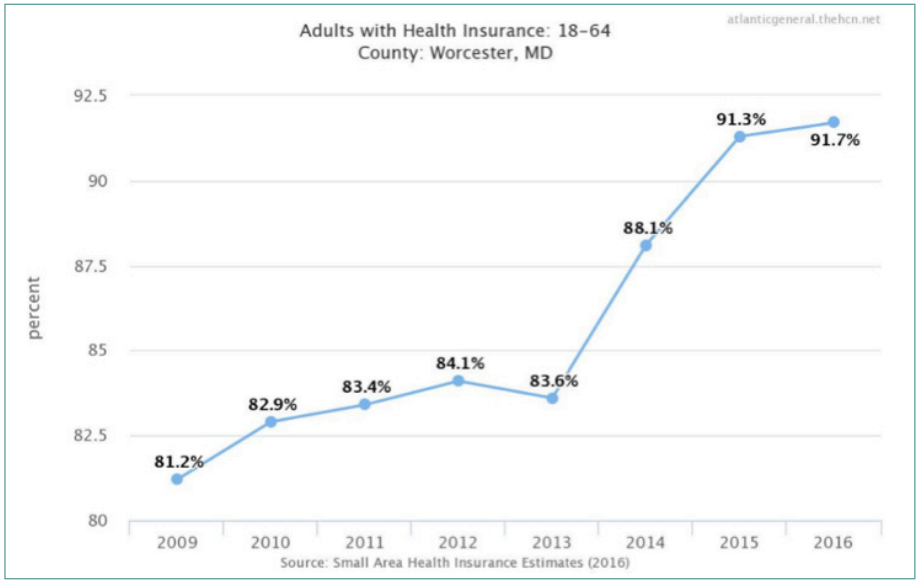
Top environmental concerns creating barriers	
Physical barriers, especially for people with disabilities	19.94%
Natural environment, such as plants, weather, or climate change	19.67%
Exposure to toxic substances and other physical hazards	19.67%
Housing, homes, and neighborhoods	16.62%
Built environment, such as buildings or transportation	10.25%
Aesthetic elements, such as good lighting, trees, or benches	7.20%
Worksites, schools, and recreational settings	6.65%
Other:	
"access to quality healthcare"	
"most people don't take responsibility for their health, rely on medical experts to fix them when ill, rather than partner with doctor to create healthy lifestyle"	
"second hand smoke"	
"too much light "end of night""	
"crime and violence in city an communities"	

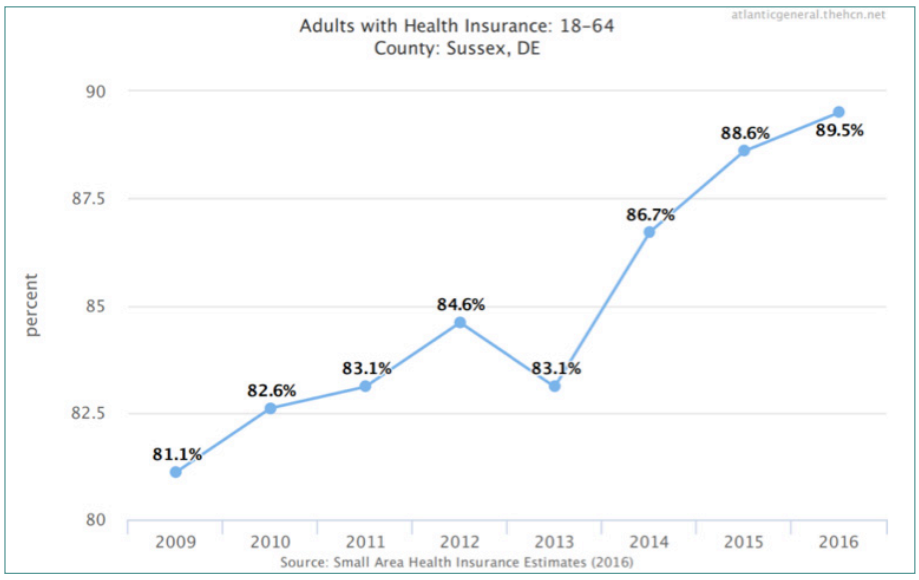
Impact of Previous Actions Taken

2016 - 2018 Community Needs

The community needs prioritized in previous CHNA include: Access to Care, Heart Disease and Stroke, Cancer, Respiratory Disease, including smoking, nutrition, physical activity and weight, diabetes, opioid abuse, arthritis, osteoporosis and chronic back pain, and mental health. The identified needs were prioritized based on the following criteria: size and severity of the problem, health systems ability to impact, and availability of resources that exist. The goal and actions taken are found in the associated Implementation Plans (Appendix F). The community's needs are key focus areas in the Atlantic General Hospital Strategic Plan – Vision 2020.

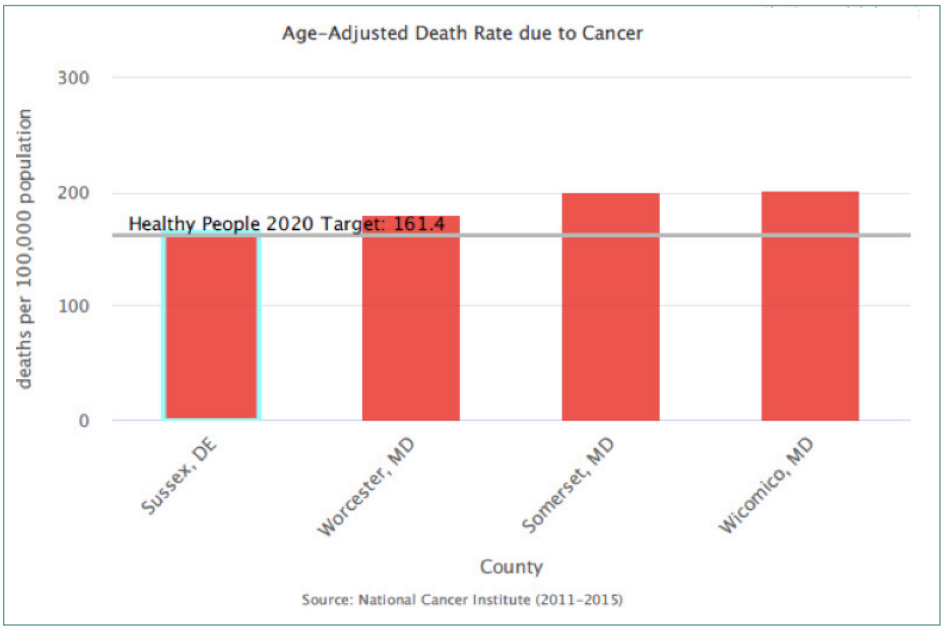
Community Health Progress

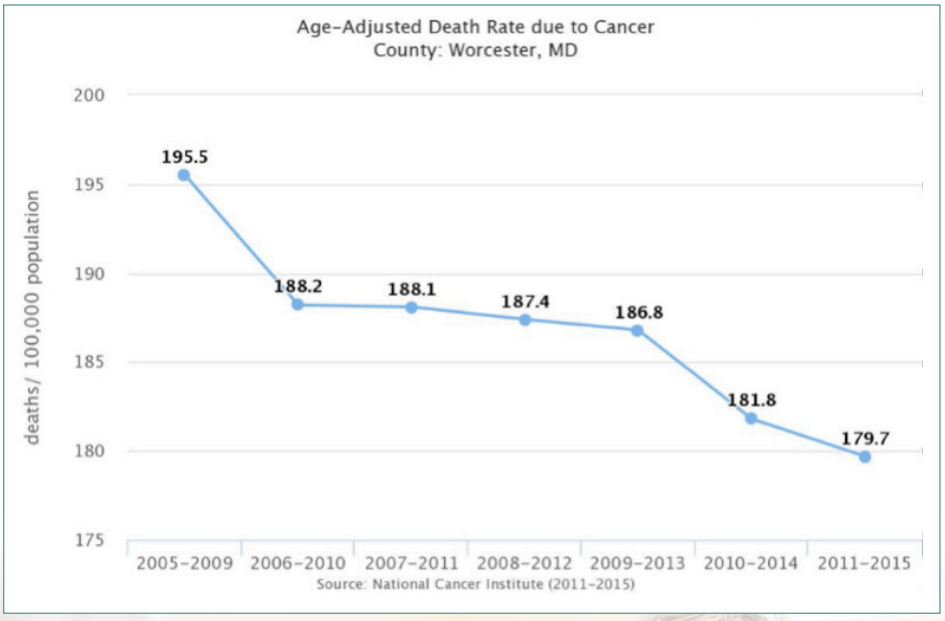




The *Healthy People 2020* national health target is to increase the proportion of people with health insurance to 100%.

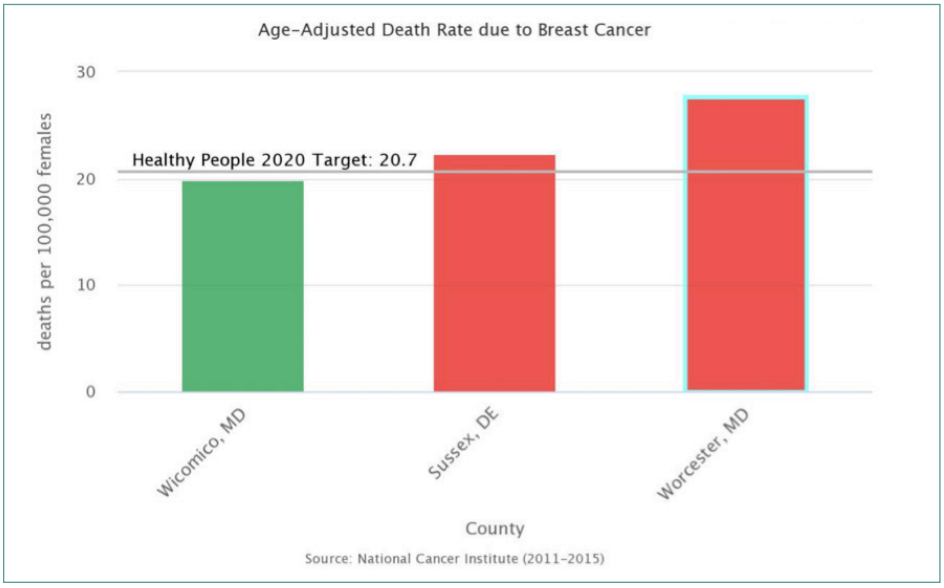
Priority Area: Cancer

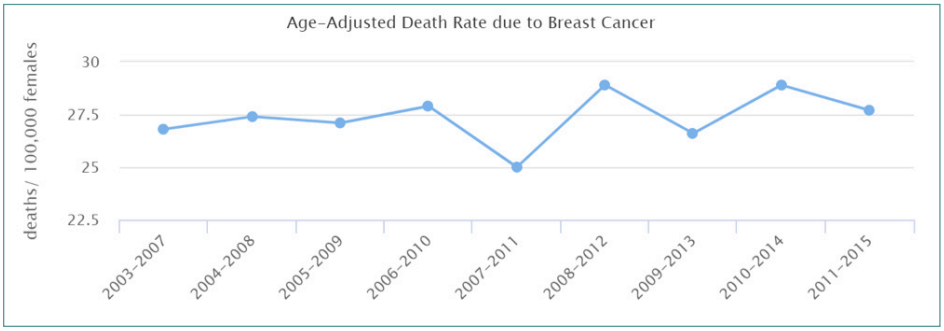




The *Healthy People 2020* target is to reduce the overall cancer death rate to 161.4 deaths per 100,000 population.

Breast Cancer

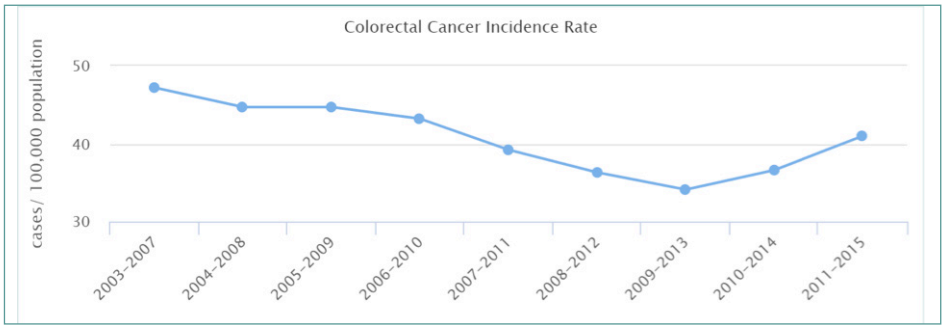




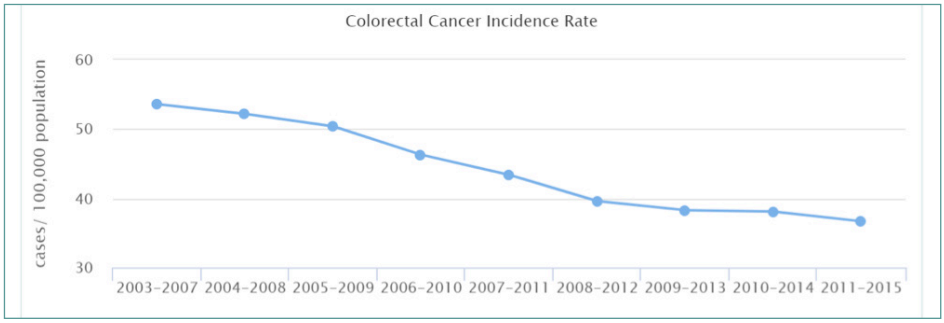
The *Healthy People 2020* national health target is to reduce the breast cancer death rate to 20.7 deaths per 100,000 females.

Colorectal Cancer

Worcester



Sussex

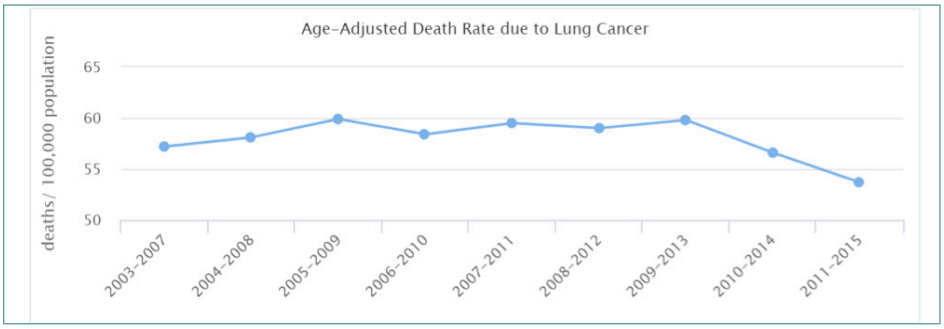


Over time, Sussex County is significantly decreasing (36.6).

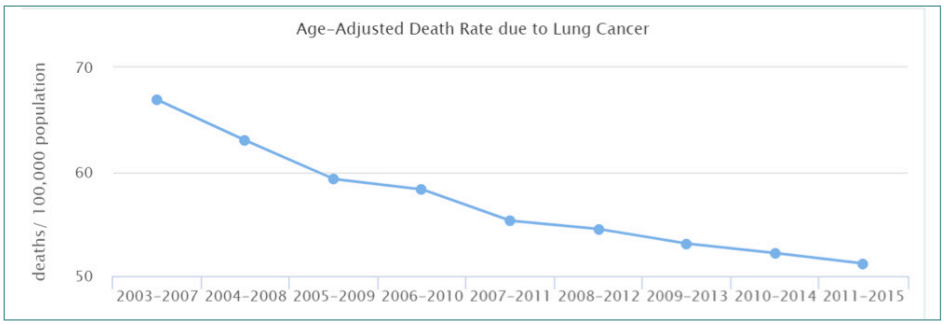
The *Healthy People 2020* national health target is to reduce the colorectal cancer incidence rate to 39.9 cases per 100,000 population.

Lung Cancer

Worcester



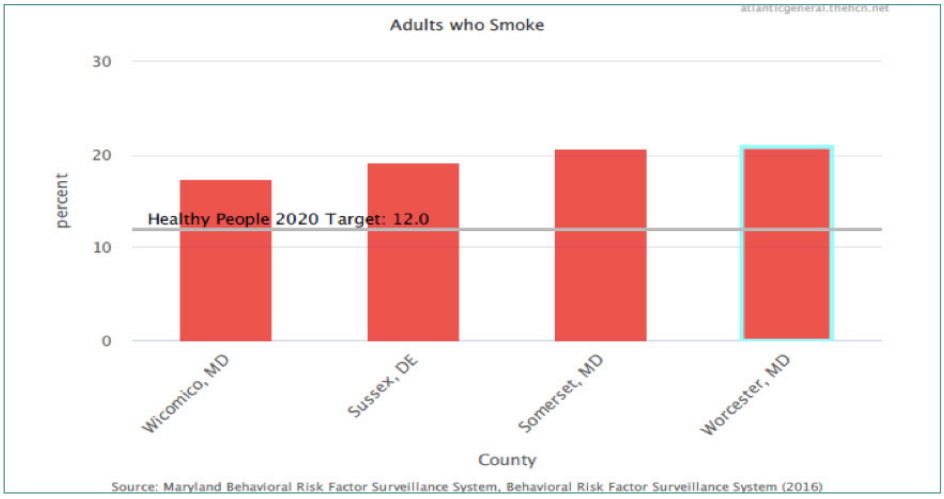
Sussex

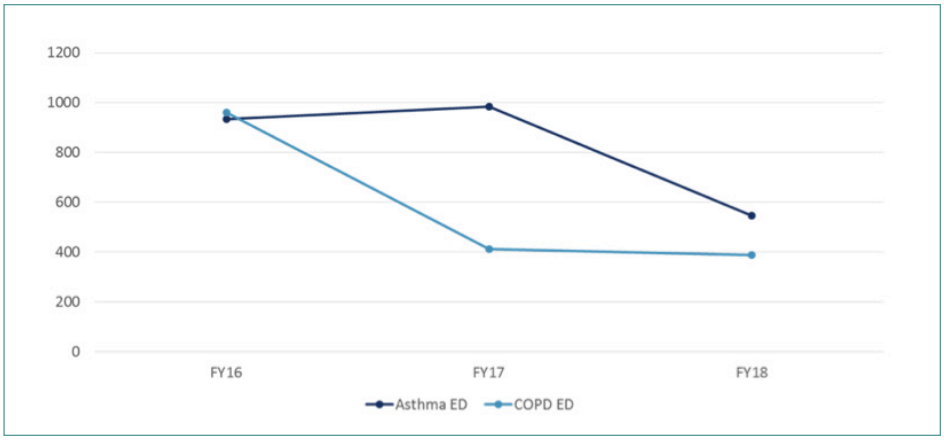


Worcester County is trending down (53.7) as is Sussex County (51.2).

The *Healthy People 2020* national health target is to reduce the lung cancer death rate to 45.5 deaths per 100,000 population.

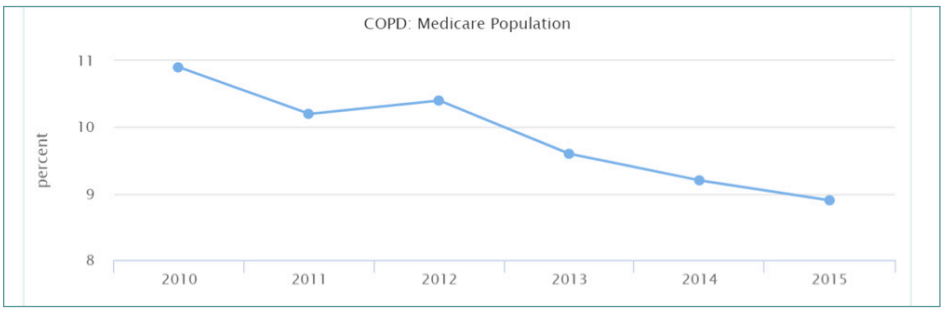
Priority Area: Respiratory Disease, including Smoking

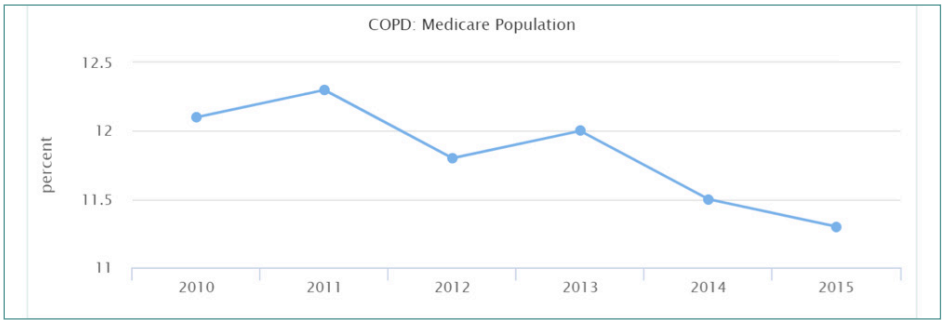




The *Healthy People 2020* national health target is to decrease adults who smoke below 12.0%.

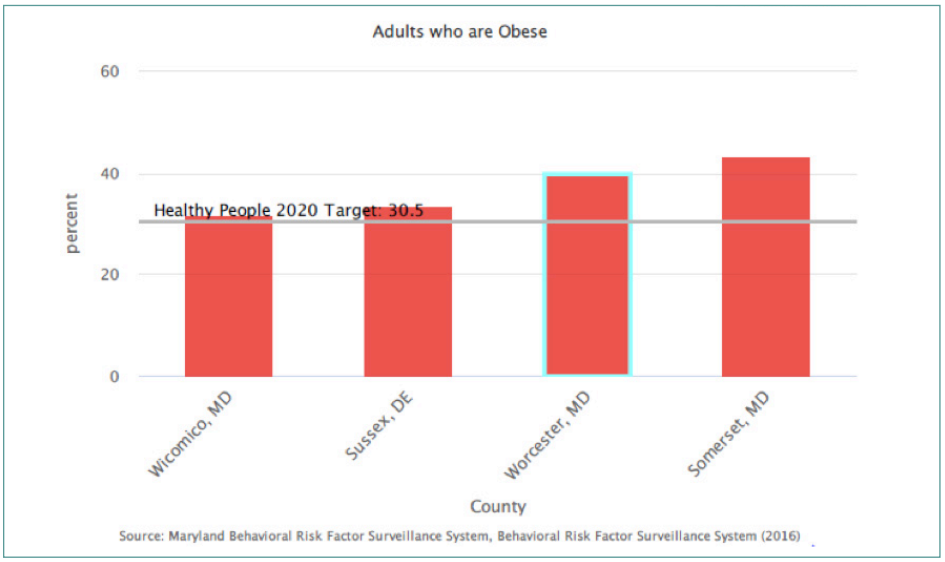
AGH Internal Data shows ED Visits are decreasing for COPD and Asthma.

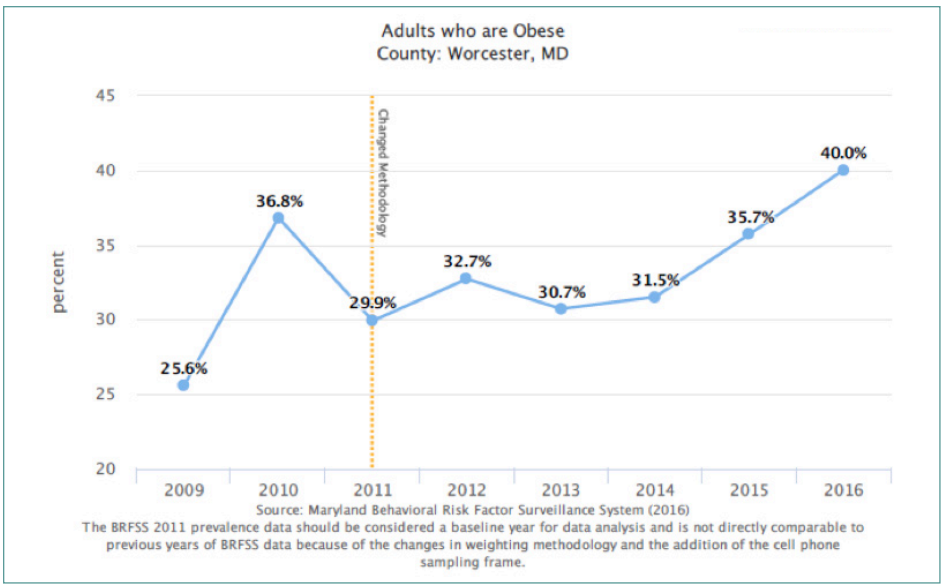




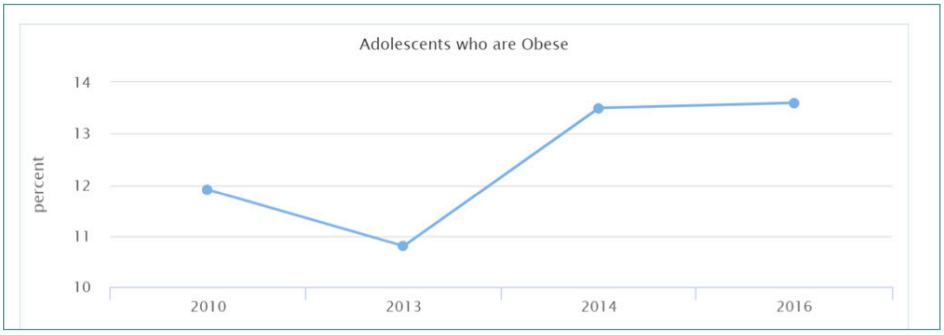
The Worcester County Medicare percentage is decreasing significantly (8.9%), as is Sussex County (11.3%).

Priority Area: Nutrition, Physical Activity & Weight





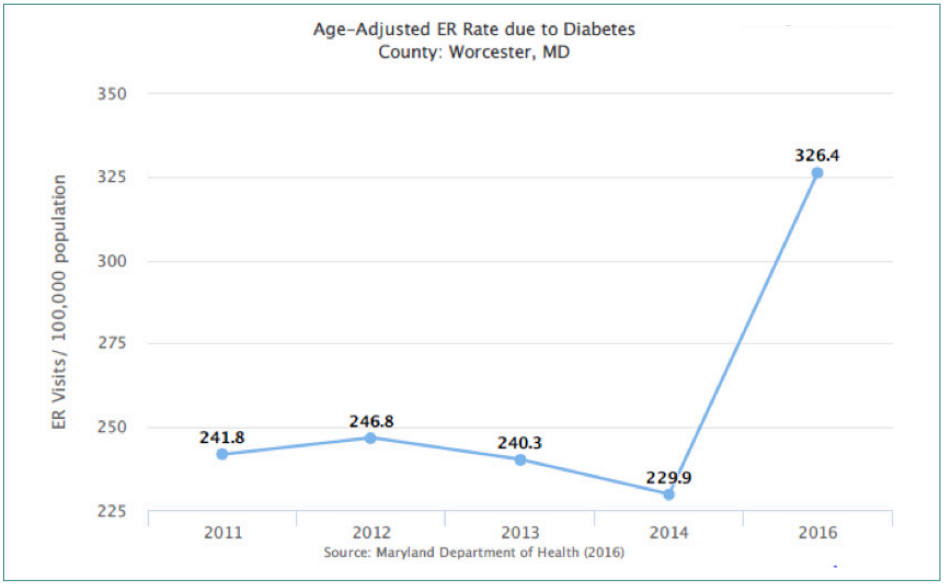
The *Healthy People 2020* national health target is to reduce the proportion of adults aged 20 and older who are obese to 30.5%.

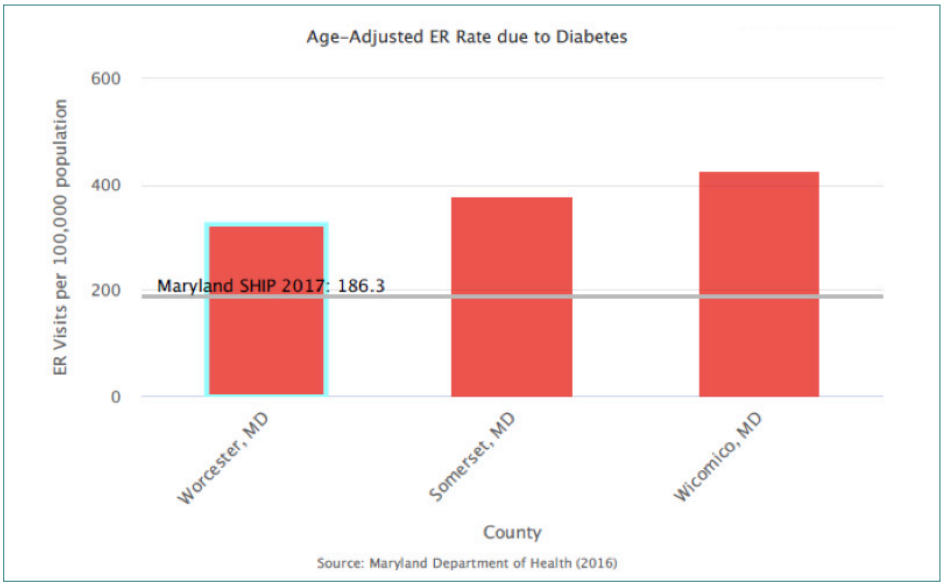


Worcester County has exceeded the *Healthy People 2020* target at 13.6%.

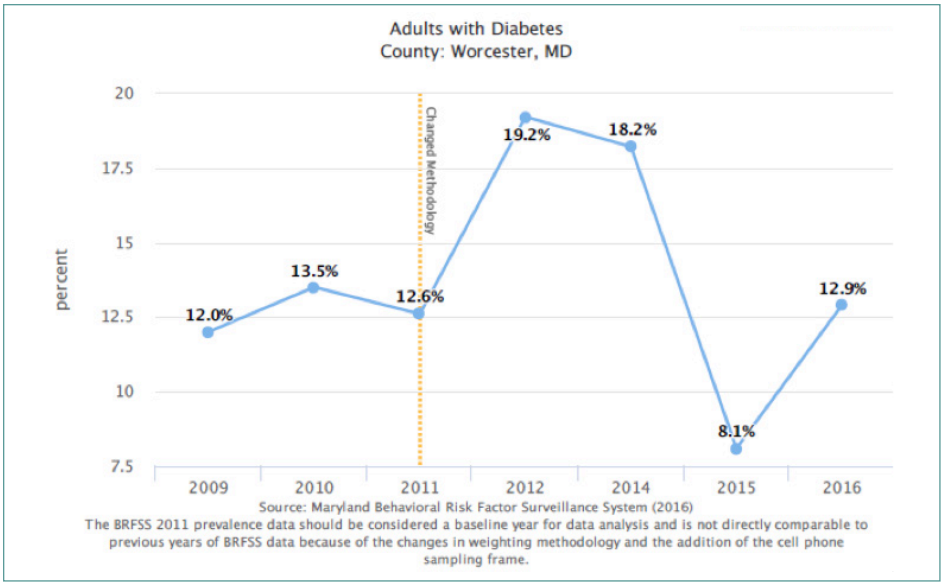
The *Healthy People 2020* national health target is to reduce the proportion of adolescents ages 12 to 19 who are obese to 16.1%.

Priority Area: Diabetes



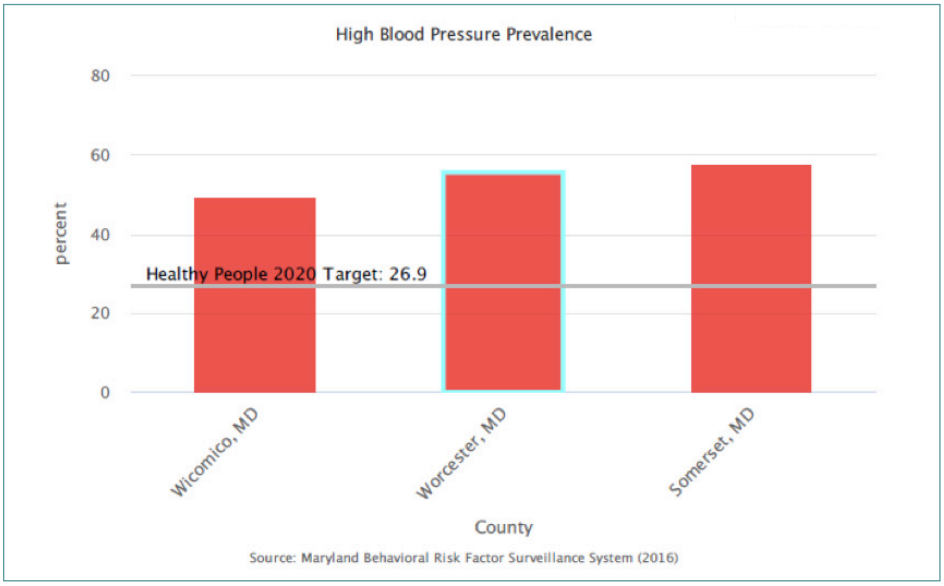


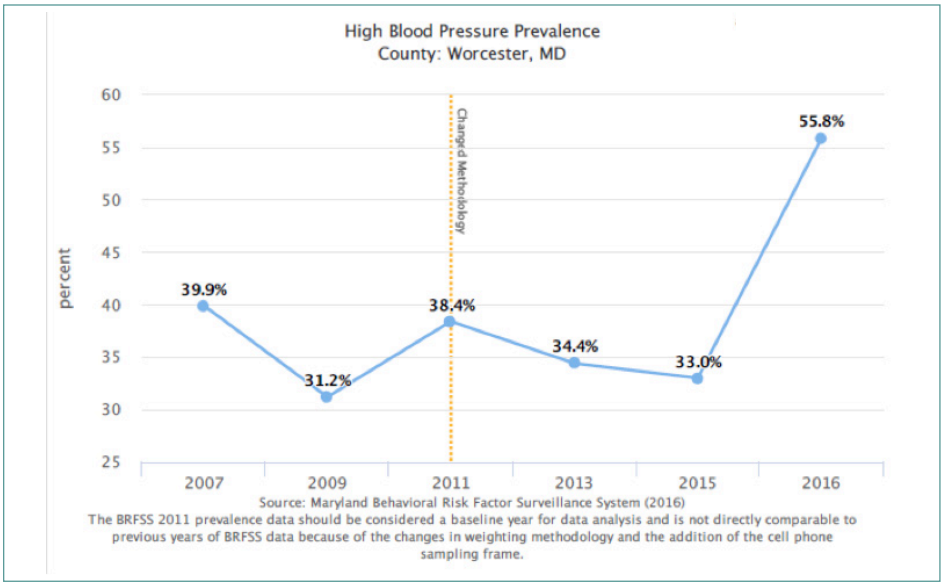
The Maryland SHIP 2017 Target is to reduce the rate of emergency room visits due to diabetes to 186.3 emergency room visits per 100,000 population.



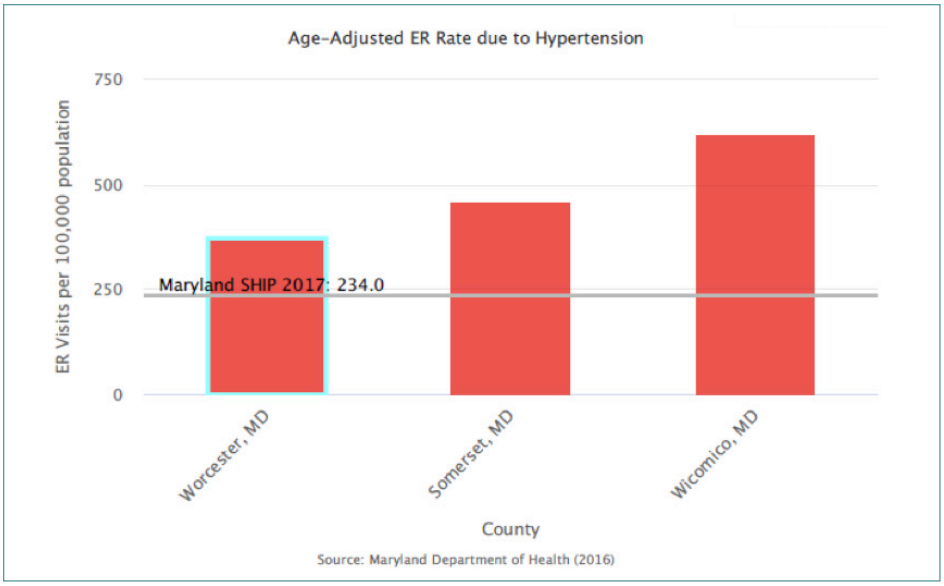
Priority Area: Heart Disease & Stroke

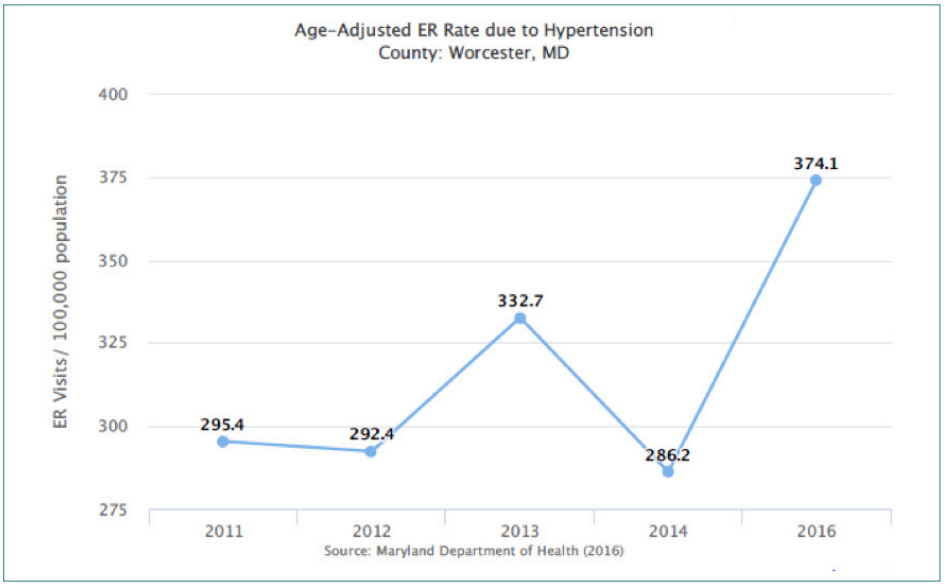
Healthy People 2020

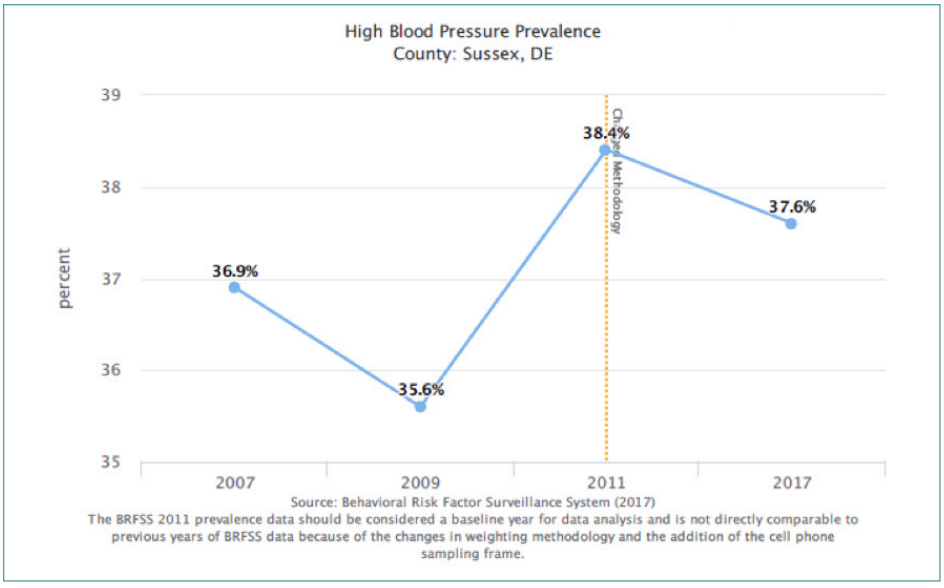




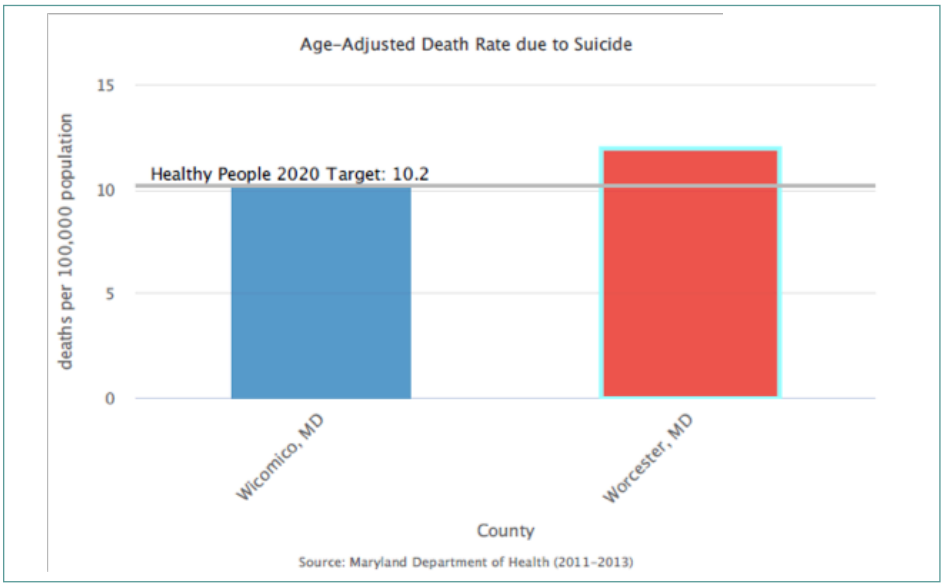
The *Healthy People 2020* national health target is to reduce the prevalence of high blood pressure to 26.9%



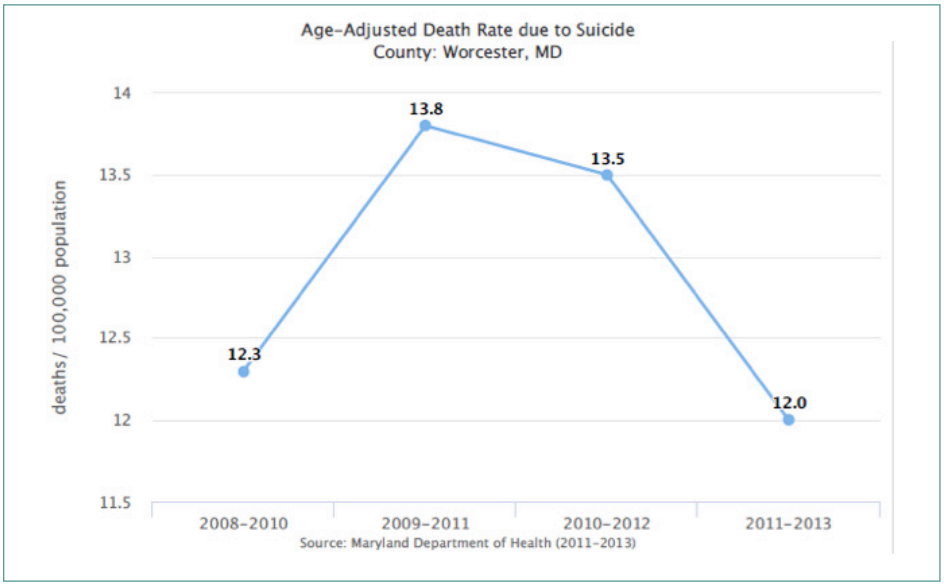




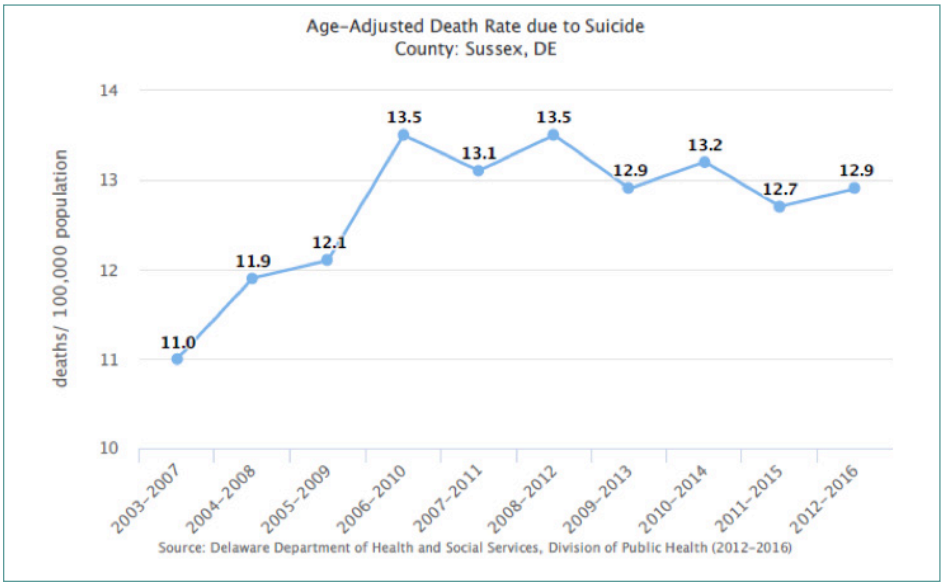
The *Healthy People 2020* national health target is to reduce age-adjusted ER rate due to hypertension to 23.4%.

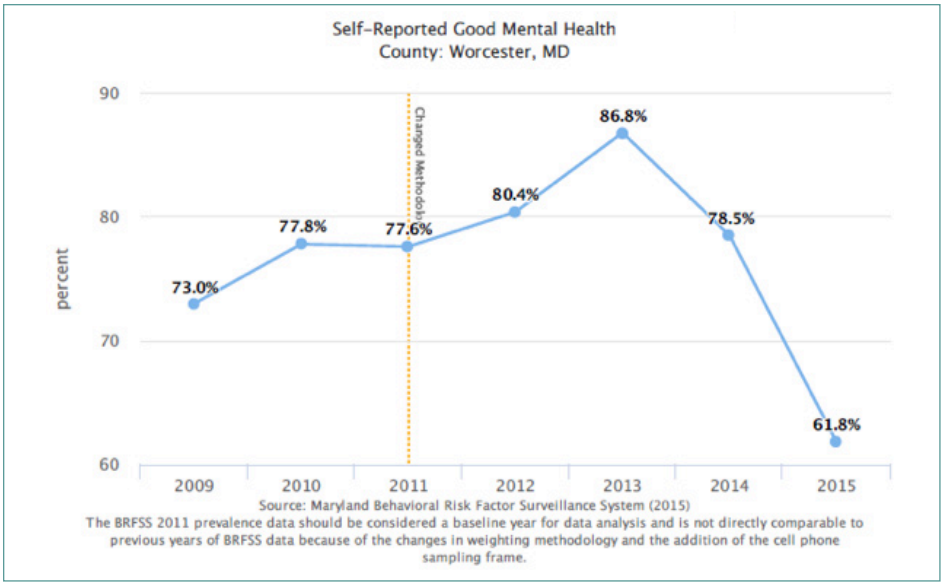


Healthy People 2020

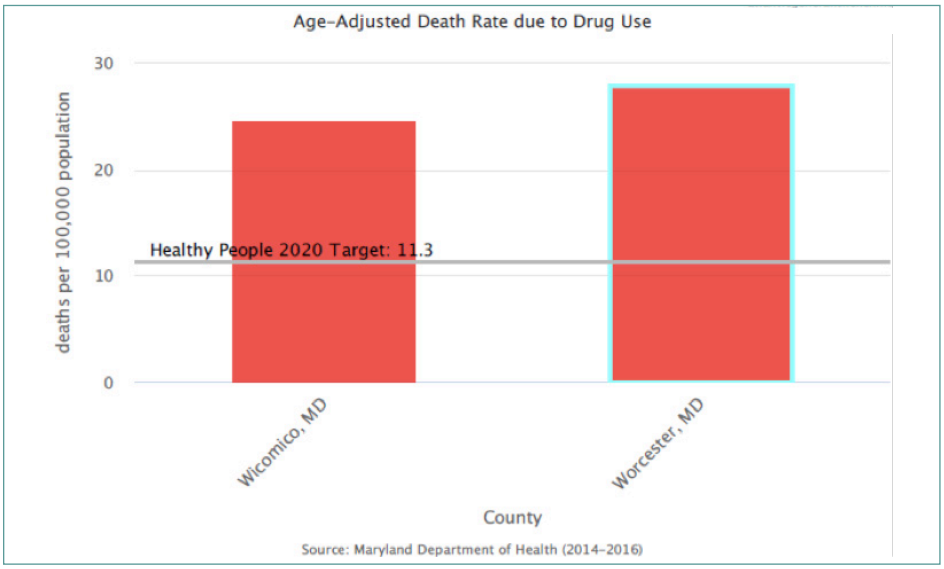


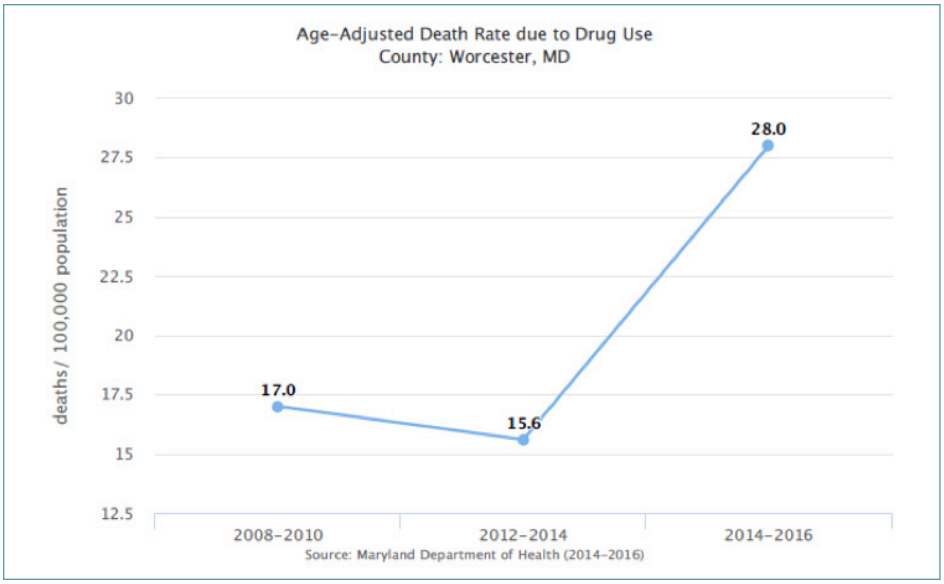
The *Healthy People 2020* national health target is to reduce the age-adjusted death rate due to suicide to 10.2 deaths per 100,000 population.





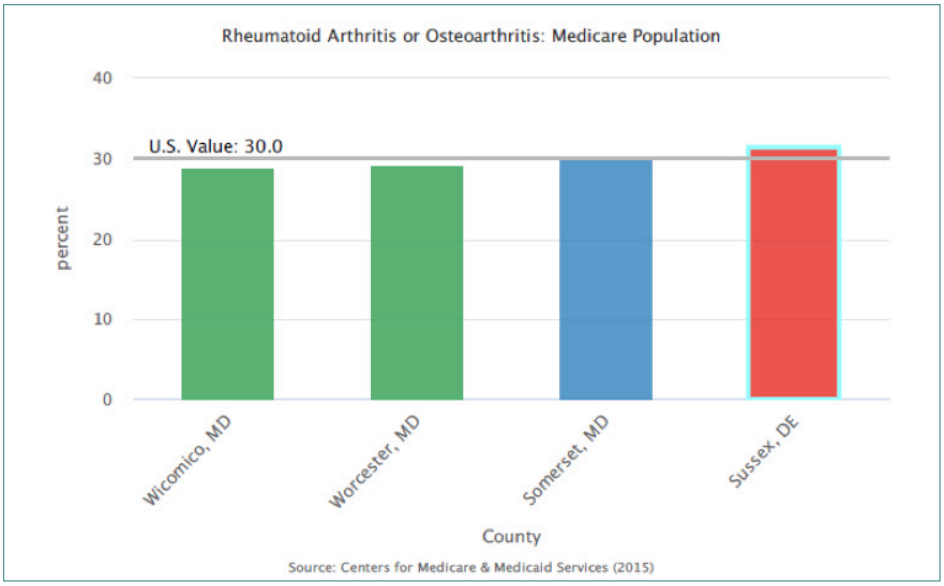
Priority Area: Opioid Abuse

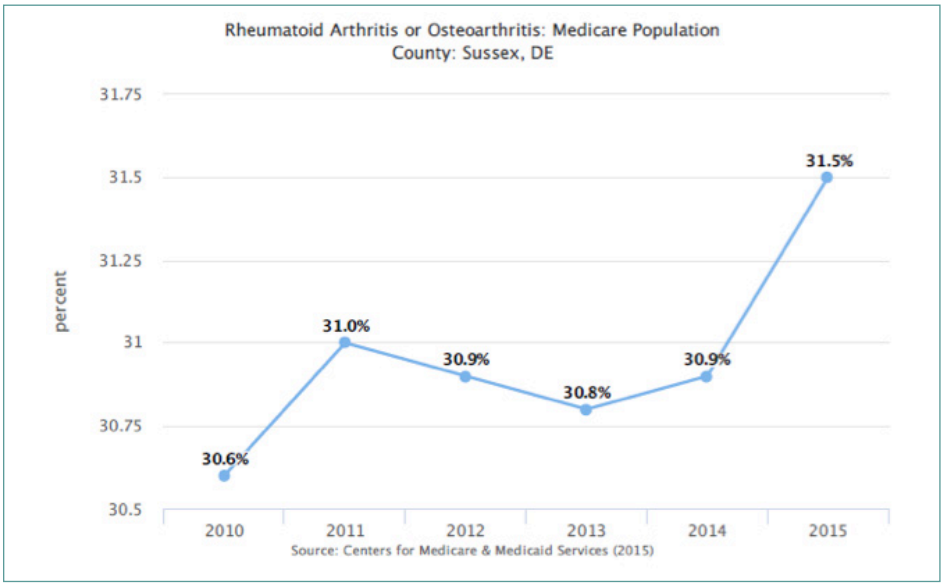


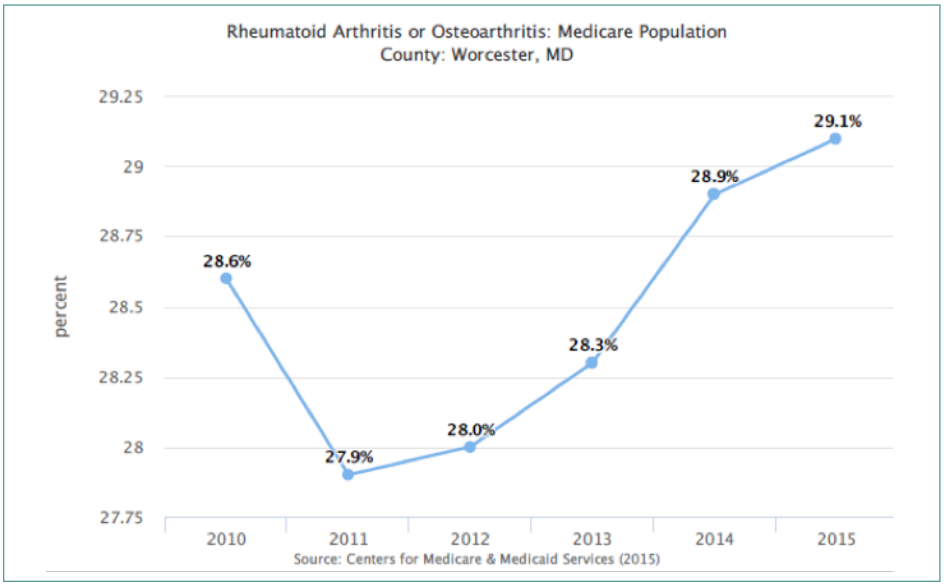


Healthy People 2020

The *Healthy People 2020* national health target is to reduce the age-adjusted death rate due to drug use to 11.3 deaths per 100,000 population.







Healthy People 2020

The *Healthy People 2020* national health target has been met in Worcester, not Sussex County. Both counties are showing steep inclines due to the changing demographics in the area.

Community Benefit Priorities

Key findings from all resources were used as a framework to develop community benefit priorities. These are closely aligned with local, state, and national priority areas. The process for determining the priorities of the Community Outreach programs involves many people inside and outside the organization. The hospital's strategic initiatives are determined by the Hospital Board of Trustees, the Medical Staff and the Leadership of the hospital. Each year those long term initiatives are evaluated and updated with environmental information, such as the most recent Community Health Needs Assessment. In addition to input from those groups there are two committees that have a part in setting our priorities; they are the Community Benefits Committee and the Healthy Happenings Advisory Board.

The Healthy Happenings Committee is made up of hospital and community members who have a health connection in the community. Through this board we are able to keep our pulse on the needs of the community.

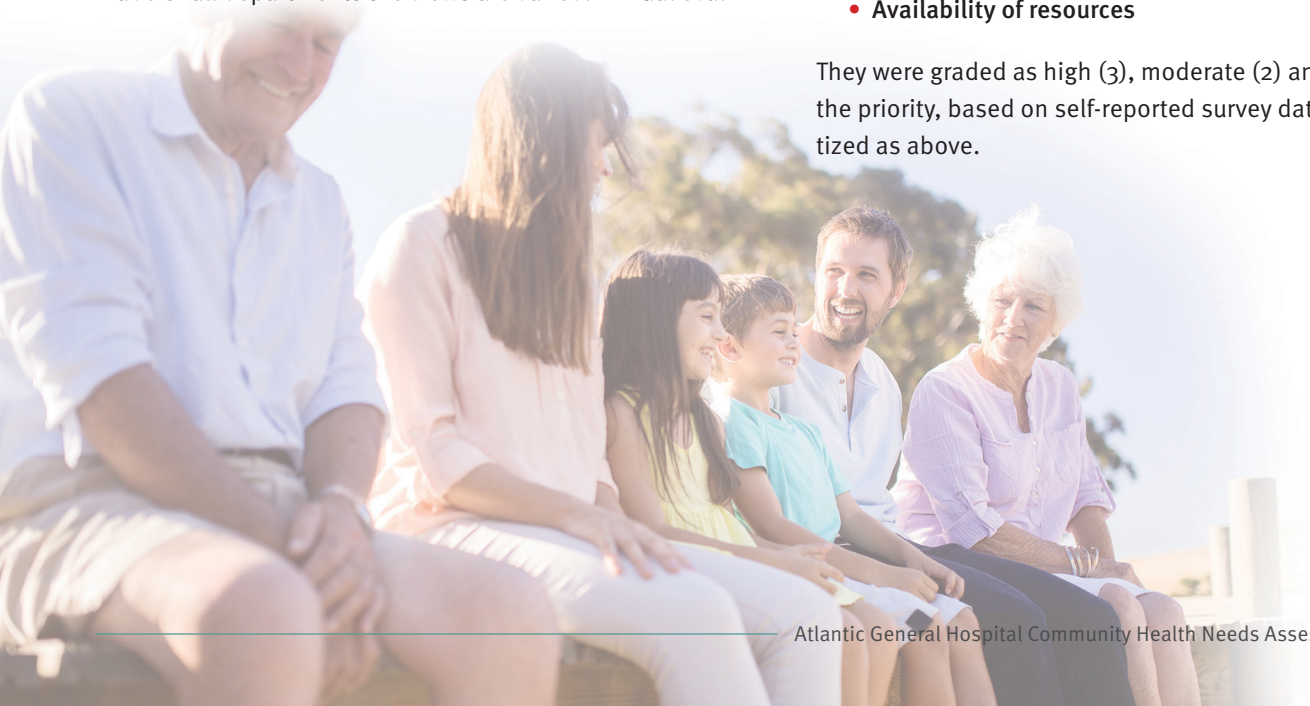
Each department in the hospital has an appointee who sits on the Community Benefits Committee. The purpose of this committee is to oversee the Community Outreach of the hospital and comply with the government regulations regarding reporting Community Benefits. Because the committee is made of all departments the views are varied. Annual evaluations of each initiative's success are found in the HSCRC Community Benefit Report sent to the State of Maryland.

Our hospital leaders are involved on many community boards and community entities (both for profit and not-for-profit). Through these boards we are able to keep abreast of the underserved, low income and/or minority needs in the community. We are involved in the health departments throughout our service area in Maryalnd and Delaware and coordinate services with them to decrease duplication of services and know what services are needed to fill the gaps. Obviously working with the target areas of the state improvement initiatives influences the priorities we set. Our Population Health outreach providers are out in the community and are able to observe community needs. Through our Patient Centered Medical Home, Care Coordination models and Population Health Department, we are able to have another resource in the community that we can use for assisting us in setting priorities.

The 2019-2021 Community Benefit priorities are based on the criteria of

- **Size and severity of the problem determined by what percentage of the population is effected by risks**
- **Health system's ability to impact the need**
- **Availability of resources**

They were graded as high (3), moderate (2) and low (1) to rank the priority, based on self-reported survey data and prioritized as above.



Areas of Opportunity

		Ø size and severity of the problem determined by what percentage of the population is effected by risks	Ø health system's ability to impact the need	Ø availability of resources	Total
Access to Health Services	Difficulty getting a physician appointment Physician recruitment Cost of care	high	high	high	9
Cancer	Prevalence of Cancer	high	high	high	9
Diabetes	Prevalence of Diabetes Borderline/Pre-Diabetes	high	mod	high	8
Respiratory Disease	COPD Asthma diagnosis	mod	mod	high	7
Nutrition, Physical Activity & Weight	Prevalence of overweight & obesity Meeting physical activity guidelines lack of leisure time physical activity	high	mod	mod	7
Heart Disease & Stroke	Heart Disease Prevalence High Blood Pressure High blood cholesterol Overall Cardiovascular Risk	high	mod	mod	7
Behavioral Health	Mental Health, Suicide prevention Substance Abuse	high	mod	low	6
Arthritis, Osteoporosis & Chronic back conditions	Prevalence of Sciatica/Chronic Back Pain	mod	low	high	6
Dental Health	Adolescents & Adults	mod	low	low	4
Injury & Violence Prevention	Use of Seatbelts	low	low	low	3

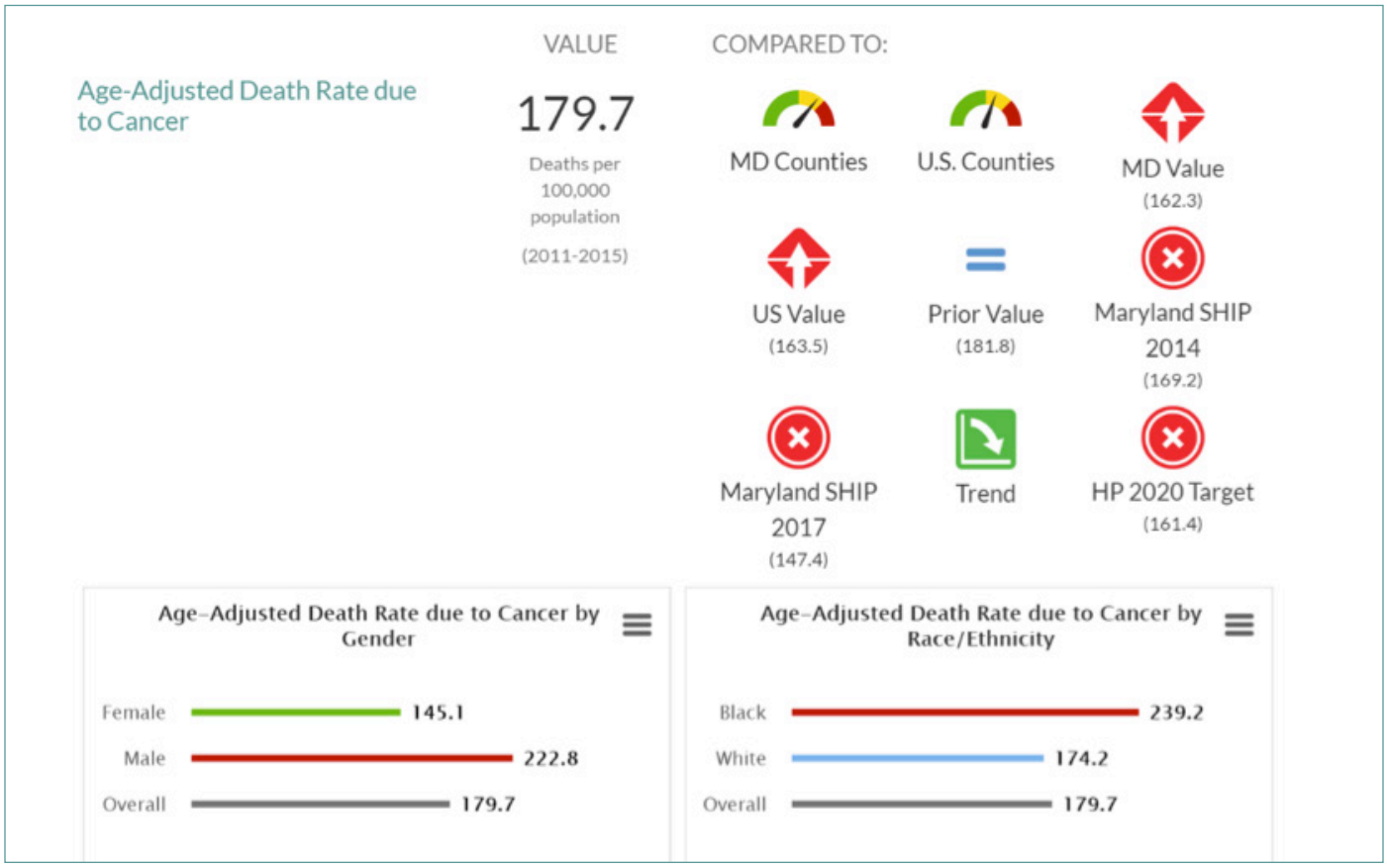
*Dental Health, Injury & Violence Prevention will not be areas of priority to address, Planning Committee 4/24/19

Vulnerable Populations and Disparities

According to the U.S. Health Resources and Services Administration, health disparities are defined as "population-specific differences in the presence of disease, health outcomes, or access to healthcare." Worcester County, MD residents 6-17 years of age are the largest age group with Healthcare Coverage in Maryland. The age groups most likely to have health care coverage are 6-17 and 55-64, for men and women respectively. Nationally, 6-17 (for men) and 6-17 (for women) are the age groups most likely to have coverage. A closer look at health disparities in the area through the new Healthy Communities tool, which synthesizes data from several primary sources, provides a clear visual representation of many of the strengths and weakness evident in Worcester and Sussex Counties.

Cancer rates in the Black population exceed other ethnicities. The cancer rate is higher in males than females. In particular, lung and prostate cancer hold the same trends with black males.

Cancer



Age-Adjusted Death Rate due to Lung Cancer

53.7

Deaths per 100,000 population

(2011-2015)

MD Counties

U.S. Counties

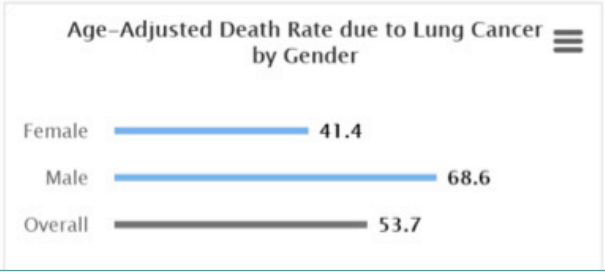
MD Value (41.5)

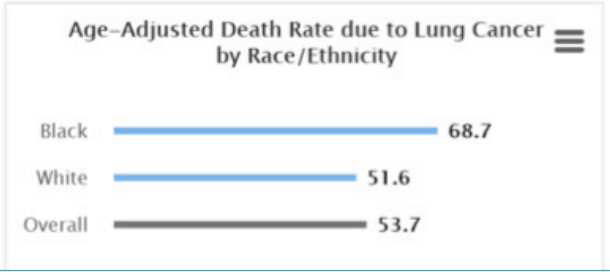
US Value (43.4)

Prior Value (56.6)

Trend

HP 2020 Target (45.5)





Age-Adjusted Death Rate due to Prostate Cancer

23.0

Deaths per 100,000 males

(2011-2015)

MD Counties

U.S. Counties

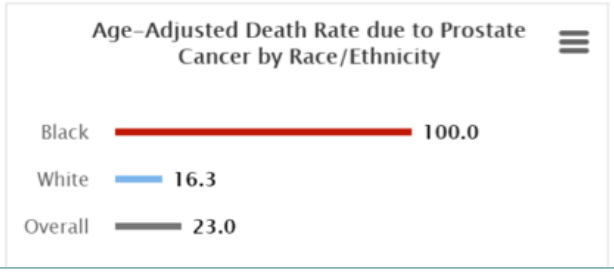
MD Value (20.1)

US Value (19.5)

Prior Value (22.7)

Trend

HP 2020 Target (21.8)



Prostate Cancer Incidence Rate

116.2

Cases per 100,000 males

(2011-2015)

MD Counties

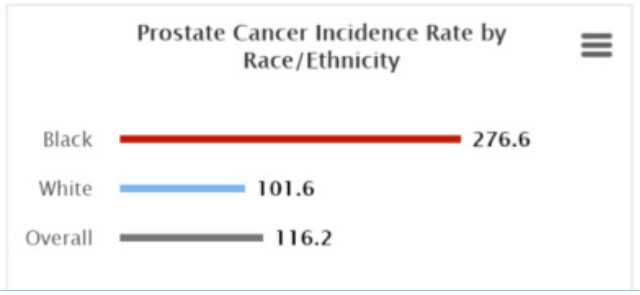
U.S. Counties

MD Value (125.7)

US Value (109.0)

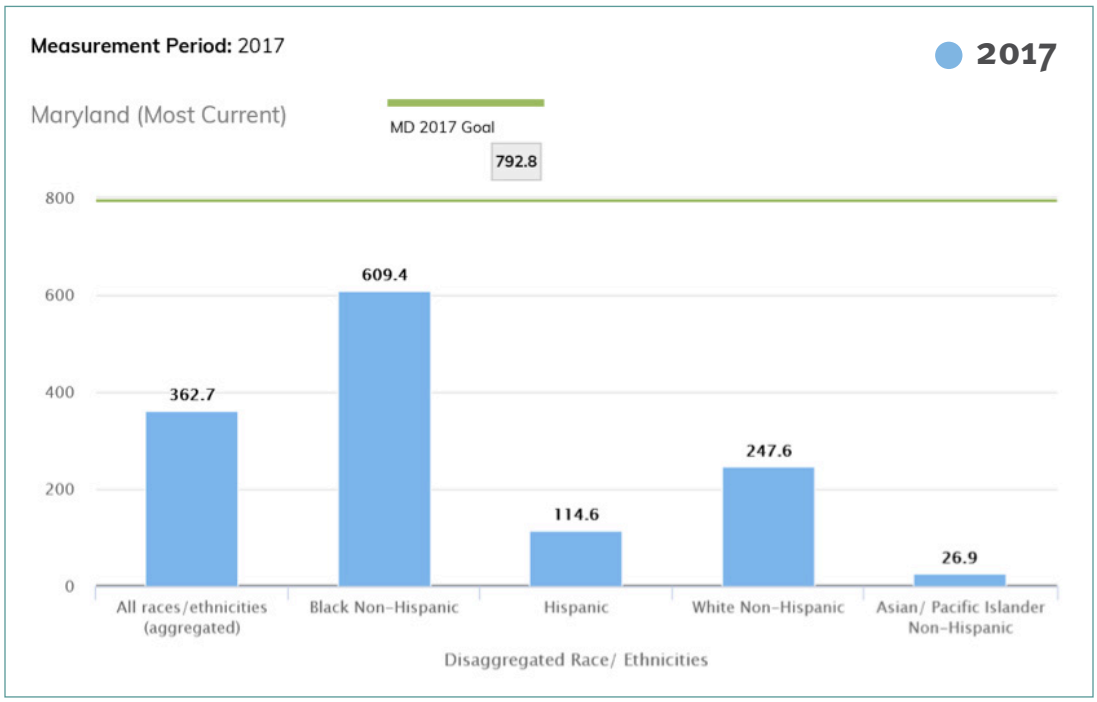
Prior Value (137.8)

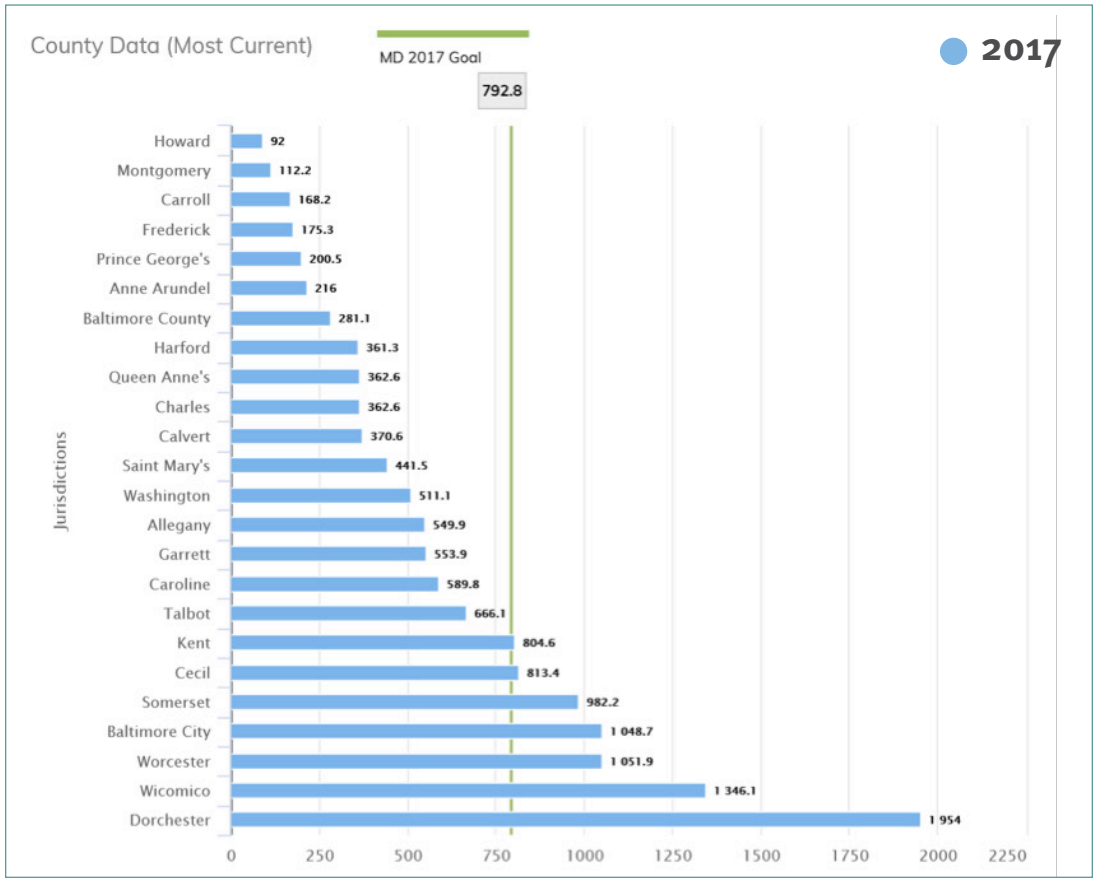
Trend



Dental

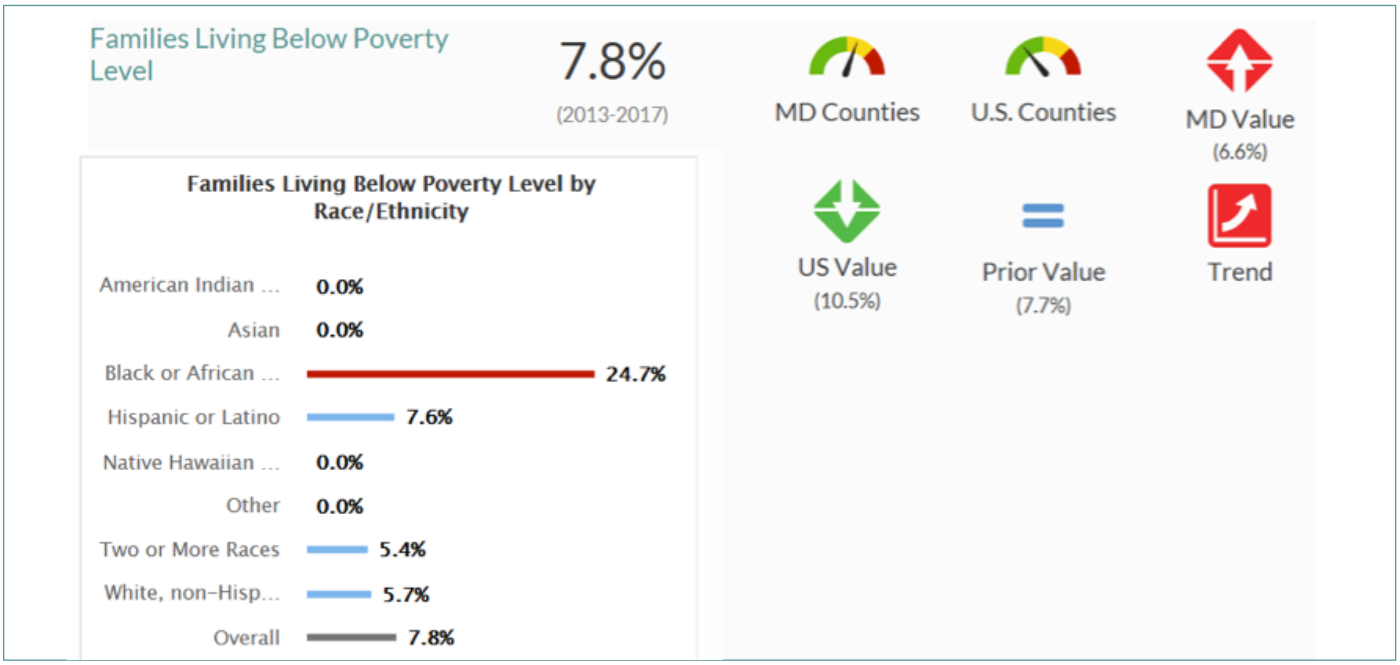
Emergency department visit rate for dental care shows the emergency department visit rate related to dental problems (per 100,000 population). The utilization of dental services in Emergency departments has steadily risen over the last decade. Dental emergency department visits are growing as a percentage of all emergency department visits throughout the United States. Data reported through the Maryland Health Services Cost Review Commission (HSCRC), Research Level Statewide Outpatient Data Files reflects:





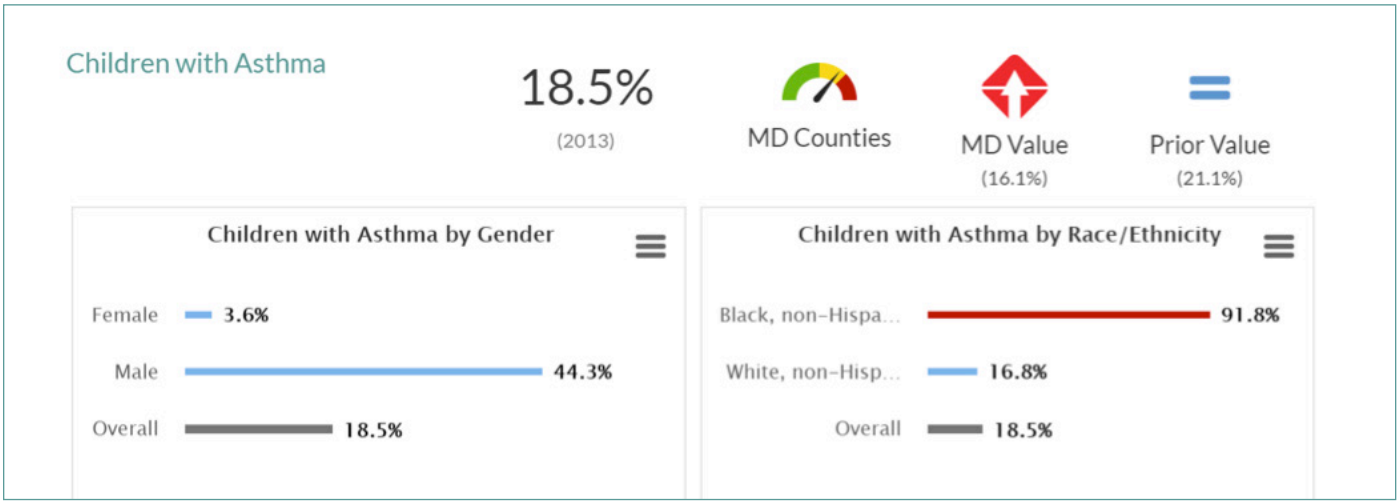
Poverty Rate

Families living below the poverty level are more likely to be in the Black population than any other group by four-fold percentage.



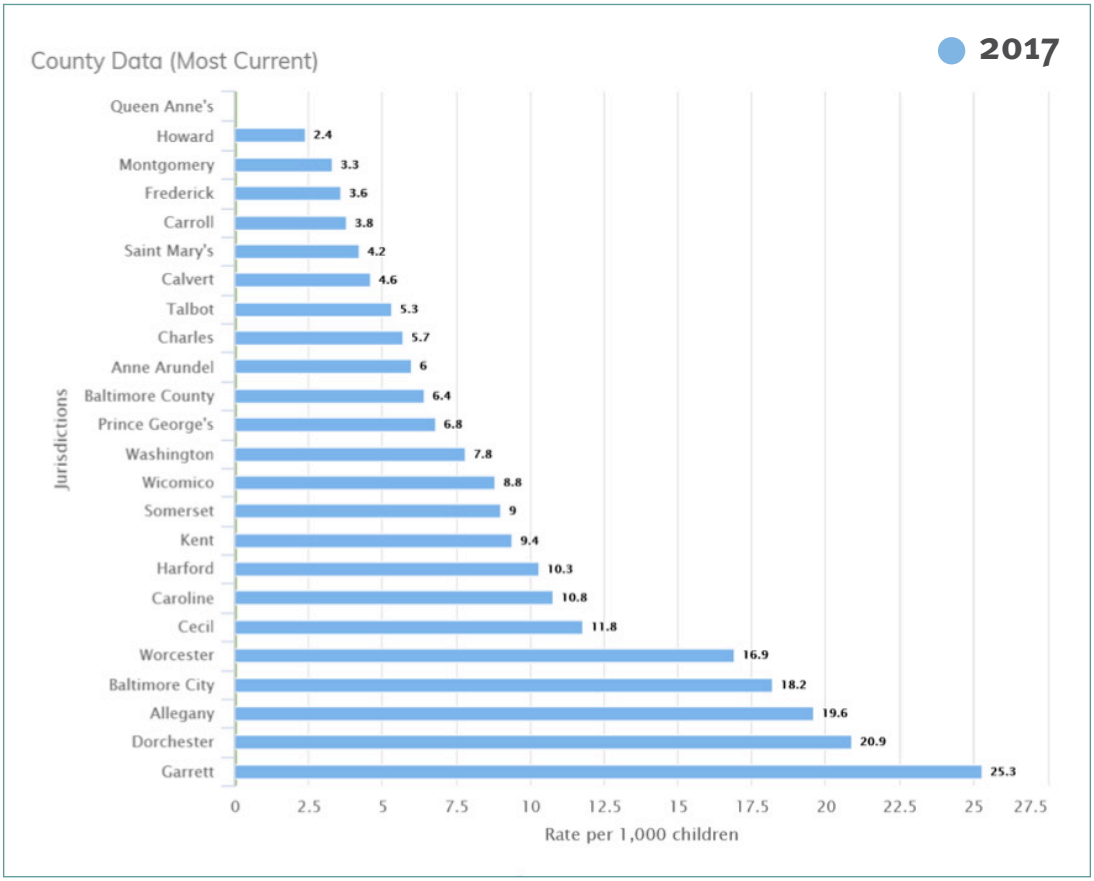
Asthma

Asthma, in Worcester County is predominately reported in Black, non-Hispanic males.



Maltreatment of Children

Worcester County ranks as the 5th highest in Maryland for the rate of children who are maltreated per 1,000 population under the age of 18. Child abuse or neglect can result in physical harm, developmental delays, behavioral problems, or death. Abused and neglected children are at greater risk than other children for delinquency and mistreatment of their own children. As reported by Maryland Department of Human Resources (DHR) through 2017.



Priority Needs Not Addressed

Dental Health

At this time AGH/AGHS has no resources to meet this need other than referral services. The Worcester County Health Department does have a dental health program in Berlin, Maryland. In our neighboring counties (Somerset and Wicomico) there is a federally funded and run dental health program run through Chesapeake Health Services TLC clinic (Three Lower Counties). In lower Delaware, the services are provided by La Red, a comprehensive health service center. AGH currently plays a role in the Mission of Mercy that comes into the region every two years to provide free dental care.

Communicable Disease

Though not designated as a priority, AGH does provide immunization services to the communities we serve. We provide free flu immunizations to all our associates and their families, as well as all of the volunteers at the hospital. We also provide free community flu clinics at local businesses, and health fair events by AGH. Our neighboring hospital PRMC does a large drive-through flu event which services Wicomico and Somerset counties. In addition, the Health Departments partnered with AGH, provide other services for communicable diseases to assist with any outbreaks if needed, partnered with UMES Pharmacy School, WCHD and AGH Vote and Vax initiative.

While transportation, public or private, remains a barrier in the rural community, there are other community organizations better aligned to address this priority. It did not rank as high in this CHNA, although still discussed in focus groups. AGH has been addressing some transportation needs through a voucher system.

Data Gaps Identified

While this Community Health Needs Assessment is comprehensive, AGH recognizes that it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups (such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish) are not represented in the survey data. Other population groups (for example, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups) might not be identifiable or might not be represented in numbers sufficient for independent analyses. Available data was extensive, especially in Maryland, however data gaps may exist. Due to the large geographic area Sussex County, Delaware encompasses, specific zip code level data was not available for several indicators and may not be fully represented.

In conclusion, the list of identified issues is far too long to provide an exhaustive review in a single document. In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Public Dissemination

This Community Health Needs Assessment is available to the public on its website www.agh.care/community.

- Informs readers that the CHNA Report is available and provides instructions for downloading it;
- Offers the CHNA Report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.

AGH will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. AGH will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.

References

County Health Outcomes & Roadmaps, 2019, http://www.countyhealthrankings.org

Charts of Selected Black vs. White Chronic Disease SHIP Metrics: Tri-county Health Planning Initiative http://dhmh.maryland.gov/mhhd/Documents/Tri%20County%20SHIP%20Disparities%20Data%20Charts%20033012.pdf

Delaware Behavioral Risk Factor Surveillance System http://www.dhss.delaware.gov/dhss/dph/dpc/files/de10countydata.pdf

Healthy Communities Network www.healthycommunitiesinstitute.com

Healthy People 2020 www.cdc.gov/nchs/healthy_people/hp2010.htm

Maryland State Health Improvement Process (SHIP) www.dhmh.maryland.gov/ship

State of Delaware Community Health Status Assessment, 2012, Delaware Health and Social Services, Division of Public Health http://dhss.delaware.gov/dhss/dph/files/shachsa.pdf

Tri-County Health Improvement Plan (T-CHIP) http://www.worcesterhealth.org/community-health-improvement-planning-chip/tri-county-health-improvement-planning-t-chip

Worcester County Community Health Assessment http://worcesterhealth.info/files/2012%20Community%20Health%20Assessment.pdf

Worcester County Community Health Improvement Plan (CHIP) http://worcesterhealth.info/files/Final%20CHIP%202012.pdf

Atlantic General Hospital Medical Staff Survey (2018)

US Census Bureau

Delaware Department of Labor, (2016)

Delaware Health Tracker http://www.delawarehealthtracker.com

Healthier Sussex County Task Force (2016). http://www.healthiersussexcounty.com

Beebe Medical Center Community Health Assessment http://www.beebehealthcare.org/sites/default/files/1-CHNA%20FINAL%20DRAFT_0.pdf

HEROIN & OPIOID EMERGENCY TASK FORCE https://governor.maryland.gov/ltgovernor/wp-content/uploads/sites/2/2015/12/Heroin-Opioid-Emergency-Task-Force-Final-Report.pdf

Atlantic General Hospital. Creating Healthy Communities. http://www.atlanticgeneral.org/Community-Health-Wellness/Creating-Healthy-Communities.aspx?hcn=CommunityDashboard

CDC National Center for Health Stats (2015). Retrieved from http://www.cdc.gov/nchs/fastats

CDC Diabetes Public Health Resource (2014). Diabetes Public Health Resource (1980 – 2014). Retrieved from http://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm

CDC Heart Disease Statistics and Maps (2015). Retrieved from http://www.cdc.gov/HeartDisease/facts.htm

CHSI (2015). Community Health Status Indicators 2015. Retrieved from http://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/

County Health Rankings (2016). Worcester County, Maryland, Sussex County, Delaware Data. Retrieved on August 25, 2016, from http://www.countyhealthrankings.org/app/

NCI (2015). National Cancer Institute: Obesity, National Institute of Health. Retrieved on August 25, 2016, from http://www.cancer.gov/about-cancer/causes-prevention/risk/obesity

Mental Health Surveillance (2013). CDC. Retrieved on August 30, 2016, from https://www.cdc.gov/mentalhealthsurveillance/

PRC Survey (2015). Professional Research Consultants, Inc.

State Cancer Profiles (2009-2013) Healthy People 2020 Objective Number: C-8 Reduce the melanoma cancer death rate. Retrieved from https://statecancerprofiles.cancer.gov/cgi-bin/deathrates/deathrates.pl?10&053&00&0&001&0&1&1&1#results

1 Internal Revenue Bulletin: 2015-5 February 2, 2015 TD 9708 Additional Requirements

Community Health Needs Assessments for Charitable Hospitals; Requirement of a Sect and Time for Filing the Return. See https://www.irs.gov/irb/2015-5_IRB/ar08.html

Appendices

Appendix A: Worcester County Health Department Community Health Document Links

Appendix B: Worcester County Measures Relative to the State Health Improvement Plan

Appendix C: Master List: Who was Involved in Assessment?

Appendix D: Worcester and Sussex County 2019 Health Rankings

Appendix E: Maryland State Health Improvement Process (SHIP) Indicators

Appendix F: Atlantic General Hospital Community Health Needs Assessment Survey

Appendix G: CHNA Survey Results with Written Comments

Appendix H: 2016-2018 Goals and Actions Implemented

Appendix A

Worcester County Health Department Community Health Document Links

Worcester County 2017 Community Health Assessment

http://www.worcesterhealth.org/files/Final%202017%20CHA(1).pdf

Worcester County 2017-2020 Community Health Improvement Plan

http://www.worcesterhealth.org/images/CHIP-final-2017_final-2.pdf

Community Health Data

http://www.worcesterhealth.org/about-us/25-the-wchd/1135-yrbs-worcester-data

Worcester County Measures Relative to the State Health Improvement Plan

Big Chart 2 *Worcester County SHIP measurements*

Focus Area	Indicator	Jurisdictions	Value	Change	Goal me..
Healthy Beginnings	Infant Death Rate	Worcester	12.6	-6.4	No
	Babies with Low Birth Weight	Worcester	5.0	-1.0	Yes
	Sudden Unexpected Infant Death Ra..	Worcester	Null	Null	N/A
	Teen Birth Rate	Worcester	12.9	-2.0	Yes
	Early Prenatal Care	Worcester	78.6	-1.8	Yes
	Students Entering Kindergarten Rea..	Worcester	56.0	11.0	N/A
	High School Graduation Rate	Worcester	91.7	-1.4	No
	Children Receiving Blood Lead Scree..	Worcester	58.7	0.6	No
Healthy Living	Adults Who Currently Smoke	Worcester	20.9	Null	No
	Adolescents Who Use Tobacco Produ..	Worcester	18.4	-4.1	No
	HIV Incidence Rate	Worcester	4.4	-2.2	Yes
	Chlamydia Infection Rate	Worcester	468.6	-17.8	No
	Life Expectancy	Worcester	77.9	-0.6	No
	Increase Physical Activity	Worcester	48.6	-3.3	No
	Adolescents Who Have Obesity	Worcester	13.6	0.1	No
	Adults Who Are Not Overweight Or ..	Worcester	30.9	-9.5	No
Healthy Co mmunities	Child Maltreatment Rate	Worcester	16.9	5.4	N/A
	Suicide Rate	Worcester	Null	Null	N/A
	Domestic Violence	Worcester	606.5	49.2	No
	Children With Elevated Blood Lead L..	Worcester	0.1	-0.1	Yes
	Fall-Related Death Rate	Worcester	Null	Null	N/A
	Pedestrian Injury Rate On Public Ro..	Worcester	81.3	-8.1	No
	Affordable Housing	Worcester	62.5	3.7	Yes
Access to Health Care	Adolescents Who Received A Wellne..	Worcester	52.1	-3.1	No
	Children Receiving Dental Care In T..	Worcester	64.5	0.7	No
	Persons With A Usual Primary Care ..	Worcester	78.3	12.4	No
	Uninsured ED Visits	Worcester	6.4	-0.9	Yes
Quality Preventive Care	Emergency Department Visit Rate D..	Worcester	310.5	80.6	No
	Emergency Department Visit Rate D..	Worcester	417.2	131.0	No
	Drug-Induced Death Rate	Worcester	Null	Null	N/A
	Emergency Department Visits Relat..	Worcester	3502.8	-4006..	No
	Hospitalization Rate Related To Alzh..	Worcester	407.7	261.6	No
	Annual Season Influenza Vaccinations	Worcester	39.9	14.3	No
	Emergency Department Visit Rate D..	Worcester	79.1	15.0	No
	Age-Adjusted Mortality Rate From H..	Worcester	186.9	6.0	No
	Emergency Department Visits for Ad..	Worcester	1977.1	-319.7	No
	Emergency Department Visit Rate F..	Worcester	1051.9	-389.6	No
	Cancer Mortality Rate	Worcester	173.7	-6.7	No

Appendix C

Master List: Who was involved in Assessment?

Community Group, Organization or Partner

Advocate Health

Leader/Member:
Michael Franklin

AGH Foundation Board of Directors – The Foundation is committed to promoting the philanthropic support for the enhancement of the health of our community. We will achieve this mission through supporting the objectives of Atlantic General Hospital and Health System to continually improve the health of our residents and visitors to Maryland's lower Eastern Shore.

Leader/Member:
Todd Ferrante, Chair
Toni Keiser

AGH Junior Auxiliary Group –The Atlantic General Hospital Auxiliary promotes the welfare of the hospital by fostering good public relations, providing service to the hospital, organizing health related projects and spearheading fund raising activities.

Leader/Member:
Jill Ferrante, Chair
Toni Keiser

American Cancer Society Tri-County Leadership Committee – The American Cancer Society is a nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem. Headquartered in Atlanta, Georgia, the ACS has 12 chartered Divisions, more than 900 local offices nationwide, and a presence in more than 5,100 communities. The Tri-County Leadership Committee is the overseeing body for all of the ACS initiatives in Worcester, Wicomico and Somerset County.

Leader/Member:
Arlene Schneider

Atlantic Club Board – The Atlantic Club is a non-profit service organization dedicated to helping individuals and their families recover from the disease of addiction. Provides the support necessary to live a healthy life in recovery and become an active member of our community. Offers 12-step programs and sober events.

Leader/Member:
Sue Rodden, Lead
Colleen Wareing

Behavioral Health Operational Team – Comprised of AGH and Worcester County Health Department members involved in behavioral health services. Define the service availability in current state. Identify gaps in services both in Worcester county and surrounding areas including adjacent states. Improve through monitoring reports and concerns the delivery of operational services shared between organizations. Evaluate shared contracts and collaborate on grants or additional contracts to meet community need for behavioral health services. Determine the need for future services such as Medical Detox, partial hospitalization, Geriatric behavioral health services and recovery housing.

Leader/Member:
Donna Nordstrom, Chair
Several

Bethany/Fenwick Chamber of Commerce Board of Directors – Provides oversight and guidance to the Executive Director in carrying out Chamber business.

Leader/Member:
Lauren Weaver, Exec Director
Toni Keiser
Amy Hedger

Big Brothers Big Sisters – National organization which matches boys and girls with mentors.

Leader/Member:
Gail Foltz, Lead

Blood Bank of Delmarva – Work with local chapter to promote blood donation and lifesaving activities.

Leader/Member:
John Ferretti, President & CEO
Michael Franklin, VP
Blood Bank

Child Fatality Review Team – A team that reviews cases in Worcester County

Leader/Member:
Debra Stevens, Chair

Cricket Center Board, Child Advocacy Board – Board for the care of children that have been physically or sexually abused. Look at processes, use of our forensic nurses and the team, partnering for their care and seeking prosecution for the acts.

Leader/Member:
Monica Martin, Lead
Althea Foreman

CRT Advisory Board – Addresses the care of our behavioral health patients and getting them to another level of care. Ex inpatient psych, alcohol rehab, etc.

Leader/Member:
Monica Martin, Lead
Althea Foreman

Disaster Preparedness – Develop Disaster Preparedness Plans, Responses, and Mitigation Strategies: Worcester County Local Emergency Planning Committee, Ocean City Local Emergency Planning Committee, Maryland Medical Region IV Emergency Planning Committee

Leader/Member:
Fred Webster
Bill Birch
Laurie Gutberlet

Delmarva Regional Health Mutual Aid Group (DRHMAG)

Leader/Member:
Kristen McMenamin

DMV Youth Council – The purpose of the Youth Council is to provide expertise in youth policy and assist the local board in developing and recommending local youth employment and training policy and practice. The Youth Council also endeavors to broaden the youth employment and training focus in a community and to incorporate a youth development perspective.

Leader/Member:
Several

Domestic Violence Fatality Review Board – It is a board that explores reasons/cause for domestic violence and tries to see if there are resources that are available to stop future crimes against victims of domestic violence.

Leader/Member:
Several

Drug Overdose Fatality Review Team – A team that reviews cases in Worcester County

Leader/Member:
Christina Purcell, Lead
Several

EMS Advisory Board, EMS Advisory Board – Andi West-McCabe, Dr. Jeff Greenwood, Harvey Booth (ED), and Colleen Wareing – Meeting with all the EMS companies from DE, MD, and VA to ensure ambulance patients are appropriate to be cared for here and address any concerns.

Leader/Member:
Dr. Jeff Greenwood
Several

Faith Based Partnership – A group of community members from various places of worship in our area who meet to plan programming to meet health needs.

Leader/Member:
Gail Mansell, Lead
Several

Greater Salisbury Committee – A non-profit association of business leaders on the Delmarva peninsula, who work together to improve the communities in which we live.

Leader/Member:
Mike Dunn, Exec Director
Michael Franklin

Greater Ocean City Chamber of Commerce Board of Directors, Legislative, Scholarship and Special Events Committees – The Mission of The Greater Ocean City Chamber of Commerce is to provide community leadership in the promotion and support of economic development and the continued growth of tourism in Ocean City. The Chamber serves as the hub for the development, education and communication within the business community of Ocean City to preserve the viability, quality of life and aesthetic values of our town.

Leader/Member:
Toni Keiser

Habitat for Humanity – Local volunteer group which builds houses for those in need.

Leader/Member:
Several

Healthcare Provider Council in DE – Regional group of healthcare providers who work in collaboration with one another to provide needed services throughout the area.

Leader/Member:
Anna Short, Chair
Amy Hedger

Healthy Happenings Committee – Hospital and Community members who plan and implement health education in the community.

Leader/Member:
Michelle McGowan, Chair
Donna Nordstrom
Several

Homelessness Committee Worcester – provides homeless outreach and resource navigation to reduce homelessness in Worcester County

Leader/Member:
Tracey Simpson, Co-Chair
Jessica Sexauer, Co-Chair
Donna Nordstrom

Hudson Health Services – Offers inpatient treatment for substance use disorders in Salisbury, Maryland as well as Halfway and Recovery Housing in Maryland

Leader/Member:
Michelle Grager, Chair
Toni Keiser

Junior Achievement Board – To prepare young people to thrive in the 21st century workplace and global economy by inspiring a passion in free enterprise and entrepreneurship, and instilling an understanding of personal financial literacy.

Leader/Member:
Beth Bell, Chair
Jayme Hayes, CEO
Jim Brannon

Komen MD Coalition for Eastern Shore – Group of community members and health agencies which looks at breast cancer services and gaps in the area and works to fill gaps and promote programming.

Leader/Member:
Lori Yates, Lead
Donna Nordstrom

Lower Shore Dental Task Force – To reduce dental health disparities and access to dental services for adults in the Tri-County area.

Leader/Member:
Dr. James Cockey, Chair
Donna Nordstrom

Local Health Improvement Coalition (LHIC) Worcester – Groups of jurisdictional-level stakeholders. Each LHIC sets public health priorities for their respective communities. LHICs address these health priorities through programs, policies, and coordinated efforts with programmatic, data, and infrastructure support from the state and county

Leader/Member:
Teresa Tyndall, Chair
Kim Justice
Donna Nordstrom

Local Management Board Worcester County

Leader/Member:
Roberta Baldwin, Chair
Donna Nordstrom ***(open sessions)***

Lower Shore Red Cross – Provides disaster relief. The board plans events in collaboration with other agencies to meet the needs in our area.

Leader/Member:
Theresa Young
Joan Scott

Maryland Hospital Association Community Connections Advisory Board – MHA's membership is comprised of community and teaching hospitals, health systems, specialty hospitals, veterans' hospitals, and long-term care facilities. Allied with the American Hospital Association, MHA is an independent organization headquartered in Elkridge, Maryland. The mission of this committee is to Help small, rural and independent hospitals and health systems to better communicate and serve their communities by providing them leadership, advocacy, education, and innovative programs and services.

Leader/Member:
Toni Keiser

Mid-Atlantic Society for Healthcare Strategy and Market Development – To provide healthcare planning, marketing, and communications professionals with the most highly valued resources for professional development.

Leader/Member:
Kelsey Mohring, Chair
Sarah Yonker

Maryland State Health and Wellness Council – October 2017, the State Advisory Council on Health and Wellness was created (Chapter 40, Acts of 2017). The Council assumes the responsibilities of the State Advisory Council on Arthritis and Related Diseases, the State Advisory Council on Heart Disease and Stroke, and the State Advisory Council on Physical Fitness. To carry out that work, the Council works through at least four committees concerned with arthritis, diabetes, heart disease and stroke, and physical fitness. Council promotes evidence-based programs for developing healthy lifestyles, and for the prevention, early detection, and treatment of chronic diseases. To the Maryland Department of Health, the Council makes recommendations on chronic disease prevention, health, and wellness.

Leader/Member:
Vivienne Rose, Sadie Peters, Leads
Donna Nordstrom

National Alliance for Mental Illness (NAMI) Lower Shore – A grassroots organization dedicated to advocacy, education, and support for persons with mental illness, their families, and the wider community.

Leader/Member:
Carole Spurrier, Lead
Gail Mansell

Ocean City Drug and Alcohol Abuse and Prevention Committee – In 1989, then Governor William Donald Schaefer asked the Mayor of Ocean City, Roland Powell, to set up a committee to fight the abuse of alcohol and other drugs in our community. Thus, was born the Ocean City Drug Alcohol Abuse Prevention Committee Inc. that works in a partnership with state and local government agencies, as well as many businesses and concerned citizens. Currently the committee is comprised of members from the Town of Ocean City including elected officials and town employees from the Town of Ocean City Police Department and Ocean City Recreation & Parks Department, Worcester County Health Department and Department of Juvenile Services personnel, local school administrators, and teachers, volunteers from community service organizations, and many caring and concerned citizens.

Leader/Member:
Donna Greenwood, Chair
Michelle McGowan

Ocean Pines Chamber of Commerce Board of Directors – Provides oversight and guidance to the Executive Director in carrying out Chamber business.

Leader/Member:
Several

Opioid Intervention Team – Local jurisdictions utilize resources provided by the state to engage in a wide range of their prevention, protection, and expansion of treatment efforts to fight opioid epidemic, and use performance measures to evaluate the effectiveness of projects.

Leader/Member:
Bill Birch, Chair
Colleen Wareing

Opioid Task Force – Looking at use, trends and prevention in the community

Leader/Member:
Beau Olgesby, Lead
Colleen Wareing

Parkside Technical High School Board – Oversees from the community healthcare perspective the CNA and GNA program at the technical high school.

Leader/Member:
Tracy Hunter
Sherry Whitt

Play it Safe Committee – The mission of Play It Safe is to encourage high school graduates to make informed, healthy choices while having responsible fun without the use of alcohol and other drugs

Leader/Member:
Donna Greenwood, Chair
Michelle McGowan

Relay For Life – American Cancer Society group with raises money, awareness and educates the public on cancers.
Resource Coordination Committee

Leader/Member:
Kristy McIntyre, Chair
Donna Nordstrom
Michelle McGowan

Retired Nurses of Ocean Pines – A group of retired nurses (from various locations in the country) who now reside in the area and help with volunteer projects and give feedback for programming in the healthcare field.

Leader/Member:
Joyce Britan

SAFE – Sexual Assault Forensic Examiners – Meetings of the certified RNs and standardizing care for domestic violence, elder abuse, play it safe, lethality assessment, etc.

Leader/Member:
Althea Foreman

Safe Seniors/MIH Committee – Committed comprised of first responders, AGH staff, commission on aging and local health department and veteran's resources. Define a program that will incorporate concepts of safe critical strategic plan and best practice for mobile integrated health to promote senior safety and access to care.

Leader/Member:
Andi West-McCabe
Donna Nordstrom Co-Chairs

SART – Same as SAFE except it involves all the agencies from Worcester County including Social Services, Patient Advocates, Law Enforcement, States' Attorney, etc

Leader/Member:
Althea Foreman

Save a Leg, Save a Life – A grass roots organization founded in Jacksonville, Florida. There are approximately 45 SALSAL chapters in the U.S., Latin America, and overseas. The immediate goal is a 25% reduction in lower extremity amputations in communities where SALSAL Chapters are established. Currently the Eastern Shore Chapter spans from Dover, DE – Easton, MD – Salisbury, MD – Berlin, MD

Leader/Member:
Geri Rosol

State Advisory Council on Quality Care at the End of Life – Discuss quality initiatives for quality palliative medicine and end of life services that may result in legislative actions for the state of Maryland.

Leader/Member:
Gail Mansell

LESSPC Suicide Awareness – Community members working together to raise awareness and prevention of suicides.

Leader/Member:
Jackie Ward, Co-Chair
Jennifer LaMade, Co-Chair
Donna Nordstrom
Michelle McGowan

Tobacco and Cancer Coalition – Worcester County, Sharing group of partners from different agencies and community members looking at measures, outcomes and prevention of cancers in the area.

Leader/Member:
Committee merged to LHIC

Tri County Diabetes Alliance – Collaborative group from Worcester, Wicomico and Somerset County who plan collaborative programming to educate, treat and prevent diabetes.

Leader/Member:
Mimi Dean, Lead
2019 Alliance no longer meets

Tri-County Health Planning Coalition – To improve the health of residents of Somerset, Wicomico and Worcester counties; increase accessibility, continuity, availability of quality of health services; optimize cost-effectiveness of providing health services and prevent unnecessary duplication of health resources.

Leader/Member:
Jennifer LaMade (Worcester)
Cara Rozaieski (Wicomico)
Sharon Lynch (Somerset)
Kim Justice, Donna Nordstrom

United Way – An organization that provides funding for non-profit groups in the local community. Through this board many community needs are identified and partnerships are formed to meet the needs.

Leader/Member:
Dana Seiler, Chair

Worcester County Board of Education – Oversees the public education in Worcester County.

Leader/Member:
Lou Taylor, Superintendent

Worcester County Drug and Alcohol Board – Community partners working together to oversee the safe use of alcohol and tobacco in the community by planning awareness/ educational events and compliance checks for the merchants.

Leader/Member:
Col. Doug Dodd, Jim Freeman
Colleen Wareing

Worcester County School Health Council – The purpose of this Council will be to act as an advisory body to the Worcester County Board of Education in the development and maintenance of effective and comprehensive health programs which afford maximum health benefits to students enrolled in Worcester County Public Schools. Recognizing that citizen participation is inherent in the development and maintenance of an effective comprehensive health program, the Council will broadly represent the views of Worcester County citizens.

Leader/Member:
Judy Daye, Chair
Julia Perrotta

Worcester County Health and Medical Emergency Preparedness Committee – To prepare for emergency situation responses and to protect the health of the community.

Leader/Member:
Kristy Kagan, Chair

Worcester County Warriors Against Opioid Use

Leader/Member:
Heidi McNeely, Chair
Colleen Wareing

Worcester GOLD: Giving Other Lives Dignity – A non-profit organization that provides assistance to community members of all ages such as school supplies, utilities assistance, summer camp sponsor for children, Christmas support to families, replacement of a roof, rainbow room; children's clothing & food supplies. All families or person (s) are screened by Social Services Department of Worcester County

Leader/Member:
Carol Jacobs, Chair
Donna Nordstrom
Cheryl Nottingham

Worcester County Mental Health Advisory Committee/Public Safety Net/Jail Coalition – In collaboration with Local Behavioral Health Authority and local stakeholders' works to ensure a coordinated quality system of care is available to individuals with behavioral health conditions.

Leader/Member:
Donna Nordstrom, Chair

Worcester Technical High School Biomed Program Advisory Committee – Program advisement.

Leader/Member:
Bill Severn, Chair
Julia Perrotta
Kim Justice

Appendix D

Worcester and Sussex Counties 2019 Health Rankings

County Health Rankings & Roadmaps

Building and Culture of Health, County by County

Worcester (WO) County Demographics

	County	State
Population	51,690	6,052,177
% below 18 years of age	17.4%	22.3%
% 65 and older	27.3%	14.9%
% Non-Hispanic African American	13.0%	29.7%
% American Indian and Alaskan Native	0.4%	0.6%
% Asian	1.5%	6.7%
% Native Hawaiian/Other Pacific Islander	0.0%	0.1%
% Hispanic	3.5%	10.1%
% Non-Hispanic white	80.0%	50.9%
% not proficient in English	0%	3%
% Females	51.4%	51.5%
% Rural	35.5%	12.8%

Cancer For 2019 Sussex County Health rankings, visit **www.countyhealthrankings.**

	Worcester County	Error Margin	Top U.S. Performers	Maryland	Rank (of 24)
Health Outcomes					16
Length of Life					22
Premature death	9,500	8,300-10,600	5,400	7,100	
Quality of Life					10
Poor or fair health **	15%	14-15%	12%	14%	
Poor physical health days **	3.3	3.2-3.4	3.0	3.1	
Poor mental health days **	3.7	3.6-3.9	3.1	3.5	
Low birthweight	7%	6-8%	6%	9%	
Additional Health Outcomes (not included in overall ranking)					
Life expectancy	77.9	76.9-78.8	81.0	79.2	
Premature age-adjusted mortality	390	360-420	280	330	
Child mortality	70	50-100	40	50	
Infant mortality	10	7-14	4	7	
Frequent physical distress	10%	10-10%	9%	9%	
Frequent mental distress	11%	11-11%	10%	10%	
Diabetes prevalence	14%	12-16%	9%	11%	
HIV prevalence	202		49	658	
Health Factors					17
Health Behaviors					16
Adult smoking **	15%	15-16%	14%	14%	
Adult obesity	33%	30-37%	26%	30%	
Food environment index	8.2		8.7	9.1	
Physical inactivity	26%	23-29%	19%	21%	
Access to exercise opportunities	90%		91%	92%	
Excessive drinking **	16%	15-16%	13%	17%	
Alcohol-impaired driving deaths	45%	38-51%	13%	30%	
Sexually transmitted infections	358.9		152.8	510.4	
Teen births	19	16-22	14	19	
Additional Health Behaviors (not included in overall ranking)					
Food insecurity	12%		9%	11%	
Limited access to healthy foods	4%		2%	3%	
Drug overdose deaths	39	30-50	10	31	
Motor vehicle crash deaths	12	9-16	9	9	
Insufficient sleep	32%	31-32%	27%	36%	
Clinical Care					9
Uninsured	7%	6-8%	6%	7%	
Primary care physicians	1,250:1		1,050:1	1,140:1	
Dentists	1,850:1		1,260:1	1,300:1	
Mental health providers	470:1		310:1	430:1	
Preventable hospital stays	4,016		2,765	4,695	
Mammography screening	46%		49%	41%	
Flu vaccinations	47%		52%	48%	
Additional Clinical Care (not included in overall ranking)					
Uninsured adults	8%	7-10%	6%	8%	
Uninsured children	4%	3-5%	3%	3%	
Other primary care providers	1,292:1		726:1	1,046:1	

Appendix E

Maryland State Health Improvement Process (SHIP) Indicators

http://dhmh.maryland.gov/ship/Pages/home.aspx

Maryland's State Health Improvement Process (SHIP) provides a framework for continual progress toward a healthier Maryland. The SHIP includes 39 measures in five focus areas that represent what it means for Maryland to be healthy. Each measure has a data source and a target, and where possible, can be assessed at the county level. Detailed information is provided for each objective organized by Vision Areas on the URL provided.

Healthy Beginnings

- Infant death rate
- Babies with Low birth weight
- Sudden unexpected infant death rate (SUIDs)
- Teen birth rate
- Early prenatal care
- Students entering kindergarten ready to learn
- High school graduation rate
- Children receiving blood lead screening

Healthy Living

- Adults who are a healthy weight
- Children and adolescents who are obese
- Adults who currently smoke
- Adolescents who use tobacco products
- HIV incidence rate
- Chlamydia infection rate
- Life expectancy
- Increase physical activity

Healthy Communities

- Child maltreatment rate
- Suicide rate
- Domestic Violence
- Children with elevated blood lead levels
- Life expectancy
- Increase physical activity
- Fall-related death rate
- Pedestrian injury rate on public roads
- Affordable Housing

Access to Health Care

- Adolescents who received a wellness checkup in the last year
- Children receiving dental care in the last year
- Persons with a usual primary care provider
- Uninsured ED Visits

Quality Preventive Care

- Age-adjusted mortality rate from cancer
- Emergency Department visit rate due to diabetes
- Emergency Department visit rate due to Hypertension
- Drug-induced death rate
- Emergency Department Visits Related to Mental Health Conditions
- Hospitalization rate related to Alzheimer's or other dementias
- Children (19-35 months old) who receive recommended vaccines
- Annual season influenza vaccinations
- Emergency department visit rate due to asthma
- Age-adjusted mortality rate from heart disease
- Emergency Department Visits for Addictions-Related Conditions
- Emergency department visit rate for dental care

Appendix F

Atlantic General Hospital Community Health Needs Assessment

Survey

Help us build a healthier Community by taking our Community Needs Assessment Survey. This information will help to provide much needed outreach and wellness programs in the area, keeping you and your family as healthy as possible. The results from this survey are confidential.

1. What do you believe to be the biggest health problem in your community? *(Please circle all that you think apply)*

a. Heart Disease
b. Cancer
c. Diabetes/Sugar
d. Asthma/Lung Disease
e. Smoking, drug or alcohol use
f. Mental Health Issues (Depression, Anxiety)
g. Dental Health
h. High Blood Pressure/Stroke
i. Injuries
j. Overweight/Obesity
k. Access to Healthcare/ No Health Insurance
l. HIV
m. Sexually Transmitted Diseases
n. Other _____

If selected "other," please tell us what you think: _____

2. What do you think are the problems that keep you or other community members from getting healthcare they need? *(Please circle all that you think apply)*

a. No health insurance
b. Too expensive/can't afford it
c. Couldn't get an appointment with my doctor
d. Doctor is too far away from my home
e. No transportation
f. Service is not available in our community
g. Local doctors are not on my insurance plan
h. Other _____

If selected "other," please tell us what you think: _____

3. Do you have any ideas or recommendations to help decrease the health problems in the community or to solve the problems with access to health services (please use the back if you need more space)?

_____

_____

4. What is your zip code?

5. What is your age range?

a. Under 18 years
b. 19 - 24 years
c. 25 - 30 years
d. 31 - 40 years
e. 41 - 50 years
f. 51 - 60 years
g. 61 - 65 years
h. Older than 65 years

6. What is your race/ethnicity?

a. African American
b. Asian/Pacific Islander
c. Caucasian
d. Hispanic
e. Other _____

Social determinants of health reflect the social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age. Also known as social and physical determinants of health, they impact a wide range of health, functioning, and quality-of-life outcomes.

Do any of the following social concerns create a barrier to you or your family's health? *(Check all that apply)*

____Educational opportunities

____Job opportunities

____Living wages

____Access to health foods such as fresh fruits and vegetables

____Society attitudes

____Exposure to crime or violence

____Social disorder, such as the presence of trash

____Lack of social support, and social interactions

____Lack of exposure to mass media and emerging technologies, such as the Internet or cell phones

____Socioeconomic conditions, such as concentrated poverty

____Access to quality schools

____Available transportation options

____Poor or lack of public safety

____Other _____

Do any of the following economic concerns create a barrier to you or your family's health? *(Check all that apply)*

____Job opportunities

____Living wages

____Access to affordable health care

____Access to affordable medicine

____Access to affordable transportation

____Access to health insurance

____Poverty

____Other_____

Appendix G

CHNA Survey Results with Written Comments

Total paper surveys: 286

What do you believe to be the biggest health problem in your community? *(286/286 responded)*

a.	Heart Disease	40.9%	117
b.	Cancer	52.8%	151
c.	Diabetes/Sugar	43.0%	123
d.	Asthma/Lung Disease	9.8%	28
e.	Smoking, drug or alcohol use	35.3%	101
f.	Mental Health Issues (Depression, Anxiety)	25.5%	73
g.	Dental Health	14.3%	41
h.	High Blood Pressure/Stroke	37.1%	106
i.	Injuries	12.2%	35
j.	Overweight/Obesity	40.6%	116
k.	Access to Healthcare/ No Health Insurance	19.9%	57
l.	HIV	4.2%	12
m.	Sexually Transmitted Diseases	2.4%	7

Other:

"opioids"
"arthritis/gout"
"drugs"
"opioid"
"aging/stress"
"liquor is too cheap"
"opioid addiction"
"drug addiction/use"
"drug addiction"
"exercise"
"arthritis"
"drugs"
"more doctors"
"lack of transportation"
"addiction/housing"
"substance abuse"
"Drug use"
"Opioid Problem"

What do you think are the problems that keep you or other community members from getting healthcare they need? *(286/286 responded)*

a.	No health insurance	50.0%	143
b.	Too expensive/can't afford it	58.7%	168
c.	Couldn't get an appointment with my doctor	21.0%	60
d.	Doctor is too far away from my home	13.3%	38
e.	No transportation	23.4%	67
f.	Service is not available in our community	14.7%	42
g.	Local doctors are not on my insurance plan	15.4%	44

Other:

"People Procrastinate"
"they don't care if they live or die"
"people cannot afford care/costs so high"
"have insurance"
"lack of or confusing illness prevention info"
"no problems"
"too lazy to make appt"
"insurance won't cover what you need"
"fear of unknown"
"city depts w/ job less than 40 hrs so don't have to give healthcare"
"medical qualification"
"long wait time to see a doctor"
"long waits for mental health treatment"
"no resources"
"Long wait time"
" poverty, lack of education"

Do you have any ideas or recommendations to help decrease the health problems in the community or to solve the problems with access to health services? *(76/286 responded)*

"more docs"
"more affordable health plans"
"HMO"
"more doctors"
"more seminars"
"events about arthritis"
"health van available for basic free service check up"
"make medical cannabis an alternative to Rx meds"
"create healthcare plans for people that cannot afford it"
"small busses to transport often"
"more affordable health plans"
"encourage volunteer drivers for elderly or slightly impaired"
"free fitness centers"
"more doctors/health providers"
"make it affordable, people will see doctors if they care"
"pray"
"overhaul the health care system"
"continue healthy living information for prevention of illness"
"provide inexpensive transportation to doctors"
"more salad bars"
"free clinics"
"get government out of situation"
"regular health check ups"
"need gastroenterologist"
"addiction to cell phones, exercise more and eat better"
"exercise"
"education"
"free clinics"
"free health care"
"keep this health fair going"
"address drug problems"
"access to better healthcare"
"nutrition"
"start early (young)"
"more physicians"
"car service for appts"
"FDA needs to be more diligent in passing all that applies to health"
"make it affordable and more free health screenings"
"improve access to dental care/prevention"
"I think AGH is getting the message out there"
"1. connect with drug rehab programs in the county to conduct health services and screenings. 2. recruit more GP docs. 3. look for docs. With specialties in alcohol & drugs. 4. provide public listing of docs accepting new pts & update. Problems with many to set appt. with GP & GYN. 5. look for grants to provide medical transportation for indigent folks to keep appts."
"expand ACA coverage train community health workers"
"lower insurance costs"
"education"
"more transportation for non drivers"

Do you have any ideas or recommendations to help decrease the health problems in the community or to solve the problems with access to health services? *(continued)*

"advertise more"
"more doctors"
"more doctors"
"help new arrivals find healthcare"
"support senior fitness programs"
"provide transportation as needed, more doctors general care"
"coronary care, cath lab- PRMC is too far away"
"healthcare insurance for all/transportation for seniors in wheelchairs not just for dr appt but for other areas like hair/nail appts and shopping"
"more places for homeless people that really need help"
"more education seminars on health awareness"
"availability for appts and treatment"
"arrange mental speakers to come and personally educate the public"
"funding for transportation"
"assist with funds for transportation"
"services should be more available-take the service to the sick- shut in's & those that can't get to the facility"
"transportation assistance, home visit, case manager to work 1 on 1 with people provide transportation"
"make more commercials and make the problem more aware"
"Better transportation for the sick, help with insurance"
"Offer more free check clinic without income requirement"
"Train the PA's - need more training"
"Help people adopt healthier lifestyles"
"Small buses"
"Don't know"
"Public transportation "
"N/A"
"Education -health education is needed"
"Health screening – access"
"Health fairs, mobile screening units"
"proactive care; Education"
"More health related agencies should be available in Pocomoke. Always seem to be going to Salisbury for treatment"

What is your age range? *(283/286 responded)*

Under 18 years	**0**	**0**
19 - 24 years	1.1%	3
25 - 30 years	3.2%	9
31 - 40 years	4.9%	14
41 - 50 years	4.2%	12
51 - 60 years	14.5%	41
61 - 65 years	15.9%	45
Older than 65 years	56.2%	159

What is your race/ethnicity? *(267/286 responded)*

African American	14.6%	39
Asian/Pacific Islander	1.1%	3
Caucasian	81.6%	218
Hispanic	1.9%	5
Other	0.8%	2

What is your zip code? *(274/286 responded)*

22356	1.8%	5	21060	0.4%	1
21875	0.4%	1	21032	0.4%	1
21874	0.4%	1	21013	0.4%	1
21872	0.4%	1	21012	0.4%	1
21863	2.6%	7	20601	0.4%	1
21853	1.8%	5	20164	0.4%	1
21851	5.8%	16	20064	0.4%	1
21850	0.7%	2	19979	0.7%	2
21849	0.4%	1	19975	7.7%	21
21842	23.4%	64	19970	2.2%	6
21841	0.4%	1	19967	0.4%	1
21838	0.4%	1	19966	0.7%	2
21830	0.4%	1	19958	1.5%	4
21829	0.4%	1	19956	0.4%	1
21826	0.4%	1	19947	0.4%	1
21815	0.4%	1	19945	2.9%	8
21813	1.8%	5	19944	1.1%	3
21811	32.1%	88	19940	0.4%	1
21804	1.1%	3	19939	0.4%	1
21801	0.7%	2	19709	0.4%	1
21237	0.4%	1	18137	0.4%	1
21206	0.7%	2	16137	0.4%	1
21146	0.4%	1			
21093	0.7%	2			

Do any of the following economic concerns create a barrier to you or your familiy's health? *(125/286 responded)*

Job opportunities	27.2%	34
Living wages	38.4%	48
Access to affordable health care	52.0%	65
Access to affordable medicine	50.4%	63
Access to affordable transportation	24.0%	30
Access to health insurance	29.6%	37
Poverty	12.8%	16

Other:

"access to quality healthcare"
"physician accessibility"
"none"
"No"
"N/A"

Do any of the following environmental concerns create a barrier to you or your familiy's health? *(181/286 responded)*

Natural environment, such as plants, weather, or climate change	18.8%	34
Built environment, such as buildings or transportation	11.6%	21
Worksites, schools, and recreational settings	7.7%	14
Housing, homes, and neighborhoods	18.2%	33
Exposure to toxic substances and other physical hazards	18.2%	33
Physical barriers, especially for people with disabilities	20.4%	37
Aesthetic elements, such as good lighting, trees, or benches	8.8%	16

Other:

"access to quality healthcare"
"most people don't take responsibility for their health, rely on medical experts to fix them when ill, rather than partner with doctor to create healthy lifestyle"
"second hand smoke"
"too much light "end of night""
"crime and violence in city an communities"
"Cant think of any "
"No"
"N/A"

Appendix H

2016-2018 Goals and Actions Implemented

Implementation Plan of Needs Identified in the Community Health Needs Assessment: Progress Measures – FY16-18

Community Needs Assessment

In 2015, AGH in coordination with the local health departments, neighboring hospitals and community stakeholders, conducted a community needs assessment. The needs assessment is a primary tool used by the Hospital to determine its community benefit plan, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of our service area. The Community Health Needs Assessment (CHNA) was approved by the Hospital's Board of Trustees in May 2016.

Needs Identified

The following "areas of opportunity" represent significant health needs of the community, based on information gathered through the Professional Research Consultants, Inc. and Healthy People 2020.

The following areas of health concerns were gathered through the Community Health Needs Assessment (CHNA) Survey. Areas are listed according to community priority.

	CHNA Survey
1	**Cancer** (same as FY13)
2	**Overweight/Obesity** (same as FY13)
3	**Diabetes/Sugar** (up one from FY13)
4	**Heart Disease** (down two from FY13)
5	**Smoking, drug** or *alcohol use*
6	**High Blood Pressure/Stroke** (same as FY13)
7	**Mental Health**
8	**Access to Healthcare/ No Health Insurance**
9	**Asthma/Lung Disease**
10	*Dental Health*
11	*Injuries*
12	*HIV & STD (<2% ea)*

Bold = Priorities addressed in Implementation Plan
Italicized = Priorities not addressed in Implementation Plan

PRC Assessment	Need
Access to Health Services	-Difficulty getting a physician appointment
Arthritis, Osteoporosis & Chronic Back Conditions	-Prevalence of Sciatica/Chronic Back Pain
Cancer	-Prevalence of Cancer (including skin cancer)
Diabetes	-Prevalence of Diabetes -Borderline/Pre-Diabetes
Heart Disease & Stroke	-Heart Disease Prevalence -High Blood Pressure -High Blood Cholesterol -Overall Cardiovascular Risk
Immunizations & Infectious	-Hepatitis B Vaccination
Injury & Violence	-Use of Seatbelts
Nutrition, Physical Activity & Weight	-Prevalence of Obesity & Overweight -Meeting Physical Activity Guidelines -Lack of Leisure Time Physical Activity
Oral Health	-Regular Dental Care
Respiratory Disease	-COPD -Asthma Diagnosis

Bold = Priorities addressed in Implementation Plan
Italicized = Priorities not addressed in Implementation Plan

Prioritized Needs

The identified needs were prioritized based on the following criteria: size and severity of the problem determined by what percentage of the population is affected by risks; health system's ability to impact the need; availability of resources. Based on those criteria several areas were chosen to be the most important for the hospital to focus on.

Priority Areas
Access to Health Services
Cancer
Respiratory Disease and Smoking
Nutrition, Physical Activity & Weight
Diabetes
Heart Disease & Stroke
Mental Health
Opioid Abuse
Arthritis, Osteoporosis & Chronic Back Pain

Implementation Plan

Priority Area: Access to Health Services

Goal: Increase community access to comprehensive, quality health care services.

Healthy People 2020 Goal: Improve access to comprehensive, quality health care services.

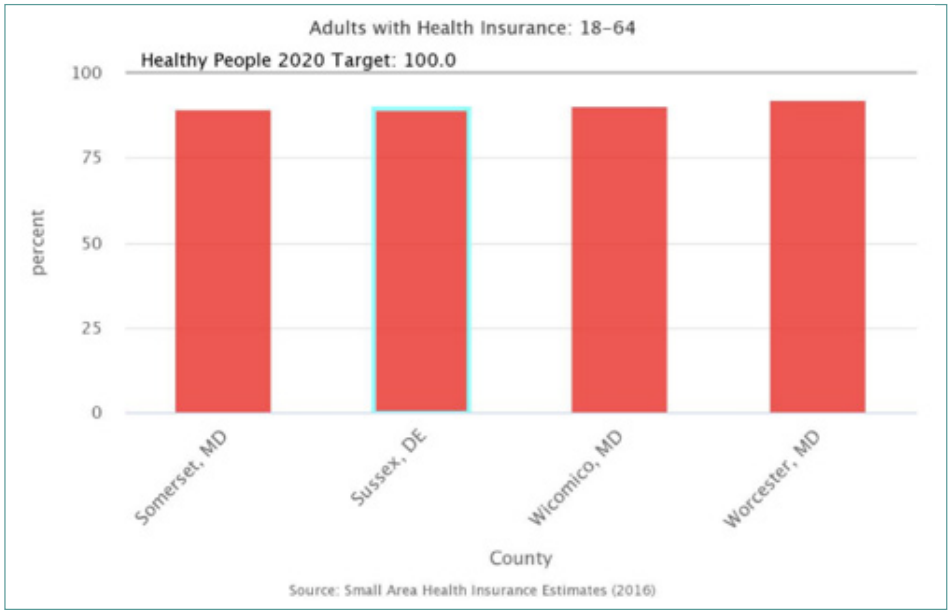
Action:

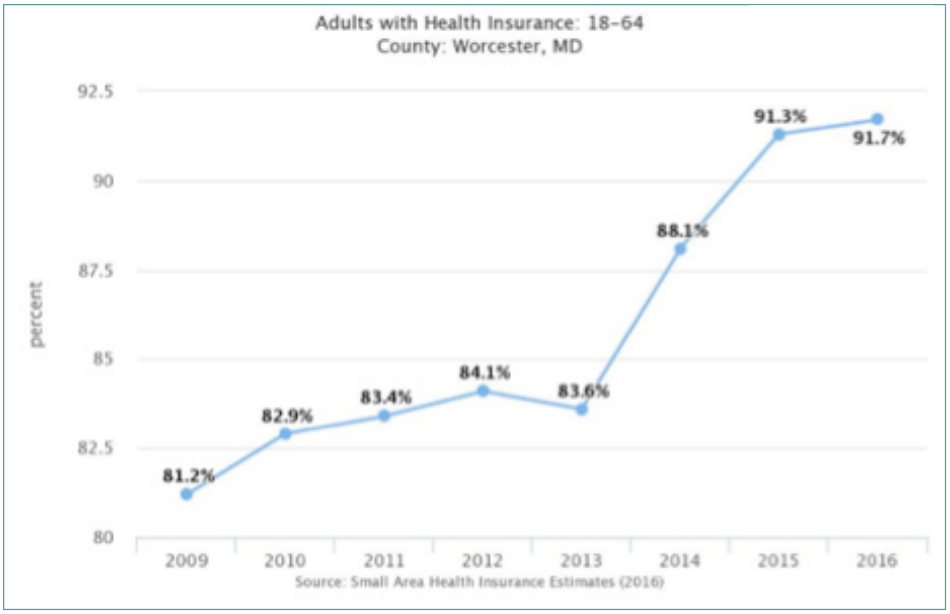
- Partner with poultry plants to promote wellness
- Provide community health events to target minority populations
- Partner with homeless shelters and food pantries to promote wellness
- Utilize Faith-based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management
- Educate community on financial assistance options
- Educate community on ED appropriate use
- Increase the number of practicing primary care providers and specialists to community
- Participate on Lower Shore Dental Task Force
- Participate on Worcester County Healthy Planning Advisory Council
- Participate on Homelessness Committee
- Refer community to local agencies such as Shore Transit and Worcester County Health Department for transportation assistance
- Participate on Tri County Health Planning Council

Measurement:

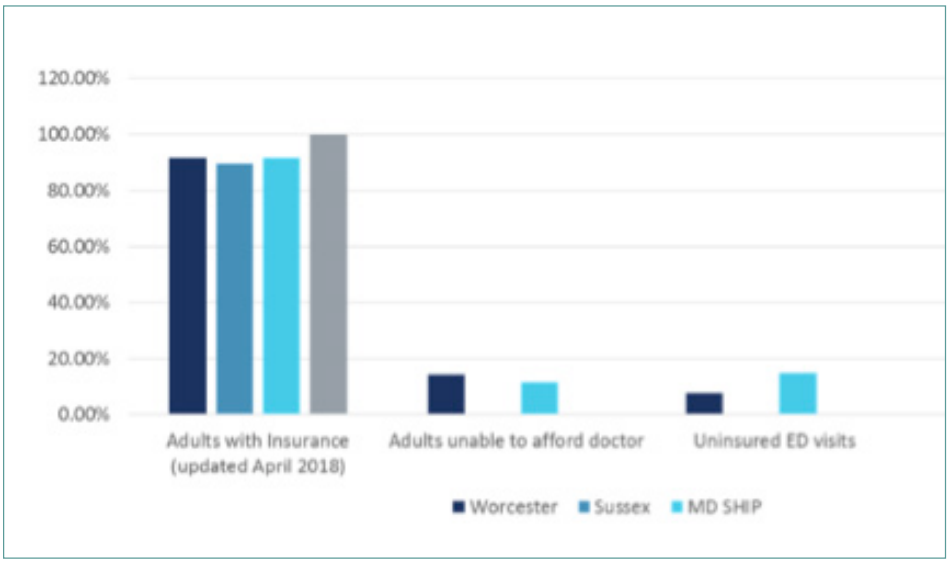
- AGH databases on ethnicity
- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/objectives
- Community Survey
- Maryland SHIP http://dhmh.maryland.gov/ship/Pages/home.aspx
- CHSI http://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/MD/Worcester/10019

Healthy People 2020





MD SHIP Summary



AGH Databases on Ethnicity and Community Survey – repeat in FY19 to compare

(Note: Effective 2017, Community Health Status Indicators 2015 (CHSI) are no longer available.)

https://www.cdc.gov/ophss/csels/dphid/CHSI.html

Priority Area: Cancer

Goal: Decrease the incidence of advanced breast, lung, colon, and skin cancer in community.

Healthy People 2020 Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.

Action:

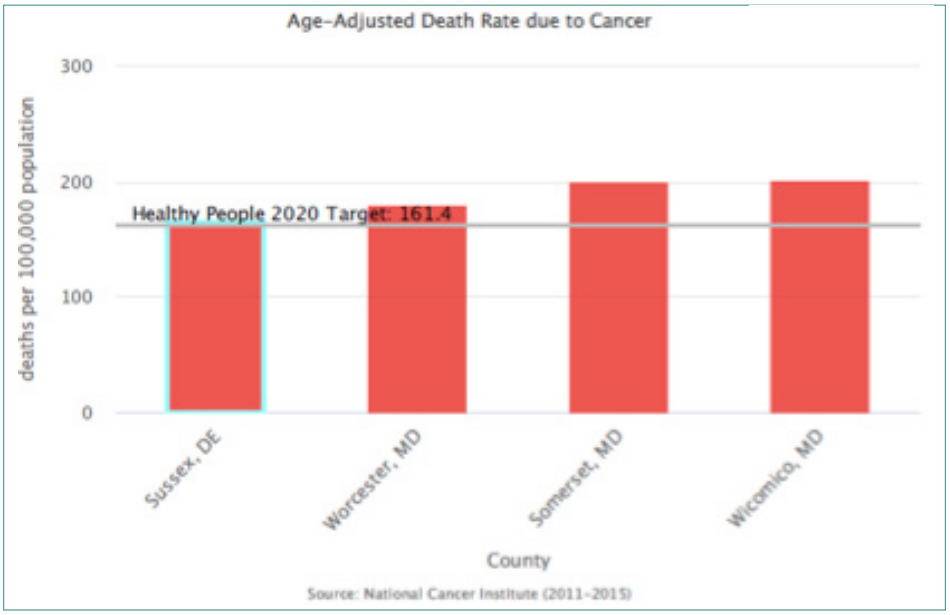
- Recruit proper professionals in community to provide for cancer related treatment
- Provide community health screenings
- Partner with local health agencies to facilitate grant application to fund cancer programs
- Improve proportion of minorities receiving colonoscopy screenings
- Improve proportion of minorities receiving LDCT screenings
- Improve proportion of minorities receiving women's preventative health services
- Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn through melanoma education and skin cancer screenings.

Measurement:

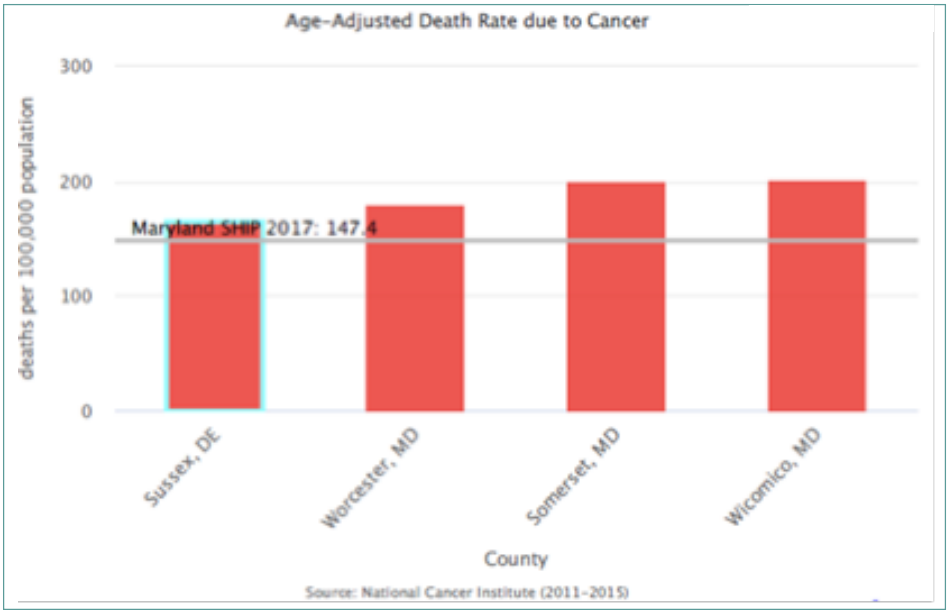
- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives
- AGH databases on ethnicity
- Maryland SHIP http://dhmh.maryland.gov/ship/Pages/home.aspx*
- CHSI http://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/MD/Worcester/310034

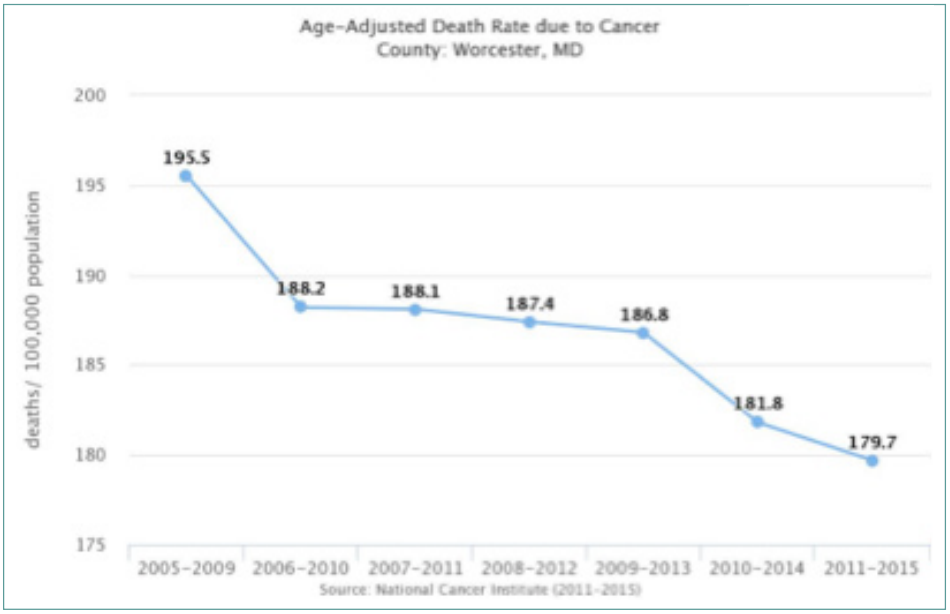
Progress Measurements:

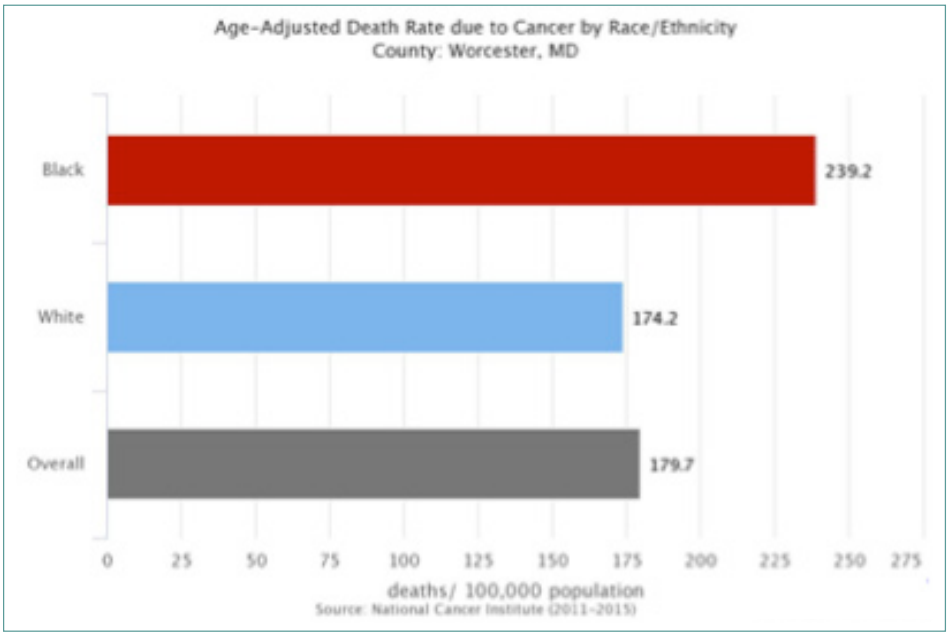
Healthy People 2020



MD SHIP 2017







AGH Internal Data

- Melanoma remains #1 cancer seen in AGH ED FY16-18
- Lung cancer remains highest mortality among African American males FY16-18 – advanced stage diagnosis
- RCCC Capital Campaign
- Before AGH began their lung cancer screening program, 88% of all lung cancer patients were diagnosed at the most advanced stage. That percentage has been steadily decreasing, and last year only 36% of patients diagnosed with lung cancer had an advanced stage. In 2017, 157 patients participated in being screened for lung cancer and continue to be followed at appropriate intervals.
- Community free cancer screening events – ›500 persons served
- Community cancer prevention education events – ›50 events AGH Database on Ethnicity – compare to FY19
- CHSI: Effective 2017, Community Health Status Indicators 2015 (CHSI) no longer available https://www.cdc.gov/ophss/csels/dphid/CHSI.html

Priority Area:
Respiratory Disease, including Smoking

Goal: Promote community respiratory health through better prevention, detection, treatment, and education efforts.

Healthy People 2020 Goal: Promote respiratory health through better prevention, detection, treatment, and education efforts.

Action:

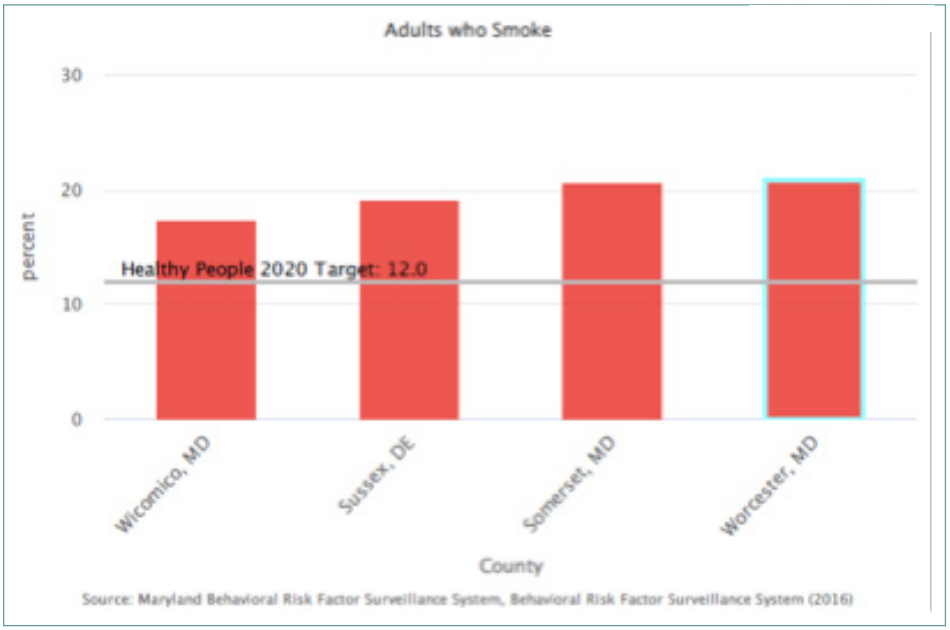
- Recruit Pulmonologist to community
- Improve proportion of minorities receiving LDCT screenings
- Collaborate with Worcester County Health Department Prevention Department
- Reduce emergency department (ED) visits for chronic obstructive pulmonary disease (COPD) and asthma
- Provide speakers to community groups on smoking cessation
- Participate in community events to spotlight pulmonary clinic services
- Improve Health Literacy in middle schools related to tobacco use

Measurement:

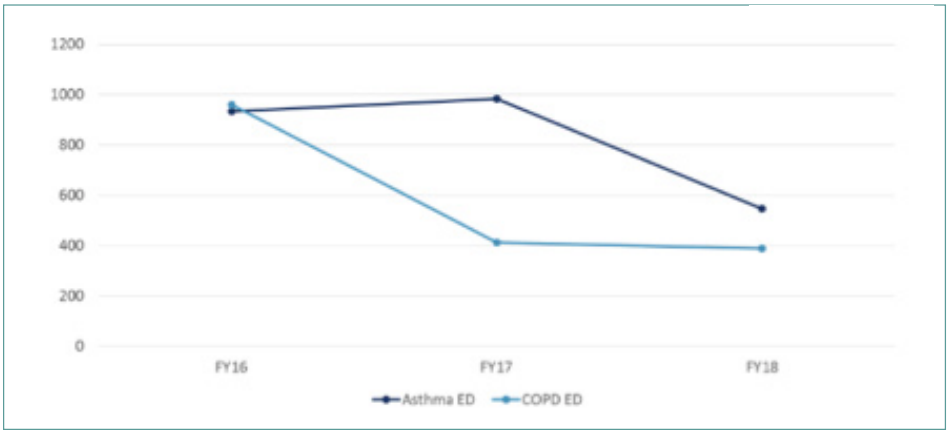
- Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/respiratory- diseases/objectives
- Decrease ED visits due to acute episodes related to respiratory condition
- CHSI http://wwwn.cdc.gov/CommunityHealth/home
- Maryland SHIP http://dhmh.maryland.gov/ship/Pages/home.aspx

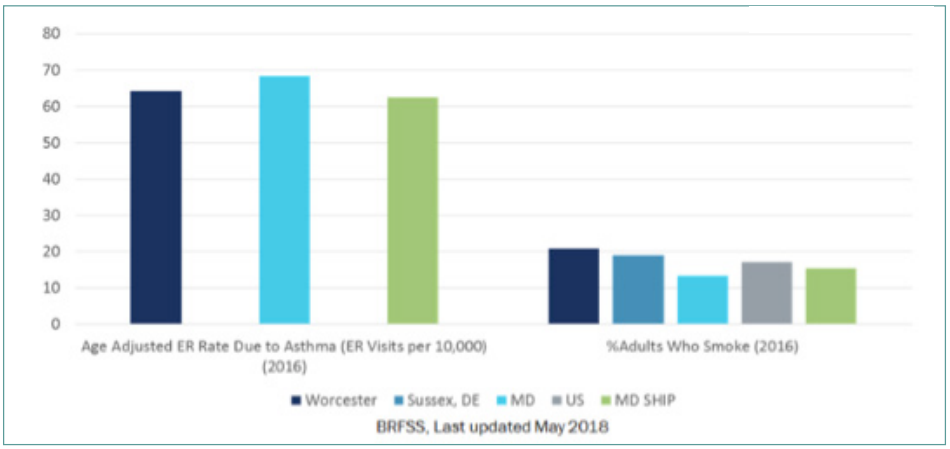
Progress Measurements:

Healthy People 2020



AGH Internal Data – ED Visits





CHSI: Effective 2017, Community Health Status Indicators 2015 (CHSI) no longer available

https://www.cdc.gov/ophss/csels/dphid/CHSI.html

Priority Area: Nutrition, Physical Activity & Weight

Goal: Support community members in achieving a healthy weight.

Healthy People 2020 Goal: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.

Action:

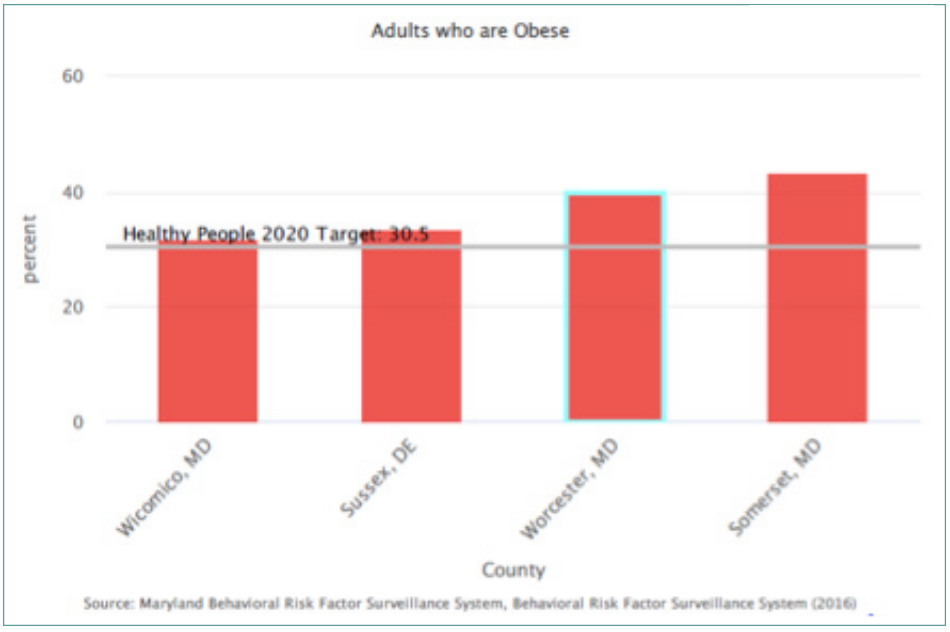
- Improve Health Literacy in elementary and middle schools related to nutrition and exercise
- Participate in the "Just Walk" program of Worcester County
- Distribution brochure to public about Farmer's Market & fresh produce preparation
- Integrate Healthy People 2020 objectives into AGHS offices
- Provide Hypertension and BMI screenings in the community
- Provide speakers to community groups on nutrition
- Continue to provide education on health living topics to Faith-based Partnership and community senior centers
- Participate in community events to spotlight surgical and non-surgical weight loss services

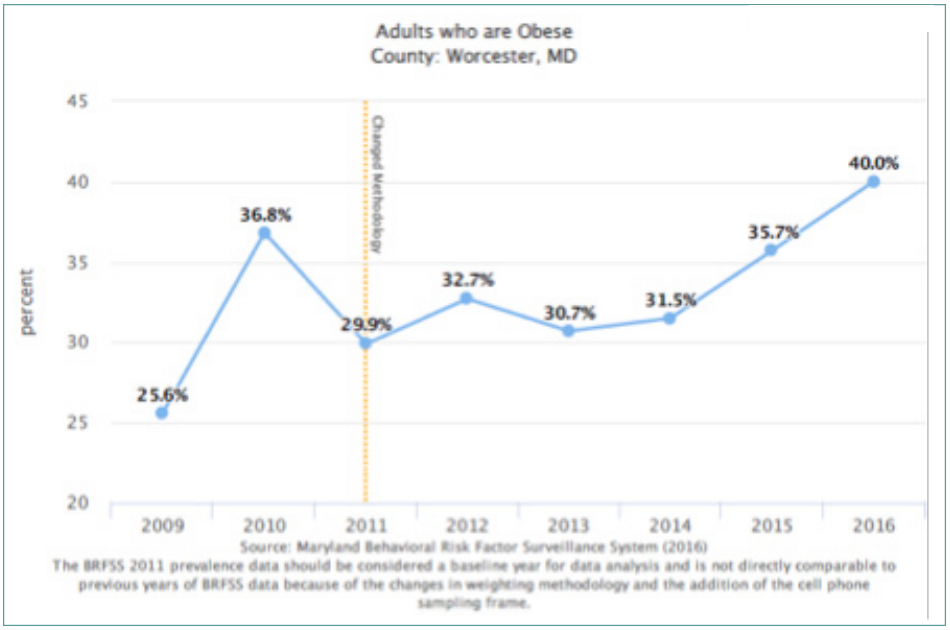
Measurement:

- Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status/objectives
- County Health Rankings
- Maryland SHIP http://dhmh.maryland.gov/ship/Pages/home.aspx

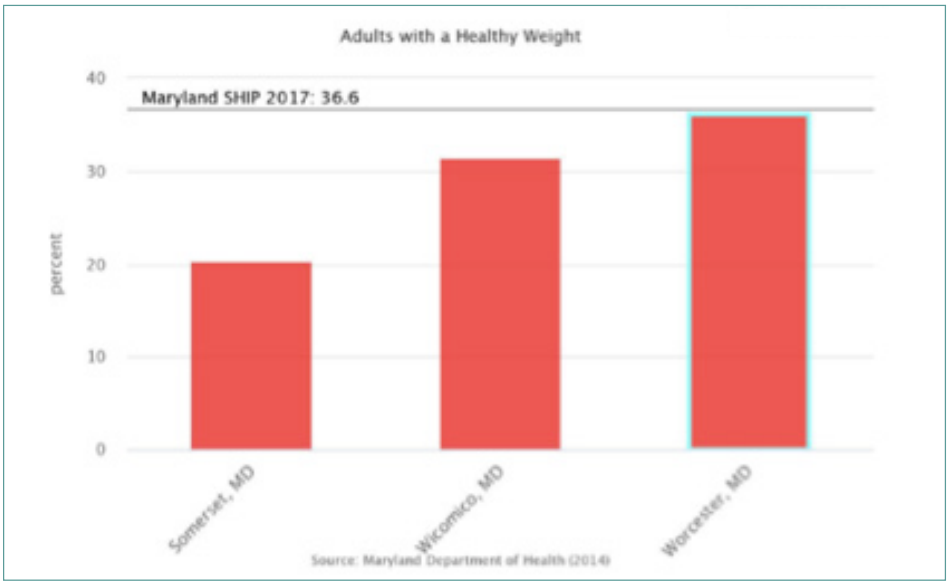
Progress Measurements:

Healthy People 2020





MD SHIP



Priority Area: Diabetes

Goal: Decrease incidence of diabetes in the community.

Healthy People 2020 Goal: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.

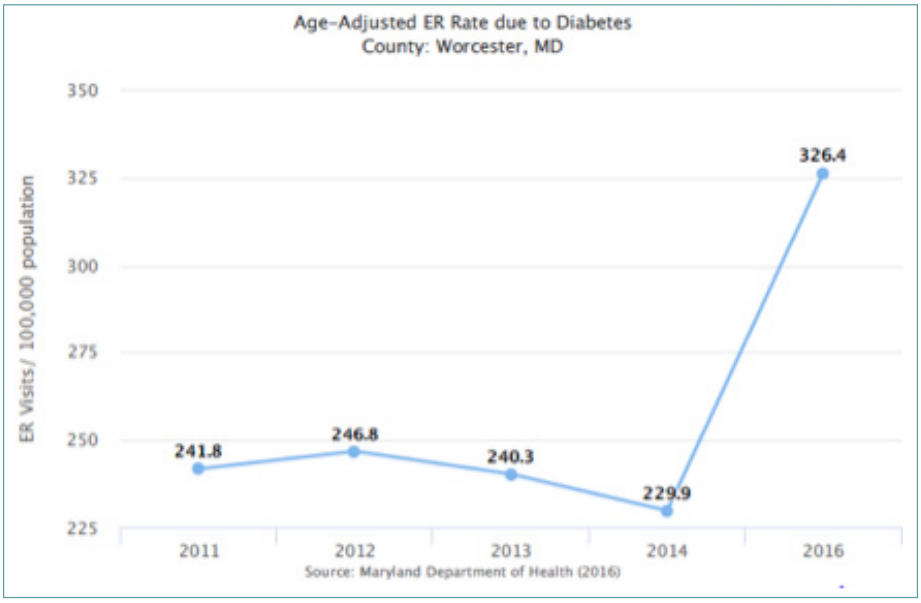
Action:

- Continue to provide Diabetes Education in Patient Centered Medical Home
- Partner with local health agencies to facilitate grant applications to fund diabetes programs
- Participate on Tri-County Diabetes Alliance
- Provide diabetes screenings in community
- Increase prevention behaviors in persons at high risk for diabetes with prediabetes
- Recruit Endocrinologist to community

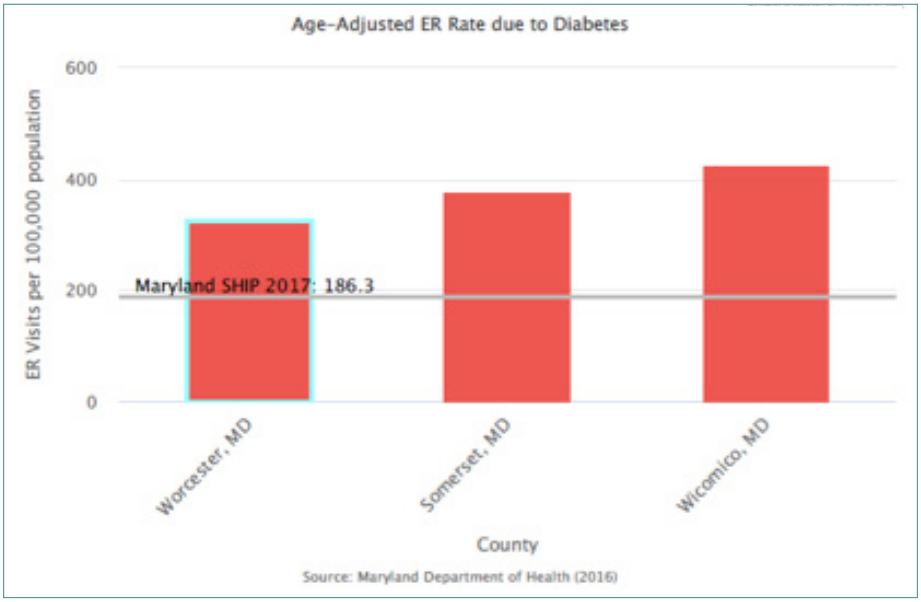
Measurement:

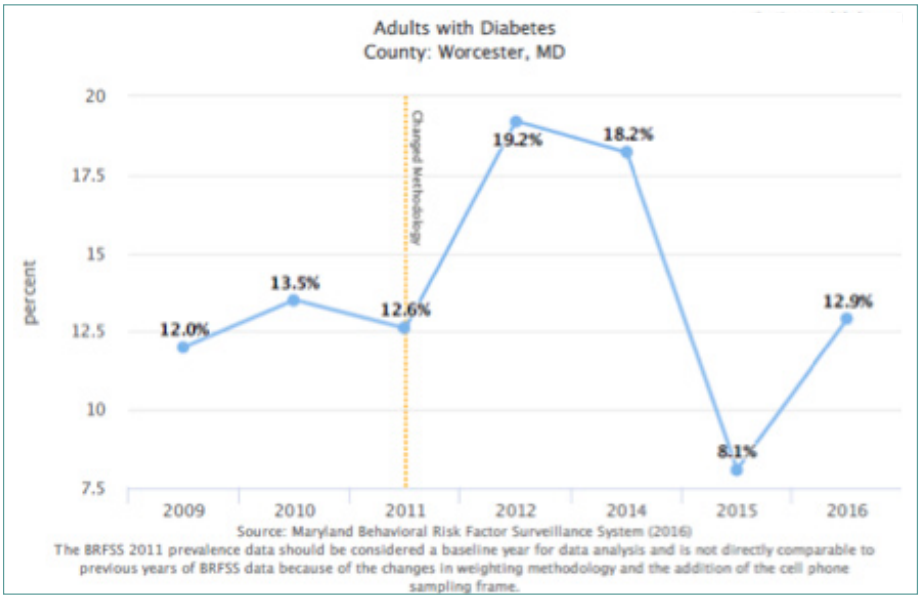
- Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes/objectives
- Incidence of adult diabetes
- Decrease ED visits due to acute episodes related to diabetes condition
- County Health Rankings
- Maryland SHIP http://dhmh.maryland.gov/ship/Pages/home.aspx

Progress Measurement:



Maryland SHIP





Priority Area: Heart Disease & Stroke

Goal: Improve cardiovascular health of community.

Healthy People 2020 Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events.

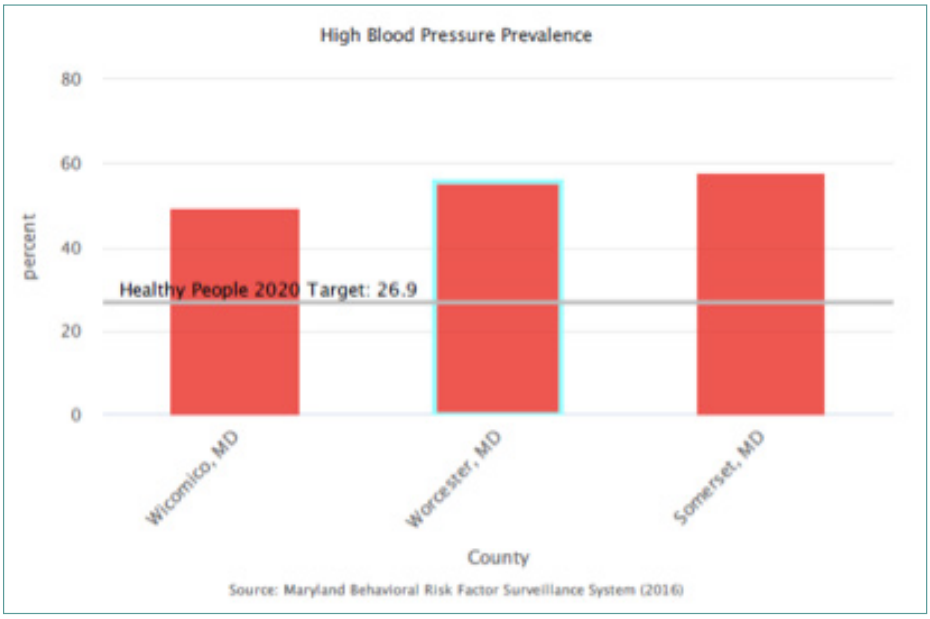
Action:

- Ensure proper professionals in community to provide vascular care
- Maintain AGH/HS campus and locations as tobacco free
- Increase community health screenings for high blood pressure, carotid artery and cholesterol
- Decrease readmissions to hospital for chronic disease management
- Utilize Faith Based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management
- Improve Health Literacy in elementary and middle schools related to heart health

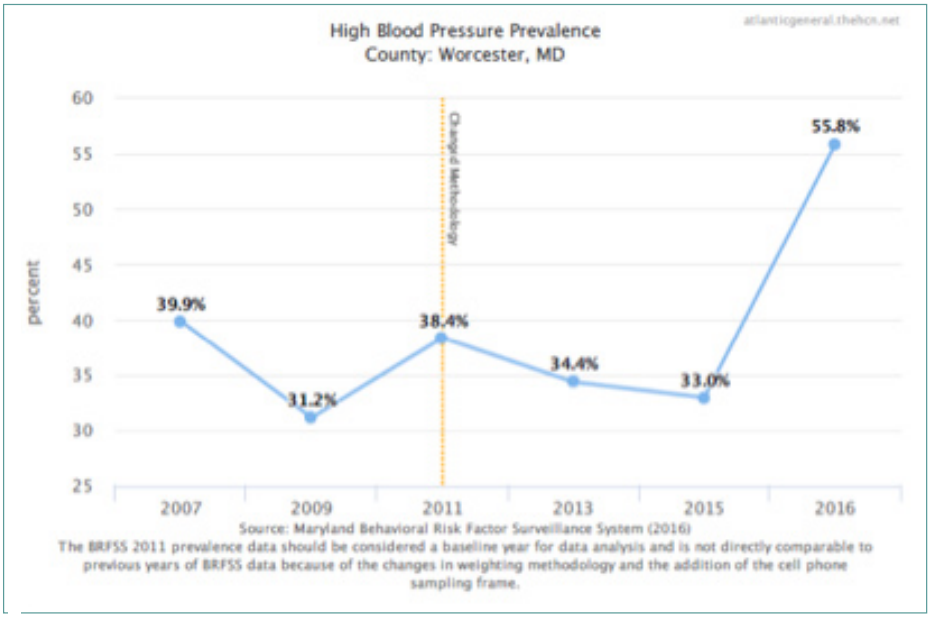
Measurement:

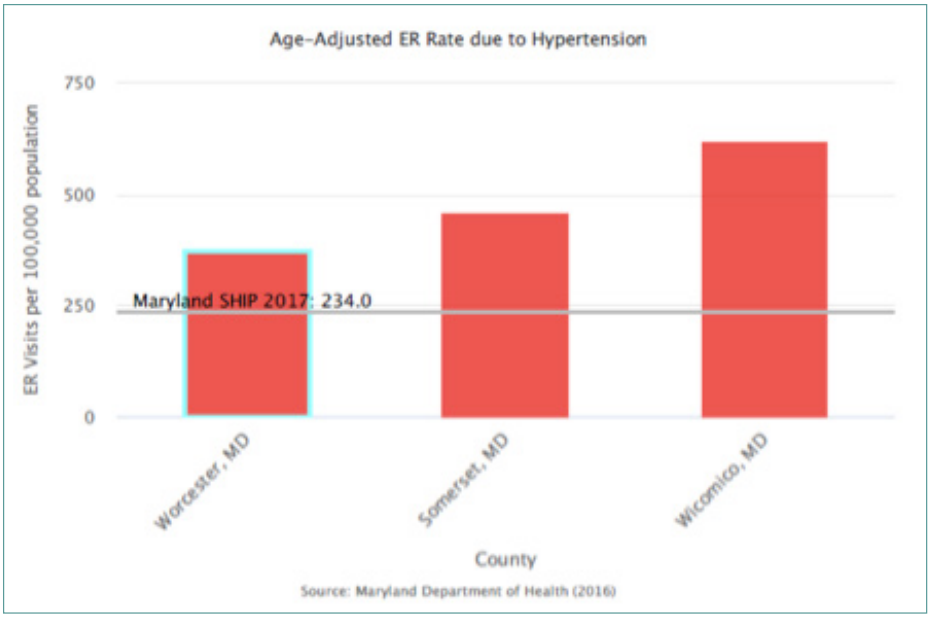
- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/heart-disease-and-stroke/objectives
- Readmission rate
- MD SHIP

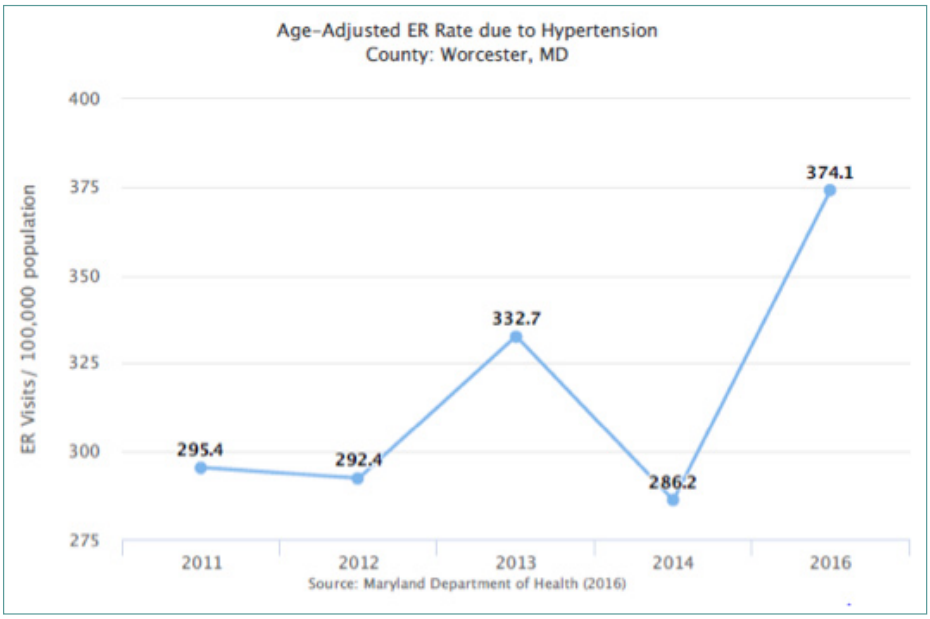
Progress Measurement:

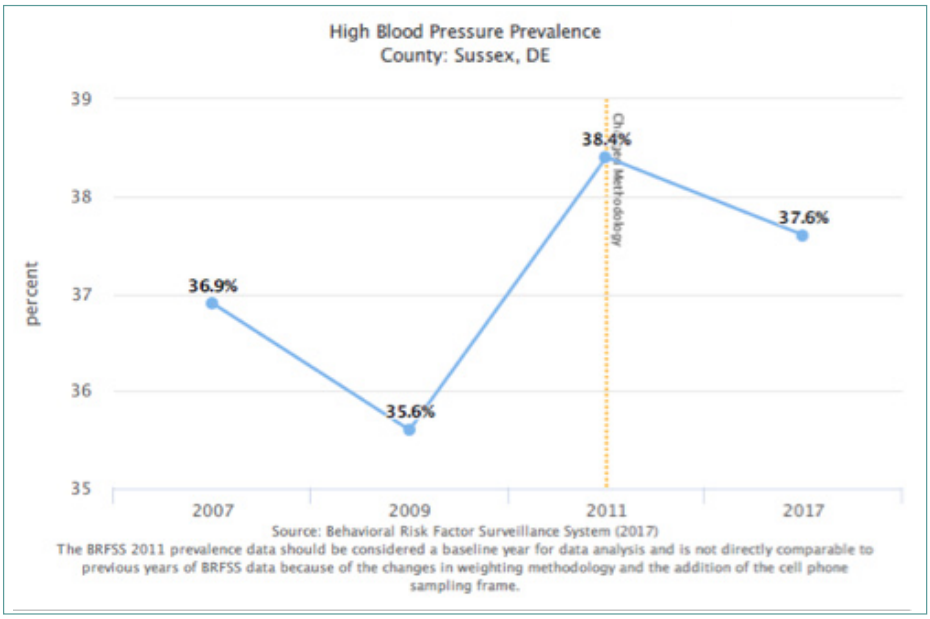


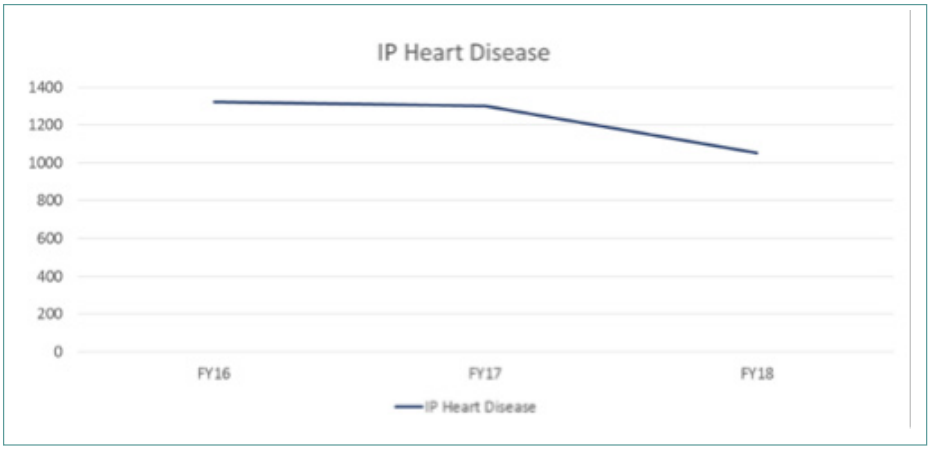
Healthy People 2020




Age-Adjusted ER Rate due to Hypertension
ER Visits per 100,000 population
750
500
250
0
Maryland SHIP 2017: 234.0
Worcester, MD
Somerset, MD
Wicomico, MD
County
Source: Maryland Department of Health (2016)


Age-Adjusted ER Rate due to Hypertension
County: Worcester, MD
ER Visits/ 100,000 population
400
375
350
325
300
275
295.4
292.4
332.7
286.2
374.1
2011
2012
2013
2014
2016
Source: Maryland Department of Health (2016)


High Blood Pressure Prevalence
County: Sussex, DE
percent
39
38
37
36
35
36.9%
35.6%
38.4%
37.6%
Change in Methodology
2007
2009
2011
2017
Source: Behavioral Risk Factor Surveillance System (2017)
The BRFSS 2011 prevalence data should be considered a baseline year for data analysis and is not directly comparable to previous years of BRFSS data because of the changes in weighting methodology and the addition of the cell phone sampling frame.



AGH Internal Data

Priority Area: Mental Health

Goal: Promote and ensure local resources are in place to address mental health.

Healthy People 2020 Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.

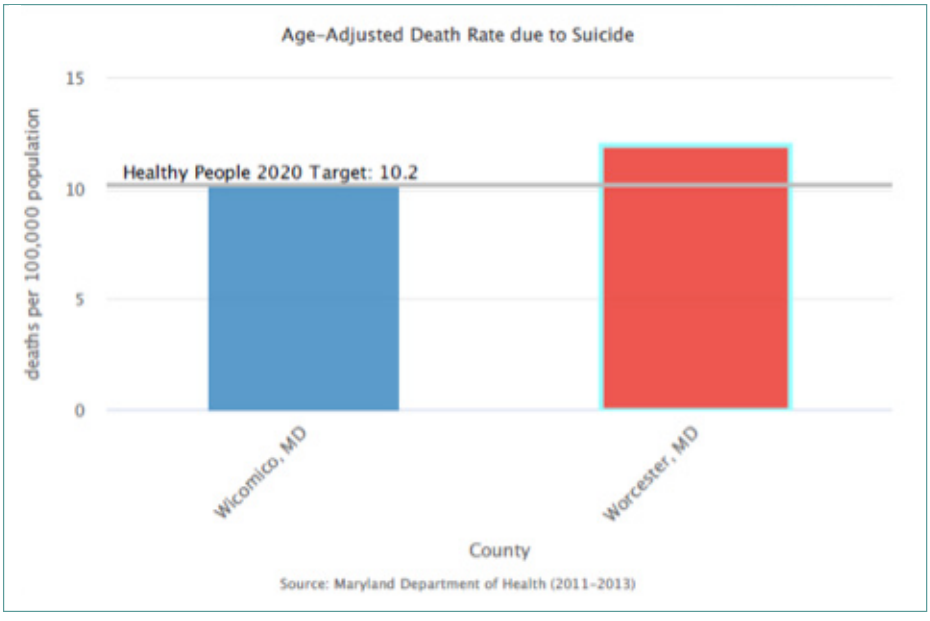
Action:

- Increase access and continue to collaborate with Sheppard Pratt telemedicine services to provide additional psychiatry professional
- Participate in community events to spotlight mental health services
- Engage critical response teams when a mental health crisis is discovered
- Improve Health Literacy in middle schools related to mental and emotional health
- Recruit Psychiatrist to the community

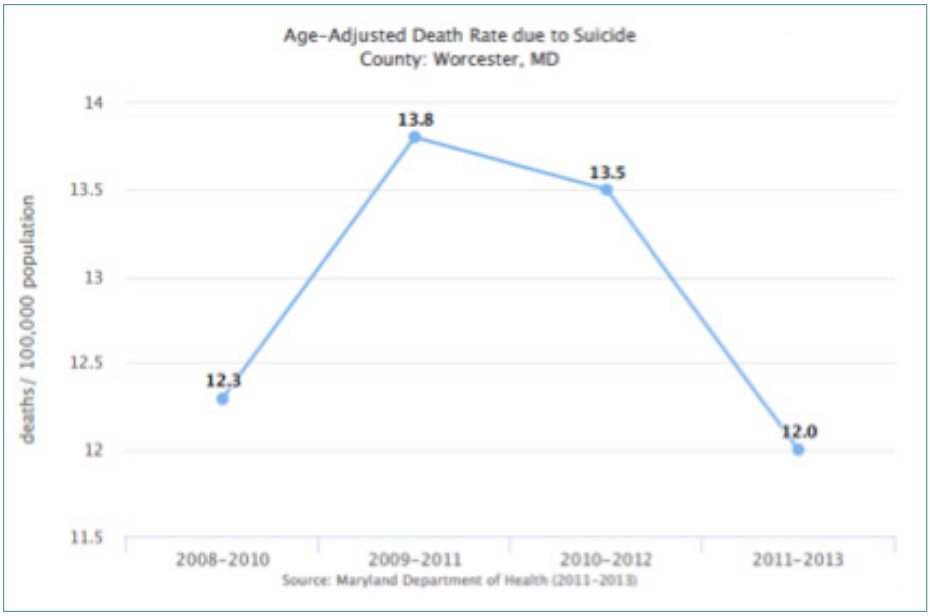
Measurement:

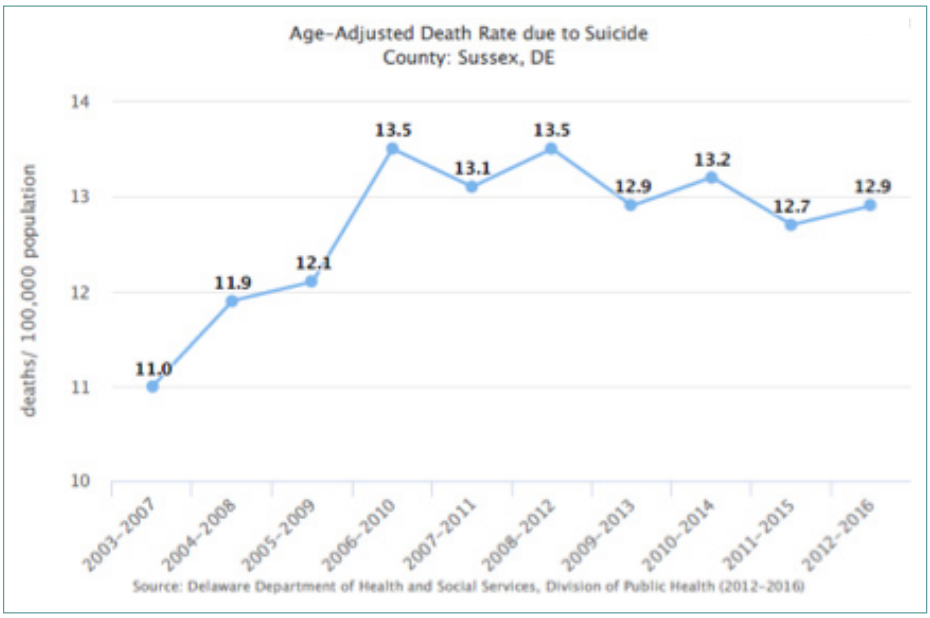
- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders
- Behavioral Risk Factor Surveillance System
- County Health Rankings
- MD SHIP

Progress Measurement:

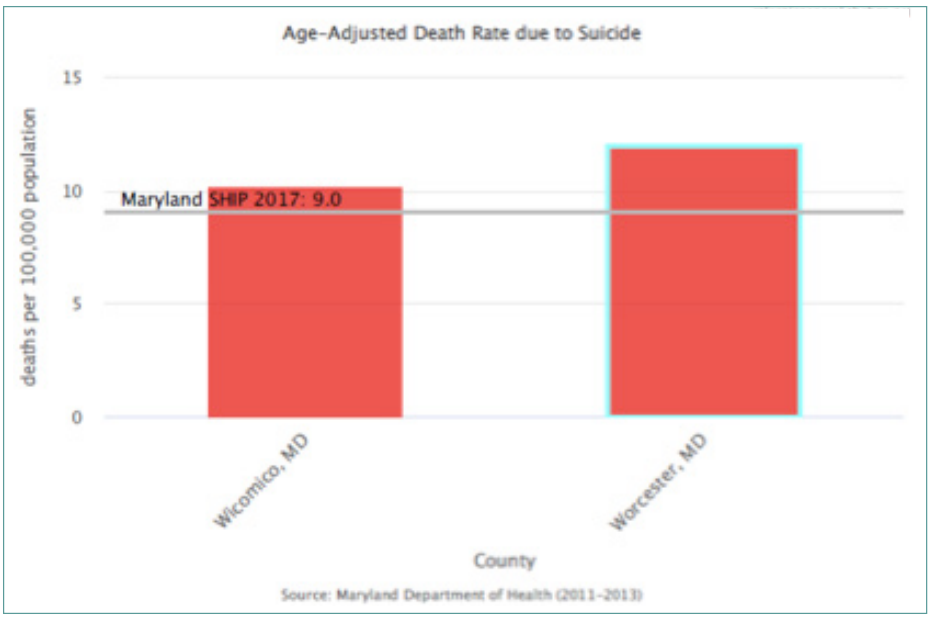


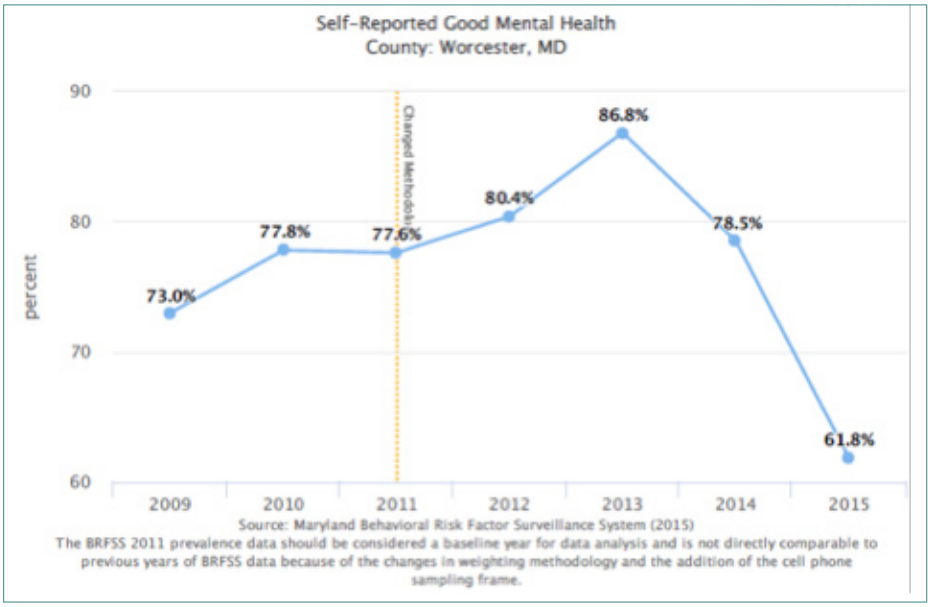
Healthy People 2020





Maryland SHIP





BRFSS

Priority Area: Opioid Abuse

Goal: Reduce opioid substance abuse to protect community health, safety, and quality of life for all.

Healthy People 2020 Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

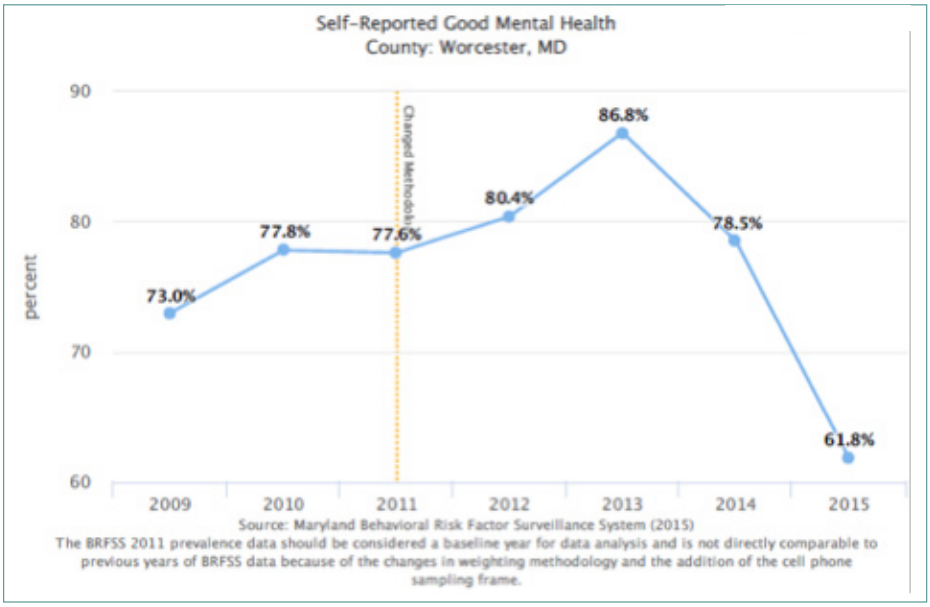
Action:

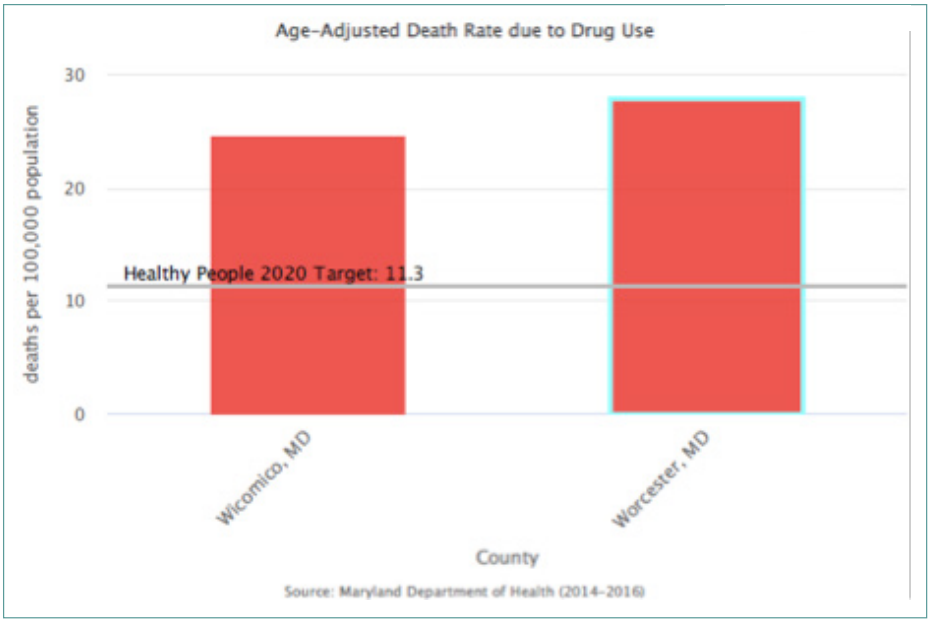
- Participate on WOW Committee
- Participate on Opioid Task Force
- Increase Health Literacy in middle schools r/t opioid use
- Provide educational opportunities to raise community awareness about opioid use
- Participate in Worcester County Health Department naloxone training sessions sponsored by Opiate Overdose Prevention Program
- Increase the proportion of persons who are referred for follow-up care for opioid problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED)
- Evaluate and educate organization and community on appropriate prescribing practices
- Implement Prescription Drug Maintenance Program (PDMP) via CRISP

Measurements:

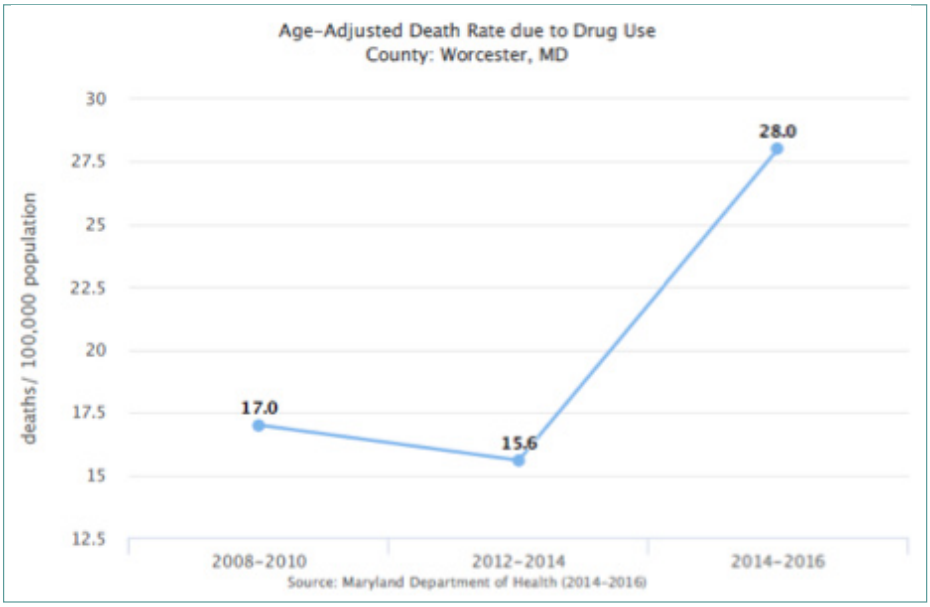
- Community Survey
- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse
- Pain management referrals

Progress Measurement:

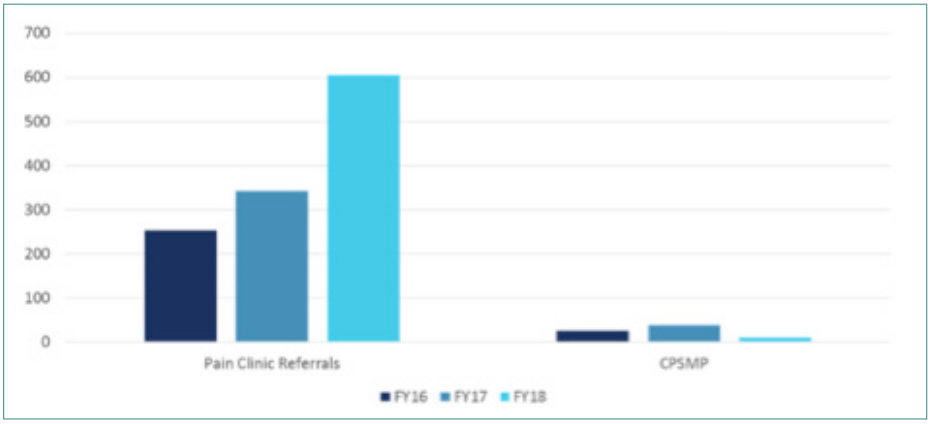




Healthy People 2020



Pain Management Referrals – AGH Internal Data



Community Survey – compare to FY19

Priority Area:
Arthritis, Osteoporosis & Chronic Back Pain

Goal: Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions in the community.

Healthy People 2020 Goal: Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions.

Action:

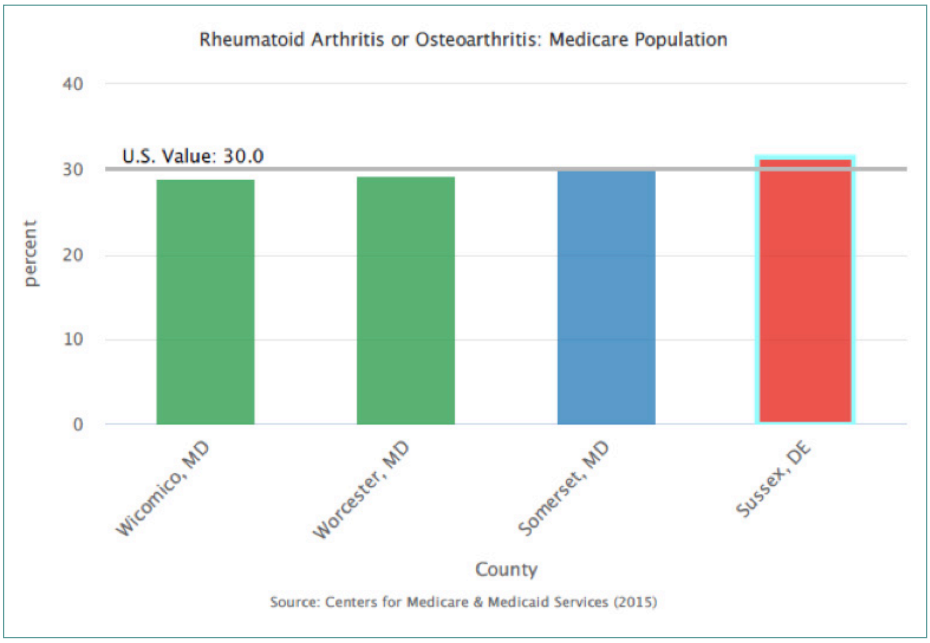
- Utilize Faith Based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic pain workshops
- Recruit Rheumatologist to community
- Utilize Women's Diagnostic Health Services, to provide access to high risk populations about healthy lifestyles and bone density screenings
- Implement Osteopenia Intervention Program
- Provide educational opportunities to raise community awareness about osteopenia/osteoporosis and provide bone density screenings
- Increase accurate and up-to-date information and referral service

Measurements:

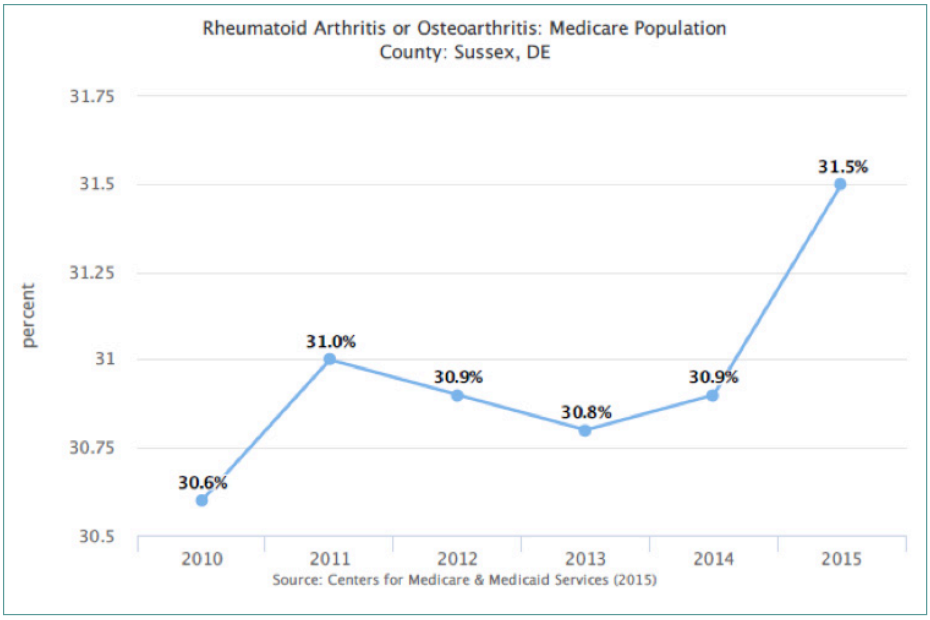
- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/Arthritis-Osteoporosis-and-Chronic-Back-Conditions
- CPSMP Workshop attendance
- Community Survey

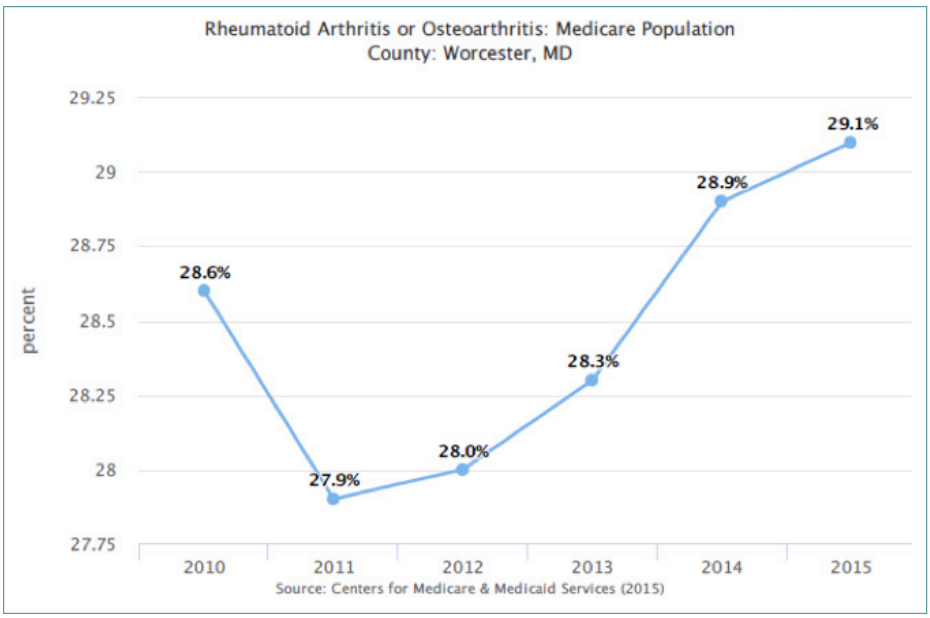
Progress Measurements:

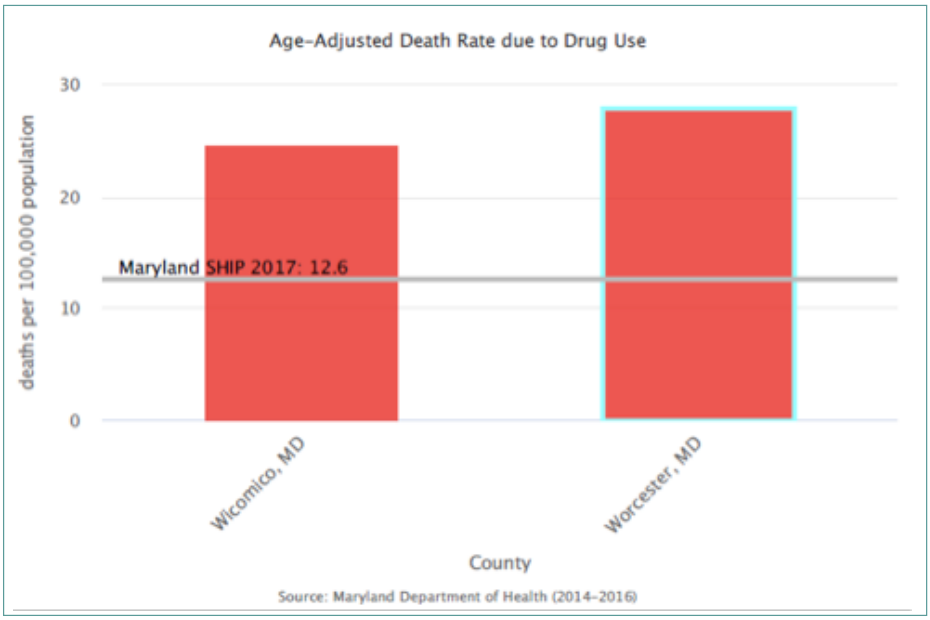
- CPSMP Workshop attendance 281 encounters FY16-18 (Source: AGH Internal Data)
- Community Survey – repeat in FY19 to compare



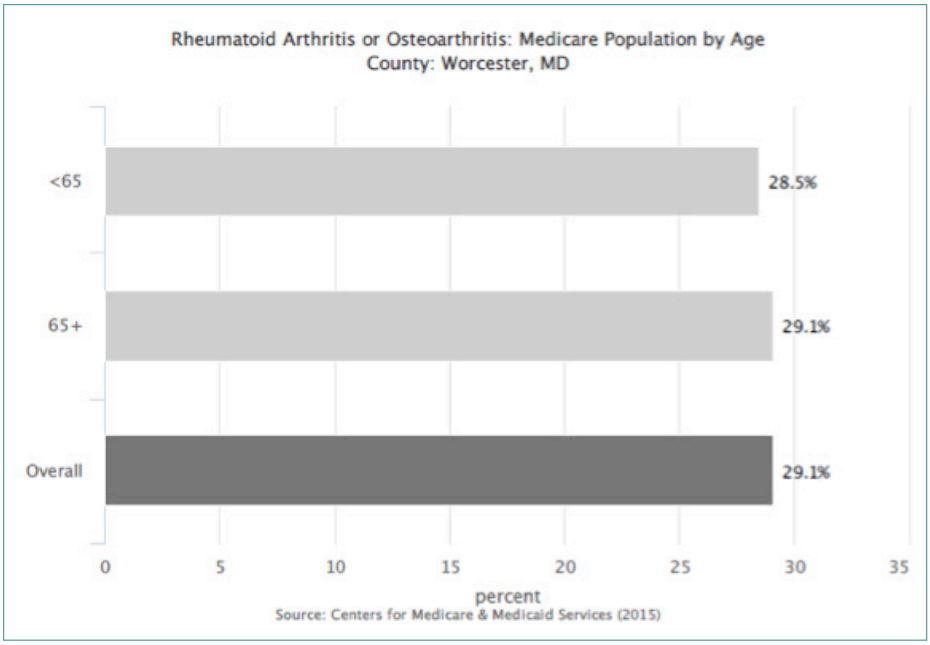
Healthy People 2020







Maryland SHIP



Strategic Vision 2020

Continuing to build upon our Mission "To create a coordinated care delivery system that will provide access to quality care," the AGH 2020 Vision will drive strategic decisions toward integration beyond the acute care facility. These decisions will build upon the current investments in developing community-based care delivery systems that incorporate primary care, specialty care, and care management of chronic conditions through our PCMH.

Accomplishing our Vision will require disciplined investment of time and resources in the "Right" principles:

Right Care – Patient/Family Centric, Error Free, Primary Care Provider-Driven, Timely Delivery, Best Practice Protocols;

Right People – Needs-Based Provider Recruitment, Service Orientation, Right Training, Continuous Learning;

Right Place – Appropriate Distribution of Primary Care, Availability of Specialists, Telemedicine, Community-Based vs. Hospital Based;

Right Partners – Advanced Acute Care Referral Relationships, Rehabilitation Care, Long-Term Care, Home Health Care, Supportive Care/Hospice, Mental Health Care, Accountable Care;

Right Hospital – The Right Leader for Coordinated Quality Care in our Community.

Our "2020 Vision" will build upon our distinctive competencies to create a new system of health. Investment in technology-based solutions will facilitate care being distributed more evenly throughout our region, creating equity in access to all. Building upon our health literacy initiatives and our relationship with the Worcester County Health Department, AGH will be a leader in addressing the individual factors that affect health promotion and prevention of disease. Continuing to promote health care interventions driven by patient-centered values to improve individual function and well-being will result in improved quality of life for those who choose to live in our community.

Strategic implications:

Building upon our previous Strategic Plans, we will focus on:

- Continued collaboration with local, state and community partners;
- Prioritizing capital investment in areas of IT, such as PERKS Optimization and Telemedicine, that will overall improve coordination of care, quality of care, and efficiency for the patient;
- Creating a collaborative care model for the delivery of care within the hospital and with pre- and post-acute care providers, in an electronic environment;
- Measuring patient outcomes throughout the system by establishing optimal health and wellness goals for patients;
- Reducing unnecessary steps throughout our system to optimize the patient experience, reduce opportunity for errors, and enhance economic stability.

A primary clinical component of this strategy that will be achieved through the continued integration of clinical care, IT, physician practice and patient involvement is the AGH Patient Centered Medical Home Model. Other coordinated care efforts include AGH Ambulatory Pharmacy Transitions in Care Program and the AGH Perioperative Surgical Home Model. Achievement of each collaborative care delivery model for those in our community with chronic illnesses, medication management needs and/or surgical services will improve access to care, reduce unnecessary visits to our ED and unnecessary admissions, and provide a continuous virtual connection for those utilizing AGH/HS services.

Other needs identified in the CHNA but not addressed in this plan:

Each of the health needs listed in the Hospital's CHNA as well as Worcester County Health Department's Community Needs Assessment is important and is being addressed by numerous programs and initiatives operated by the Hospital and/or other community partners of the Hospital. Needs not addressed as a priority area in the Implementation Plan are being addressed in the community by other organizations and by organizations better situated to address the need.

Needs Not Addressed In Plan	Rationale
Dental/Oral Health	-Need addressed by Worcester County Health Department's Dental Services for pregnant women and children less than 21 years of age -Priority Area Worcester CHIP -Need addressed by Lower Shore Dental Task Force & Mission of Mercy for adult population -Need addressed by AGH ED referral to community resources -Need addressed by La Red Sussex County -Need addressed by TLC, a federally funded dental clinic for Somerset and Wicomico Counties
Injury & Violence	-Need addressed by Worcester County Health Department Programs: Child Passenger Safety Seats Injury Prevention Highway Safety Program Safe Routes to School -Need addressed by Worcester County Sheriff's Department, State Police and Municipal Law Enforcement Agencies -Need addressed by AGH Health Literacy Program
Immunizations & Infectious	-Need addressed by Worcester County Health Department Programs: Immunization Program Communicable Disease -Priority Area Worcester CHIP -Need addressed by DHMH World Hepatitis Day
HIV & STD (<2% ea)	-Need addressed by Worcester County Health Department Communicable Disease Programs
Alcohol	-Need addressed by Worcester County Health Department Behavioral Health and Prevention Services Addictions Program -Need addressed by local AA organization -Need addressed by Drug and Alcohol Council

Notes

9733 Healthway Drive • Berlin, MD 21811
www.agh.care

Implementation Plan of Needs Identified in the
Community Health Needs Assessment
FY19-FY21

Community Needs Assessment

In 2018-19, AGH in coordination with the local health departments, neighboring hospitals and community stakeholders, conducted a community needs assessment. The needs assessment is a primary tool used by the Hospital to determine its community benefit plan, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of our service area. The Community Health Needs Assessment (CHNA) was approved by the Hospital's Board of Trustees in May 2019.

Needs Identified

This 2019-2021 CHNA combines population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH uses Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs.

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (surveys) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes information gathered through ongoing key community groups.

Secondary Data Collection AGH partners with surrounding hospitals, health departments and state agencies to bring to together a multitude of information. This Community Health Needs Assessment, a follow-up to a similar study conducted in 2012 and 2015, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area of Atlantic General Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness. The information as well as other surveys, research and community data are used to identify issues of greatest concern and guide resource allocation to those areas, thereby making the greatest possible impact on community health status. The needs assessment is a primary tool used by the Hospital to determine its community benefit priorities, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focuses on the health and social needs of our service area. A sampling of resources utilized to complete the assessment is listed below. A comprehensive list is found under CHNA FY19-21 references.

• Community meetings with persons representing the broad interests of the community
• AGH Community Needs Survey
• Maryland State Health Improvement Process (SHIP) www.dhmh.maryland.gov/ship
• Tri-County Health Improvement Plan (T-CHIP)
• Healthy People 2020
• Worcester County Community Health Improvement Plan (CHIP) LHIC Local Health Improvement Coalition
• 2018 Medical Staff Development Plan
• Health Fairs
• Community Education Events
• 2018 County Health Outcomes & Roadmaps
• State of Delaware Health Needs Assessment www.dhss.delaware.gov/dhss/dph/fles/shaship.pdf
• Delaware Health and Social Services through the Delaware Health Tracker ww.delawarehealthtracker.com
• Beebe Medical Center Community Health Needs Assessment www.beebehealthcare.org/sites/default/fles/1-CHNA%20FINAL%20DRAFT_0.pdf
• US Census Bureau

Needs Identified

The Community Health Needs Assessment survey was distributed by community outreach personnel and the Atlantic General Hospital website. Stakeholder interviews and focus groups were conducted by community outreach personnel. Community surveys represent information that is self-reported. Results from the paper surveys (286) and electronic versions (222) are found in CHNA FY19-21, Appendix G.

The top health concerns among 2018 survey respondents were prioritized as listed:
#1 Cancer
#2 Diabetes/Sugar
#3 Overweight/Obesity
#4 Smoking, drug or alcohol use
#5 Heart Disease
#6 Mental Health
#7 High Blood Pressure/Stroke
#8 Access to Healthcare / No Health Insurance
#9 Dental Health
#10 Asthma / Lung Disease
#11 Injuries
#12 Sexually transmitted disease & HIV

Bold items addressed as priority areas in implementation plan.
Italicized items not addressed as priority areas in implementation plan.

Top Health Concern Priorities Over The (3) CHNA			
	2012	2015	2018
Cancer	1	1	1
Diabetes/Sugar	4	3	2
Overweight/Obesity	3	2	3
Smoking, drug or alcohol use	5	5	4
Heart Disease	2	4	5
Mental Health	7	7	6
High Blood Pressure/Stroke	6	6	7
Access to Healthcare / No Health Insurance	8	8	8
Dental Health	10	10	9
Asthma / Lung Disease	9	9	10
Injuries	11	11	11
Sexually transmitted disease & HIV	12	12	12

Prioritized Needs

Key findings from all resources were used as a framework to develop community benefit priorities. These are closely aligned with local, state, and national priority areas. The process for determining the priorities of the Community Outreach programs involves many people inside and outside the organization. The hospital's strategic initiatives are determined by the Hospital Board of Trustees, the Medical Staff and the Leadership of the hospital. Each year those long term initiatives are evaluated and updated with environmental information, such as the most recent Community Health Needs Assessment. In addition to input from those groups there are two committees that have a part in setting our priorities; they are the Community Benefits Committee and the Healthy Happenings Advisory Board. The Healthy Happenings Board is made up of hospital and community members who have a health connection in the community. Through this board we are able to keep our pulse on the needs of the community. Each department in the hospital has an appointee who sits on the Community Benefits Committee. The purpose of this committee is to oversee the Community Outreach of the hospital and comply with the government regulations regarding reporting Community Benefits. Because the committee is made of all departments the views are varied. Annual evaluations of each initiative's success are found in the HSCRC Community Benefit Report sent to the State of Maryland.

Our hospital leaders are involved on many community boards and community entities (both for profit and not-for-profit). Through these boards we are able to keep abreast of the underserved, low income and/or minority needs in the community. We are involved in the health departments throughout our service area in Maryland and Delaware and coordinate services with them to decrease duplication of services and know what services are needed to fill the gaps. Obviously working with the target areas of the state improvement initiatives influences the priorities we set. Our Population Health outreach providers are out in the community and are able to observe community needs. Through our Patient Centered Medical Home, Care Coordination models and Population Health Department, we are able to have another resource in the community that we can use for assisting us in setting priorities.

The 2019-2021 Community Benefit priorities are based on the criteria of:
• Size and severity of the problem determined by what percentage of the population is affected by risks
• Health system's ability to impact the need
• Availability of resources
They were graded as high (3), moderate (2) and low (1) to rank the priority, based on self-reported survey data and prioritized as above.

Areas of Opportunity		Ø size and severity of the problem determined by what percentage of the population is effected by risks	Ø health system's ability to impact the need	Ø availability of resources	Total
Access to Health Services	Difficulty getting a physician appointment Physician recruitment Cost of care	high	high	high	9
Cancer	Prevalence of Cancer	high	high	high	9
Diabetes	Prevalence of Diabetes Borderline/Pre-Diabetes	high	mod	high	8
Respiratory Disease	COPD Asthma diagnosis	mod	mod	high	7
Nutrition, Physical Activity & Weight	Prevalence of overweight & obesity Meeting physical activity guidelines lack of leisure time physical activity	high	mod	mod	7
Heart Disease & Stroke	Heart Disease Prevalence High Blood Pressure High blood cholesterol Overall Cardiovascular Risk	high	mod	mod	7
Behavioral Health	Mental Health, Suicide prevention Substance Abuse	high	mod	low	6
Arthritis, Osteoporosis & Chronic back conditions	Prevalence of Sciatica/Chronic Back Pain	mod	low	high	6

FY19-21 Priority Areas
Access to Health Services
Cancer
Diabetes
Respiratory Disease
Nutrition, Physical Activity & Weight
Heart Disease & Stroke
Behavioral Health
Arthritis, Osteoporosis & Chronic Back Conditions

Implementation Plan

Priority Area: Access to Health Services

Goal: Increase community access to comprehensive, quality health care services.

Healthy People 2020 Goal: Improve access to comprehensive, quality health care services.

Anticipated Impact:

- Reduce unnecessary healthcare costs
- Reduction in hospital admissions and readmissions
- Increase in awareness and self-management of chronic disease
- Reduce health disparities
- Increase community capacity and collaboration for shared responsibility to address unmet health needs
- Increase number of practicing primary care providers and specialists to community

Impact Rationale: Atlantic General Hospital is the only hospital in Worcester County, a DHMH federally-designated medically-underserved area, a state-designated rural community, and a HRSA-designated Health Professional Shortage Area for primary care, mental health, and dental health. In AGH's service area, the top reasons for patients not seeking health care in our communities are cost, transportation, insurance plans or lack of insurance, appointment availability, and lack of providers. According to the Community Health Needs Assessment (CHNA) FY2019, the community rated the follow as the top barriers to access health care:

Too expensive/can't afford it	29.31%
No health insurance	23.53%
Couldn't get an appointment with my doctor	14.06%
No transportation	12.26%
Service is not available in our community	8.28%
Local doctors are not on my insurance plan	7.08%
Doctor is too far away from my home	5.48%

Action:

- Provide community health events to target minority populations
- Partner with homeless shelters and food pantries to promote wellness
- Utilize Faith-based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management
- Educate community on financial assistance options
- Educate community on ED appropriate use
- Increase the number of practicing primary care providers and specialists to community

- Participate on Worcester County Healthy Planning Advisory Council
- Participate on Homelessness Committee and HOT
- Refer community to local agencies such as Shore Transit and Worcester County Health Department for transportation assistance
- Participate on Tri County Health Planning Council and Local Health Improvement Coalition
- Participate on AGH's Health Equity Steering Committee to promote health equity and reduce disparities
- Pilot School Based Telehealth Program
- Promote patient engagement through adult health literacy initiative

Measurement:

- AGH database
- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/objectives
- Community Survey
- Maryland SHIP http://dhmh.maryland.gov/ship/Pages/home.aspx

Hospital Resources:

- Population Health Department
- AGH/HS
- Human Resources
- Registration/Billing Services
- Emergency Department
- Executive Care Coordination Team
- Health Equity Steering Committee

Community Resources:

- Faith-based Partnership
- Homelessness Committee
- Worcester County Healthy Planning Advisory Council
- Worcester County Health Department
- Worcester County Public Schools
- Diakonia
- Samaritan Shelter
- MD Food Bank and local pantries/soup kitchens
- Shore Transit
- Tri County Health Planning Council
- LHIC
- United Way

Priority Area: Cancer

Goal: Decrease the incidence of *advanced* breast, lung, colon, and skin cancer in community.

Healthy People 2020 Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.

Anticipated Impact:

- Increase awareness around importance of prevention and early detection
- Increase provider services in community to provide for cancer related treatment
- Reduce health disparities
- Improve access and referrals to community resources resulting in better outcomes
- Increase support to patients and caregivers
- Increase participation in community cancer screenings – especially at-risk and vulnerable populations

Impact Rationale: According to Healthy People 2020, continued advances in cancer detection, research and cancer treatment have decreased cancer incidences and death rates in the United States. Despite continued advances, cancer remains a leading cause of death second to heart disease in the United States. (Healthy People 2020)

Action:

- Recruit proper professionals in community to provide for cancer related treatment
- Provide community health screenings
- Partner with local health agencies to facilitate grant application to fund cancer programs
- Improve proportion of minorities receiving colonoscopy screenings
- Improve proportion of minorities receiving LDCT screenings
- Improve proportion of minorities receiving women's preventative health services
- Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn through melanoma education and skin cancer screenings.

Measurement:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives
- AGH database
- SHIP Measures
- Vital Statistics

Hospital Resources:

- Population Health Department
- Human Resources
- Foundation
- Women's Diagnostic Center
- Endoscopy
- Imaging
- Respiratory Therapy Department
- Regional Cancer Care Center
- AGH Cancer Committee

Community Resources:

- Worcester County Health Department
- Komen Consortium
- Relay for Life
- Women Supporting Women

Priority Area: Diabetes

Goal: Decrease incidence of diabetes in the community.

Healthy People 2020 Goal: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.

Anticipated Impact:

- Increase care for individuals suffering from chronic conditions
- Reduce unnecessary healthcare costs
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Increase awareness around importance of prevention of diabetes and early detection
- Increase provider services in community to provide for diabetes related treatment
- Increase participation in community glucose screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs

Impact Rationale: According to the CDC National Center for Health Stats (2015), national data trends for people with Diabetes show a significant rise in diagnoses. In the U.S., Diabetes is becoming more common. Diagnoses from 1980 – 2014 increased from 5.5 million to 22 million.

	Worcester County	Maryland	Sussex County	Delaware
Diabetic Monitoring (Medicare)	88%	85%	89%	86%
Diabetes Prevalence	13%	10%	13%	11%

(County Health Rankings, 2016)

Action:

- Partner with local health agencies to facilitate grant applications to fund diabetes programs
- Provide Diabetes Support Group
- Explore Diabetes Education opportunities via telehealth
- DPP for AGH Associates
- Provide diabetes screenings in community
- Increase prevention behaviors in persons at high risk for diabetes with prediabetes
- Wellness Workshops DSMP for chronic disease self-management

Measurement:

- Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes/objectives
- Incidence of adult diabetes
- SHIP Measure
- Decrease ED visits due to acute episodes related to diabetes condition
- County Health Rankings

Hospital Resources:

- Diabetes Outpatient Education Program
- Diabetes Support Group
- Population Health Department
- Emergency Department
- Foundation
- Endocrinology
- Outpatient Lab Services

Community Resources:

- Worcester County Health Department
- MAC, Inc.

Priority Area: Respiratory Disease, including Smoking

Goal: Promote community respiratory health through better prevention, detection, treatment, and education efforts.

Healthy People 2020 Goal: Promote respiratory health through better prevention, detection, treatment, and education efforts.

Anticipated Impact:

- Increase care for individuals suffering from chronic conditions
- Decrease tobacco, e cigarettes and vaping use in Worcester County
- Increase health literacy and self-management for health conditions/healthy living
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Increase awareness around importance of prevention and early detection
- Increase provider services in community to provide for respiratory related treatment
- Increase participation in community lung/respiratory screenings – especially at-risk and vulnerable populations

Impact Rationale: According to Healthy People 2020, approximately 23 million Americans have asthma and approximately 13.6 million adults have COPD. Healthy People 2020 estimates there are an equal number of undiagnosed Americans. (Healthy People 2020)

Action:

- Recruit Pulmonologist to community
- Improve proportion of minorities receiving LDCT screenings
- Collaborate with Worcester County Health Department Prevention Department
- Reduce emergency department (ED) visits for chronic obstructive pulmonary disease (COPD) and asthma
- Provide speakers to community groups on smoking cessation
- Improve Health Literacy in middle schools related to tobacco and vaping use

Measurement:

- Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/respiratory-diseases/objectives

- Decrease ED visits due to acute episodes related to respiratory condition
- SHIP

Hospital Resources:

- Respiratory Therapy
- Imaging
- Emergency Department
- Population Health Department
- Human Resources
- Pulmonology

Community Resources:

- Worcester County Health Department
- Worcester County Public Schools

Priority Area: Nutrition, Physical Activity & Weight

Goal: Support community members in achieving a healthy weight.

Healthy People 2020 Goal: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.

Anticipated Impact:

- Increase health literacy and self-management for health conditions/healthy living
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Reduce unnecessary healthcare costs
- Reduce community obesity rate
- Increase access to healthy foods and nutritional information
- Increase awareness around importance of nutrition, exercise and healthy weight
- Increase participation in community BMI screenings – especially at-risk and vulnerable populations
- Increase awareness of community resources, programs and services
- Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs

Impact Rationale: Obesity is defined as having a Body Mass Index (BMI) that is greater than or equal to 30, while being overweight is defined as having a BMI of 25 – 29.9. Obesity has been linked to a variety of cancers and chronic illnesses including diabetes, colorectal cancer, kidney cancer, breast cancer, hypertension and cardiovascular disease (NCI, 2015).

According to the CDC National Center for Health Statistics (2015), the prevalence of obesity was slightly more than 36 percent in adults and 17 percent in youth.
•The prevalence of obesity was higher in women 38.3% than in men 34.3%. No significant difference was noted by gender among youth.
•The prevalence of obesity was higher among middle-aged and older adults than younger adults. (2013 – 2014)

	Worcester County	Maryland	Sussex County	Delaware
Adult Obesity	30%	28%	31%	29%
Physical Inactivity	27%	23%	27%	25%
Limited Access to Health Foods	4%	3%	5%	6%

(County Health Rankings, 2016)

Action:

- Improve Health Literacy in elementary and middle schools related to nutrition and exercise
- Participate in the "Just Walk" program of Worcester County
- FAB Program
- Distribution brochure to public about Farmer's Market & fresh produce preparation
- Provide Hypertension and BMI screenings in the community
- Provide speakers to community groups on nutrition
- Continue to provide education on health living topics to Faith-based Partnership and community senior centers
- Bariatric Support Group
- Participate in community events to spotlight surgical and non-surgical weight loss services

Measurement:

- Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status/objectives
- CDC National Center for Health Statistics
- SHIP
- County Health Rankings

Hospital Resources:

- Population Health Department
- AGHS Offices

- FAB Program and Bariatric Support Group
- Nutrition Services
- Atlantic General Bariatric Center

Community Resources:

- Faith-based Partnership
- Worcester County Public Schools
- Worcester County Health Department
- MAC, Inc.
- Community Senior Centers
- Yoga/Tai Chi Programs
- TOPS of Berlin

Priority Area: Heart Disease & Stroke

Goal: Improve cardiovascular health of community.

Healthy People 2020 Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events.

Anticipated Impact:

- Increase care for individuals suffering from chronic conditions
- Reduce unnecessary healthcare costs
- Decrease tobacco use in Worcester County
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Increase awareness around importance of prevention and early detection of heart disease and hypertension
- Increase provider services in community to provide for cardiovascular related treatment
- Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs
- Increase health literacy and self-management for health conditions/healthy living

Impact Rationale: According to the CDC Heart Disease Statistics and Maps (2015), approximately 610,000 people die of heart disease in the United States yearly. Heart disease is the leading cause death among most ethnic groups. Hypertension, high cholesterol and smoking

are key risk factors and 47 percent of Americans have at least one risk factor Heart Disease Statistics and Maps (CDC, 2015).

Action:

- Ensure proper professionals in community to provide vascular care
- Maintain AGH/HS campus and locations as tobacco free
- Increase community health screenings for high blood pressure, carotid artery and cholesterol
- Decrease readmissions to hospital for chronic disease management
- Utilize Faith Based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management
- Improve Health Literacy in elementary and middle schools related to heart health

Measurement:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/heart-disease-and-stroke/objectives
- AGH database
- SHIP Measure
- County Health Rankings

Hospital Resources:

- Population Health Department
- AGH/HS
- Outpatient Lab Services
- Nutrition Services
- Human Resources
- Stroke Center

Community Resources:

- Faith-based Partnership
- MAC, Inc.
- Worcester County Health Department

Priority Area: Behavioral Health

Goal: Promote and ensure local resources are in place to address behavioral health services.

Healthy People 2020 Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.
Healthy People 2020 Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

Anticipated Impact:

- Increase accurate and up-to-date information and referral service
- Improve Health Literacy in elementary and middle schools related to mental health and substance use.
- Decrease opioid abuse and overdose rates in Worcester County

- Increase awareness of community resources, programs and services
- Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs
- Increase provider services in community to provide for behavioral health related treatment

Impact Rationale: According to the CDC Mental Health Surveillance (2013), mental illness affects approximately 25 percent of the U.S. population and is associated with a variety of chronic illnesses.

	Worcester County	Maryland	Sussex County	Delaware
Mental Health Providers	520:1	470:1	610:1	440:1
Poor Mental Health Days	3.5	3.4	3.5	3.7

(County Health Rankings, 2016)

According to Healthy People 2020, approximately 22 million Americans struggle with addiction to alcohol and/or drugs and approximately 95 percent are unaware they have a substance use issue. An emerging area of substance use issues includes opiate use. Teen rates of prescription drug abuse have increased over the last 5 years, including nonmedical use of drugs such as Vicodin and OxyContin. (Healthy People 2020)

	Worcester County	Maryland	Sussex County	Delaware
Drug Death Overdose	15	16	16	18
Drug Death Overdose - modeled	18.1-20.0	17.4	16.1-18.0	20.9

(County Health Rankings, 2016)

Action:

- Increase access and continue to collaborate with Sheppard Pratt telemedicine services to provide additional psychiatry professional

- Participate in community events to spotlight behavioral health services
- Engage critical response teams when a mental health crisis is discovered
- Partner with WCHD (Peer Support and Case Managers) in AGH ED
- Improve Health Literacy in middle schools related to mental and emotional health
- Recruit LSCW to the community
- Behavioral Health Integration into Primary Care
- Participate on WOW Committee
- Participate on Behavioral Health/Opioid Task Force/Pain Management Team
- Participate in Worcester County Health Department naloxone training sessions sponsored by Opiate Overdose Prevention Program
- Increase the proportion of persons who are referred for follow-up care for opioid problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED)
- Evaluate and educate organization and community on appropriate prescribing practices
- Utilize Prescription Drug Maintenance Program (PDMP) via CRISP

Measurement:

- Healthy People 2020
- Behavioral Risk Factor Surveillance System
- County Health Rankings
- AGH database
- SHIP Measure

Hospital Resources:

- Population Health Department
- Atlantic Health Center
- Human Resources
- Pastoral Care Services
- Bereavement Support Group
- Pain Rehabilitation Program
- AGH Pharmacy

Community Resources:

- Sheppard Pratt
- Worcester County Health Department
- Worcester Youth and Family Services
- Hudson Health Services
- NAMI Lower Shore Support Group
- Worcester County Public Schools
- WOW

- CRISP

Priority Area: Arthritis, Osteoporosis & Chronic Back Pain

Goal: Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions in the community.

Healthy People 2020 Goal: Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions.

Anticipated Impact:

- Reduce unnecessary healthcare costs
- Increase provider services to community to provide for arthritis and other rheumatic conditions, osteoporosis, and chronic back condition related treatments
- Increase health literacy and self-management for chronic health conditions/healthy living

Impact Rationale: According to Healthy People 2020, arthritis, osteoporosis and chronic back pain impact quality of life, activities of daily living and ability to work. Arthritis affects one in five adults. Osteoporosis affects approximately 5.3 million adults aged 50 years and older in the United States. Also, approximately 80 percent of people in the United States experience chronic back conditions. Successful and underused interventions include weight management, physical activity and self-management. (Healthy People 2020)

According to CHNA Survey summary of findings, an area of significant need includes prevalence of sciatica and chronic back pain in the community.

Action:

- Utilize Faith Based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic pain workshops
- Explore osteoporosis clinic program
- Utilize Women's Diagnostic Health Services, to provide access to high risk populations about healthy lifestyles and bone density screenings
- Provide educational opportunities to raise community awareness about osteopenia/osteoporosis and provide bone density screenings
- Increase accurate and up-to-date information and referral service

Measurements:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/Arthritis-Osteoporosis-and-Chronic-Back-Conditions
- CPSMP Workshop attendance
- SHIP
- County Health Ranking
- Community Survey

Hospital Resources:

- Population Health Department
- Human Resources
- Atlantic Health Center/Pain Management
- Women's Diagnostic Health Services

Community Resources:

- MAC, Inc.
- Faith-based Partnership

Other needs identified in the CHNA but not addressed in this plan

Each of the health needs listed in the Hospital's CHNA as well as Worcester County Health Department's Community Needs Assessment is important and is being addressed by numerous programs and initiatives operated by the Hospital and/or other community partners of the Hospital. Needs not addressed as a priority area in the Implementation Plan are being addressed in the community by other organizations and by organizations better situated to address the need.

Needs Not Addressed In Plan	Rationale
Dental/Oral Health	-Need addressed by Worcester County Health Department's Dental Services for pregnant women and children less than 21 years of age -Priority Area Worcester CHIP -Need addressed by Lower Shore Dental Task Force & Mission of Mercy for adult population -Need addressed by AGH ED referral to community resources -Need addressed by Chesapeake Health Services, a federally funded dental clinic for Somerset and Wicomico Counties

Injury & Violence	-Need addressed by Worcester County Health Department Programs: Child Passenger Safety Seats (refer to Worc GOLD) Injury Prevention Highway Safety Program Safe Routes to School -Need addressed by Worcester County Sheriff's Department, State Police and Municipal Law Enforcement Agencies -Need addressed by AGH Health Literacy Program
HIV & STD (<2% ea)	-Need addressed by Worcester County Health Department Communicable Disease Programs

References

CDC National Center for Health Stats (2015). Retrieved from http://www.cdc.gov/nchs/fastats

CDC Diabetes Public Health Resource (2014). Diabetes Public Health Resource (1980 – 2014). Retrieved from http://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm

CDC Heart Disease Statistics and Maps (2015). Retrieved from http://www.cdc.gov/HeartDisease/facts.htm

Community Health Needs Assessment FY2019-2021

County Health Rankings (2016). Worcester County, Maryland, Sussex County, Delaware Data. Retrieved on August 25, 2016, from http://www.countyhealthrankings.org/app/

NCI (2015). National Cancer Institute: Obesity, National Institute of Health. Retrieved on August 25, 2016, from http://www.cancer.gov/about-cancer/causes-prevention/risk/obesity

Mental Health Surveillance (2013). CDC. Retrieved on August 30, 2016, from https://www.cdc.gov/mentalhealthsurveillance/

PRC Survey (2015). Professional Research Consultants, Inc.

Community Benefits Narrative Report

Access to Care

A. 1. Identified Need:

A. 2. How was the need identified:

Access to Care

The 2019-2021 CHNA combined population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH used Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs.

Access to care was identified as a community health concern and the number one prioritized health need in the 2019-21 CHNA. Prioritization was based on the following criteria:

- Size and severity of the problem determined by what percentage of the population is affected by risks
- Health system's ability to impact the need
- Availability of resources

Atlantic General Hospital is the only hospital in Worcester County, a DHMH federally-designated medically-underserved area, a state-designated rural community, and a HRSA-designated Health Professional Shortage Area for primary care, mental health, and dental health. In AGH's service area, the top reasons for patients not seeking health care in our communities are cost, transportation, and lack of providers. According to the Community Health Needs Assessment (CHNA) FY2019, the community rated the follow as the top barriers to access health care:

Top Barriers to Healthcare

What do you think are the problems that keep you or other community members from getting healthcare they neeed?	
Too expensive/can't afford it	29.31%
No health insurance	23.53%
Couldn't get an appointment with my doctor	14.06%
No transportation	12.26%
Service is not available in our community	8.28%
Local doctors are not on my insurance plan	7.08%
Doctor is too far away from my home	5.48%

	Worcester County, MD	Sussex County, DE	MD Value	MD SHIP 2017	HP 2020
People with usual PCP	78.3% (2016)	NA	84.8%	83.9%	NA

	Uninsured ED visits	7.6% (2014)	NA	11.0%	14.7%	NA
	Adults with	91.1% (2017)	91.6% (2017)	NA	NA	100%

	health insurance					
	Child with health insurance	95.6% (2017)	96.4% (2017)	NA	NA	100%
	People with health insurance	92.2% (2017)	NA	NA	NA	100%

Source: https://www.atlanticgeneral.org/community-health-wellness/creatinghealthy-communities/

B: Name of hospital initiative	Initiative: Increase community access to comprehensive, quality health care services. (Healthy People 2020 Goal: Improve access to comprehensive, quality health care services) Clinical Screenings CPAP Fittings Community Meetings/Coalitions Flu Vaccine Clinics Covid Vaccine Clinics Health Fairs Health Literacy HTN Clinics Living Well Workshops Provider Recruitment Speaker's Bureau Support Groups Rural Health Service Grants Grant Writing Disaster Readiness Community Education Walk With a Doc
C: Total number of people within target population	The population of the Worcester County resort destination, Ocean City, increases to near 300,000 during the tourist season. Lower Sussex County has similar characteristics of seasonality and retirees. Frankford and Dagsboro, DE have similar demographic profiles as Worcester County, MD. Selbyville, DE has some differing characteristics. Population estimates, July 1, 2018, (V2018) 51,823, Worcester County, MD Population estimates, July 1, 2018, (V2018) 229,286 Sussex County, DE (US Census Bureau Quickfacts https://www.census.gov/quickfacts/fact/table/US/PST045218)

Population by Race	County: Worcester, MD		State: Maryland	
	Persons	% of Population	Persons	% of Population
White	42,342	81.76%	3,326,265	54.54%
Black/African American	6,694	12.93%	1,842,763	30.22%
American Indian/Alaskan Native	158	0.31%	23,550	0.39%
Asian	780	1.51%	413,172	6.78%
Native Hawaiian/Pacific Islander	20	0.04%	3,973	0.07%
Some Other Race	719	1.39%	276,169	4.53%
2+ Races	1,072	2.07%	212,528	3.48%

Population by Ethnicity	County: Worcester, MD		State: Maryland	
	Persons	% of Population	Persons	% of Population
Hispanic/Latino	1,876	3.62%	639,709	10.49%
Non-Hispanic/Latino	49,909	96.38%	5,458,711	89.51%

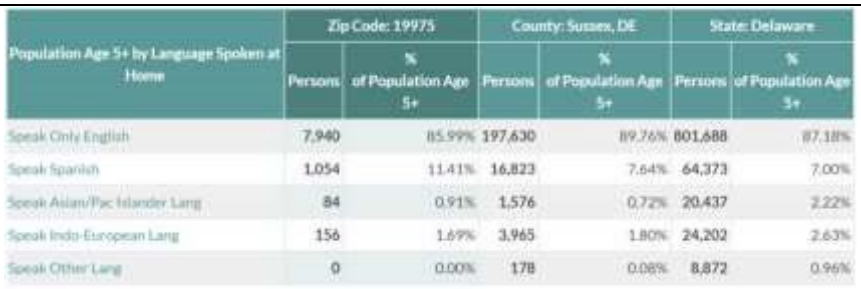
Population by Race	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
White	8,131	84.41%	181,858	78.30%	642,569	65.87%
Black/African American	638	6.62%	28,459	12.25%	217,440	22.29%
American Indian/Alaskan Native	79	0.82%	1,831	0.79%	4,751	0.49%
Asian	135	1.40%	2,980	1.28%	40,188	4.12%
Native Hawaiian/Pacific Islander	0	0.00%	196	0.08%	589	0.06%
Some Other Race	455	4.72%	10,810	4.65%	38,822	3.98%
2+ Races	195	2.02%	6,114	2.63%	31,133	3.19%

Population by Ethnicity	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
Hispanic/Latino	1,163	12.07%	22,540	9.71%	94,055	9.64%
Non-Hispanic/Latino	8,470	87.93%	209,708	90.29%	881,437	90.36%

Median Age
County: Worcester, MD
50.1 Years
State: Maryland 39.2 Years

Median Age
Zip Code: 19975
55.9 Years
County: Sussex, DE 48.7 Years
State: Delaware 40.7 Years

Population Age 5+ by Language Spoken at Home	County: Worcester, MD		State: Maryland	
	Persons	% of Population Age 5+	Persons	% of Population Age 5+
Speak Only English	46,862	94.77%	4,684,915	81.74%
Speak Spanish	905	1.83%	450,637	7.86%
Speak Asian/Pac Islander Lang	278	0.56%	215,250	3.76%
Speak Indo-European Lang	1,098	2.22%	255,992	4.47%
Speak Other Lang	305	0.62%	124,390	2.17%

	 (Source: AGH Community Needs Assessment FY19 – 21 https://www.atlanticgeneral.org/documents/AGH-9313-CHNA-Report-2019-21booklet-form-050319.pdf) 3500:1 Worcester County 2060:1 Somerset County 1870:1 Wicomico County 1165:1 Sussex County (Data: Healthy Communities Institute, 2016)
D: Total number of people reached by the initiative	23,008 Encounters in FY20; In FY21, difficult to measure as all events were cancelled, walk with a doc was virtual, Flu and Covid vaccine clinics had 15,560 encounters for FY21.

E: Primary objective of initiative:	1) Reduce unnecessary healthcare costs and reduction in hospital admissions and readmissions during FY21 a) Description: Through AGH's initiative to improve access to care reduction in unnecessary healthcare costs would be an impact of objectives improving access to care, educating the community on ED appropriate use, chronic illness self-management, and collaboration efforts with community organizations with a shared vision. b) Metrics: Hospital readmission rate 2) Increase in awareness and self-management of chronic disease during FY20 a) Description: Utilize Faith-based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management b) Metrics: Community Survey Track Wellness Workshops Track Health Fairs and Community Education Events 3) Reduce health disparities FY20/FY21 a) Description: Strategy #1-Participate on AGH's Health Equity Steering Committee to promote health equity and reduce disparities Strategy #2-Provide community health events to target minority populations by increasing relationships with faith-based partnerships, local businesses and cultural/ethnic community events. Strategy #3-Educate community on financial assistance options to improve affordability of care and reduce delay in care. Strategy #4-Promote patient engagement through adult health literacy initiative Strategy #5-Pilot School based telehealth program--postponed until FY22 b) Metrics: AGH Database Track committee participation and partnerships Community Survey Track Health Fairs and Community Education Events

	4) Increase community capacity and collaboration for shared responsibility to address unmet health needs during FY21 a) Description: Partnering with community organizations and participation on committees that address access to care and health disparities: -Partner with homeless shelters and food pantries to promote wellness -Refer community to local agencies such as Shore Transit and Worcester County Health Department for transportation assistance -Participate on Tri County Health Planning Council -Participate on Worcester County LHIC -Participate on Homelessness Committee and HOT b) Metrics: Track committee participation and partnerships 5) Increase number of practicing primary care providers and specialists to community during FY21 a) Description: Provider recruitment b) Metrics: Track provider recruitment Community Survey

F: Single or multi-year plan:	Multi-Year – Atlantic General Hospital is looking at data over the three-year cycle that is consistent with the CHNA cycle FY19 – FY21. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
G: Key collaborators in delivery:	Hospital Resources: • Population Health Department • AGH/HS • Human Resources • Registration/Billing Services • Emergency Department • Executive Care Coordination Team Community Resources: • Faith-based Partnership • Homelessness Committee • Worcester County Healthy Planning Advisory Council • Worcester County Health Department • Worcester County Public Schools • Diakonia • Samaritan Shelter • MD Food Bank and local pantries/soup kitchens • Shore Transit • Tri County Health Planning Council • LHIC • United Way
H: Impact of hospital initiative:	Objective 1: Reduce unnecessary healthcare costs and reduction in hospital admissions and readmissions during FY21 Metrics: Hospital readmission rate Outcome: FY 21: July-Dec 2020 (9.63%); Jan-June 2021 (9.95%); FY21 Target is 11.27% Objective 2: Increase in awareness and self-management of chronic disease during FY20 Metrics: Community Survey Track Wellness Workshops Track Health Fairs and Community Education Occurrences

	Outcomes-Population Health met frequently with MAC regarding wellness workshops for FY20. Unable to fill workshops due to Covid latter part of the fiscal year. Due to Covid, all events remained cancelled in FY21; Attempts were made to transition educational events to virtual events but interest was low. -Community Education Events/Health Fairs: 322 occurrences in FY20; No community education events/health fairs for FY21 Objective 3: Reduce health disparities FY20/FY21 Track committee participation and partnerships Community Survey Track Health Fairs and Community Education Occurrences Maryland SHIP Healthy People 2020 Metrics: AGH Database Outcome: Strategy #1- Participate on AGH's Health Equity Steering Committee to promote health equity and reduce disparities -AGH Health Equity Steering Committee previously became chartered committee as part of MHA Health Equity Campaign. Goal of committee reduce health disparities tracking demographic data; diversity in leadership; and increase expand cultural awareness and competency across the organization. Associate education completed as part of an expanded cultural competence training. SOGI data collection and educational materials throughout organization. Many community outreach opportunities in FY21 were cancelled due to Covid. In FY 21, we were able to coordinate Health Equity driven Covid vaccine clinics in collaboration with our Faith-based partners. Strategy #2 -Screenings during FY21: -Events in FY20 targeting minority population: 33 events; topics included free health screenings, kidney health, stroke and heart health, colon cancer, hypertension, diabetes, Covid testing, etc. Strategy #3 -Community health education events that educated community on financial assistance options to improve affordability of care and reduce delay in care. - During FY21 all community health events were cancelled due to Covid. Strategy #4-Promote patient engagement through adult health literacy initiative -AGH Health Equity Steering Committee working on adult health literacy campaign utilizing tools such as Ask ME 3 for health system and shared at community outreach activities in order to promote patient engagement and communication with providers. Will continue to monitor through affiliation with United Way – community health literacy strategic planning and interventions. Program launch was postponed due to ongoing surges of Covid in FY 21. Strategy #5-Pilot School based telehealth program

	In FY19 early planning for school based telehealth program partnership with WCPS. Equipment purchased with partial funding through a CFES grant. Participated in regular planning meetings in FY20. FY20 Spring program launch was delayed due to school closures in response to Covid. Schools transitioned to online learning and continued in a virtual hybrid model through FY21. We are continuing to work with WCBOE, MDH, and MSDE on program approval. Objective 4: Increase community capacity and collaboration for shared responsibility to address unmet health needs during FY21 Metrics: Track committee participation and partnerships Outcome: --Continued relationship with local shelters and food pantries through Faith Based Partnership to explore and assess need for opportunities to promote wellness via community education events and access to screenings. Will continue to promote relationship efforts FY21 pending Covid restrictions. - Director Population Health active participation on the following committees to promote care coordination and community collaboration: Tri County Health Planning Council, Worcester County Healthy Planning Advisory Council LHIC, and Homelessness Committee (HOT). Objective 5: Increase number of practicing primary care providers/specialists Metrics: Track provider recruitment Community Survey Outcome: In FY 21, we had a net gain of five providers with the following recruitment occurring: • 1 Gastroenterologist • 1 Surgeon • 1 Behavioral Health CRNP • 1 Urgent Care CRNP • 1 Primary Care CRNP	
I: Evaluation of outcome	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements include: Community Survey to be completed as part of CHNA FY22-24 Maryland SHIP Healthy People 2030	
J: Continuation of initiative:	We will continue to monitor connections made to community programming for access to care programs.	
K: Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	a. Total Cost of Initiative for Current Fiscal Year FY21 $104,277	b. Restricted Grants/Direct offsetting revenue FY 20 CFES Grant for School Based Telehealth $4,278 for telehealth equipment. No funds for CFES Grant for FY 21

		FY 20 HSCRC Regional Grant wellness van $4,225.00 HSCRC Regional wellness van funding ended prior to FY21, no funds to report.

Community Benefits Narrative Report - Initiative 3 Decrease incidence of diabetes in the community

A. 1. Identified Need:
2. How was the need identified:

Diabetes

The 2019-2021 CHNA combined population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH used Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs.

Diabetes was identified as a community health concern and the number three prioritized health need in the 2019-21 CHNA. Prioritization was based on the following criteria: • Size and severity of the problem determined by what percentage of the population is affected by risks
• Health system's ability to impact the need
• Availability of resources

According to the CDC National Center for Health Stats (2015), national data trends for people with Diabetes show a significant rise in diagnoses. In the U.S., Diabetes is becoming more common. Diagnoses from 1980 – 2014 increased from 5.5 million to 22 million.

	Worcester County, MD	Sussex County, DE	MD Value	MD SHIP 2017	HP 2020
Age adjusted ER rate due to Diabetes per 100,000 visits	310.5 (2017)	NA	243.7	186.3	NA

B: Name of hospital initiative

Initiative:

Decrease incidence of diabetes in the community.
(Healthy People 2020 Goal: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.) Clinical Screening
Heath Fairs
Support Group
Chronic Disease Self-Management Program (evidence based)
Speaker's Bureau
Community Education

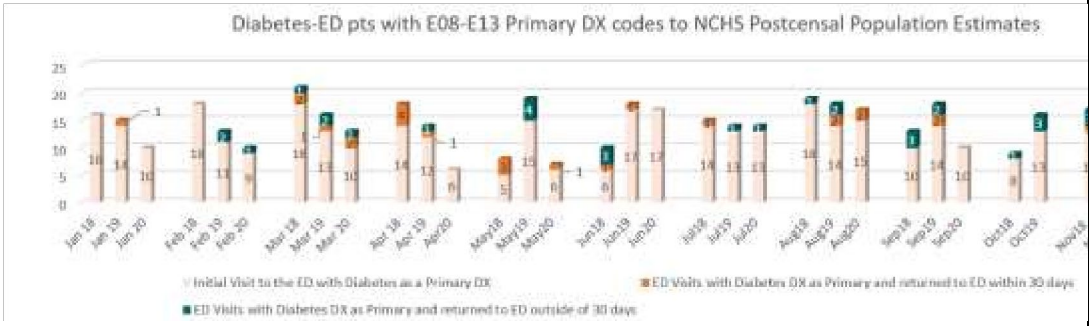
C: Total number of people within target population	Worcester County 14% Diabetes Prevalence Sussex County 13% Diabetes Prevalence (Data: County Health Rankings 2019)
D: Total number of people reached by the initiative	In FY20, 995 encounters through community education, health fairs, clinical screenings, Living Well Workshops, and support groups. Due to Covid, all community education events, health fairs, clinical screenings, Living Well workshops, and support groups were cancelled in FY21. **However, we did have 19 self-management workgroups in FY 21. Unfortunately, attendance was poor at these virtual events, with many having zero or one attendees.**
E: Primary objective of initiative:	1) <u>Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions</u> a) Description: Through AGH's initiative to improve access to care reduction in unnecessary healthcare costs would be an impact of objectives improving access to care, educating the community on ED appropriate use, Diabetes chronic illness self-management, Diabetes prevention, and collaboration efforts with community organizations with a shared vision. b) Metric: Track hospital admissions ED and inpatient FY20 and FY21 2) <u>Increase awareness around importance of prevention of diabetes and early detection</u> a) Description: Strategy #1 -Provide diabetes screenings in community via health fairs and clinical screening events Strategy #2 - Increase prevention behaviors in persons at high risk for diabetes with prediabetes through community education opportunities and support groups. b) Metric: Strategy #1 - Track Diabetic community screening opportunities and support groups. Strategy #2 - Track community education opportunities that highli**ght Diabetes and pre-Diabetes.** 3) <u>Increase patient engagement in self-management of chronic conditions</u> a) Description: AGH partners with MAC, local senior centers and faith-based partnerships to bring Stanford self-management workshops to the community to increase patient engagement and self-management of chronic disease b) Metric: Track DSMP wellness workshops 4) <u>Increase provider services in community to provide for diabetes related treatment</u> a) Description: Strategy #1 – Explore Diabetes Education opportunities via telehealth b) Metric: Strategy #1 -Track Diabetes Education telehealth opportunities 6) <u>Increase community capacity and collaboration for shared responsibility to address unmet health needs</u> a) Description: -Partner with local health agencies to facilitate grant applications to fund diabetes programs - DPP for associates b) Metric: -Track partnerships with local health agencies

F: Single or multiyear plan:	Multi-Year – Atlantic General Hospital is **looking at data over the three-**year cycle that is consistent with the CHNA cycle FY19 – FY21. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
G: Key **collaborators** in delivery:	Hospital Resources: •Diabetes Outpatient Education Program •Diabetes Support Group •Population Health Department •Emergency Department •Foundation •Endocrinology •Outpatient Lab Services Community Resources: •Worcester County Health Department •MAC, Inc.
H: Impact of hospital initiative:	Objective #1 -<u>Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions</u> Metric: Track hospital admissions IP and ED FY20 and FY21

- Outcome:

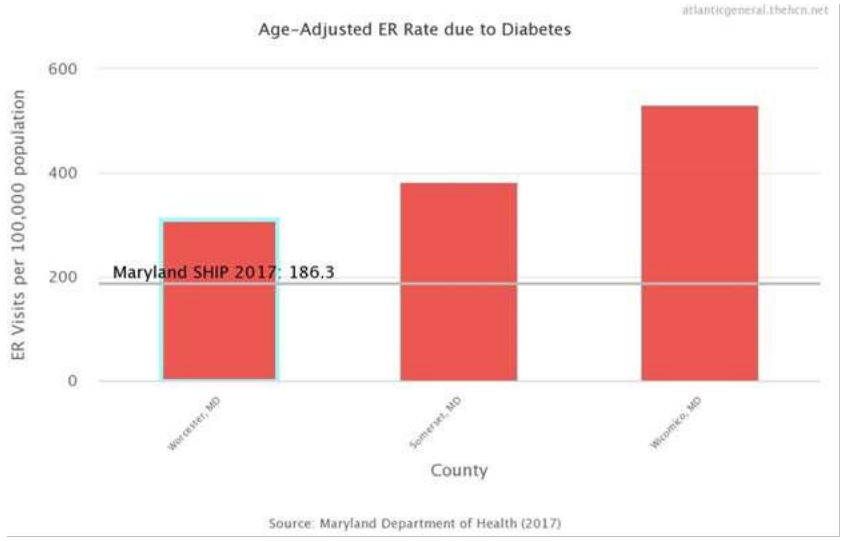
AGH Internal Data: Diabetes (top 3 diagnosis codes)

FY	ED	IP	Totals
FY2020	852	241	1093
FY2021	1974	818	2792



-AGH Database

-MD SHIP/Healthy People 2020



ADULTS WITH DIABETES

	Strategy #1 and Strategy #**2 combined**– FY20 South Bethany Library Diakonia Snow Hill Elementary School Worcester County Parks and Recreation Captain's Cove Health Fair UMES Ocean Pines Health Fair Multiple Faith-based Partnership Church Health Fairs Diabetes Support Group x 12 TOPS Due to Covid, no events were held in FY21 Objective #3 - <u>Increase patient engagement in self-management of chronic conditions</u> Metric: Track DSMP wellness workshops during FY20 and FY21 • Outcome: DSMP zero enrollment in workshops offered to the community FY20. Zero enrollment in workshops in FY21 due to cancellation of all scheduled events due to Covid. Objective #4 -<u>Increase provider services in community to provide for diabetes related treatment</u> b) Metric: Strategy #1 -Track Diabetes Education telehealth opportunities • Outcome: Strategy #1- No data to track for FY20. In FY21, three patients were enrolled in Diabetes education via telehealth. Objective #6 - Increase community capacity and collaboration for shared responsibility to address unmet health needs Metric: Track partnerships with local health agencies FY20 and FY21 • Outcome: AGH continues to partner with the following: -MD Diabetes Action Plan community workgroups -Referral process in place with local health departments -Area Agencies on Aging/MAC -Faith-based partnerships -AGH continues to partner with local health agencies to facilitate grant applications to fund Diabetes Programs. Will continue to track. -AGH and WCHD partnership which provided DPP training to expand services in Worcester targeting AGH employees and family members.
I: Evaluation of outcome	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section Primary Objectives Long Term Measurements: -Healthy People 2030 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes/objectives -Incidence of adult diabetes -Decrease ED visits due to acute episodes related to diabetes condition - County Health Rankings -MD SHIP

J: Continuation	In June 2021, **we signed an MOU for a Diabetes** mini-grant in collaboration with WCHD and Chesapeake Health to increase pre-diabetes and diabetes screenings. Will begin FY22.

K: Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	a. Total Cost of Initiative for FY20 $7,510.00 community education, screenings, health fairs and support groups Total Costs for FY21 was zero dollars for community education, health fairs and support groups For FY 21 no restricted grants offsetting revenue	b. Restricted Grants/Direct offsetting revenue None related to community education, screenings, health fairs and support groups activities tracked in cost for initiative. None related to community education, screenings, health fairs and support group activities

A. 1. Identified Need:

A. 2. How was the need identified:

Cancer

The 2019-2021 CHNA combined population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH used Healthy Communities
Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs.

Cancer was identified as a community health concern and the number two prioritized health need in the 2019-21 CHNA. Prioritization was based on the following criteria:

- Size and severity of the problem determined by what percentage of the population is affected by risks
- Health system's ability to impact the need
- Availability of resources

According to Healthy People 2020, continued advances in cancer detection, research and cancer treatment have decreased cancer incidences and death rates in the United States. Despite continued advances, cancer remains a leading cause of death second to heart disease in the United States. (Healthy People 2020)

	Age-Related Death Rate per 100,000	Worcester County MD	Sussex County, DE	MD Value	MD SHIP 2017	HP 2020	
	Cancer	179.7 (2011-2015)		162.3	147.4	161.4	

B: Name of hospital initiative

Initiative:

Decrease the incidence of advanced breast, lung, colon, and skin cancer in community. (Healthy People 2020 Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.)

Community Education

Clinical Screenings

Grant Writing

Speakers Bureau

Support Groups

C: Total number of people within target population

Worcester County 533/100,000 persons

Sussex County 548.8/100,000 persons

Rate if all new cancer cases (2012-2016) https://gis.cdc.gov/Cancer/USCS/DataViz.html

D: Total number of people reached by the initiative

In FY20, 1586 encounters through community education, speaker's bureau, support group, health fairs and community clinical screening events. Due to size of initiative, these events are the only accurate tracking record for number of encounters. Due to Covid-19, no community educations events, screenings or speaker events occurred in FY21.

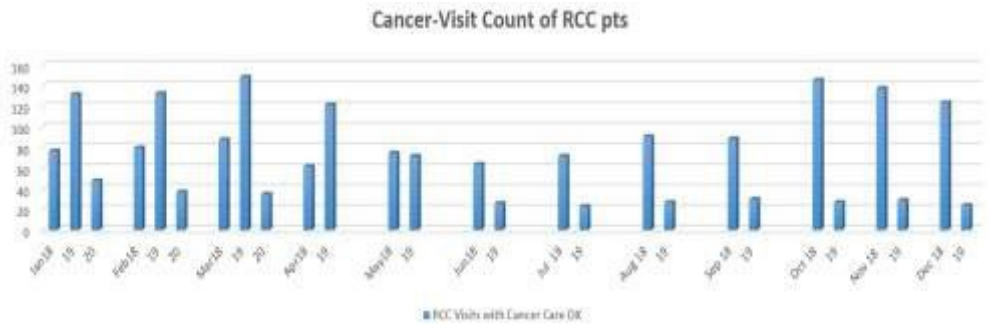
E: Primary objective of initiative:	1) Increase awareness around importance of prevention and early detection and reduce health disparities a) Description: -Improve proportion of minorities receiving women's preventative health services -Improve proportion of minorities participating in community health screenings b) Metrics: Healthy People 2020 MD SHIP AGH databases AGH CHNA Vital Statistics 2) Increase provider services in community to provide for cancer related treatment a) Description: Recruit proper professionals in community to provide for cancer related treatment b) Metrics: Track provider recruitment FY21 3) Improve access and referrals to community resources resulting in better outcomes a) Description: Partner with local health agencies to facilitate grant application to fund cancer programs b) Metrics: Track grant opportunities and formal partnerships in FY20/FY21 4) Increase support to patients and caregivers a) Description: Patients and caregivers need support throughout the cancer treatment process. Patients experience the physical and emotional stressors undergoing treatment while caregivers fulfill a prominent and unique role supporting cancer patients and multitude of services such as home support, medical tasks support, communication with healthcare providers and patient advocate. AGH community education opportunities provide support and promote an informed patient and caregiver. b) Metrics: Track cancer prevention and educational opportunities in FY20/FY21 5) Increase participation in community cancer screenings – especially at-risk and vulnerable populations a) Description: -Provide community health screenings: -Improve proportion of minorities receiving colonoscopy screenings -Improve proportion of minorities receiving LDCT screenings -Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn through melanoma education and skin cancer screenings b) Metrics: Track community screening events and persons screened FY20/FY21
F: Single or multi-year plan:	Multi-Year – Atlantic General Hospital is looking at data over the three-year cycle that is consistent with the CHNA cycle FY19 – FY21. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.

G:Key collaborators in delivery:	Hospital Resources: • Population Health Department • Human Resources • Foundation • Women's Diagnostic Center • Endoscopy • Imaging • Respiratory Therapy Department • Regional Cancer Care Center • AGH Cancer Committee Community Resources: • Worcester County Health Department • Komen Consortium • Relay for Life • Women Supporting Women

H: Impact of hospital initiative:	Objective 1: Increase awareness around importance of prevention and early detection and reduce health disparities Metrics: HP 2020/HP2030 MD SHIP AGH database AGH CHNA Vital Statistics Outcome: AGH Regional Cancer Care, ED, IP Volumes

CANCER ED/IP VOLUMES (First 3 Dx

FY	ED	IP	Totals
FY2019	287	189	476
FY2020	247	130	377
FY2021	126	110	236



Objective 2: Increase provider services in community to provide for cancer related treatment

Metrics: Track provider recruitment FY21

•Outcome:

Regional Cancer Care Center grand opening FY18 and second full fiscal year of operation

FY20 promoting rural community access to state of the art cancer treatment services. The Burbage Regional Cancer Care Center continues to offer genetic counseling services through its telehealth partnership with the University of Maryland Medical Center's Greenebaum Cancer Center. Telegenetics is available for individual with a family history of cancer and for patient sin treatment who are concern about their family's risk. Zero providers were hired in FY20 for RCCC. Despite recruitment efforts, zero providers were recruited for FY21. Covid-19 impacted recruitment efforts in all areas.

Objective 3: Improve access and referrals to community resources resulting in better outcomes

Metrics: Track grant opportunities and formal partnerships FY21

•Outcome:

There were zero grant awards for RCCC FY21.

Formal partnerships during FY21 include:

Komen

Local Health Departments

Women Supporting Women Support Group

Objective 4: Increase support to patients and caregiver

Metrics:

Track cancer prevention and educational opportunities FY21

	•Outcome: In FY20: Increase awareness around importance of prevention and early detection and reduce health disparities – 26 occurrences. All community education events were cancelled in FY21. Improve proportion of minorities receiving women's preventative health services – 1 event at the Ocean Pines Health Fair. A Hope In Bloom event was planned for April 2020 but postponed to Sept 2020 due to Covid. Unfortunately, due to Covid, the rescheduled event was also cancelled and was not rescheduled in FY21.We began planning for our CHAMP initiative (Community Health Awareness, Messages and Prevention) in FY 21, which focuses on cancer-related disparities. However, we did not launch this program until FY22. We also began planning our Stamp Out Cancer program with a target Go-Live in Feb 2022.

		<u>Objective 5: Increase participation in community cancer screenings – especially at-risk and vulnerable populations</u> Metrics: Track community screening events and persons screened FY20 and FY21 •Outcome: Screenings provided at health fairs and clinical screening events FY20: Zero Prostate Screenings in FY20. One event planned but cancelled due to Covid. One Respiratory Screening event in FY 20, 19% referred to follow-up. AGH provided 2 screening events which were aimed to improve proportion of minorities participating in community health screenings. Decline in events offered due to Covid restrictions. We provided community outreach and education via social media information on raising cancer screening awareness and linkage to providers. No community data available at this time to report on the proportion of minorities receiving colonoscopy screenings in FY 21. Due to Covid, only virtual social media outreach and education done in FY21. Events resumed slowly starting in July 2021, which is FY22 and will be reported accordingly.
I: Evaluation of outcome		The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements: AGH CHNA AGH databases Healthy People 2020 and 2030 SHIP Measures Vital Statistics
J: Continuation of initiative:		We will continue to monitor connections made to community programming for access to cancer prevention and screenings FY20.

K: Expense:	a. Total Cost of Initiative for Current Fiscal Year 20	b. Restricted Grants/Direct offsetting revenue
A. Total Cost of Initiative for Current Fiscal Year	$2,905.00	Zero revenue for community education, speakers, groups and community clinical screening events
B. What amount is Restricted Grants/Direct offsetting revenue	Community education, free screening events, Speaker's Bureau, and Support Groups No dollars were spent for community education events, free screening events or speaker's bureau in FY21 due to Covid necessitating cancellation of events.	

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

TITLE: **FINANCIAL ASSISTANCE POLICY**

DEPARTMENT: **PATIENT FINANCIAL SERVICES**

Effective Date:	7/1/16	Number:	
Revised:	8/18	Pages:	Five (5)
Reviewed:	8/18, 01/2021	Approval Date:	9/6/18

Signature:

Vice President, Finance	Director, Patient Financial Services Author

APPROVAL DATES:

9/6/18, 02/05/2021 Board of Trustees	Finance Committee

POLICY:

It is the policy of Atlantic General Hospital/Health System (AGH/HS) to provide medically necessary services without charge or at a reduced cost to all eligible patients who lack healthcare coverage or whose healthcare coverage does not pay the full cost of their bill for AGH/HS services. The intent of this policy is to ensure access to AGH/HS services regardless of an individual's ability to pay, and to provide those services on a charitable basis to qualified indigent persons consistent with this policy. Financial Assistance (FA) is granted after all other avenues have been exhausted, including, but not limited to Medical Assistance, private funding, grant programs, credit cards, and/or payment arrangements. FA applies only to bills related to services provided by the AGH/HS. Fees for healthcare and professional services that are not provided by AGH/HS are not included in this policy. Emergent and urgent services, including those services provided at the AGH ambulatory surgery facility, may be considered for FA. All hospital regulated services will be charged consistently as established by the Health Services Cost Review Commission (HSCRC), and the amounts generally billed (AGB). All patients requesting charity care services from an AGHS provider in an unregulated area will be charged the fee schedule plus the

standard mark-up, unless a final determination of eligibility for FA is made for services provided to a qualified indigent individual consistent with the procedures set forth below. A roster of providers that deliver emergent, urgent, and other medically necessary care is updated quarterly and available on the hospital website at www.atlanticgeneral.org, indicating which providers are covered and which are not under the FA policy. This information is also available by calling a Financial Counselor at (410) 629-6025. The patient must have a valid social security number, valid green card or valid visa. A patient's payment for reduced-cost care for AGH shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission (HSCRC).

Definitions:

Emergent Care: An emergency accident, meaning a sudden external event resulting in bodily injury, or an emergency illness, meaning the sudden onset of acute symptoms of such severity that the absence of immediate attention may result in serious medical consequences.

Medical Necessity: Inpatient or outpatient healthcare services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms, which otherwise left untreated, would pose a threat to the ongoing health status. Services must:

- Be clinically appropriate and within generally accepted medical practice standards
- Represent the most appropriate and cost effective supply, device or service that can be safely provided and readily available with a primary purpose other than patient or provider convenience.

Immediate Family: A family unit is defined as all exemptions on the income tax return for the individual completing the application, whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not been filed, then income from all members living in the household must be submitted.

Post-Discharge Billing Statement: The first billing statement after the discharge date of an Inpatient or the service date of an outpatient.

Medical Hardship: Medical debt incurred by a family over the course of the previous twelve months that exceeds 25% of the family's income. The hospital will provide reduced-cost, medically necessary care to patients with family income at or below 500% of the Federal Poverty Level.

Liquid Assets: Cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc. The availability of liquid assets plus annual income may be considered in relation to the current poverty guidelines published in the Federal Register.

Medical Debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs for medical costs by AGH/HS.

Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

Plain Language Summary: A summary of the Financial Assistance Policy which includes information on how to apply, appeal, and how to obtain additional information.

Income: The amount of income as defined on the tax returns, pay stubs, social security award letter, unemployment report, etc.

Procedures:

The Maryland State Uniform FA application, (Attachment 1) the AGH/HS FA policy, Collection policy and the Plain Language Summary (PLS) are available in English and Spanish. No other language constitutes a group that is 5% or more of the hospital service area based on Worcester County population demographics as listed by the U.S. Census Bureau. The policies, application, and PLS can be obtained free of charge in English and in Spanish by one of the following ways:

1. Available upon request by calling (410) 629-6025.
2. Applications are located in the registration areas and AGHS Offices
3. Downloaded from the hospital website;

   www.atlanticgeneral.org/FAP
4. The PLS is inserted in the Admission packet
5. FA language is included on all the patient's statement and includes the telephone number to call and request a copy and the website address where copies may be obtained.
6. FA notification signs are posted in the main registration areas
7. An annual notification is posted in the local newspaper
8. Patients who have difficulty in completing the application can orally provide the information
9. The PLS is sent with each collection statement.

No ECA will be taken within 120 days of the first post-discharge billing statement. A message will be on the statement thirty days prior to initiating ECA notifying the patient. During the 120 day period, the patient will be reminded of the FA program during normal collection calls. If the application is ineligible, normal collection actions will resume, which includes notifying the agency if applicable to proceed with ECA efforts. If the application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all Extraordinary

Collection Actions (ECA) until the application and all appeal rights have been processed. A list of approved ECA actions may be found in the Credit and Collection Policy. The patient may appeal a denied application by submitting a letter to the Director of Patient Financial Services indicating the reason for the request.

If the FA application is submitted incomplete, any ECA efforts that have been taken will be suspended for 30 calendar days and assistance will be provided to the patient in order to get the application completed. A written notice that describes the additional information and/or documentation required will be mailed which includes a phone contact to call for assistance.

Approved FA applies to all applicable open balances at the time the application is approved, and shall remain in effect for future medically necessary services for 6 months. For patients that have paid $5.00 or more, and within a two-year period was found to be eligible for FA at 100%, any amount paid exceeding $5.00 shall be refunded.

Within two business days following a patient's request for charity care services, application for medical assistance, or both, AGH/HS shall make a determination of probable eligibility and communicate the determination to the patient and/or the patient's representative. The determination of probable eligibility will be made on the basis of an interview with the patient and/or the patient's representative. The interview will cover family size, insurance and income. The determination of probable eligibility will be made based on the information provided in the interview. No application form, verification or documentation of eligibility will be requested or required for the determination of probable eligibility to be made. A final eligibility determination for charity care for qualified indigent persons will be provided in writing within 2 business days of receipt of a completed application for FA.

Automatic Eligibility:

If the patient is enrolled in a means-tested program, the application is approved for 100% FA on a presumptive basis, not requiring supporting financial data. Examples of a means-tested program are reduced/free school lunches, food stamps, energy and housing assistance, out of state Medicaid, WIC, and the Specified Low Income Beneficiary Program. The patient is responsible for providing proof of eligibility.

FA will be granted for a deceased patient with no estate.

Patients approved under any Federal or State Grant are eligible for FA for the balance over the grant payment.

FA may be approved based on their propensity to pay credit scoring.

Eligibility Consideration:

Generally only income and family size will be considered in approving applications for FA. Liquid assets such as rental properties, stocks, bonds, CD's, and money market funds will be considered if one of the following scenarios occurs:

1. The amount requested is greater than $20,000
2. The tax return shows a significant amount of interest income
3. The patient has a savings or checking account greater than $10,000
4. If the patient/guarantor is self-employed, a current tax return may be required
5. If AGH/HS has reason to believe the information is unreliable or incorrect, or obtained under duress, or through the use of coercive practices, FA may be denied.

The following assets are excluded:

1. The first $10,000 of monetary assets
2. Up to $150,000 in a primary residence
3. Certain retirement benefits such as a 401K where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans where the patient potentially could pay taxes and/or penalties by cashing in the benefit.

FA approval is based on the following income level:

- 0% to 200% of the Federal Poverty Guideline – 100% reduction for Medically Necessary care
- Between 201% and 225% of the Federal Poverty Guidelines – Reduced cost Medically Necessary care at 75%
- Between 226% and 250% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 50%
- Between 251% and 300% of the Federal Poverty Guidelines - Reduced cost care Medically Necessary care at 25%

Medical Hardship is based on the following income level:

- 0% to 200% of the Federal Poverty Guideline – 100% reduction for Medically Necessary care
- Between 201% and 300% of the Federal Poverty Guidelines – Reduced cost Medically Necessary care at 75%
- Between 301% and 400% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 50%
- Between 401% and 500% of the Federal Poverty Guidelines - Reduced cost care Medically Necessary care at 25%

If the patient qualifies for both reduced cost-care and Medical Hardship, the reduction that is most favorable to the patient will be applied. The Federal Poverty Guideline, family size, and income level can be referenced on Attachment 2.

This policy may not be changed without the approval of the Board of Trustees. Furthermore, this policy must be reviewed by the Board and re-approved at least every two years.

From: Hilltop HCB Help Account
To: tsimmons@atlanticgeneral.org; Hilltop HCB Help Account
Subject: Clarification Required - Atlantic General FY 21 Community Benefit Narrative
Date: Thursday, August 4, 2022 1:41:02 PM
Attachments: AtlanticGeneral_HCBNarrative_FY2021_20220225.pdf

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Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for Atlantic General Hospital Corporation. In reviewing the narrative, we encountered an item that requires clarification.

The response provided for Question 223 on page 24 of the attached indicates that your hospital did not report physician gap subsidies on its FY 2021 Community Benefit Financial report. However, the financial report lists two physician gap subsidies. In order to clarify this discrepancy, please provide details about the reported subsidies using the following supplemental survey:
https://umbc.co1.qualtrics.com/jfe/form/SV_0pUcGQwJhlCaj6S?Q_CHL=gl&Q_DL=t2Izp8uqGGaAHXZ_0pUcGQwJhlCaj6S_CGC_YdyYBV7aLB1sJeP