

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](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](mailto: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?		If no, please provide the correct information here:
	Yes	No	
The proper name of your hospital is: TidalHealth McCreeady Pavilion	<input checked="" type="radio"/>	<input type="radio"/>	TidalHealth McCreeady Pavilion located in Crisfield, Maryland is now a Freestanding Medical Facility and is no longer a designated hospital.
Your hospital's ID is: 210045	<input checked="" type="radio"/>	<input type="radio"/>	TidalHealth McCreeady is a department of TidalHealth Peninsula Regional. The HSCRC will continue to use the now defunct CMS Certification ID 210045.
Your hospital is part of the hospital system called TidalHealth.	<input checked="" type="radio"/>	<input type="radio"/>	
The primary Narrative contact at your hospital is Cindy Sapp	<input type="radio"/>	<input checked="" type="radio"/>	Henry Nyce
The primary Narrative contact email address at your hospital is cindy.sapp@tidalhealth.org	<input type="radio"/>	<input checked="" type="radio"/>	henry.nyce@tidalhealth.org
The primary Financial contact at your hospital is Camesha Spence	<input type="radio"/>	<input checked="" type="radio"/>	Cindy Sapp
The primary Financial email at your hospital is camesha.spence@tidalhealth.org	<input type="radio"/>	<input checked="" type="radio"/>	Cindy.Sapp@tidalhealth.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.

- Median household income
- Percentage below federal poverty line (FPL)
- Percent uninsured
- Percent with public health insurance
- Percent with Medicaid
- Mean travel time to work
- Percent speaking language other than English at home
- Race: percent white
- Race: percent black
- 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.

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

[FY2021 Additional Resources for Community Benefits Market and Demographics \(1\).docx](#)  
2.7MB  
application/vnd.openxmlformats-officedocument.wordprocessingml.document

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

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allegany County     | <input type="checkbox"/> Charles County    | <input type="checkbox"/> Prince George's County     |
| <input type="checkbox"/> Anne Arundel County | <input type="checkbox"/> Dorchester County | <input type="checkbox"/> Queen Anne's County        |
| <input type="checkbox"/> Baltimore City      | <input type="checkbox"/> Frederick County  | <input checked="" type="checkbox"/> Somerset County |
| <input type="checkbox"/> Baltimore County    | <input type="checkbox"/> Garrett County    | <input type="checkbox"/> St. Mary's County          |
| <input type="checkbox"/> Calvert County      | <input type="checkbox"/> Harford County    | <input type="checkbox"/> Talbot County              |
| <input type="checkbox"/> Caroline County     | <input type="checkbox"/> Howard County     | <input type="checkbox"/> Washington County          |
| <input type="checkbox"/> Carroll County      | <input type="checkbox"/> Kent County       | <input type="checkbox"/> Wicomico County            |
| <input type="checkbox"/> Cecil County        | <input type="checkbox"/> Montgomery County | <input type="checkbox"/> 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.

- |   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> 21817 | <input checked="" type="checkbox"/> 21838 | <input type="checkbox"/> 21866            |
| <input checked="" type="checkbox"/> 21821 | <input type="checkbox"/> 21851            | <input type="checkbox"/> 21867            |
| <input type="checkbox"/> 21822            | <input checked="" type="checkbox"/> 21853 | <input checked="" type="checkbox"/> 21871 |
| <input checked="" type="checkbox"/> 21824 | <input type="checkbox"/> 21857            | <input type="checkbox"/> 21890            |
| <input type="checkbox"/> 21836            |   |   |

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.

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

Q34. How did your hospital identify its CBSA?

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

Based on ZIP codes in your global budget revenue agreement. Please describe.

Based on patterns of utilization. Please describe.

TidalHealth McCreedy Pavilion identifies its service area based on facility utilization history.

Other. Please describe.

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

<https://www.tidalhealth.org/about-us/mission-values>

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

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)

06/06/2019 - TidalHealth McCreedy Pavilion is no longer a hospital, but instead a Freestanding Medical Facility (FMF) and now is a department of TidalHealth Peninsula Regional and falls under their CHNA requirements. TidalHealth Peninsula Regional's CBSA includes Somerset County which is the same CBSA area of TidalHealth McCreedy.

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

<https://www.tidalhealth.org/community-outreach-partners/community-health-research-data>

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

[TidalHealth Peninsula Regional CHNA 2019.pdf](#)  
8.7MB  
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										Other - If you selected "Other (explain)," please type your explanation 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)	
CB/ Community Health/Population Health Director (facility level)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
CB/ Community Health/ Population Health Director (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Board of Directors or Board Committee (facility level)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Board of Directors or Board Committee (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The Board of Trustees receives a copy of the Community Health Assessment and the Implementation Strategy Plan to review, and approve. There are also periodic updates to action plans, metrics, and progress updates.
	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 explanation below:
Clinical Leadership (facility level)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Clinical Leadership (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Population Health Staff (facility level)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation 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 explanation below:
Population Health Staff (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Community Benefit staff (facility level)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Community Benefit staff (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Those identified in the preceding positions (nurses, social workers, etc.) make up the Community Benefit Task Force. Others from Behavioral Health, Marketing, and Planning were also participants in the Community Benefit Task Force.
Physician(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nurse(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hospital Advisory Board	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Participants in each of these departments use their unique expertise to contribute to the CHNA
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your explanation 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.







	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	
Local Health Department -- Please list the Local Health Departments here: Wicomico County Health Department and Somerset County Health Department	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Identify & Engage Stakeholders <input checked="" type="checkbox"/> Define the community to be assessed <input type="checkbox"/> Collect and analyze the data <input checked="" type="checkbox"/> Select priority community health issues <input checked="" type="checkbox"/> Document and communicate results <input checked="" type="checkbox"/> Plan Implementation Strategies <input checked="" type="checkbox"/> Implement Improvement Plans <input checked="" type="checkbox"/> Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here: Wicomico County LHIC	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Identify & Engage Stakeholders <input checked="" type="checkbox"/> Define the community to be assessed <input type="checkbox"/> Collect and analyze the data <input checked="" type="checkbox"/> Select priority community health issues <input checked="" type="checkbox"/> Document and communicate results <input checked="" type="checkbox"/> Plan Implementation Strategies <input checked="" type="checkbox"/> Implement Improvement Plans <input checked="" type="checkbox"/> Evaluate Progress
Maryland Department of Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Identify & Engage Stakeholders <input type="checkbox"/> Define the community to be assessed <input type="checkbox"/> Collect and analyze the data <input type="checkbox"/> Select priority community health issues <input type="checkbox"/> Document and communicate results <input type="checkbox"/> Plan Implementation Strategies <input type="checkbox"/> Implement Improvement Plans <input type="checkbox"/> Evaluate Progress
Other State Agencies -- Please list the agencies here: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Identify & Engage Stakeholders <input type="checkbox"/> Define the community to be assessed <input type="checkbox"/> Collect and analyze the data <input type="checkbox"/> Select priority community health issues <input type="checkbox"/> Document and communicate results <input type="checkbox"/> Plan Implementation Strategies <input type="checkbox"/> Implement Improvement Plans <input type="checkbox"/> Evaluate Progress
Local Govt. Organizations -- Please list the organizations here: Wicomico County Executive	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Identify & Engage Stakeholders <input checked="" type="checkbox"/> Define the community to be assessed <input type="checkbox"/> Collect and analyze the data <input checked="" type="checkbox"/> Select priority community health issues <input type="checkbox"/> Document and communicate results <input type="checkbox"/> Plan Implementation Strategies <input type="checkbox"/> Implement Improvement Plans <input type="checkbox"/> Evaluate Progress
Faith-Based Organizations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Identify & Engage Stakeholders <input checked="" type="checkbox"/> Define the community to be assessed <input type="checkbox"/> Collect and analyze the data <input checked="" type="checkbox"/> Select priority community health issues <input type="checkbox"/> Document and communicate results <input type="checkbox"/> Plan Implementation Strategies <input type="checkbox"/> Implement Improvement Plans <input type="checkbox"/> Evaluate Progress

	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 health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here: Wicomico High School	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School - Colleges, Universities, Professional Schools -- Please list the schools here: Salisbury University and University of Maryland Eastern Shore	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Organizations -- Please list the organizations here: Lower Shore Enterprises and Lower Shore Clinic	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Service Organizations -- Please list the organizations here: MAC, Inc.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Post-Acute Care Facilities -- please list the facilities here: Salisbury Rehabilitation and Skilled Nursing Center - Genesis, Deers Head and Peninsula Home Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community/Neighborhood Organizations -- Please list the organizations here: HOPE Inc. and HALO	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consumer/Public Advocacy Organizations -- Please list the organizations here:

Other -- If any other people or organizations were involved, please list them here:

TGM Group LLC, Salisbury Police Department, Wicomico County Sheriff's Department, Chesapeake Health Care, Perdue Farms

	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
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

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

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

[TidalHealth Peninsula Regional Implementation Strategy Plan.pdf](#)  
3.3MB  
application/pdf

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

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

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

[TidalHealth McCreedy Attachments.pdf](#)  
3MB  
application/pdf

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Initiative B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Initiative C	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Initiative D	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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.

*This question was not displayed to the respondent.*

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				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
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.

*This question was not displayed to the respondent.*

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				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
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.

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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	Tri-County Behavioral Health Engagement (TRIBE)	The newly formed collaboration is a regional partnership between TidalHealth Peninsula Regional, Atlantic General Hospital and nine behavioral health community partner agencies. TRIBES immediate goal is to design behavioral health crisis stabilization centers or behavioral health urgent care centers. The primary objective is a three-county centralized response to reduce emergency department utilization, hospital admissions and readmissions for individuals experiencing behavioral health issues	Gaps and fragmentation has been identified with the goal of more seamless and "real time" behavioral health urgent care services.	Monthly meetings. This program is supported by grant funding and is continuing to evolve in support of a seamless local behavioral health process for the community at large.
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.

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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.

*This question was not displayed to the respondent.*

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.

*This question was not displayed to the respondent.*

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	Somerset County Opioid United Team (SCOUT)	The primary goal of the SCOUT program is to reduce overdose mortality which aligns with the SIHIS measure for Total Population Health - Opioid Use Disorder as well as the SHIP quality preventative care measure for reducing emergency department visits for addictions-related conditions. The SCOUT's efforts impact overall reduction in admissions, readmissions and ED visits. The objective is to work collaboratively to address policy, develop education and raise community awareness in the fight against opioid use and continue to reduce instances of heroin overdose each year.	Number of individuals exposed to opioid related messaging Number of impressions Number of additional officer hours Number of overdose cases shared by Law Enforcement with the Health Department	306,389 individuals exposed to opioid related messaging (Shore Birds stadium 50,000 fans, Clear Channel Billboard 106,389 impressions, The Voice radio station 150,000 listeners) Due to COVID, no education or trainings were held in the community in FY2021, but bags were provided that advertised Somerset OIT grant with educational information to the increasing food pantries that popped up due to COVID-19 368.75 additional officer hours dedicated to opioid related calls and initiatives were funded by this grant 100 overdose cases shared by Law Enforcement with the Health Department
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.

Health Behaviors - Health Communication 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				

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

*This question was not displayed to the respondent.*

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.

	Health Behaviors - Preventive 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				

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.

*This question was not displayed to the respondent.*

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

Health Behaviors - Vaccination 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				

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

*This question was not displayed to the respondent.*

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

Populations - Adolescents 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				

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

Populations - Children 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				

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.

Populations - Older Adults 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				

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.

Populations - Women 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				

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.

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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.

	Settings and Systems - Hospital and Emergency Services 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				

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.

	Social Determinants of Health - Education Access and Quality 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				

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	Community Wellness Team	The goals of the Community Wellness team are to 1) Increase access to care by providing health screenings in underserved communities; 2) Improve engagement with community partners by working collaboratively with stakeholders and members of disadvantaged groups to provide prevention and health education programming and services; 3) Improve effectiveness of care by screening for and addressing social determinant of health barriers among disadvantaged populations. Provide basic healthcare, health education and health screenings in the community. These services are geared towards low income, historically disadvantaged communities with little to no health insurance coverage such as areas with high rates of homelessness, poverty, housing and food insecurities.	Number of COVID-19 Vaccinations administered Number of community-based flu shots administered Number of Vulnerable Population Task Force One Stop Events Number of Community Health Worker encounters	44,519 COVID-19 Vaccinations administered 1,286 community-based flu shots administered 22 Vulnerable Population Task Force One Stop Events attended - screening approximately 125 individuals Thousands of American Cancer Screening Fact Sheets provided at COVID-19 Mass Vaccination clinics attended Community Health Worker encounters - 4,187 encounters for 206 patients
Initiative B	Smith Island Telehealth	The goals of the Smith Island telehealth initiative are to 1) Increase access to care by providing telemedicine and in-person primary care to the remote, isolated community; 2) Increase effectiveness by preventing ED visits and hospitalizations through primary care - primary and secondary prevention, health education, screening. Provide community health workers and primary care visits on Smith Island and operate a telemedicine program for the approximately 300 residents of Smith Island. The telemedicine function allows the opportunity to speak with a Nurse Practitioner remotely in place of traveling to the Emergency Room and in-person visits occur every two weeks.	Number of Labs Number of Telehealth visits Number of office visits Number of medication refills Number of blood pressure screenings Number of COVID-19 tests administered Number of flu shots administered Number of pneumonia vaccines administered	126 Labs 32 Telehealth visits 68 Office visits 42 Medication refills 48 Blood Pressure screenings 55 COVID-19 tests administered 58 Flu shots administered 3 Pneumonia vaccines administered
Initiative C	Wagner Wellness Van Expansion	The primary goals are 1) Increase access to care by deploying mobile medical van with nurse and community health worker to underserved communities to provide health screenings, outreach and education. 2) Increase effectiveness by expanding diabetes risk assessments and blood pressure checks in community, screening for social determinants of health, and primary care/health care coverage. 3) Engagement - link uninsured and individuals without a PCP to health care coverage and primary care. Working in partnership with the Wicomico County Health Department and Somerset County Health Department to increase access to diabetes screening, education and connection to community resources. This program, which includes Wagner Wellness Van outreach, provides health outreach events that are both large-scale and small-scale, and can be aimed toward the general public or a targeted population or geographic area. It also offers additional cancer prevention programs and screening options for low income community members and connect those that need it to treatment. Increase knowledge of at-risk activities for cancer, importance of healthy behaviors in prevention of cancer and importance of screening activities	Number of screenings Number of flu shots given Number of events attended	Screenings were delayed due to COVID-19 pandemic, but did provide thousands of American Cancer Society screening literature to individuals who came to the COVID-19 vaccination clinics.
Initiative D				
Initiative E				
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.

This question was not displayed to the respondent.

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 - Cancer, Health Conditions - Diabetes, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Overweight and Obesity, Health Behaviors - Drug and Alcohol Use, Health Behaviors - Health Communication, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Physical Activity, Health Behaviors - Preventive Care, Health Behaviors - Vaccination, Populations - Adolescents, Populations - Children, Populations - Older Adults, Populations - Women, Settings and Systems - Health Care, Settings and Systems - Hospital and Emergency Services, Social Determinants of Health - Education Access and Quality, Social Determinants of Health - Health Care Access and Quality**

**Other:**

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

- |  |   |
|--|---|
| <input type="checkbox"/> Access to Health Services: Health Insurance                       | <input type="checkbox"/> Heart Disease and Stroke                       |
| <input type="checkbox"/> Access to Health Services: Practicing PCPs                        | <input type="checkbox"/> HIV  |
| <input type="checkbox"/> Access to Health Services: Regular PCP Visits                     | <input type="checkbox"/> Immunization and Infectious Diseases           |
| <input type="checkbox"/> Access to Health Services: ED Wait Times                          | <input type="checkbox"/> Injury Prevention                              |
| <input type="checkbox"/> Access to Health Services: Outpatient Services                    | <input type="checkbox"/> Lesbian, Gay, Bisexual, and Transgender Health |
| <input type="checkbox"/> Adolescent Health   | <input type="checkbox"/> Maternal and Infant Health                     |
| <input type="checkbox"/> Arthritis, Osteoporosis, and Chronic Back Conditions              | <input type="checkbox"/> Nutrition and Weight Status                    |
| <input type="checkbox"/> Behavioral Health, including Mental Health and/or Substance Abuse | <input type="checkbox"/> Older Adults                                   |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Oral Health                                    |
| <input type="checkbox"/> Children's Health   | <input type="checkbox"/> Physical Activity                              |
| <input type="checkbox"/> Chronic Kidney Disease  | <input type="checkbox"/> Respiratory Diseases                           |
| <input type="checkbox"/> Community Unity   | <input type="checkbox"/> Sexually Transmitted Diseases                  |
| <input type="checkbox"/> Dementias, including Alzheimer's Disease                          | <input type="checkbox"/> Sleep Health                                   |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Telehealth                                     |
| <input type="checkbox"/> Disability and Health   | <input type="checkbox"/> Tobacco Use                                    |
| <input type="checkbox"/> Educational and Community-Based Programs                          | <input type="checkbox"/> Violence Prevention                            |
| <input type="checkbox"/> Environmental Health  | <input type="checkbox"/> Vision   |
| <input type="checkbox"/> Family Planning   | <input type="checkbox"/> Wound Care                                     |
| <input type="checkbox"/> Food Safety   | <input type="checkbox"/> Housing & Homelessness                         |
| <input type="checkbox"/> Global Health   | <input type="checkbox"/> Transportation                                 |
| <input type="checkbox"/> Health Communication and Health Information Technology            | <input type="checkbox"/> Unemployment & Poverty                         |
| <input type="checkbox"/> Health Literacy   | <input type="checkbox"/> Other Social Determinants of Health            |
| <input type="checkbox"/> Health-Related Quality of Life & Well-Being                       | <input type="checkbox"/> Other (specify) <input type="text"/>           |

Q132. Why were these needs unaddressed?

There were additional social determinants of health and other health care related needs that were not addressed due to limited funding and the need for specialized human resources that are scarce.

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

TidalHealth McCready Pavilion is no longer a hospital, but instead a Freestanding Medical Facility (FMF). TidalHealth optimizes several data analytics tools and platforms to track and reduce health disparities among the communities it serves. The following tools support analysis of the disparities in priority chronic conditions such as CHF, COPD, Diabetes, Hypertension, Cancer as well as behavioral health conditions and create a stronger understanding of the specific populations in terms of geography, zip codes, race, ethnicity, age, gender most affected by these conditions as well as the social determinants of health that may be exacerbating poor health outcomes in certain communities. Below is a summary of the tools TidalHealth uses to implement, improve, monitor and evaluate strategies and interventions: Community Health Needs Assessment and Community Health Improvement Plan: To ensure that our health system resources are put to the best use, TidalHealth conducts research into our community's health needs. TidalHealth partners with Conduent Healthy Communities Institute to discover what the most pressing health challenges are in Somerset, Wicomico and Worcester counties of Maryland. Conduent's specialized team analyzes secondary and primary qualitative and quantitative data to develop the triannual Community Health Needs Assessment and accompanying Community Health Improvement Plan. The Local Health Improvement Coalitions work with TidalHealth to identify the top health priorities and health disparities to address based on the data presented in the CHNA. The CHIP includes the strategies to address the identified priorities. Epic EMR – Healthy Planet Dashboard: TidalHealth optimizes its Epic EMR software module, Healthy Planet, to build a suite of reports and dashboards that compiles and aggregates patient record data in terms of demographics and quality health indicators. Reports generated from the platform allow the healthcare system to better manage patient populations, coordinate care and monitor cost and health indicators. Lightbeam Health Solutions: TidalHealth as a Care Transformation Organization and as part of the Peninsula Regional Clinically Integrated Network uses Lightbeam Health Solutions analytics platform to analyze, track and reduce health disparities among the Medicare population served. The platform supports our team's ability to close care gaps and improve quality of care as well as coordinate care for high risk and high-cost patients. CRISP: The Chesapeake Regional Information System, i.e. the designated Health Information Exchange in Maryland and D.C. provides reporting services for analytics for the health care community to improve patient outcomes and reduce cost of care. Our data analysts use this suite of reports to drill down into health care utilization and health care disparity data to better understand trends and assist with strategic planning for reducing admissions and readmissions as well as ED utilization among our patient populations. Manual tracking mechanisms for new programs: TidalHealth is employing several new and innovative strategies to address health disparities. When new programs are being implemented, we initially capture data through manual data entry while we work with our IT solutions to build reports into our electronic systems.

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:

- Regional Partnership Catalyst Grant Program
- The Medicare Advantage Partnership Grant Program
- The COVID-19 Long-Term Care Partnership Grant
- 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.

[FY2021 Community Benefit Narratives McCreedy.docx](#)  
25.7KB

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.

- 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.

Both the spreadsheet and narrative component of the Community Benefits Report is reviewed by the Finance Department and the Strategy and Business Development Department. Upon completion of their review, the Vice President of Population Health and the Director of Community Health Initiatives evaluates and provides additional input to the narrative component. Following review/audit by these three departments, the Report is forwarded to the Executive Staff for final review.

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.

Community Benefit planning and investments are included in TidalHealth's strategic plan through the three themes of Access, Effectiveness and Engagement. TidalHealth continually links its Community Benefit initiatives to Access, Engagement and Effectiveness in order to meet HSCRC and IRS requirements regarding the Community Health Needs Assessment. The assortment of programs that TidalHealth Peninsula Regional is involved in dovetail the three strategic themes in TidalHealth Peninsula Regional's strategic plan.

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

This is not available online, but we will email to the Hilltop Institute as part of this submission.

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.](#)

Diabetes - Reduce the mean BMI for Maryland residents

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.

TidalHealth's strategies align with various state and local plans for population health improvement, improved quality of care, and reduction in the total cost of care. For example, the interventions meet the State Integrated Health Improvement Strategy goals for: Hospital Quality - reducing avoidable admissions and readmissions. Care Transformation Across the System - Improve care coordination for patients with chronic conditions. Total Population Health - Diabetes - Reduce the mean BMI for adult Maryland residents. Total Population Health - Opioid Use Disorder - Improve overdose mortality. The program's interventions are also aligned with the following State Health Improvement Process (SHIP) framework measures: Health Living Measures: Increase the proportion of adults who are not overweight or obese. Increase physical activity. Increase life expectancy. Access to Health Care measures: Increase the proportion of people with usual primary care providers. Reduce the uninsured emergency department visits. Quality Preventative Care: Reduce Emergency Department visit rate due to diabetes. Reduce Emergency Department visit rate due to hypertension. Reduce the cancer mortality rate. Reduce Emergency Department Visits for Addictions-Related Conditions. Provide Annual Seasonal Influenza Vaccinations. TidalHealth wanted to ensure alignment with local health improvement plans developed from Community Health Needs Assessments.

### 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 HGS19-303, 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.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Anesthesiology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Cardiology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Dermatology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Emergency Medicine	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Endocrinology, Diabetes & Metabolism	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Family Practice/General Practice	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Geriatrics	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Internal Medicine	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Medical Genetics	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Neurological Surgery	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Neurology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Obstetrics & Gynecology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Oncology-Cancer	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Ophthalmology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>



Orthopedics	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Otolaryngology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Pathology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Pediatrics	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Physical Medicine & Rehabilitation	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Plastic Surgery	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Preventive Medicine	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Psychiatry	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Radiology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Surgery	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Urology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Other (Describe)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>

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.

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

Q140. Section VI - Financial Assistance Policy (FAP)

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

[Financial Assistance - Poverty Guidelines.pdf](#)  
5.1MB  
application/pdf

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

<https://www.tidalhealth.org/medical-care/financial-admin-services/billing/tidalhealth-financial-assistance>

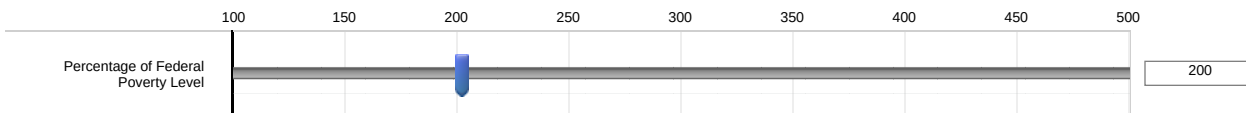
Q147. Has your FAP changed within the last year? If so, please describe the change.

No, the FAP has not changed.

Yes, the FAP has changed. Please describe:

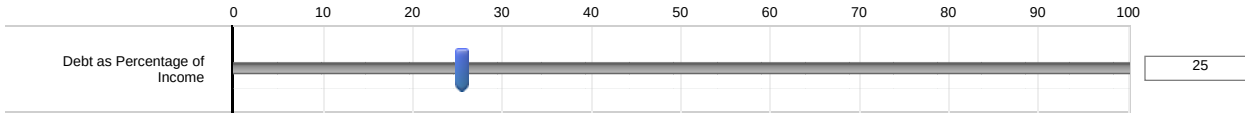
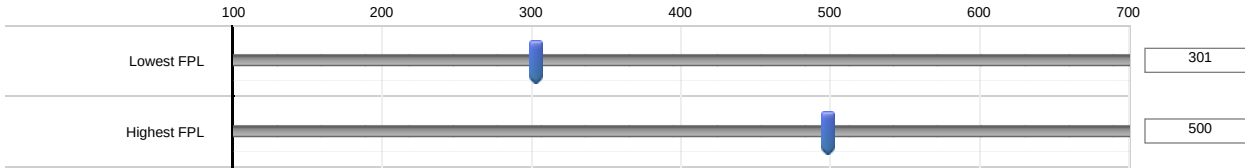
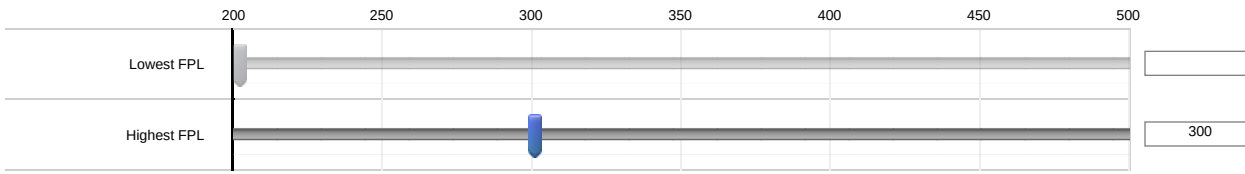
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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.



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)

- Federal corporate income tax
- State corporate income tax
- State sales tax
- Local property tax (real and personal)
- Other (Describe)

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](mailto: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: [\(38.379196166992, -75.630699157715\)](#)

Source: GeolIP Estimation



## Additional Resources for Community Benefits

For the Community Benefit Report, TidalHealth utilized multiple sources to gather information. The sources we used were Conduent Healthy Communities Institute (HCI), the Maryland Vital Statistics Report for 2019, IntelliMed, ESRI, the Community Health Needs Assessment (CHNA) and Sg2.

Conduent Healthy Communities Institute (HCI) is a multi-disciplinary team of public health experts, including healthcare information technology veterans, academicians and former senior government officials, all committed to help health-influencing organizations be successful with their projects. HCI used collaborative approaches to data gathering

Maryland Vital Statistics – The Maryland Department of Health Vital Statistics Administration releases a yearly report to inform the public on Maryland’s population, life expectancy, birth rates, infant mortality, the 10 leading causes of death, marriage and divorce rates, etc. The report also breaks down Maryland by regions so that TidalHealth can be better informed about the Eastern Shore region numbers when compared to the rest of the state of Maryland.

IntelliMed – IntelliMed is TidalHealth’s vendor for hospital data sets that are used for analyzing market share, competitor analysis and healthcare market trends. Data can be extracted for multiple variables about patients with no personal information included.

ESRI – ESRI is a geographic information system software that TidalHealth uses to visually estimate population size, estimate population density and show the Primary and Secondary Service Areas of TidalHealth. The software can be manipulated in various forms to show layers of different data from multiple locations to give the big picture of the markets and populations on the Delmarva Peninsula.

CHNA – The Community Health Needs Assessment (CHNA) is a report collaborated on with Conduent Healthy Communities Institute that analyzes the needs of Worcester, Wicomico and Somerset Counties based on various criteria. The Wicomico County Health Department and the Somerset County Health Department collaborated with TidalHealth in the local assessment to determine population health.

Sg2 – Sg2 is a software program that TidalHealth uses to determine current populations, insurance coverages, healthcare use rates and age breakdowns. Truven can also be used to estimate and compare five and ten year predictions on populations, insurance coverages, and healthcare use rates and age breakdowns.

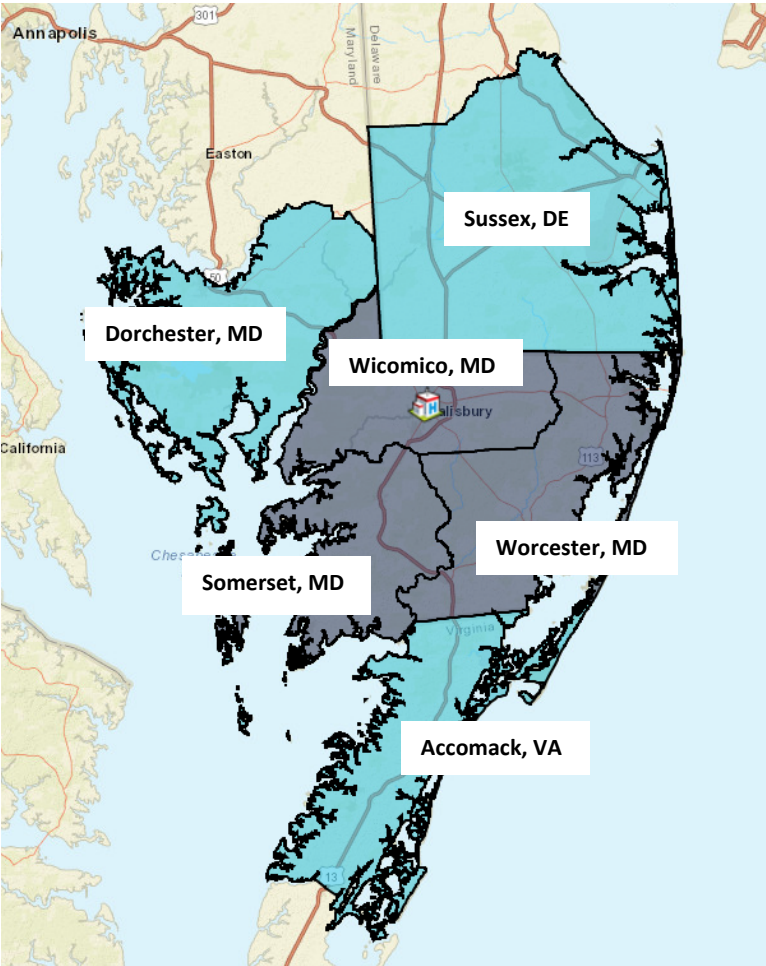
TidalHealth Demographics

*Zip Codes included in the organization’s CBSA, indicating which include geographic areas where the most vulnerable populations reside.*

(i) *A list of the zip codes included in the organization’s CBSA*

The Community We Serve

TidalHealth functions as the primary hospital provider for the rural southernmost three counties on the Eastern Shore of Maryland. These counties include Wicomico, Worcester and Somerset Counties (highlighted in green). In FY2021, approximately % of the patients discharged from TidalHealth Peninsula Regional were residents of the primary service area, which has an estimated population of approximately 185,198 in 2021 and is expected to increase to 189,161 in 2026, or by 2%.



TidalHealth Peninsula Regional's CBSA consists of those zip codes within its primary service area. Most of the population resides in Wicomico County, with a population of 104,969. Salisbury, MD serves as the capital of the Eastern Shore of Maryland with a population of 72,565 in 2021. Salisbury is located on the headwaters of the Wicomico River and is located at the crossroads of the Chesapeake Bay and the Atlantic Ocean. Salisbury is a unique region; the city of Salisbury has similar socio-economic and demographic characteristics of a large city, however, the area surrounding Salisbury is rural and has parallel characteristics of small-town America. Due to these contrasting area characteristics, delivering healthcare to these areas presents challenges. The other two counties in TidalHealth Peninsula Regional's CBSA include Worcester County with a population of 53,728 in and Somerset County with a population of 26,501 in 2021.

### **Insert Map of TidalHealth's Primary Service Area Population by Zip Code**

The greater "metropolitan" Salisbury area (zip codes 21801 and 21804) has a higher population density than the surrounding rural areas. This area has a vulnerable population that includes an indigent population and a higher Medicaid mix. Moving east towards the beach and the Atlantic Ocean, are several larger towns in Worcester County such as Berlin (zip code 21811) and Ocean City (zip code 21842) which have a high population density. South of Salisbury are the larger towns in Somerset County of Princess Anne (zip code 21853) and Crisfield (zip code 21817). Excluding the greater Salisbury area, the landscape and environment of TidalHealth Peninsula Regional's CBSA is considered rural, made of small businesses and agriculture.

All three counties can be classified as rural with a historic economic foundation centralized around agriculture, the poultry industry and tourism. Watermen and farmers have consistently comprised a large percentage of the Delmarva Peninsula's population, however, their numbers have been slowly declining with the growth in the population and the expansion of other small businesses. Ocean City, MD, located in Worcester County, is a major tourist destination. During the summer weekends between Memorial Day and Labor Day, the city hosts between 320,000 and 345,000 vacationers and upwards of 8 million visitors annually.

The three counties have a diversified economic base, but it is predominately made up of smaller employers (companies with less than 50 employees). Major employers include local hospitals, the poultry industry, local colleges and teaching institutions. The median income of \$53,855 in our Community Benefits Service Area is considerably less than Maryland's median income of \$86,104. In addition, July 2021 unemployment rates were higher for Maryland's Eastern Shore counties. The unemployment rate in Maryland was 6.0%, the United States was 5.4% compared to Wicomico County at 5.3%; Worcester County at 6.2%; and Somerset County at 6.8%. These rates were not seasonally adjusted as Worcester County, specifically Ocean City, MD relies heavily on summer seasonal workers. Research indicates lower median incomes and higher unemployment rates contribute to a disparity in access to medical care and a prevalence of untreated chronic diseases.

(iii) Describe how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with >3 hospitalizations in the past year). This information may be copied directly from the community definition section of the organization's' federally required CHNA Report.

TidalHealth Peninsula Regional has embarked on identifying and targeting "Super Utilizers" within our CBSA; these residents will be identified and targeted for population health management.

- Demographics (block groups and zip codes)
- Race/Ethnicity
- Age-Cohorts
- Chronic Conditions

The target population includes patients that have chronic conditions who have demonstrated to have been high utilizers at TidalHealth Peninsula Regional or are identified as being at risk of high utilization based on his/her chronic conditions and patterns of care. Current data indicates a continued "overreliance" by residents on TidalHealth Peninsula Regional's emergency room for primary care and chronic condition needs. In response, TidalHealth Peninsula Regional has introduced interventions, care management programs, education and follow-up with measurement and outcomes.

TidalHealth Peninsula Regional is targeting CBSA zip codes based on social and economic determinants of health to include the uninsured, the indigent population, residents who lack transportation, lack education and/or availability of healthy foods. Targeting this by cluster and block groups, we seek to impact the health of these populations by providing both primary care health services, education and access to care. More importantly, we want to foster lasting relationships with the communities we serve. For example, TidalHealth's Wagner Wellness Van travels locally to block groups in TidalHealth Peninsula Regional's CBSA where there was an identified need for basic health services. The Wagner Wellness Van also brings education to local ethnic churches and civic organizations and helps connect uninsured residents with contacts for TidalHealth Primary Care Providers (PCPs). We also have a continued joint program with the Wicomico County Health Department and the City of Salisbury Emergency Medical Service team that provides home visits for individuals who are frequent users of 911 services. This program, names SWIFT, helps reduce overuse of emergency services and improves access to care for these residents by connecting them with healthcare options that are performed in a primary care or specialty care setting.

TidalHealth Peninsula Regional CBSA

Race/Ethnicity	TidalHealth Peninsula Regional's CBSA		USA % of Population
White Alone	123,942	66.9%	69.2%
Black Alone	46,927	25.3%	13.0%
American Indian Alone	631	0.3%	1.0%
Asian Alone	4,359	2.4%	5.9%
Pacific Islander Alone	86	0.0%	0.2%
Some Other Race Alone	3,903	2.1%	7.1%
Two or More Races	5,350	2.9%	3.6%
<b>Total</b>	<b>185,198</b>	<b>100.0%</b>	<b>100.0%</b>

Within TidalHealth Peninsula Regional's CBSA, Wicomico County has the highest Hispanic/Latino population at 5.8%. However, all three counties have smaller percentages compared to the state of Maryland. Worcester County has the highest percentage of White residents (81.3%), whereas Somerset County has the lower percentage (52.5%). Somerset County has the largest proportion of Black/African American residents at 41.3%, whereas Worcester County has the lowest percentage at 12.9%. The other racial groups comprise a tiny sliver of the tri-county population in comparison.

The three counties in TidalHealth Peninsula Regional's CBSA have varying age distributions when compared to each other and the state of Maryland. The proportion of young adults in Somerset County and Wicomico County are higher when compared to the state of Maryland and Worcester County. Over half of Maryland is comprised of adults aged 25 to 64. This age group accounts for slightly below % of the population in each of the three counties. The baby boomer population (residents aged 55+) represent a greater portion of the total population TidalHealth Peninsula Regional's CBSA when compared to the Nation. The Delmarva Peninsula is becoming a popular retirement destination and the trend is likely to continue. The chronic conditions of this age group consume health care resources at much higher rates than those of the younger age cohorts.

Age Cohort	TidalHealth Peninsula Regional's CBSA	TidalHealth Peninsula Regional's CBSA % of Total Population	USA % of Total Population
0-14	28,595	15.1%	18.18%
15-17	5,860	3.1%	3.57%
18-24	21,353	11.3%	9.21%
25-34	21,751	11.5%	13.99%
35-44	23,561	12.5%	12.78%
45-54	20,218	10.7%	12.05%
55-64	23,802	12.6%	12.95%
65+	44,021	23.3%	17.26%
<b>Total</b>	<b>189,161</b>	<b>100.0%</b>	<b>100.0%</b>



### Insert CBSA Population Sex breakdown

#### CBSA Health Disparities (Wicomico, Worcester and Somerset)

The most recent key findings from The Office of Minority Health and Health Disparities (MHHD) at the Department of Health and Mental Hygiene include:

##### Wicomico County

African Americans in Wicomico County had higher mortality rates than Whites for All-Cause mortality and for three of the top six causes of death (Stroke, Diabetes and Kidney Disease).

The mortality ratio disparity was greatest for diabetes and kidney disease, where African Americans had 2.5 times the diabetes death rate and 1.8 times the kidney disease death rate when compared to Whites.

##### Worcester County

African Americans in Worcester County had higher mortality rates than Whites for All-Cause mortality and for five of the top six causes of death (Heart, Cancer, Stroke, Diabetes and Kidney Disease).

The greatest mortality ratio disparity for African Americans compared to Whites was for kidney disease, where African Americans have 3.3 times the rate of death compared to Whites.

##### Somerset County

African Americans in Somerset County had higher mortality rates than Whites for All-Cause mortality and for five of the top six causes of death (Cancer, Stroke, Lung, Diabetes and Kidney Disease).

The diabetes mortality rate for African Americans was 2.4 times higher than for Whites and the kidney disease mortality rate was 1.9 times higher for African Americans when compared to Whites.

#### Chronic Disease Management

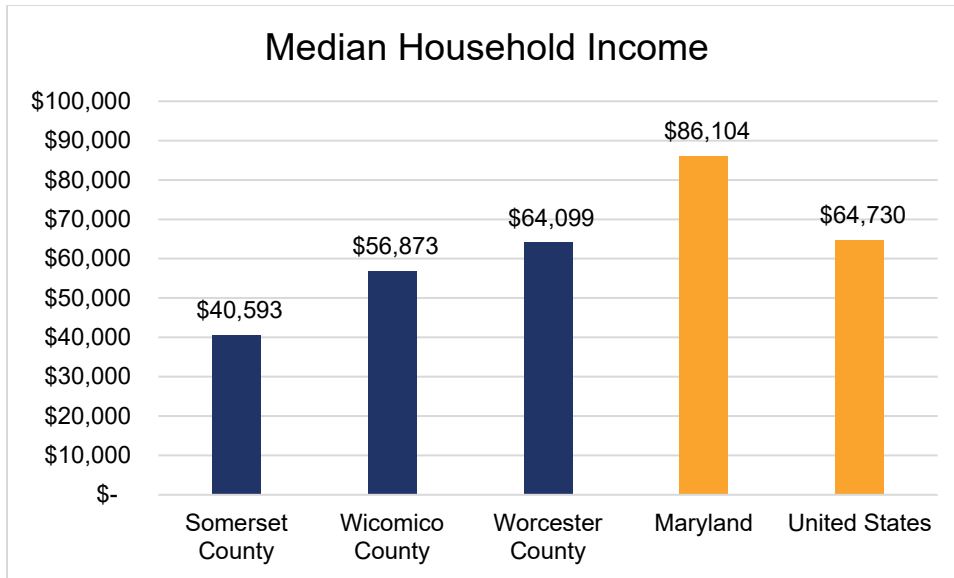
In a report prepared by the Office of Minority Health and Health Disparities of the Maryland Department of Health and Mental Hygiene, the largest disparities between Black and White people in the three lower counties for visit rates to the emergency department are for diabetes, asthma and hypertension.

Source: Maryland Chartbook of Minority Health and Minority Health Disparities Data – 2013

#### Median Household Income within the CBSA

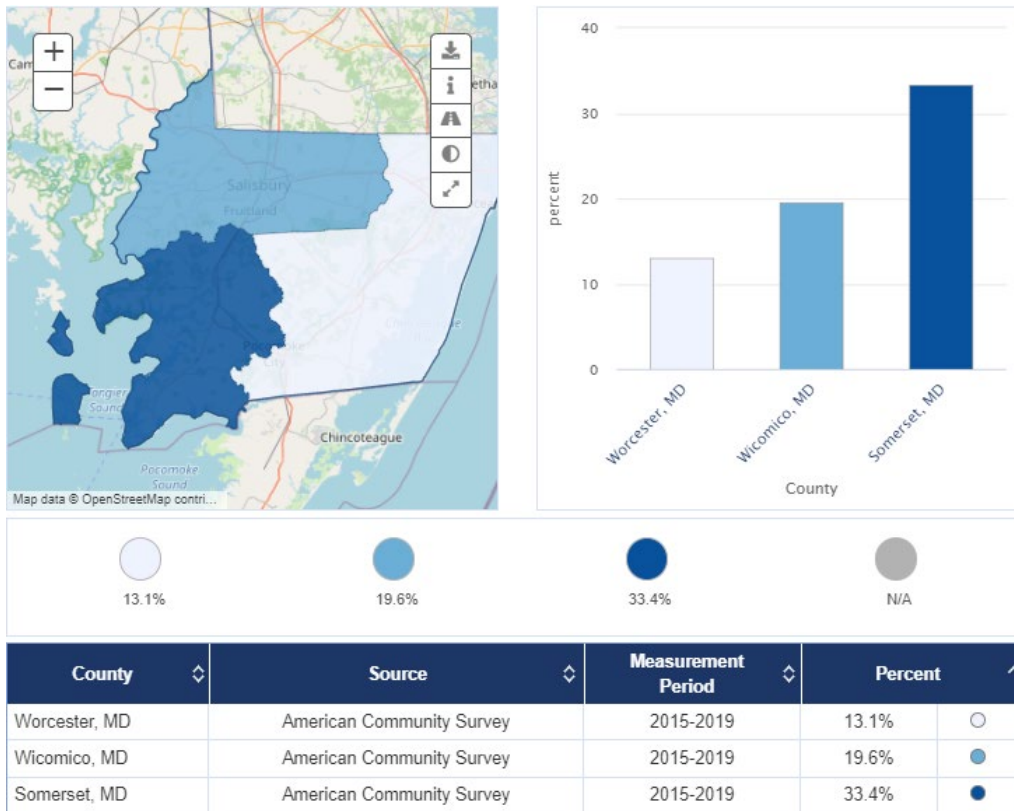
The median household income values in all three counties are lower than that of the state of Maryland. Somerset County has the lowest median household income in the Community Benefit Service Area with a value of \$40,593. Worcester County has the highest median household income in the service area at \$64,099. Wicomico County has a median household income of \$56,873.

Source: ESRI ArcGIS



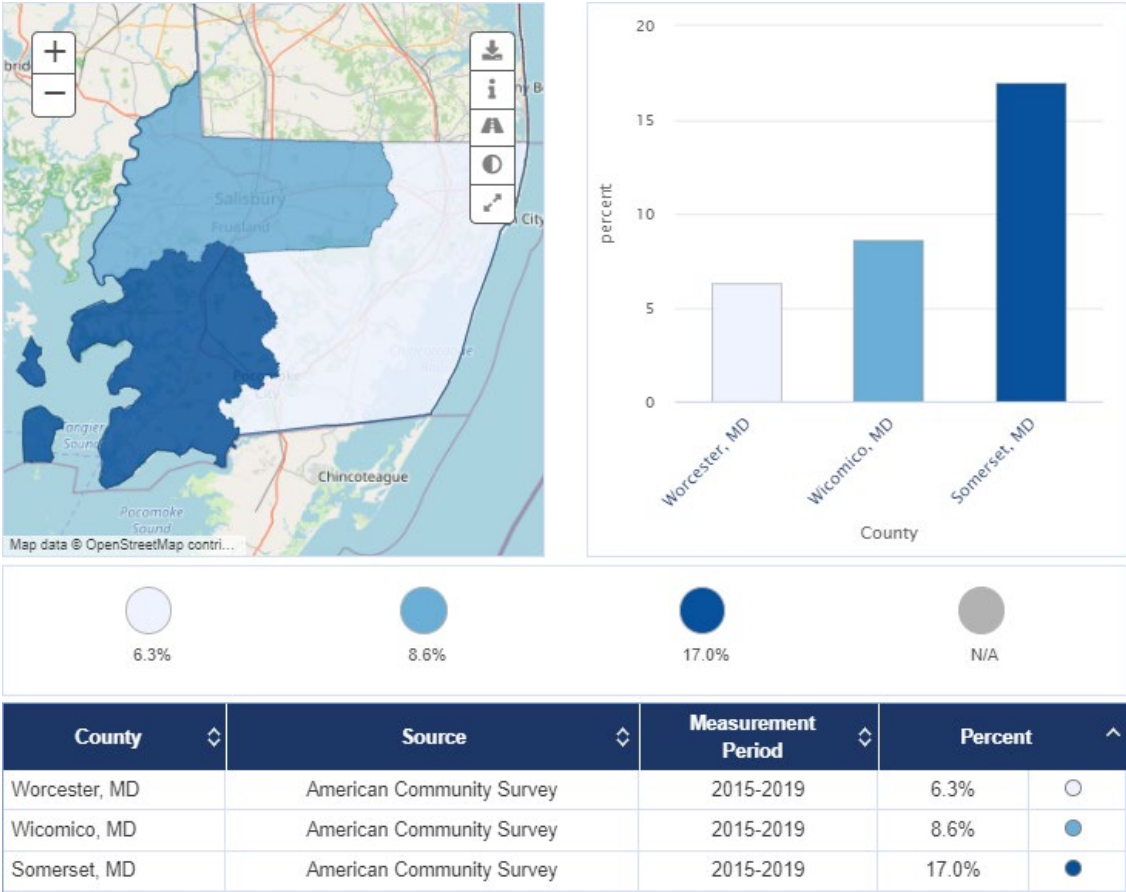
In all identified areas of poverty, Somerset County has the highest percentage of families living in poverty, children living in poverty and those over the age of 65 living in poverty. Wicomico County and Worcester County closely follow Somerset County's percentages, respectfully.

### Children Living Below Poverty



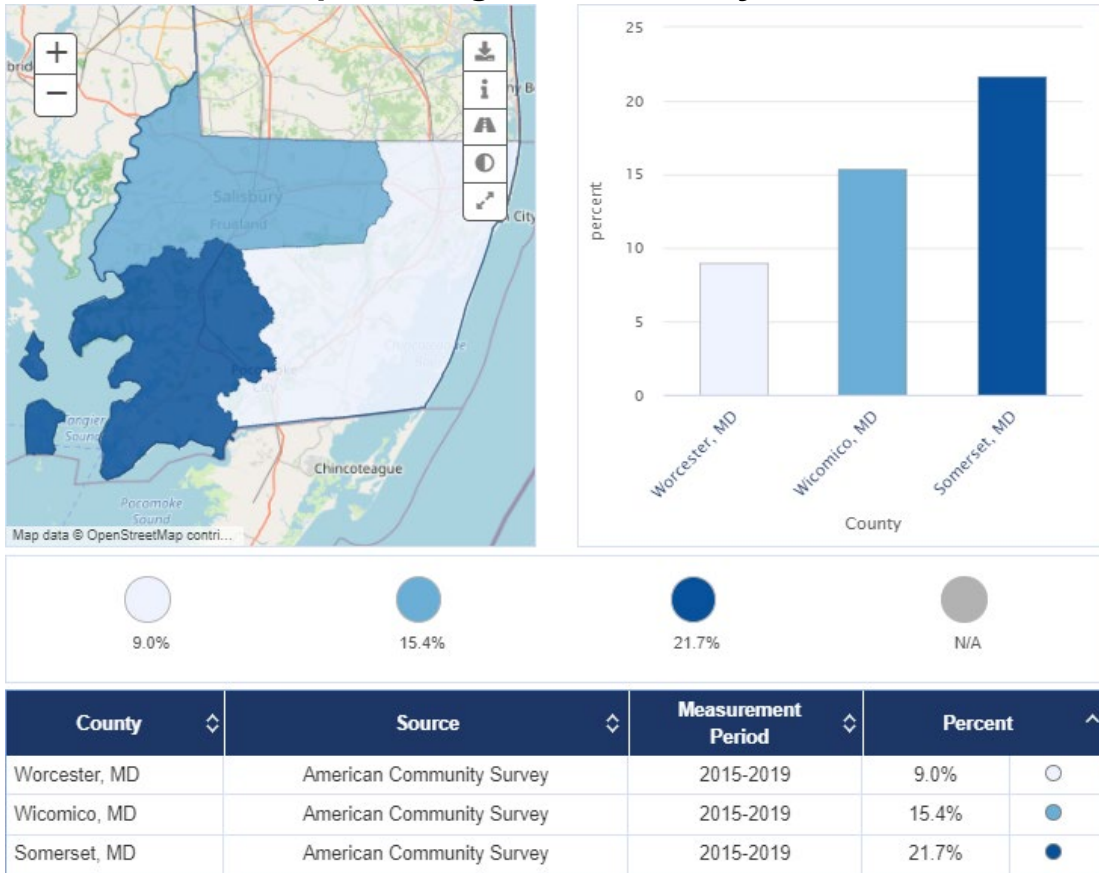
Source: Healthy Communities Inc., 2021

# Families Living Below Poverty



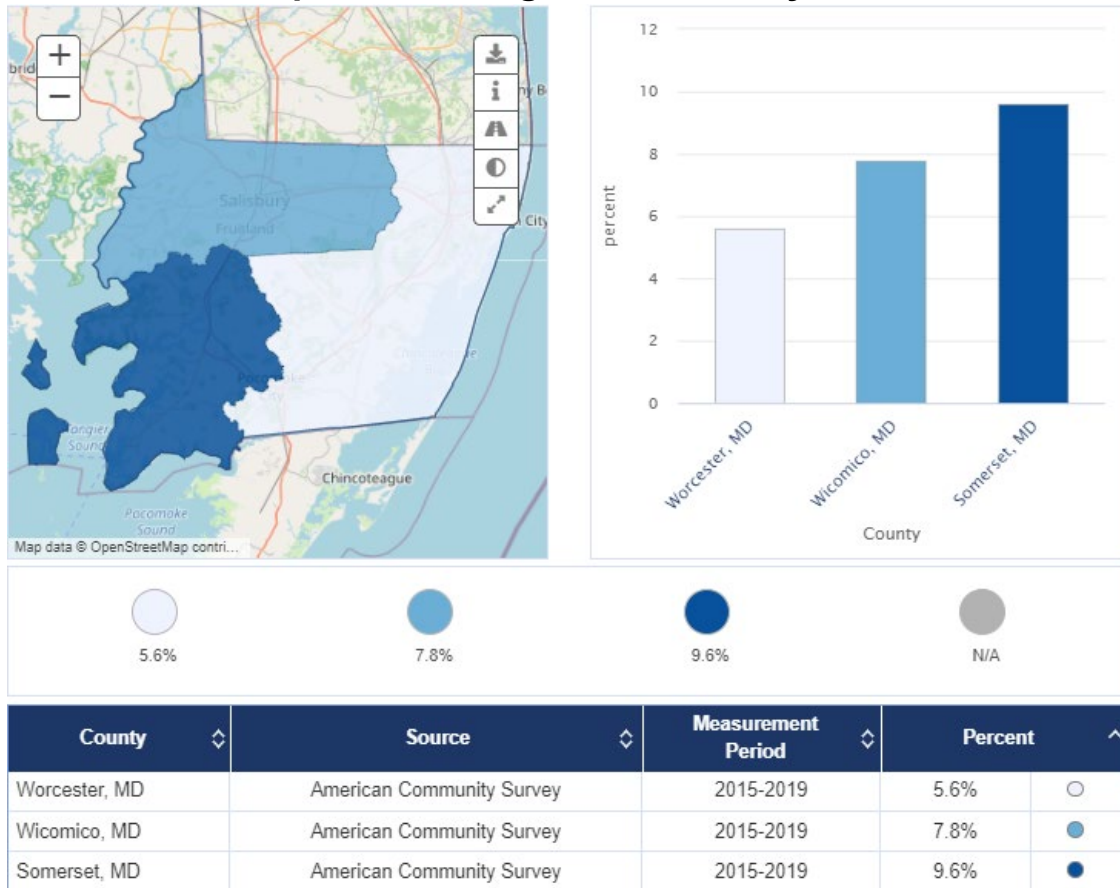
Source: Healthy Communities Inc., 2021

## People Living Below Poverty Level



Source: Healthy Communities Inc., 2021

## People 65+ Living Below Poverty Level



Source: Healthy Communities Inc., 2021

For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links:

<http://www.census.gov/hhes/www/hlthins/data/acs/aff.html>;

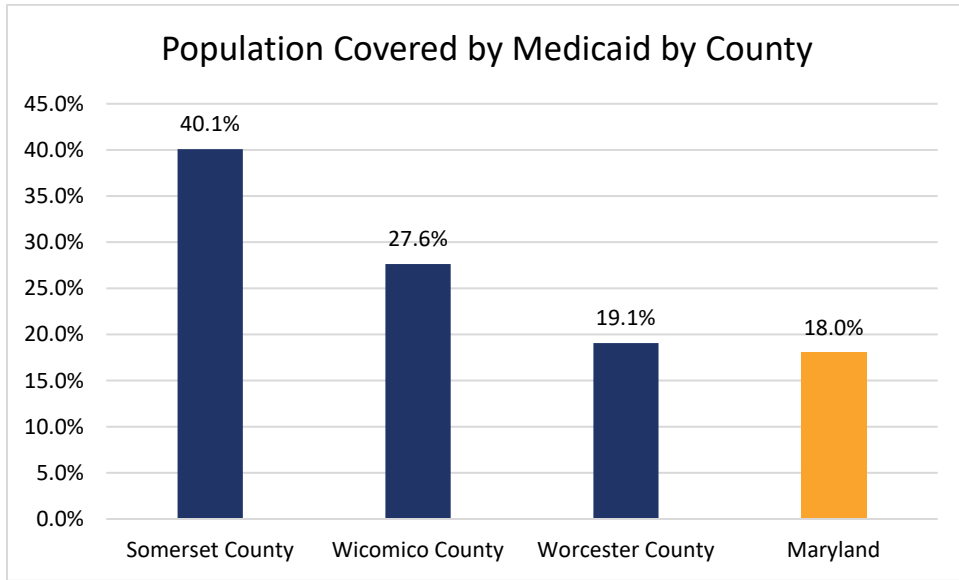
[http://planning.maryland.gov/msdc/American\\_Community\\_Survey/2009ACS.shtml](http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml)

All three counties in TidalHealth Peninsula Regional's CBSA have a greater percentage of its population that are uninsured. Somerset County has almost 2.5 times the percentage of uninsured residents compared to the state of Maryland.

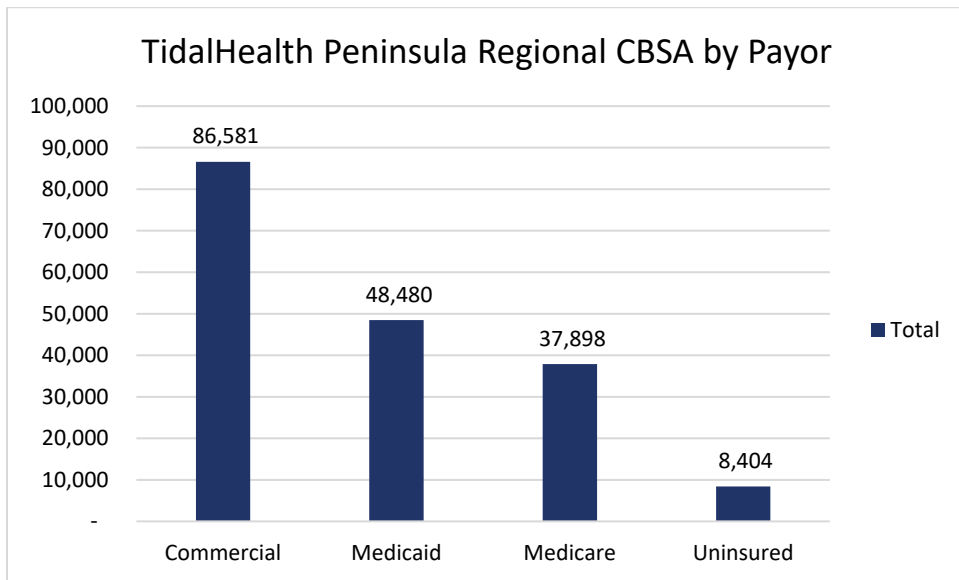
### Percentage of Medicaid recipients by County within the CBSA

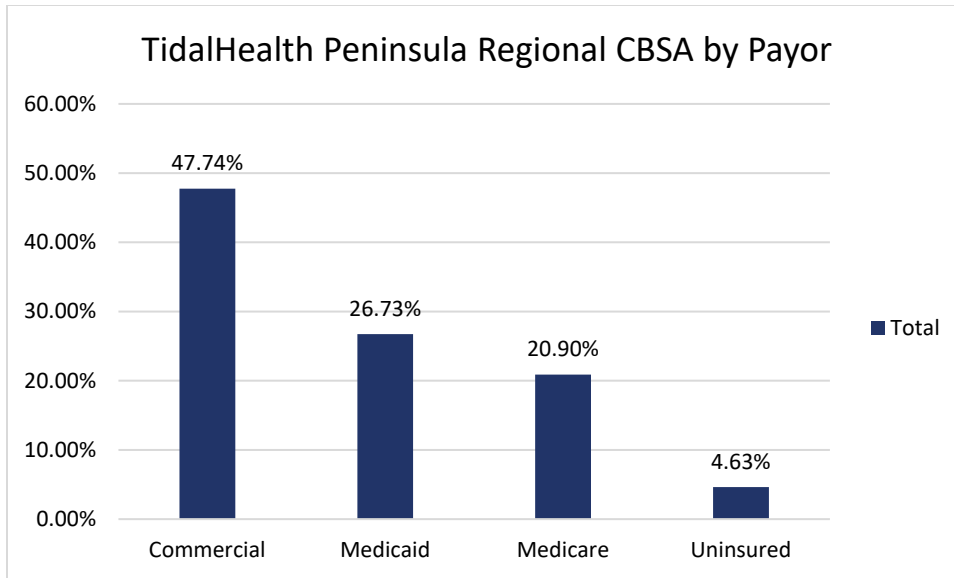
In comparison to the state of Maryland, TidalHealth Peninsula Regional's CBSA has a greater proportion of Medicaid recipients. Several of the poorer counties in Maryland, Wicomico County and Somerset County, have a substantially higher percentage of Medicaid recipients than the state of Maryland. The continued growth of Medicaid recipients within TidalHealth Peninsula Regional's CBSA has reduced the total number of uninsured patients. Most importantly, more patients have health insurance on the Eastern Shore of Maryland, providing lower income families access to appropriate care. Social determinants such as lower median income, higher

unemployment rates, rural economies and lower educational attainment continue to challenge the access to care and healthy lifestyle changes.



Source: Sg2 Analytics





Source: Sg2 Analytics

Life expectancy by County within the CBSA (including by race and ethnicity where data is available).

See SHIP website:

<http://dhmh.maryland.gov/ship/SitePages/Home.aspx>

<http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx>

The life expectancy in all three counties is a few years below the Maryland SHIP Target of 79.8 years of age. Worcester County is very close to meeting the SHIP target of 79.8 years of age. Somerset County is 5 years behind in meeting the SHIP longevity target. The top leading causes of death in TidalHealth Peninsula Regional’s CBSA are heart-related and cancer-related diseases, which as a percentage, are higher than other Maryland counties. Supporting social determinants of health indicate an underlying lack of healthy lifestyle adoption/education, poverty and the lack of chronic disease management/education.

County	Life Expectancy		
	All Races	White	Black
Somerset	75.5	74.7	75.3
Wicomico	76.6	77.2	74.8
Worcester	79.6	80.2	75.9
Maryland SHIP Target	79.2	79.9	76.9

Source: Most current Maryland Vital Statistic Report 2019

Maryland DHMH Vital Statistics Administration (VSA) Annual Report. Date Range 2016-2018

### Mortality Rates by County within CBSA

## **Crude Death Rate**

The crude death rate for Wicomico County is 1203.2, Worcester County is 1203.2 and Somerset County is 1034.5, are all higher than Maryland's crude death rate of 841.5 deaths/1,000. The large crude death rates reflect multiple factors: specifically, a more aging 65+ population, in addition to healthcare access issues, cultural and lifestyle characteristics not conducive to healthy lifestyles and lack of education regarding chronic disease management in rural areas.

## **Healthy Disparity Age-Adjusted Death Rates**

Disparities in death rates exist for all three counties (Wicomico County, Worcester County and Somerset County) compared to the state of Maryland for diseases of the heart, malignant neoplasms and chronic lower respiratory diseases.

### **Diseases of the Heart Age-Adjusted Death Rates (2017-2019)**

For diseases of the heart, several counties' age-adjusted death rates are much higher than the Maryland average:

Wicomico County: 70.3 points higher heart age-adjusted death rate than the state of Maryland.

Worcester County: 24 points higher heart age-adjusted death rate than the state of Maryland.

Somerset County: 123 points higher heart age-adjusted death rate than the state of Maryland.

### **Malignant Neoplasms Age-Adjusted Death Rates (2017-2019)**

For malignant neoplasms, all counties' age-adjusted death rates are higher than Maryland.

Wicomico: 40.3 points higher malignant neoplasm age-adjusted death rate than MD.

Worcester: 6 points higher malignant neoplasm age-adjusted death rate than MD.

Somerset: 48.2 points higher malignant neoplasm age-adjusted death rate than MD.

### **Chronic Lower Respiratory Diseases Age-Adjusted Death Rates (2017-2019)**

For chronic lower respiratory diseases, all counties' age-adjusted death rates are both higher and lower than Maryland:

Wicomico: 11.7 points higher chronic lower respiratory diseases age-adjusted death rate than MD.

Worcester: 3.4 points lower chronic lower respiratory age-adjusted death rate than MD.

Somerset: No percentage\*\*\* \*\*\*Rates based on <20 events in the numerator are not presented since such rates are subject to instability.

Source: Most current available Maryland Vital Statistics Report 2019

## **Wicomico County**

Blacks or African Americans in Wicomico County had higher mortality rates than Whites for All-Cause mortality for three of the top six causes of death. The mortality ratio disparity was greatest for diabetes and kidney disease, where Blacks or African Americans had 2.5 times the diabetes death rate and 1.8 times the kidney disease death rate compared to Whites.



## Worcester County

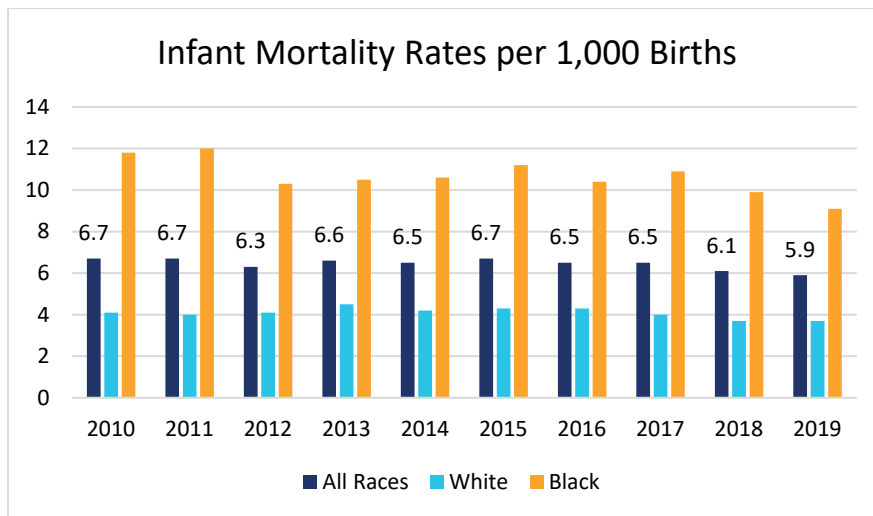
Blacks or African Americans in Worcester County had higher mortality rates than Whites for all-cause mortality and for five of the top six causes of death. The greatest mortality ratio disparity for Blacks or African Americans compared to Whites was for kidney disease, where Blacks or African Americans had 3.3 times the rate of deaths compared to Whites.

## Somerset County

Blacks or African Americans in Somerset County had higher mortality rates than Whites for all-cause mortality and for five of top six causes of death.

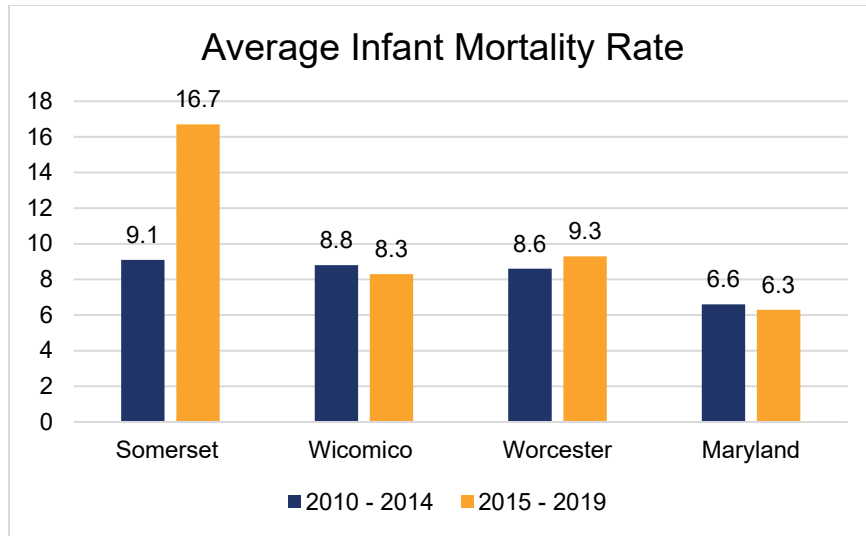
The diabetes mortality rate for Blacks or African Americans was 2.4 times higher than for Whites; and the kidney disease mortality rate was 1.9 times higher for Blacks or African Americans.

According to the 2019 Maryland Vital Statistics, the infant mortality rate continues to fall slightly in the state of Maryland over the past decade.



Source: Maryland Department of Health

Despite the statewide decline in infant mortality rate over the past decade, the Lower Eastern Shore's average infant mortality rate was higher than the state of Maryland's average.



Source: Maryland Department of Health

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources).

See SHIP website for social and physical environmental data and county profiles for primary service area information: <http://dhmh.maryland.gov/ship/SitePages/measures.aspx>

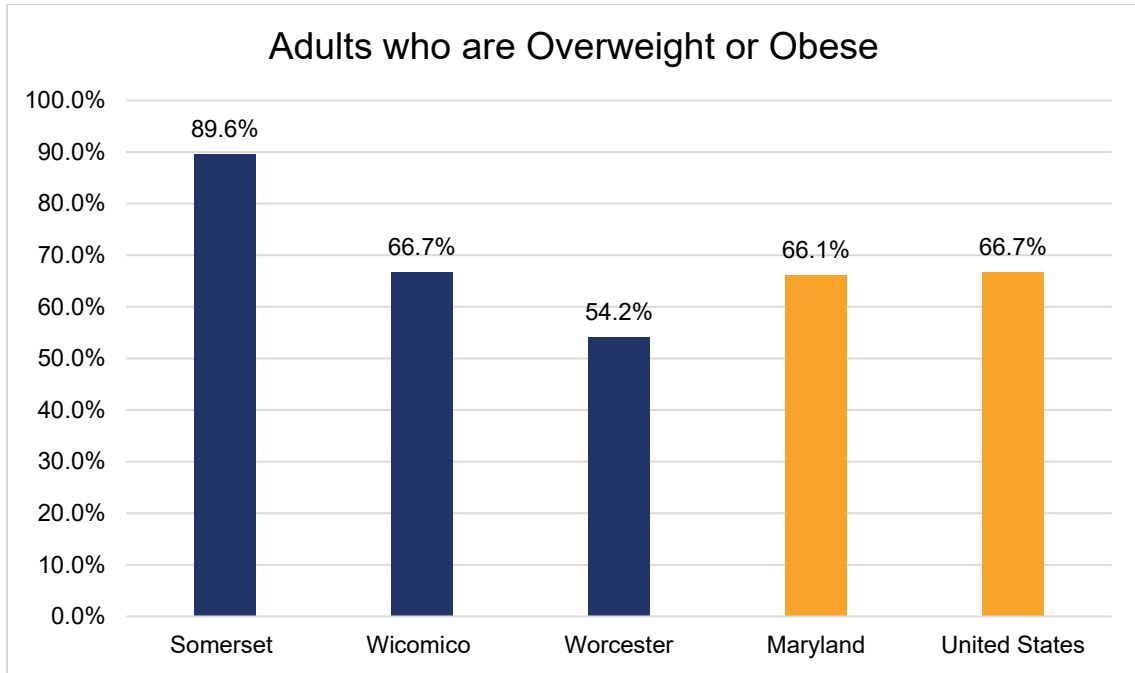
### Access to Healthy Food

#### Healthy Food/Healthy Lifestyle Environmental Factors

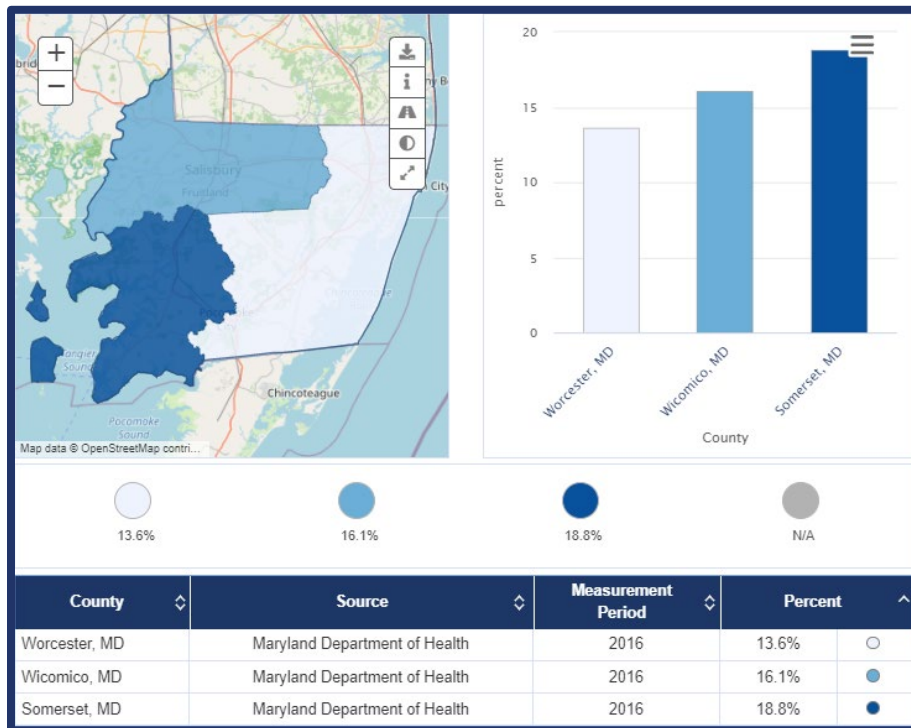
Obesity continues to be a health issue in Wicomico, Worcester and Somerset counties. Somerset County has a high percentage of adolescent obesity: 18.8% compared to the Maryland SHIP 2020 target of 16.1% and the Maryland state value of 12.6%. TidalHealth Peninsula Regional's CBSA has a higher percentage of overweight or obese adults than the state of Maryland and is an indicator of general overall health. Additionally, increased weight and obesity amplifies the risk of many diseases and health conditions. These diseases include type 2 diabetes, cancer, hypertension, stroke, liver problems, gallbladder problems and respiratory problems. Being obese also carries significant economic costs due to increased healthcare spending.

Fast food is often high in fat, high in calories and lacks in recommended nutrients for healthy eating. Frequent consumption of fast food increases the risk of the population becoming overweight and/or obese. Based on the density of grocery stores per 1,000 population, residents of Wicomico County and Somerset County have limited access to grocery stores that sell a variety of nutritious foods. Because TidalHealth Peninsula Regional's CBSA is considered rural, there are a higher number of convenience stores that sell less nutrient-dense foods. Residents in these rural counties living outside of local cities typically use convenience stores for a variety of reasons. However, the summer months increase availability of nutrient rich foods from local farmer's markets. Fresh fruits and vegetables can be found in towns and along

highways for a relatively low cost. The fruit and vegetables also are locally grown and sourced, giving back to the local economy that has a strong agricultural heritage.



### Adolescents who are Obese

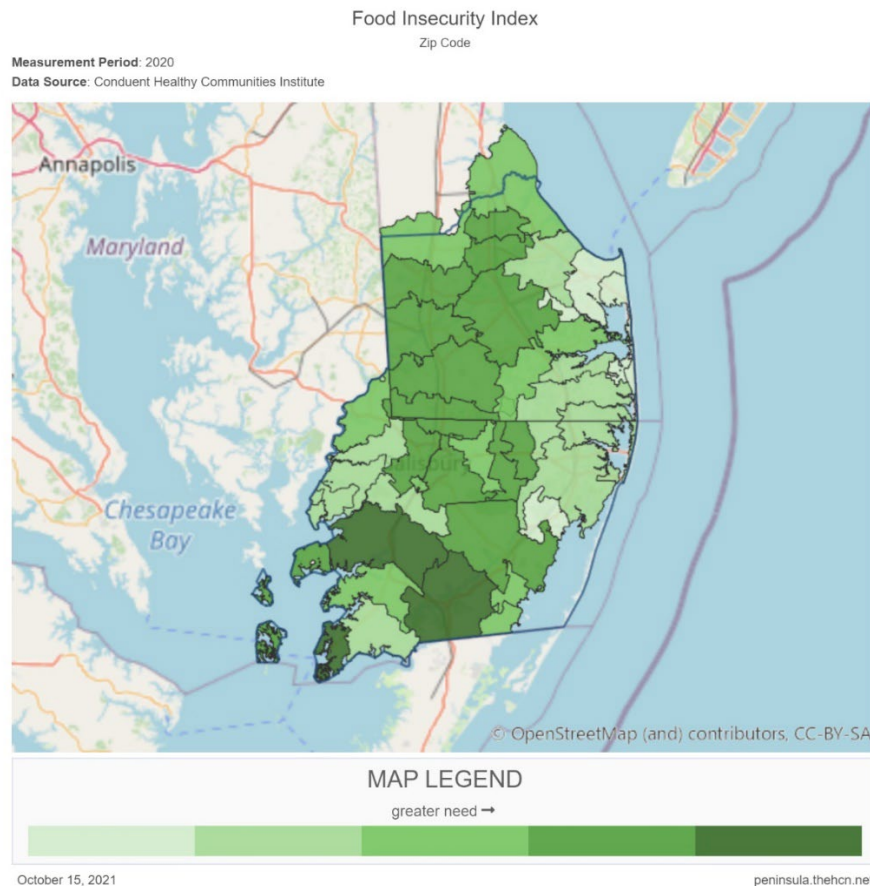


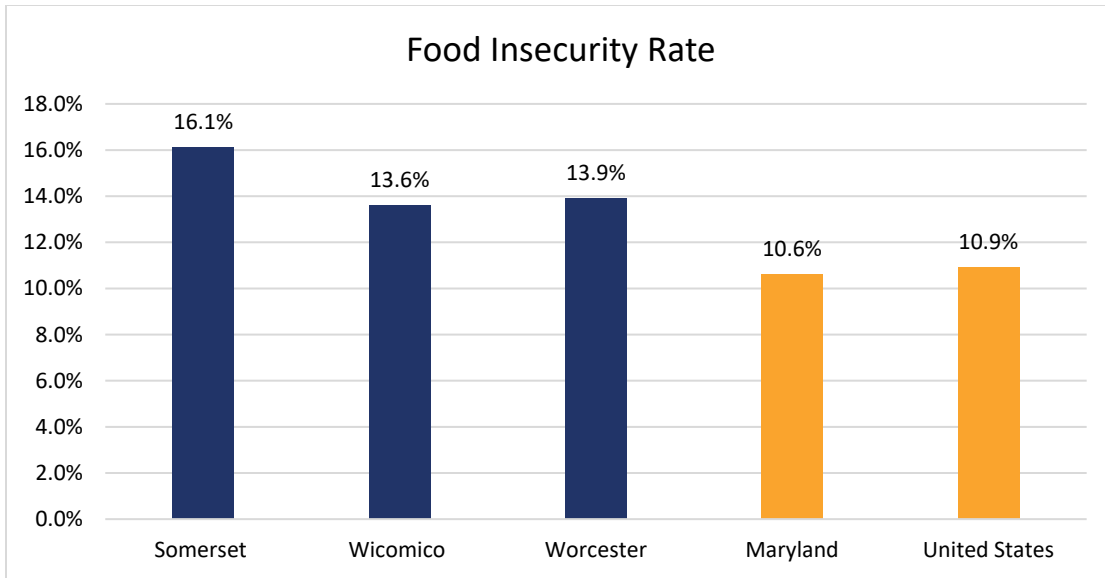
Source: Healthy Communities Inc., 2021

## Food Insecurity

Food insecurity is an economic and social indicator of the health of a community. The United States Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways. Poverty and unemployment are frequently predictors of food insecurity in the United States. Wicomico County and Worcester County have negative food insecurity ratings which are associated with chronic health problems like diabetes, heart disease, high blood pressure, obesity and depression.

The zip codes of Somerset County and lower Worcester County have an exceptionally high food insecurity rate compared to the nation norms and the state of Maryland. Consequently, the likelihood of childhood obesity is intensified as reflected in the following Food Security Index map and graph. The availability of grocery stores in this rural area, in addition to poverty and lack of nutritional education, results in lifelong habitual patterns that contribute to being overweight and/or obese. Over a lifetime, poor nutritional habits lead to various comorbidities and chronic diseases.

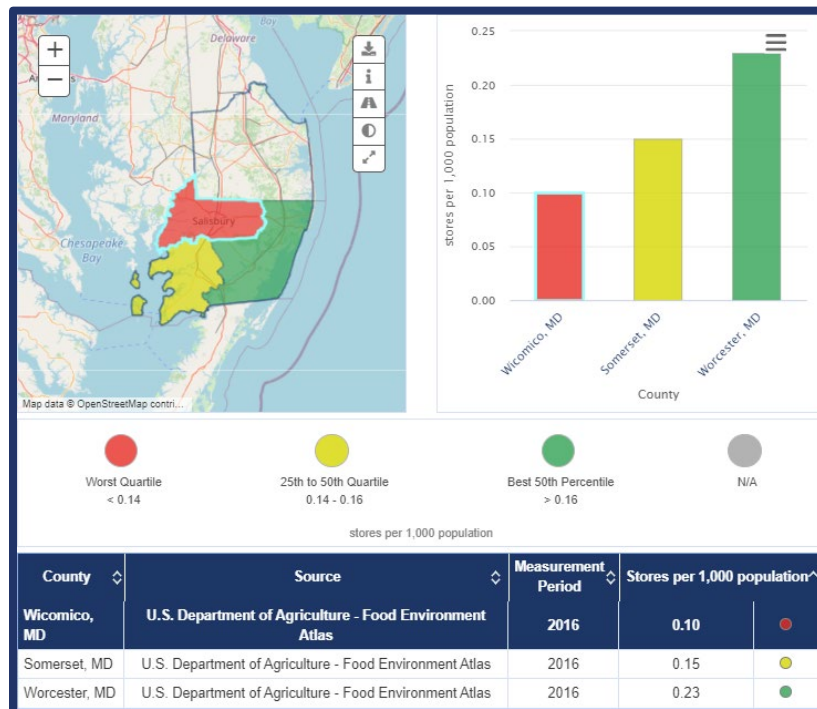




### Grocery Store Density

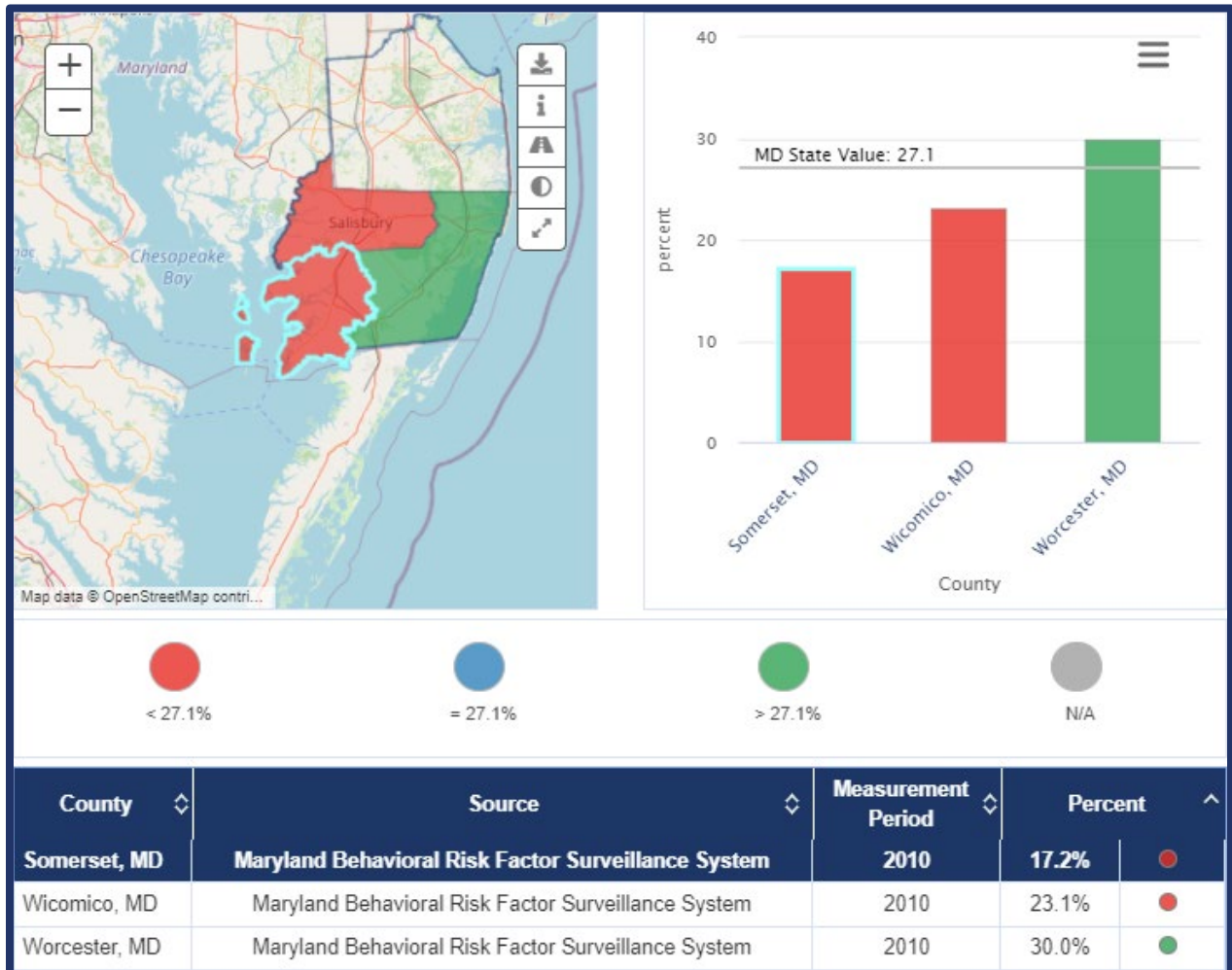
There are strong correlations between the density of grocery stores in a neighborhood and the nutrition and diets of its residents in proximity to the grocery store. The availability and affordability of healthy and varied food options in the community increases the likelihood that residents will have a balanced and nutrient rich diet.

Wicomico County and Somerset County have low grocery store densities when compared to other Maryland counties, which can be a cause of having an unhealthy lifestyle. Combining these low grocery store densities with rural, poverty stricken areas, this creates severely low access to nutritious food.



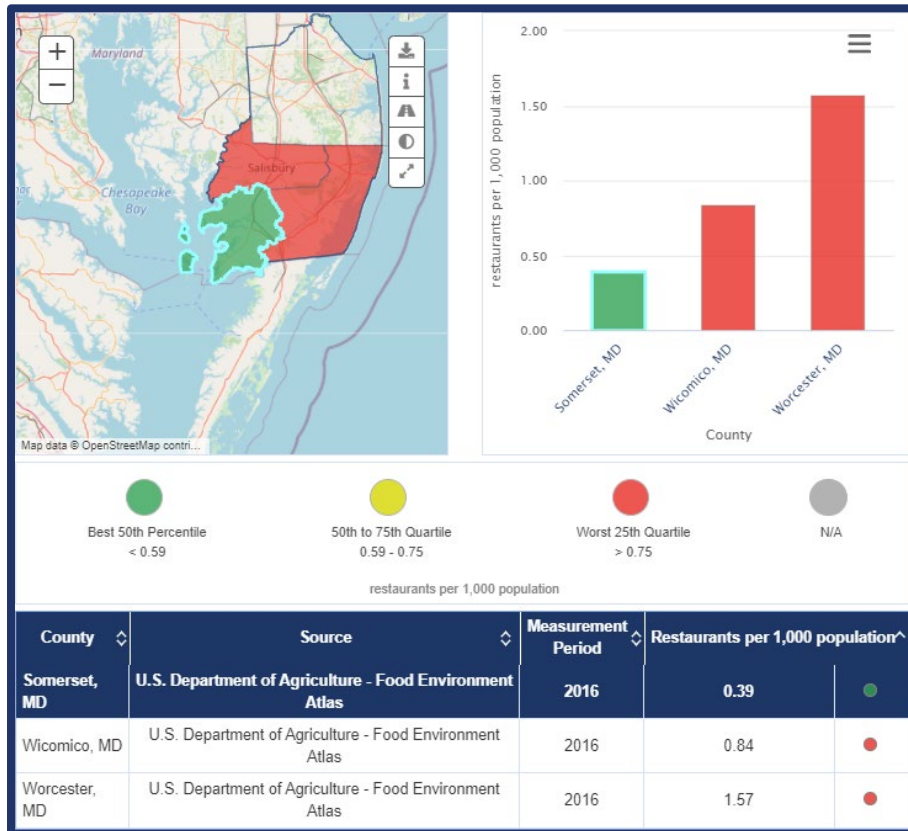
## Adult Fruit and Vegetable Consumption

Based on the state of Maryland's most recent Behavioral Risk Factor Surveillance System, adults living in Wicomico County and Somerset County are not consuming adequate amounts of fruits and vegetables to maintain a healthy diet. This statistic indicates that an opportunity exists for education about healthy lifestyle choices. Worcester County is a more affluent county that has a positive grocery store density to population ratio. This chart compares TidalHealth Peninsula Regional's CBSA to the state of Maryland value.



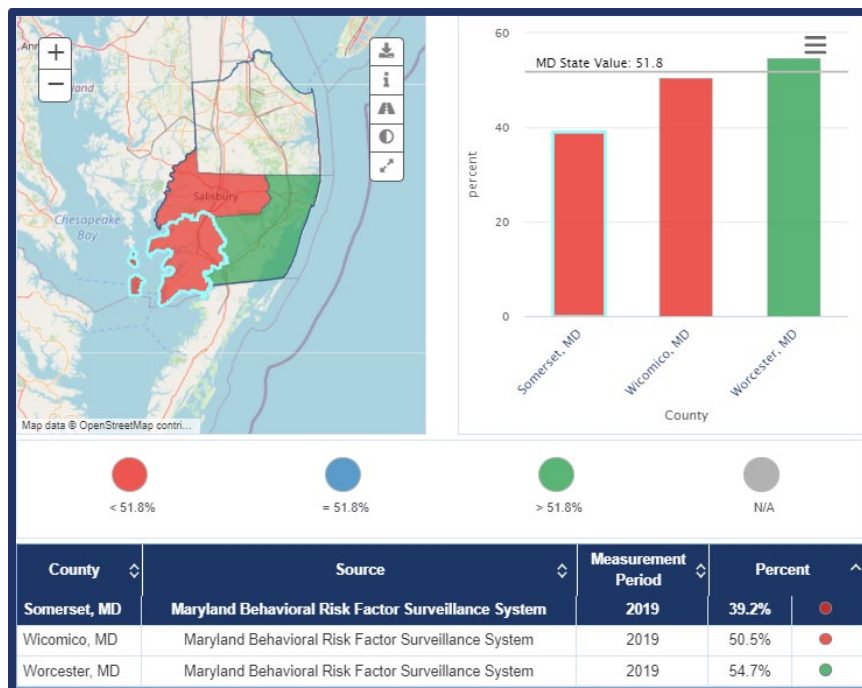
## Fast Food Restaurant Density

Based on the latest U.S. Department of Agriculture – Food Environment Atlas, TidalHealth Peninsula Regional’s CBSA has a high number of fast food restaurants per 1,000 population in Wicomico County and Worcester County compared to United States counties. A high density of fast food restaurants leads to days per week of eating out for lunch or dinner and these meals are high in fat content. Worcester County at a rate of 1.57 fast food restaurants per 1,000 population is over twice the rate of being in the 25<sup>th</sup> quartile in these rankings of 0.75 fast food restaurants per 1,000 population.



## Adults Engaging in Regular Physical Activity

According to the latest Maryland Behavioral Risk Factor Surveillance System report, Somerset County and Wicomico County fall below the approximately 52% of adult Marylanders who engage in regular physical activity. Reduced physical activity can lead to future health problems, chronic pain issues, etc. that physical activity can alleviate. Comparatively, the United States value of adults engaging in regular physical activity was 20.3% in 2017. There is room for improvement and adding regular physical activity with healthy eating habits and other wellness strategies can improve the health of the adult population in TidalHealth Peninsula Regional's CBSA.



The social determinants of health within our CBSA (as evidenced by the preceding charts) suggests that residents would benefit from a “Healthy Lifestyles” campaign. This campaign is designed to create awareness and provide a forum for becoming engaged and actively pursuing living a healthy lifestyle. Previous programs like “Live Well Delmarva” promote healthy lifestyles and provides information and access to free screenings and healthy living tips.

## Transportation Services

TidalHealth Peninsula Regional makes transportation services available for those residents in extenuating circumstances. Every effort is made to assist patients receiving care under a series account like radiation oncology or chemotherapy by utilizing various community resources. When community resources aren't available, the transportation coordinator arranges transportation as available through Hart to Heart Ambulance Services van transportation company.

Upon inpatient hospital discharge from TidalHealth Peninsula Regional, the hospital also provides transportation for certain elderly patients who do not drive and/or who may lack a



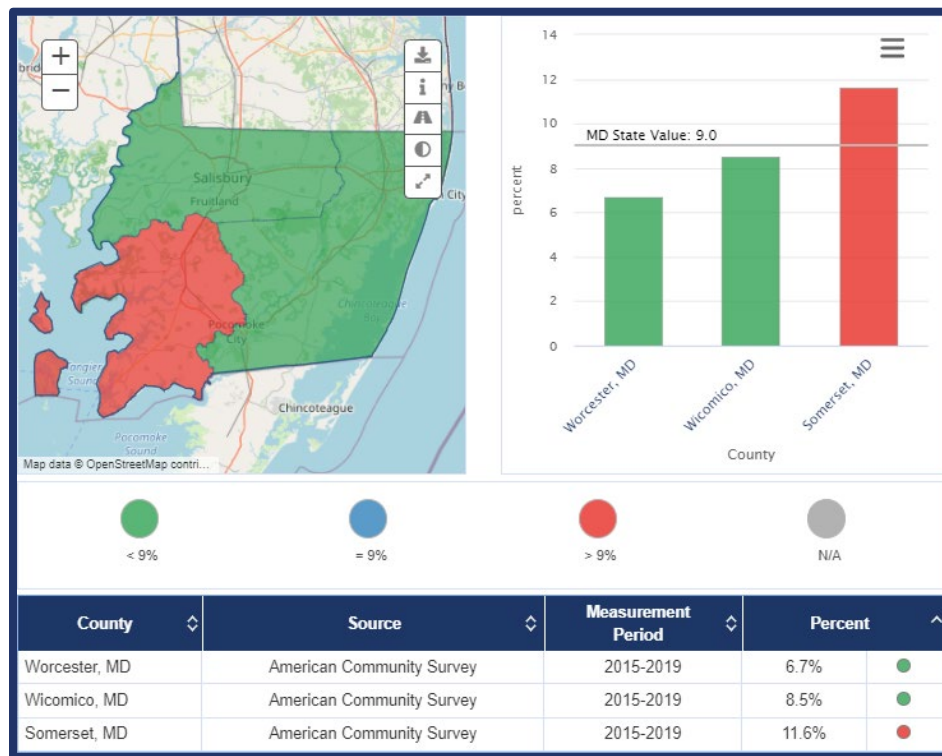
caregiver. A bus ticket or taxi fare is provided for those patients who are indigent or may lack a vehicle. TidalHealth Peninsula Regional's Patient Care Management Department manages these cases on a patient-by-patient basis.

The Wicomico County Health Department does have medical assistance transportation to help those who have medical conditions and lack access to bus services and do not own a car. The office hours are 8:00 am to 5:00 pm Monday through Friday and its phone number is (410) 548-5142. Transportation for residents includes locations in four counties: Wicomico, Worcester, Somerset and Dorchester counties.

TidalHealth Peninsula Regional and its Outpatient Services are accessible by Shore Transit, a division of the Tri-County Council for the Lower Eastern Shore of Maryland, the public transit agency for the Maryland Lower Eastern Shore counties of Somerset, Wicomico and Worcester. Shore Transit also offers public transportation via fixed route and origin-to-destination services.

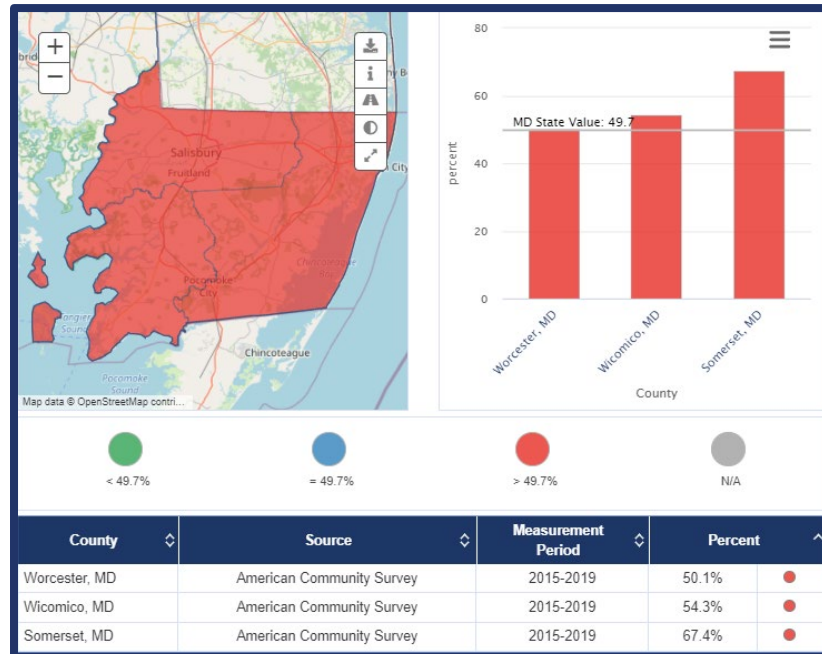
### Households without a Vehicle

Vehicle ownership is directly related to the ability to travel. In general, people living in a household without a car and its independent transportation it offers will make fewer than half the number of journeys compared to households with a car. This lack of transportation limits their access to essential local services such as supermarkets, post offices, doctors' offices and hospitals. Most households with above average incomes have a car, while only half of low income households have a car. Per the map below, Wicomico County and Somerset County have issues accessing healthcare due to many households having limited access to a vehicle.



## Affordable Housing

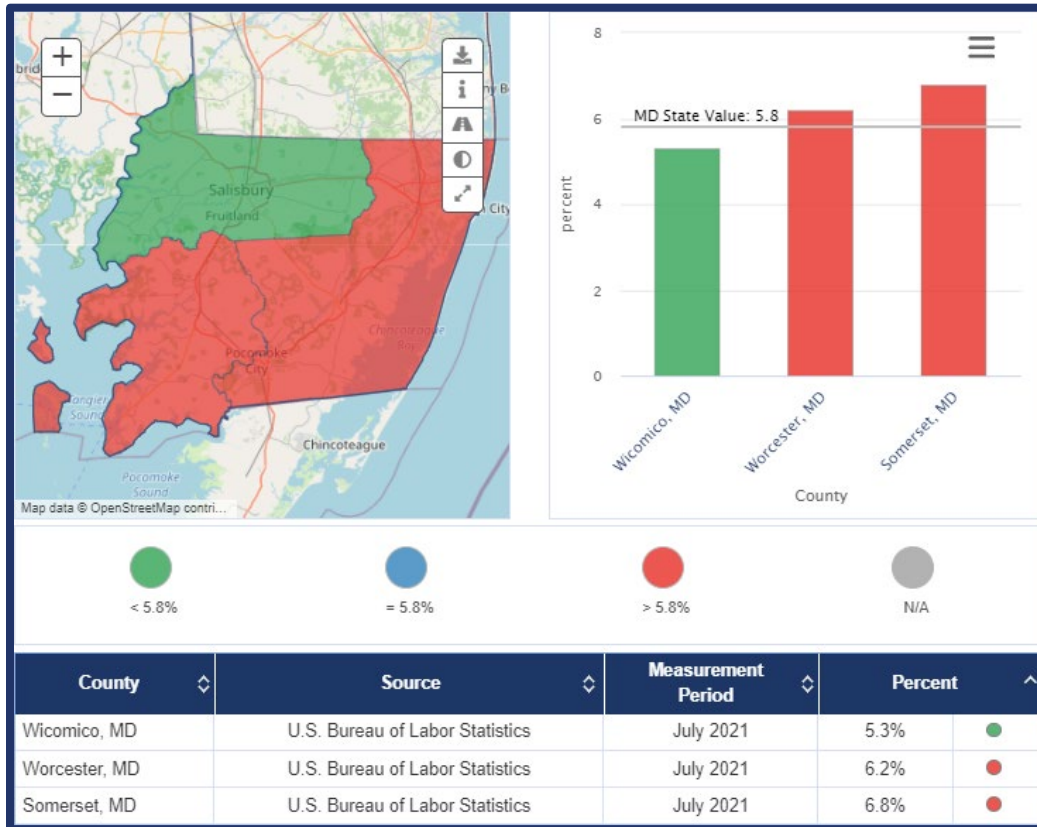
TidalHealth Peninsula Regional's CBSA has exceptionally high household rent compared to other counties in Maryland. Spending a substantial percentage of household income on rent can create financial hardship, especially for lower-income renters. Limited income due to high rent makes it difficult to access healthcare services, afford a car or eat healthy, nutrient rich meals that are more expensive than cheap, unhealthy meals.



Safe and affordable housing is an important component of healthy communities. Based on the following data, both Wicomico County and Somerset County have widespread housing problems. Residents who do not have a kitchen in their home are more likely to spend money on unhealthy convenience foods. Research has also found that young children who live in crowded housing conditions are at an increased risk for food insecurity, which can impede their academic growth and performance. In areas where housing costs are high, low income residents may be forced into substandard living conditions against their will.

## Unemployment

Compared to the state of Maryland which had a July employment rate of 5.8%, the unemployment rate is higher in Worcester County and Somerset County. Unemployment is a key indicator of the health of the economy. In addition, high unemployment rates can be related to reduced access to healthcare resources and unhealthier living conditions.



Sources:

Healthy Communities (HCI) 2021

[www.shoretransit.org](http://www.shoretransit.org)

ESRI ArcGIS 2021

Sg2 2021

Available detail on race, ethnicity and language within CBSA.

See SHIP County profiles for demographic information of Maryland jurisdictions.



**PENINSULA REGIONAL MEDICAL CENTER,  
WICOMICO COUNTY HEALTH DEPARTMENT, AND  
SOMERSET COUNTY HEALTH DEPARTMENT**

2019 Community  
Health Needs  
Assessment

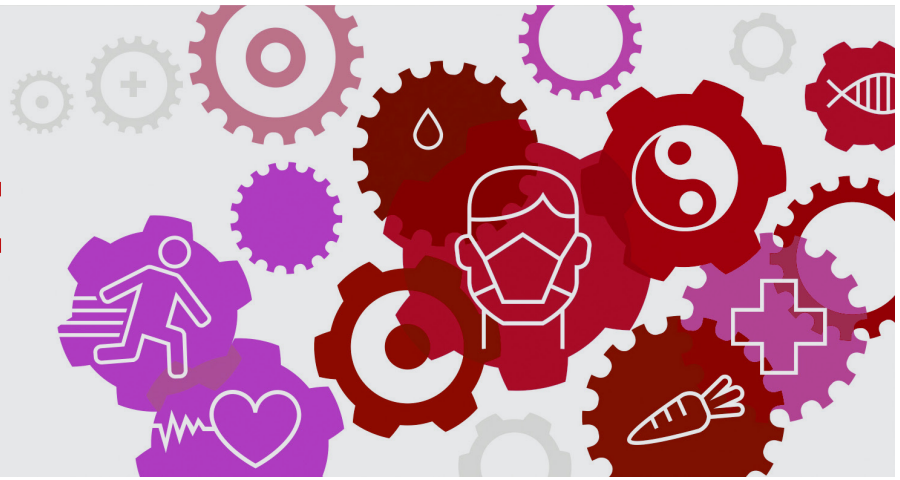


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# EXECUTIVE SUMMARY



## 1.1 INTRODUCTION

Peninsula Regional Medical Center (PRMC), Wicomico County Health Department (WCHD), and Somerset County Health Department (SCHD) are pleased to present the 2019 Community Health Needs Assessment (CHNA). This CHNA report was developed to provide an overview of the health needs in the PRMC Tri-County Service Area, including Somerset, Wicomico, and Worcester counties in Maryland. PRMC, WCHD, and SCHD partnered with Conduent Healthy Communities Institute (HCI) to conduct the CHNA. The goal of this report is to offer a meaningful understanding of the greatest health needs across the PRMC, WCHD, and SCHD service areas, as well as to guide planning efforts to address those needs. Special attention has been given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

Members of the community are invited to provide feedback and comments on this report by emailing [community.relations@peninsula.org](mailto:community.relations@peninsula.org).

## 1.2 SUMMARY OF FINDINGS

The CHNA findings are drawn from an analysis of an extensive set of secondary data (over 100 indicators from national and state data sources) and in-depth primary data from community health leaders and organizations that serve the community at large, as well as non-health professionals and community members. The main source for the secondary data, or data that has been previously collected, is the Peninsula Regional Medical Center Creating Healthy Communities platform, a publicly available data platform that is embedded on the main PRMC website. That platform can be found here: <https://www.peninsula.org/community/creating-healthy-communities>. You can read in more detail about the methods behind the secondary and primary data analysis in Section 5 of this report.

Significant Health Needs based on primary and secondary data:

- Access to Health Services
- Cancer
- Diabetes
- Economy
- Low Income / Underserved
- Mental Health & Mental Disorders
- Older Adults & Aging
- Oral Health
- Social Environment
- Substance Abuse
- Transportation

### **1.3 SELECTED PRIORITIZED AREAS**

On October 24, 2018, PRMC's Community Benefit team and other members from various departments in the hospital as well as representatives from WCHD and SCHD came together to prioritize the significant health needs in a session led by consultants from HCI. While considering several prioritization criteria, the following three topics were identified as priorities to address:

- Behavioral Health (focusing on the combined topic areas of Mental Health & Mental Disorders as well as Substance Abuse)
- Diabetes
- Cancer





## SECTION 2

# INTRODUCTION

### 2.1 ABOUT “THE PARTNERSHIP”

A partnership was formed between PRMC, WCHD, and SCHD to collaborate for the benefit of the community. These organizations have been partnering together on local assessment efforts since 1995. Two of the organizations are required to complete a CHNA: PRMC as a non-profit hospital and WCHD as an accredited health department. SCHD is in the early phases of public health accreditation.

#### 2.1.1 PRMC

Mission: To improve the health of the communities we serve.

Peninsula Regional Medical Center (PRMC) in Salisbury, Maryland offers the widest array of specialty and subspecialty services on the Delmarva Peninsula.

PRMC is one of just four hospitals in Maryland, and the only on the Eastern Shore, to be awarded a five-star rating — the highest possible — by the Centers for Medicare & Medicaid Services (CMS) in 2018 and 2019. In 2018 and 2019, it was also the recipient of an A safety grade by the Leapfrog Group and was named a Distinguished Hospital for Clinical Excellence by Healthgrades, placing it among the top 5% of hospitals in the United States.

At 288 acute care beds, PRMC is the 8th largest hospital in Maryland, and the region’s largest, most advanced tertiary care facility, which has been meeting the healthcare needs of Delmarva Peninsula residents since 1897. Its 3,300 physicians, staff, and volunteers provide safe, compassionate, and affordable care designed to exceed the expectations of the nearly 500,000 patients who rely on the Medical Center team each year for inpatient, outpatient, diagnostic, sub-acute and emergency/trauma services. It is the region’s oldest healthcare institution with the most experienced team of healthcare professionals. It also infuses over \$500 million annually into its regional economy, and is the recipient of over 125 national awards, recognitions, and certifications in the past half-decade for the care it offers patients and the outcomes they experience.

Peninsula Regional Medical Center offers a full range of services, including neurosurgery, robotic surgery, cardiothoracic surgery, joint replacement, emergency/trauma care, wound care, women’s and children’s services, and weight loss and wellness services. Additionally, breast care and comprehensive cancer care are provided at institutes in Salisbury and Ocean Pines, MD, and community and population health services are provided through a network of family medicine and specialty care offices across Maryland and Delaware, health pavilions in Millsboro, DE and Ocean Pines, MD, and with the Wagner Wellness Van.

## SECTION 2 INTRODUCTION

In 2014, PRMC joined with Bayhealth of Delaware to form a partnership known as HealthVisions Delmarva, LLC. The two health systems share best practices to provide best-in-class healthcare services and leverage the intellectual assets of each organization for the benefit of their patients across Delmarva. However, each maintains its own financial autonomy. A similar partnership has been established with six Western Shore Hospitals (Adventist Healthcare, Inc., LifeBridge Health, Inc., Mercy Health Services, Inc., Frederick Regional Health System, Meritus, and Western Maryland) to form the Advanced Health Collaborative, LLC.

Peninsula Regional is also proud to be an affiliate of the Johns Hopkins Clinical Research Network (JHCRN), a group of academic and community-based clinical researchers designed to provide new opportunities for research collaborations. It's also home to the Richard A. Henson Research Institute.

New technologies, including robotic and small incision surgery, and advanced disease detection and treatment options, continue to define the standard for safer care, faster recoveries, and better outcomes.

Keep in touch with PRMC on Facebook at [www.facebook.com/PeninsulaRegional](http://www.facebook.com/PeninsulaRegional), on the PRMC blog at [prmc Salisbury.com](http://prmc Salisbury.com), or on the Peninsula Regional website at [www.peninsula.org](http://www.peninsula.org).

### 2.1.2 WCHD

Mission: To maximize the health and wellness of all members of the community through collaborative efforts.

Vision: Healthy People in Healthy Communities.

The local public health department, accredited by the Public Health Accreditation Board on March 8, 2016, has expanded over the years to meet changing needs of the community and continually works toward protecting the health and environment of the people of Wicomico County.

Health Department Leadership:

- Health Officer Lori Brewster MS, APRN/BC, LCADC
- Physician Deputy Health Officer James Cockey, M.D.
- Administrative Deputy Health Officer Darlene Jackson-Bowen, Ph.D., PA

### 2.1.3 SCHD

Mission: Dedicated to serving the Public by preventing illness, promoting wellness and protecting the health of our community.

Vision: Healthy People in Healthy Communities

Health Department Leadership:

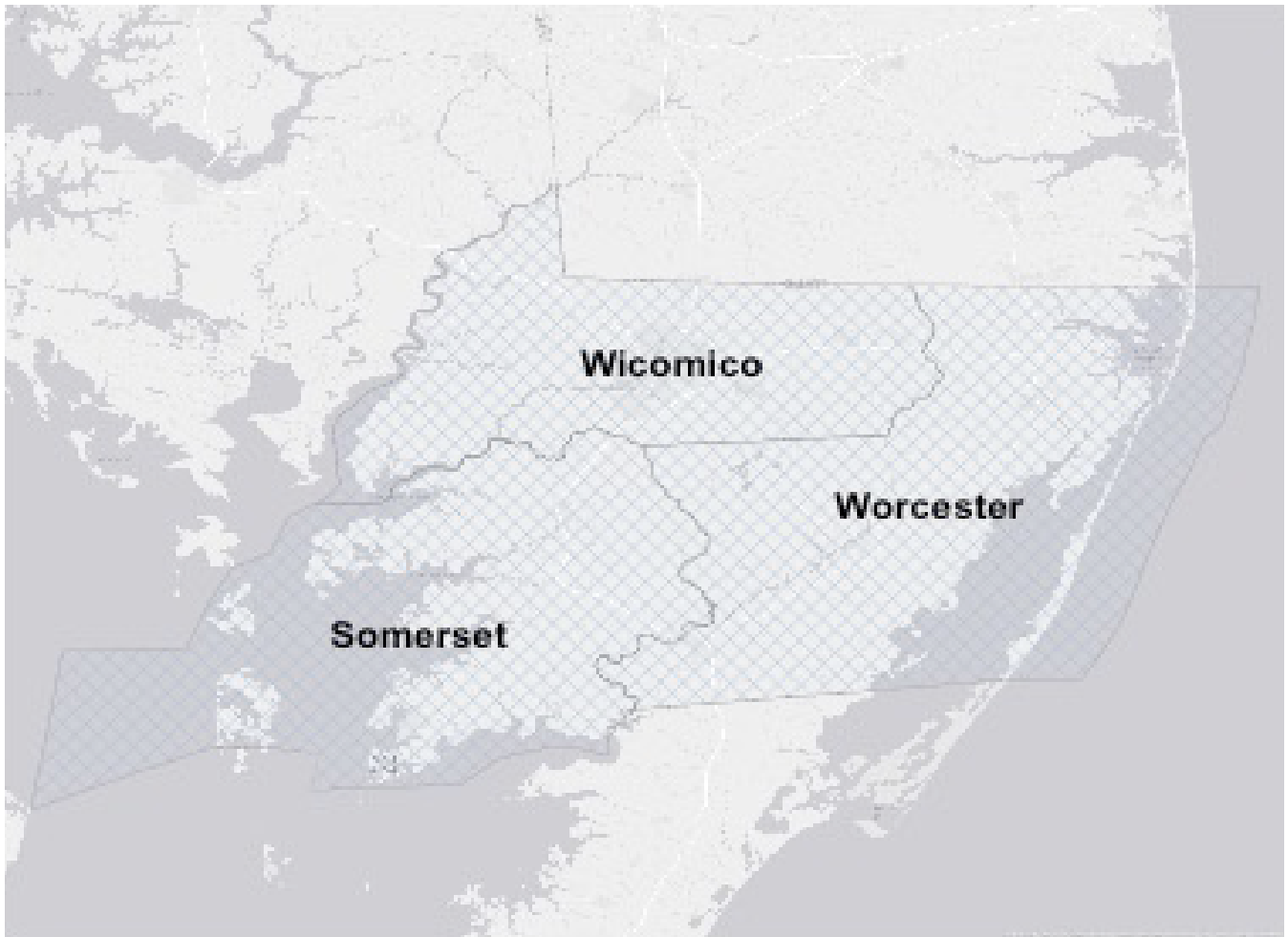
- Health Officer Lori Brewster MS, APRN/BC, LCADC
- Acting Physician Deputy Health Officer James Cockey, M.D.
- Administrative Deputy Health Officer Danielle Weber, RN, MS

The Health Department continues to change with the changes in the healthcare system. Somerset County Health Department is in the initial planning stage of the Public Health Accreditation process.

### 2.1.4 DEFINITION OF COMMUNITY AND MAP

Peninsula Regional Medical Center's, Wicomico County Health Department's, and Somerset County Health Department's service areas are jointly defined by Somerset, Wicomico, and Worcester counties in the state of Maryland. These three counties are referred to as the Tri-County Service Area. Additionally, the service area includes the 43 zip codes and associated census places and census tracts within those three counties.

**FIGURE 1. MAP OF SERVICE AREA**



### 2.1.5 OTHER PARTNERSHIPS

Both PRMC, WCHD, and SCHD leverage existing relationships with other organizations and groups in order to further their community work. Some of the existing partnerships include:

- COAT team — Wicomico County, PRMC, Local Law enforcement, and State's Attorneys office
- Community classes for CDSMP, Falls, and PEARLS - PRMG, AGH, and Peninsula Regional Clinically Integrated Network, MAC, Inc. Living Well Center of Excellence
- SWIFT — Salisbury Wicomico First Care Team, EMT-P, NP, RNs, CHWs — Wicomico County Health Department, Salisbury Fire Department, and PRMC
- Walkability — City of Salisbury, Wicomico County Health Department, and PRMC

- MOTA vendor (FY19 Community Empowerment Center)
- Veterans Administration
- Local Behavioral Health Authority
- Live Healthy Wicomico Coalition
- Walk Wicomico
- HOPE, Inc.
- Shore Transit
- Drs. Gray and Allen
- Delmarva Smile Corner
- PRMC Wagner Wellness Van
- Eastern Shore Area Health Education Center

### 2.2 CONSULTANTS

The Partnership commissioned Conduent Healthy Communities Institute (HCI) to assist with its Community Health Needs Assessment and author this report, as well as the 2013 CHNA.

Conduent Healthy Communities Institute is a multi-disciplinary team of public health experts, including healthcare information technology veterans, academicians and former senior government officials, all committed to help health-influencing organizations be successful with their projects. HCI uses collaborative approaches to improve community health and provides web-based information systems to public health, hospital and community development sectors, to help them assess population health.

HCI works with clients across most states in the U.S. to drive improved community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing progress monitoring systems, and implementing performance evaluation processes. Working with diverse clients nationwide has contributed to HCI's national knowledge base of population health solutions. In addition, by engaging directly with clients and communities through the primary data collection process and final workshops, HCI works on behalf of clients to build trust between and among organizations and their communities.

To learn more about Conduent Healthy Communities Institute, please visit <https://www.conduent.com/community-population-health/>.

Report authors from Conduent HCI include:

- Jenny Belforte, MPH
- Emily Hummel, MPH
- Andrew Juhnke, MPH
- George Nguyen

# SELECTED PRIORITY AREAS



On October 24, 2018, PRMC, WCHD, and SCHD came together to prioritize the significant health needs in a session facilitated by Conduent HCI consultants. Using a prioritization matrix, participants voted on the most critical needs while considering the following criteria:

- Importance of problem to the community
- Alignment with Maryland SHIP 2017 objectives
- Opportunity for partnership
- Addresses disparities of subgroups
- Existing resources/programs to address the problem

The following three topics were selected as the top priorities:

- ① Behavioral Health (Mental Health & Mental Disorders as well as Substance Abuse)
- ② Diabetes
- ③ Cancer



A plan for addressing these priority areas will be further described in Peninsula Regional Medical Center's 2019 Implementation Strategy report.

# EVALUATION OF PROGRESS SINCE PRIOR CHNA



## 4.1 IMPACT SINCE PRIOR CHNA

Priority areas identified in the previous 2016 CHNA include:

- Diabetes
- Exercise, Nutrition & Weight
- Behavioral Health (Mental Health & Mental Disorders as well as Substance Abuse)

In 2016, PRMC developed an Implementation Strategy report to address these issues, with specific strategies and programs. For more details on the impact since the prior CHNA, see Appendix 13.5.

## 4.2 COMMUNITY FEEDBACK ON PRIOR CHNA

The 2016 CHNA was posted for public consumption on the Peninsula Regional Medical Center website (<https://www.peninsula.org>) under “Community” then “Community Health Needs Assessment”. The direct link to the file is: <http://online.fliphtml5.com/cxbl/wkij/#p=1>. The website allows for members of the community to email various individuals and departments. Paper copies were also made available at the main entrances to the hospital. Community members were invited to read the report and provide comments. No community feedback was received.

# METHODS

## 5.1 SECONDARY DATA SOURCES AND ANALYSIS

Data on the Peninsula Regional Medical Center Creating Healthy Communities platform is retrieved from a variety of state and national sources, including sources such as the American Community Survey and the Maryland Department of Health. As of June 1, 2018, when the data was queried, there were 162 health and quality of life indicators for the Tri-County Service Area on the PRMC data platform for which the analysis outlined in the appendix of this report was conducted. For each indicator, the online platform and subsequent data analysis include several ways, or comparisons, by which to assess the status of each county within the Tri-County area. These include comparing each county to: other Maryland counties, the Maryland state value, U.S. counties, the U.S. value, the trend over time, relevant Healthy People 2020 targets, and Maryland State Health Improvement Process (MD SHIP) measure targets. For more information about the secondary data analysis methodology, please see Appendix 13.1.2.

## 5.2 PRIMARY DATA COLLECTION AND ANALYSIS

### 5.2.1 KEY INFORMANT INTERVIEWS

To expand upon the information gathered from the secondary data, HCI consultants conducted key informant interviews to collect community input. Interviewees who were asked to participate were recognized as having expertise in public health, special knowledge of community health needs and/or represented the broad interest of the community served by the hospital and health department, and/or could speak to the needs of medically underserved or vulnerable populations. 20 individuals were contacted for the service area, and 14 agreed to participate and scheduled an interview. The following organizations are representative of the individuals who participated in the interviews:

- Chesapeake Health Center
- CoreLife
- Deer's Head Hospital Center
- HOPE, Inc. (Health and Outreach Point of Entry)
- Lower Shore Clinic
- Lower Shore Enterprises
- MAC, Inc. (Maintaining Active Citizens)
- Salisbury Rehabilitation and Skilled Nursing Center - Genesis Healthcare
- Salisbury University

- TGM Group LLC
- Wicomico County Executive
- Wicomico County Health Department
- Peninsula Regional Medical Center
- Somerset County Health Department

The 14 interviews were conducted from July 26, 2018 through August 30, 2018 by telephone. They ranged from 30 - 60 minutes in length. During the interviews, questions were asked to learn about the interviewee’s background and organization, biggest health needs and barriers of concern in the community, as well as the impact of health issues on vulnerable populations. A list of the questions asked during the interviews can be found in Appendix 13.2.1.

Each interview included both an interviewer and a note taker from HCI, so much of the conversation was captured verbatim. The interview transcripts and notes were entered in the web application Dedoose, a qualitative data analysis software. The transcripts were coded according to a list of major health and quality of life topics. Input from key informants is included in each relevant health need topic area detailed in sections 8 and 9 of this report.

Additionally, notes were uploaded to a summary qualitative data analysis tool, WordItOut.com, which creates a word cloud. Word clouds help to identify the words or phrases mentioned most often in the interviews, and those appear in the largest and darkest font as seen below.

FIGURE 2. KEY INFORMANT INTERVIEW THEMES



The word cloud was used to get a visual sense of the major themes that emerged from the coding and analysis of the key informant interviews.



### 5.2.2 FOCUS GROUPS

PRMC, WCHD, and SCHED organized and facilitated three focus groups with members of the community. The focus groups convened on August 23th, August 29th, and September 14th of 2018. Participants were recruited using multiple modes: direct email invitations, newspaper advertisements, flyers, and social media postings.

The August 23rd focus group consisted of professionals and providers from various disciplines in the tri-county area and was held at PRMC. The August 29th focus group was held in Salisbury in the county of Wicomico at the Salvation Army and included members of the greater Salisbury community. The September 14th focus group was held in Pocomoke City in Worcester County at the Pocomoke Library and included members of the greater Pocomoke area. Efforts were made to have a 4th focus group in the county of Somerset, but there was not enough interest in the community to get a minimum number of participants.

Each focus group included both a facilitator and a note taker from PRMC, WCHD, or SCHED so much of the conversation was captured verbatim. A list of the questions asked during the focus groups can be found in Appendix 13.2.2. The focus group transcripts and notes were entered in the web application Dedoose, a qualitative data analysis software. The transcripts were coded according to a list of major health and quality of life topics. Input from focus group participants is included in each relevant health need topic area detailed in sections 8 and 9 of this report.

Additionally, notes were uploaded to a summary qualitative data analysis tool, WordItOut.com, which creates a word cloud. Word clouds help to identify the words or phrases mentioned most often in the focus groups, and those appear in the largest and darkest font in Figure 3 below.

FIGURE 3. FOCUS GROUP THEMES



**5.2.3 COMMUNITY SURVEY**

Another form of community input collected was via a community survey. The survey was available online via Survey Monkey tool and as a paper hard copy. It was distributed across PRMC’s entire service area from July 23, 2018 – September 10, 2018. A total of 584 responses were collected. Results in this report are based on the Tri-County service area — Somerset, Wicomico and Worcester. This was a convenience sample, which means results may be vulnerable to selection bias and make the findings less generalizable. Another limitation is that, although the survey in English was translated into Spanish and Creole, there may have been other non-English speaking groups that were missed. A list of the questions asked in the survey can be found in Appendix 13.2.3.

Out of the 584 respondents, about 70% were female and 30% were male. They were comprised of about 35% of people who work in the health field, the rest were community members. And about 81% of respondents resided in Wicomico County. Their race/ethnicities, as well as age ranges, can be seen in the figures below.

**FIGURE 4. RACE/ETHNICITY OF COMMUNITY SURVEY RESPONDENTS**

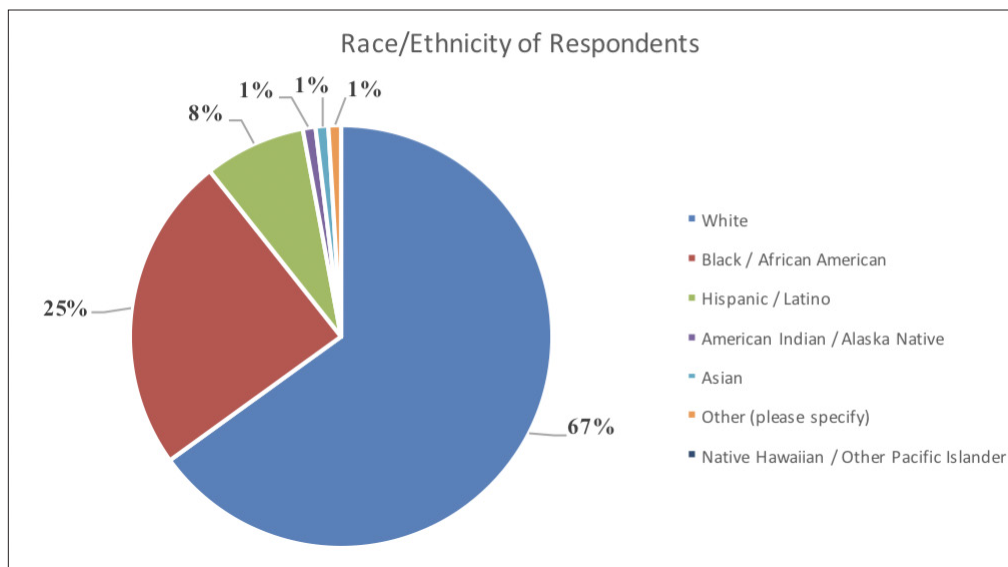
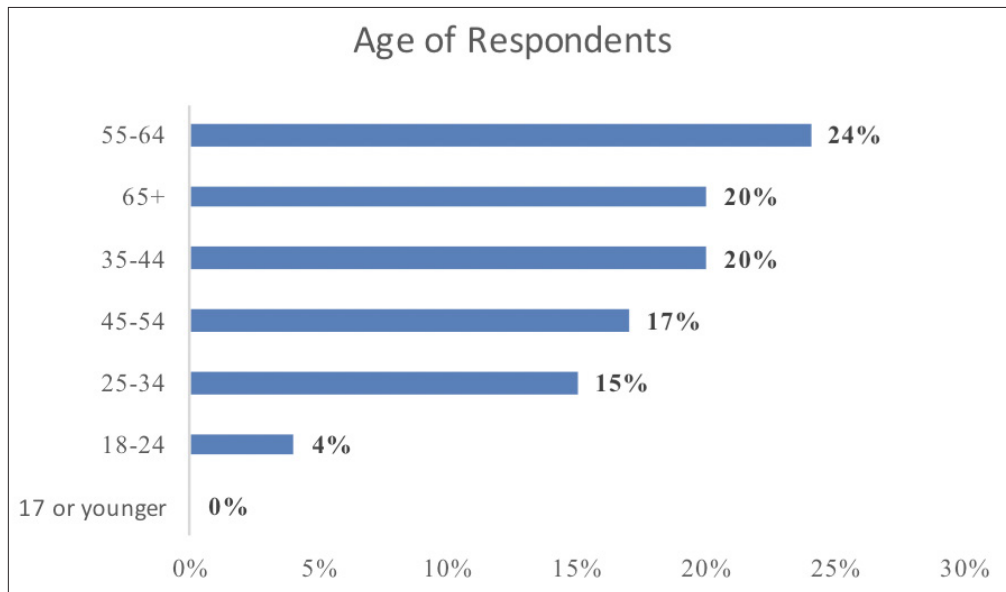


FIGURE 5. AGE OF COMMUNITY SURVEY RESPONDENTS



### 5.3 PRIORITIZATION

In order to better target community issues with regards to the most pressing health needs, PRMC, WCHD, and SCHD members participated in a group discussion facilitated by HCI to hone in on the 11 significant health needs presented. Those health needs will be under consideration for the development of an implementation plan that will address some of the community's most pressing health issues.

#### 5.3.1 PRIORITIZATION SESSION PARTICIPANTS

- Chris Hall – VP Strategy & Business Development / Chief Business Officer, PRMC
- Kathryn Fiddler – VP Population Health, PRMC
- Stephanie Elliott – Director of Community Health Initiatives, PRMC
- Henry Nyce – Manager Strategic Planning, PRMC
- Lori Brewster – Health Officer, Wicomico County Health Department and Somerset County Health Department
- Logan Becker – Planning Analyst, PRMC
- Dr. James Cockey – Deputy Health Office, Wicomico County Health Department and Somerset County Health Department
- Bonnie Willey – Social Worker, PRMC
- Diane Hitchens – Director Women's and Children's
- Brooke Shulz – Registered Nurse, PRMC
- Lisa Renegar – Planner, Wicomico County Health Department

#### 5.3.2 PRIORITIZATION PROCESS

On October 24, 2018 the above participants convened at Peninsula Regional Medical Center to review and discuss the results of HCI's primary and secondary data analysis leading to the preliminary top 11 significant health needs discussed in detail in Section 8. From there, participants utilized a prioritization toolkit (Appendix 13.4) to examine how well each of the 11 significant health needs met the

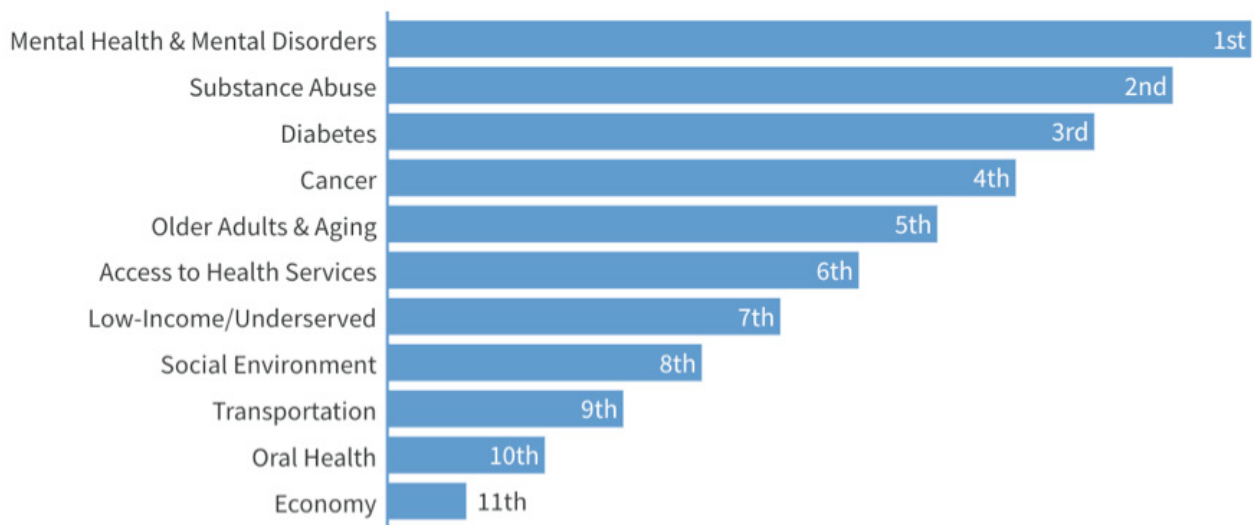
criteria set forth by PRMC project team. The criteria for prioritization can be seen in Figure 6 below:

FIGURE 6. PRIORITIZATION CRITERIA

- **Importance of problem to the community**
- **Alignment with Maryland SHIP 2017 objectives**
- **Opportunity for partnership**
- **Addresses disparities of subgroups**
- **Existing resources/programs to address the problem**

Completion of the prioritization toolkit allowed participants to arrive at numerical scores for each health need that correlated to how well each health need met the criteria for prioritization. Participants then ranked the top 11 health needs according to their topic scores, with the highest scoring health needs receiving the highest priority ranking. Participants were encouraged to use their own judgment and knowledge of their community in the event of a tie score. After completing their individual ranking of the 11 health needs, participants’ rankings were submitted into an online polling platform that collates the responses, resulting in an aggregate ranking of the health topics. The aggregate ranking can be seen below.

FIGURE 7. PRIORITIZATION TOPIC AREA RANKINGS



Poll Everywhere

### 5.3.3 PRIORITIZATION RESULTS

Upon seeing the group ranking above, prioritization participants engaged in a discussion about the topics that make most sense to prioritize for PRMC's Tri-County Service Area. As mental health and substance abuse are often linked together, and were also combined as a priority area to address in 2016, the group decided on Behavioral Health to address root causes. All participants agreed to prioritize three needs. Therefore, the top three health priorities for the Peninsula Regional Medical Center and Wicomico and Somerset counties health departments' Tri-County Service Area to consider for subsequent implementation planning are:

- **Behavioral Health (Mental Health & Mental Disorders + Substance Abuse)**
- **Diabetes**
- **Cancer**

These three health needs will be broken down in further detail below to understand how findings in the secondary data and community input led to each issue becoming a high priority health need for the Tri-County Service Area.

## 5.4 DATA CONSIDERATIONS

Several limitations of the data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and quality of life topic areas, within each topic area there is a varying scope and depth of quantitative data indicators (secondary data) and qualitative findings (primary data). In some topics there is a robust set of quantitative data indicators, but in others there may be a limited number of indicators for which data is collected. The breadth of qualitative data findings is dependent on who was selected to be a key informant, as well as the availability of selected key informants for interviews during the time period of qualitative data collection. Additionally, data from focus groups was limited by those who were chosen to participate and were influenced by where and for whom the focus groups were conducted. For the community survey, although it was distributed across the entire three county service area and made available both online and as a paper hard copy, it was a convenience sample. This means that results may be vulnerable to selection bias and make findings less generalizable. Another limitation is that, although the survey was translated into Spanish and Creole, there may have been other non-English speaking groups that were missed. The Index of Disparity is also limited by data availability: there is no subpopulation data for some indicators, and for others, there are only values for a select number of racial or ethnic groups. For both quantitative and qualitative data, efforts were made to include as wide a range as possible of topic and expertise areas for data.

# DEMOGRAPHICS



The demographics of a community significantly impact its health profile. Poverty, lack of a vehicle, and poor public transportation can limit the ability to access healthy foods and health services. Unsafe neighborhoods can make it difficult to get enough physical activity. Linguistic isolation can make it difficult for a patient to effectively communicate with their physician. Additionally, different race/ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. All reported demographic figures are sourced from Claritas 2018 estimates unless otherwise noted.

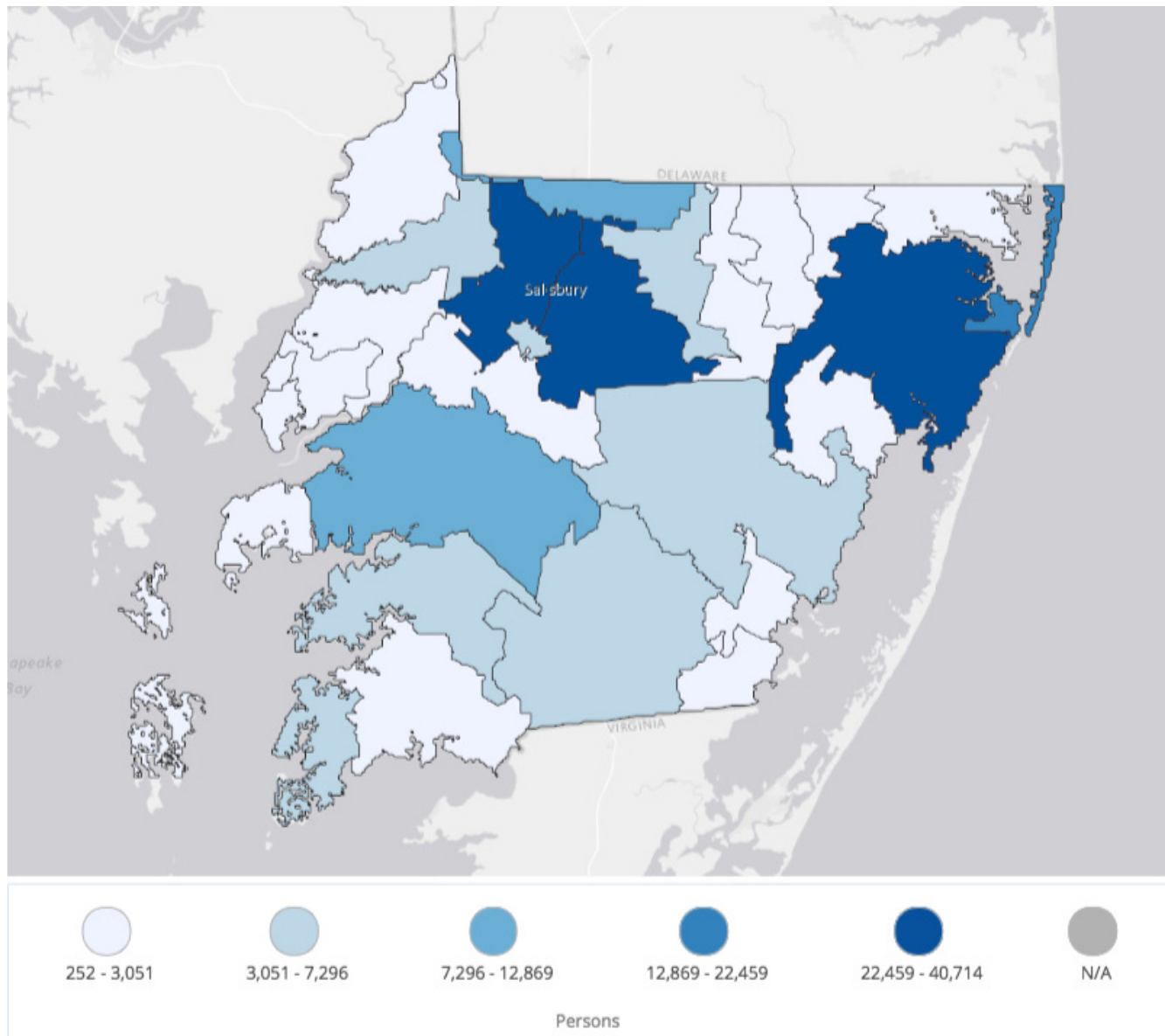


## 6.1 POPULATION

### 6.1.1 POPULATION COUNT

The total population estimate for the Tri-County Service Area is 180,778. The majority of the population lives in Wicomico County, which has an estimated 103,378 residents. Worcester and Somerset counties, meanwhile, have estimated populations of 51,455 and 25,945, respectively. The map below shows zip codes by population count range for all zip codes in the three service area counties. Zip codes 21804 and 21801, both in the north central part of the service area, have the highest population counts within the service area, with populations of 40,714 and 30,768 respectively. Zip codes 21824 and 21814, both on the western side of the service area on the water of the Chesapeake Bay, have the lowest population counts within the service area, with populations of 252 and 301 people, respectively.

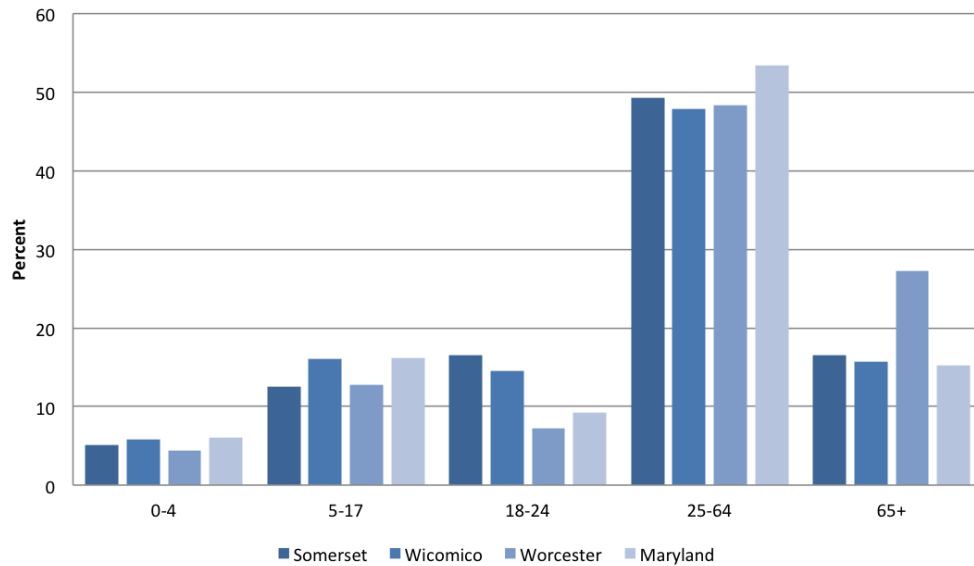
FIGURE 8. TRI-COUNTY SERVICE AREA POPULATION COUNT BY ZIP CODE



**6.1.2 AGE**

The counties in the Tri-County Service Area have varying age distributions when compared to each other and to the state of Maryland. The proportion of young adults in Somerset and Wicomico are higher compared to both Worcester and Maryland as a whole. Over half of Maryland is comprised of adults ages 25 to 64, whereas this age group accounts for slightly below half of the population of each of the three counties individually. Also, the proportion of older adults (65+) is much higher in Worcester County when compared to the other counties in the service area.

**FIGURE 9. TRI-COUNTY SERVICE AREA DEMOGRAPHICS: AGE**

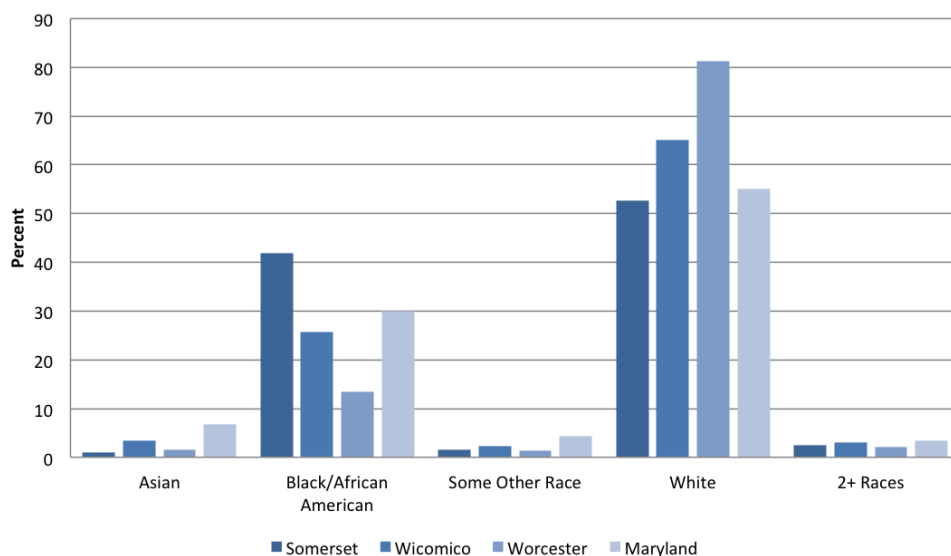




**6.1.3 RACIAL/ETHNICITY DIVERSITY**

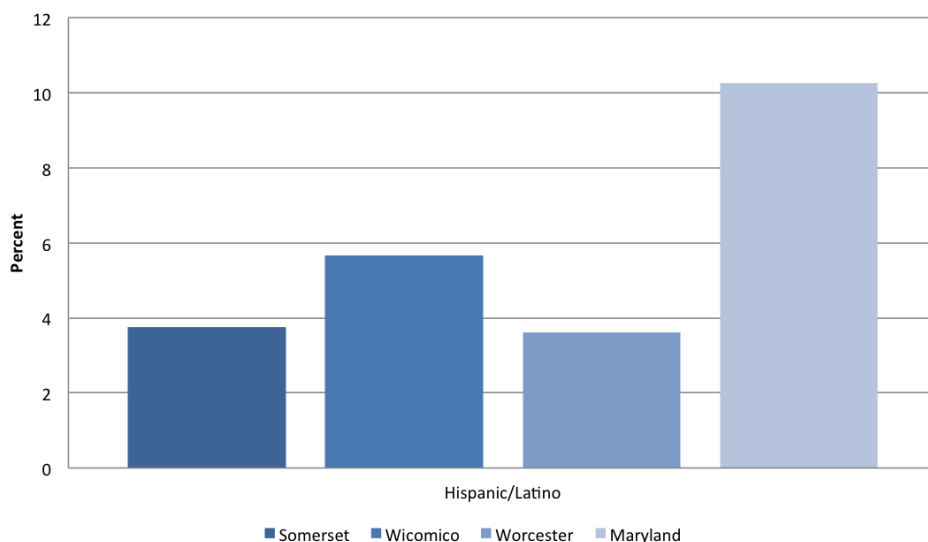
Worcester County has the highest percentage of people in the White race group (81.2%), whereas Somerset has the lowest percentage (52.6%). Both Worcester and Wicomico (65.1%) have a higher percentage of Whites than the state of Maryland as whole (55.1%). Somerset County has the largest proportion of Black/African Americans (41.9%), whereas Worcester has the lowest (13.4%). Wicomico’s percentage of Black/African Americans mirrors the state of Maryland the closest, with values of 25.8% and 29.9% respectively. The other race groups comprise a tiny sliver of the Tri-County counties’ populations in comparison. In Somerset and Worcester counties, those who are two or more races are the next highest racial group (2.5% and 2.1%); while in Wicomico County, Asians comprise the next largest group (3.4%).

**FIGURE 10. TRI-COUNTY SERVICE AREA DEMOGRAPHICS: RACE**



Additionally, Wicomico County has the highest Hispanic/Latino population in the Tri-County Service Area (5.7%), although all three counties have much smaller percentages compared to the state of Maryland as a whole.

**FIGURE 11. TRI-COUNTY SERVICE AREA DEMOGRAPHICS: ETHNICITY**



## 6.2 SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

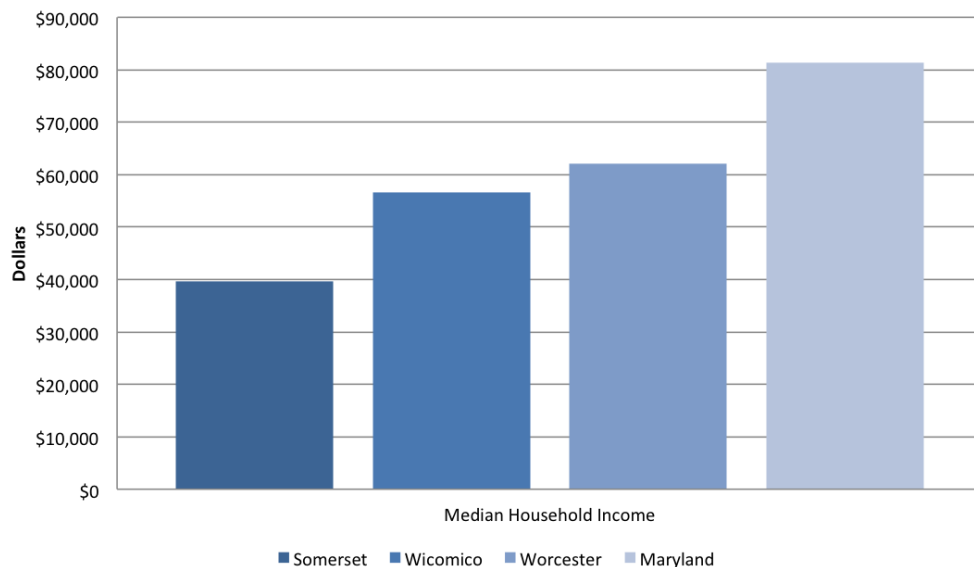
Healthy People 2020 defines social determinants of health as conditions in which people are born, grow, live, work, and age that affect a wide range of health outcomes and risks. The social determinants of health partly explain why some people are healthier than others, and generally why some people are not as healthy as they could be. Resources that address the social determinants of health and improve quality of life can have a significant impact on population health outcomes. Examples of these resources include access to education, public safety, affordable housing, availability of healthy foods, and local emergency and health services.

Understanding the different social determinants in a service area can lead to potential programs and services that work to improve disparities within that community. Programs that address the social determinants such as: targeted outreach to people living alone, translation services for people with limited English proficiency, and financial counseling for people living in poverty, can help to improve the overall health of the community.

### 6.2.1 INCOME

The median household income values in all three counties in the Tri-County Service Area are lower than that of the state of Maryland. Somerset County has the lowest median household income in the service area with a value of \$39,677. Worcester County has the highest median household income in the service area at \$62,166.

FIGURE 12. TRI-COUNTY SERVICE AREA MEDIAN HOUSEHOLD INCOME

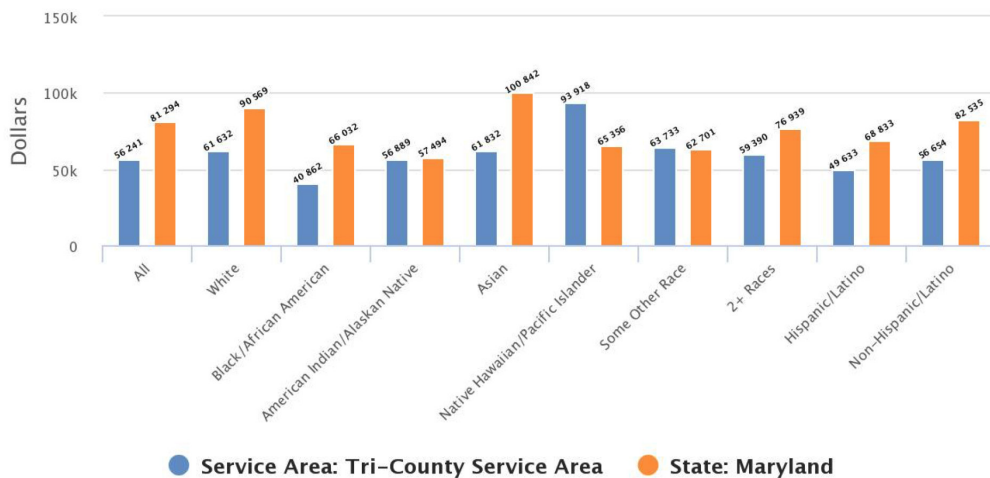


When looking at the median household income breakdown by race/ethnicity, it is seen the service area generally has lower median household incomes for race/ethnicity subgroups compared to the overall state values, except for the Native Hawaiian/Pacific Islander group, which has a much higher median household income for the service area compared to the state. Those who identify as a race not listed (“Some Other Race”) also have a slightly higher median household income than the state value. Overall, for all races, the median household income for the service area is \$56,241, which is \$25,053 lower than the median state value. Notably,

SECTION 6 **DEMOGRAPHICS**

Whites and Asians have two of the larger negative differences when comparing the Tri-County Service Area and the state. Black/African Americans also have a much lower value for the service area than the state.

FIGURE 13. TRI-COUNTY SERVICE AREA MEDIAN HOUSEHOLD INCOME BY RACE/ETHNICITY



6.2.2 **POVERTY**

Somerset County has by far the highest percentage of families living below the federal poverty level in the service area at 20.2%. Worcester has the lowest value at 7.5%. In comparison to the state of Maryland overall, all three counties in the Tri-County Service Area have higher percentages of families living in poverty.

FIGURE 14. TRI-COUNTY SERVICE AREA FAMILIES LIVING BELOW THE POVERTY LEVEL

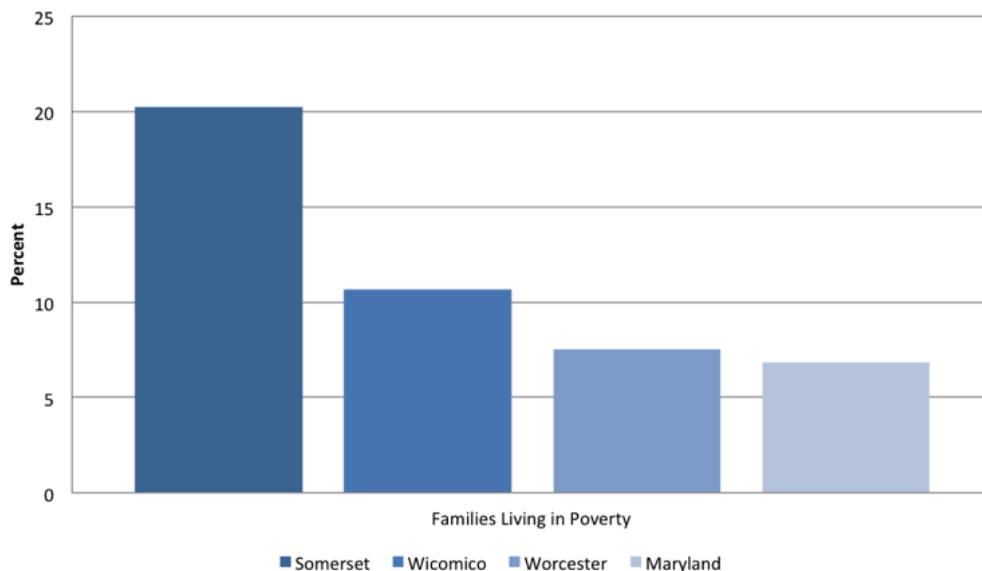
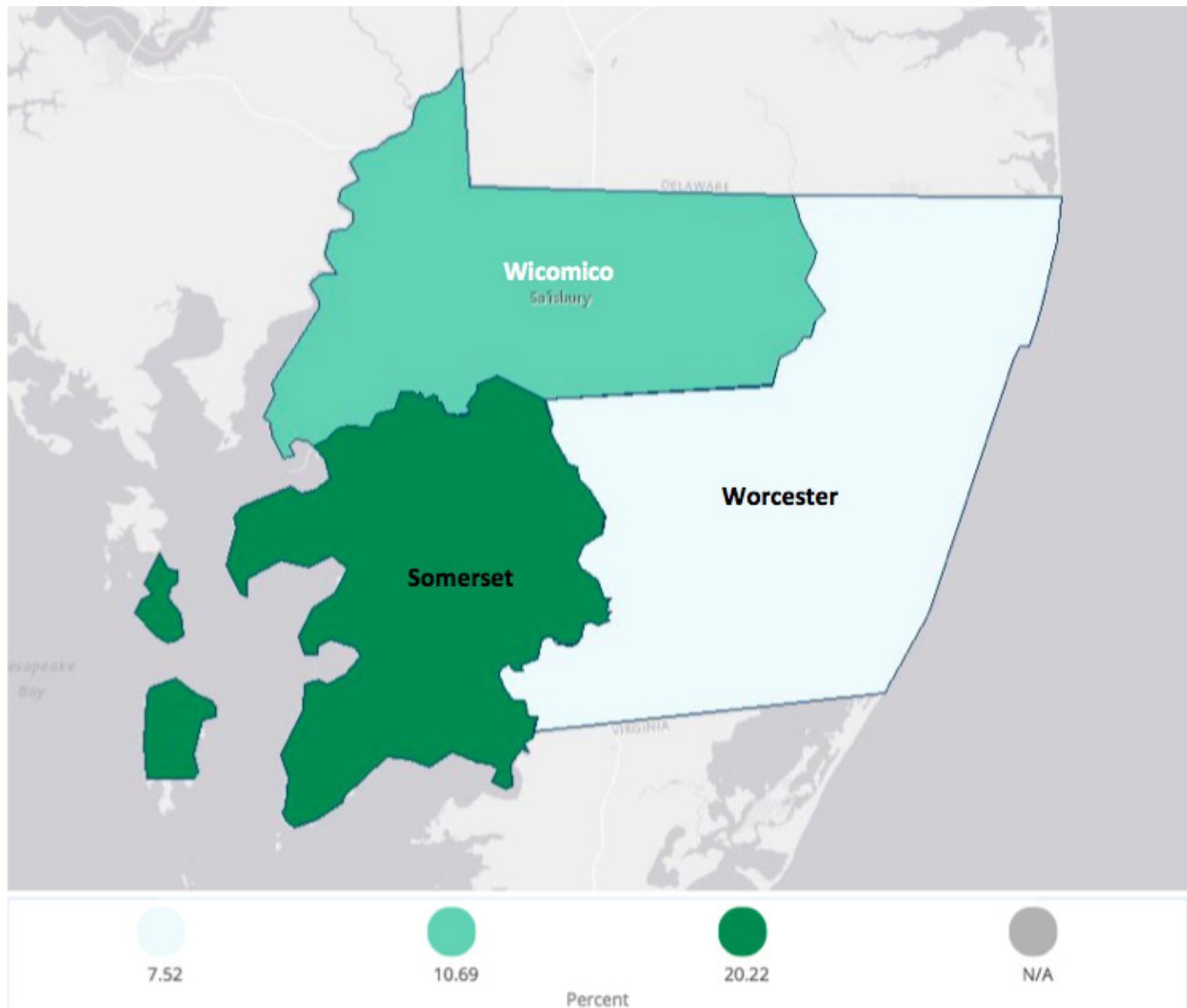


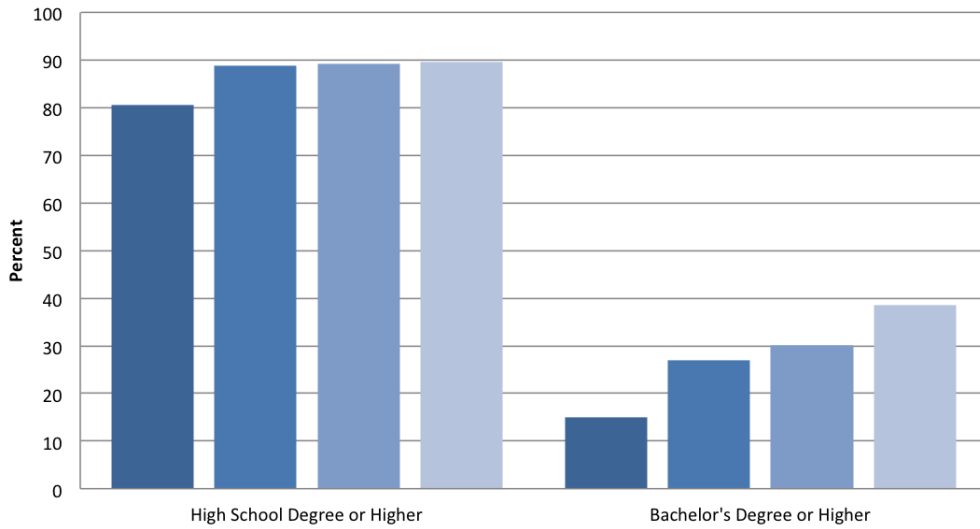
FIGURE 15. TRI-COUNTY SERVICE AREA MAP OF FAMILIES LIVING IN POVERTY



### 6.2.3 EDUCATION

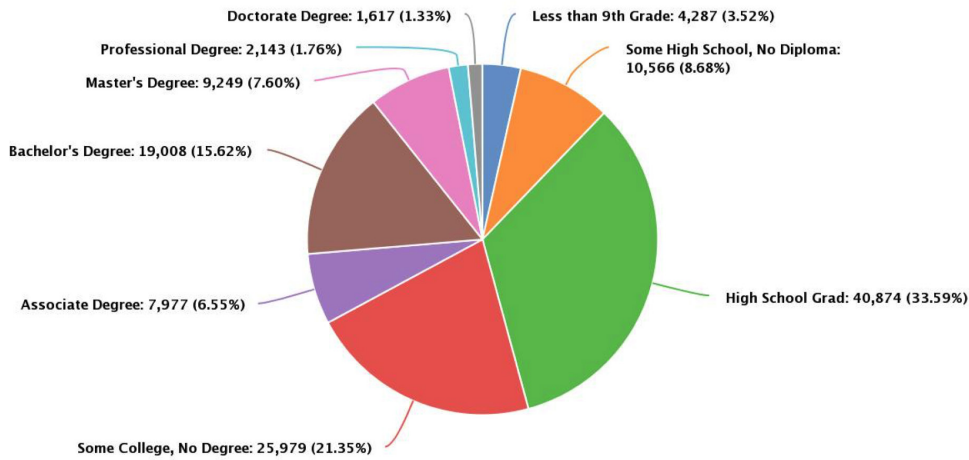
As seen with the income and poverty demographic figures, Somerset County also has the highest percentage of people aged 25 years and older without a high school education in the service area. Additionally, Somerset has the lowest percentage of people with a bachelor's degree or higher, at less than 15%. Wicomico and Worcester counties both have roughly the same percentage of high school graduates as the state of Maryland as whole (89.6%), however, both counties have much lower percentages of people with bachelor's degrees or higher than the state. The Tri-County Service Area overall has a big gap in educational attainment, as 87.8% of the population aged 25 and older has a high school graduate's degree, but that number drops precipitously to only 26.3% for those with a bachelor's degree or higher.

**FIGURE 16. TRI-COUNTY SERVICE AREA EDUCATIONAL ATTAINMENT BY COUNTY**



**FIGURE 17. TRI-COUNTY SERVICE AREA EDUCATIONAL ATTAINMENT**

**Population 25+ by Educational Attainment**  
**Service Area: Tri-County Service Area**

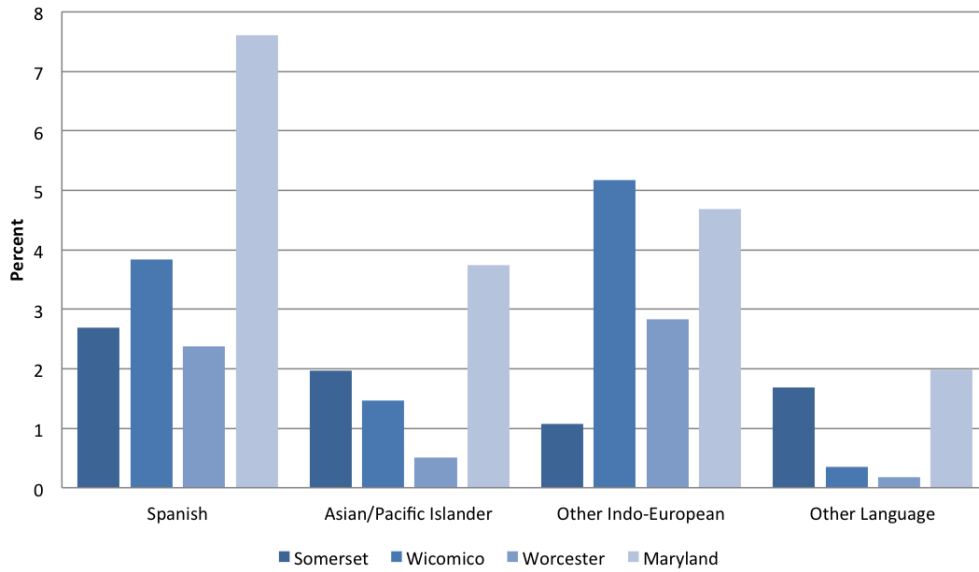


Claritas, 2018. peninsula.thehcn.net

**6.2.4 LANGUAGES SPOKEN**

Of the three counties in the service area, Wicomico has the most Spanish-speaking households and households that speak another Indo-European language, while Somerset has the highest percentage of households that speak an Asian or Pacific Islander language. Overall, the three counties have mostly lower percentages of those who speak a language other than English at home when compared to the entire state of Maryland.

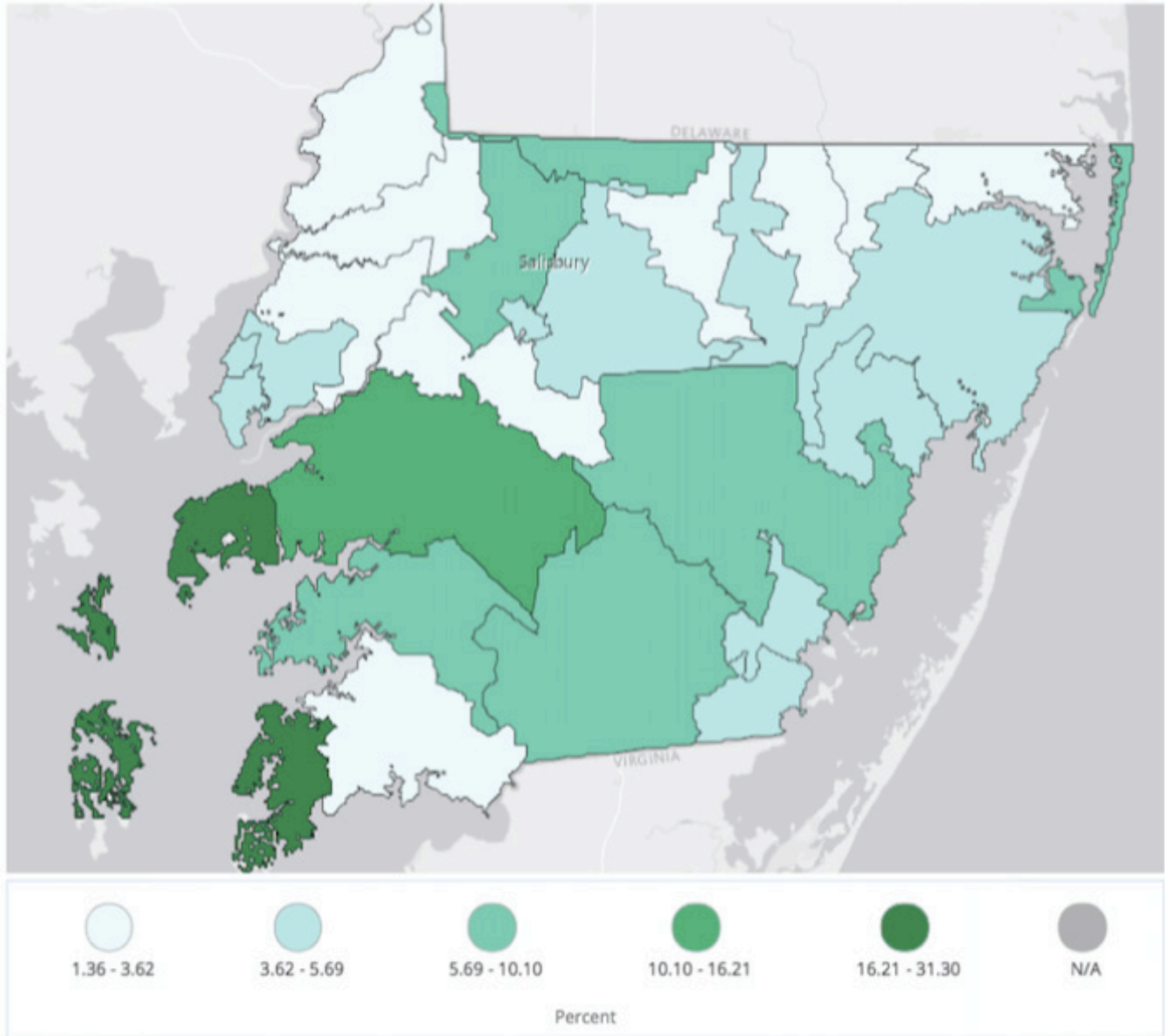
**FIGURE 18. TRI-COUNTY SERVICE AREA LANGUAGE SPOKEN AT HOME**



**6.2.5 HOUSEHOLDS WITH NO VEHICLE**

Zip codes 21824, 21821, and 21817 have by far the highest percentage of households without a vehicle in the Tri-County Service Area (31.3%, 21.5%, and 16.2%, respectively). These zip codes lie in the western-most part of the service area and are located right on the bay. The other zip codes in the service area range in percentages without a vehicle from 1.4% to 10.1%.

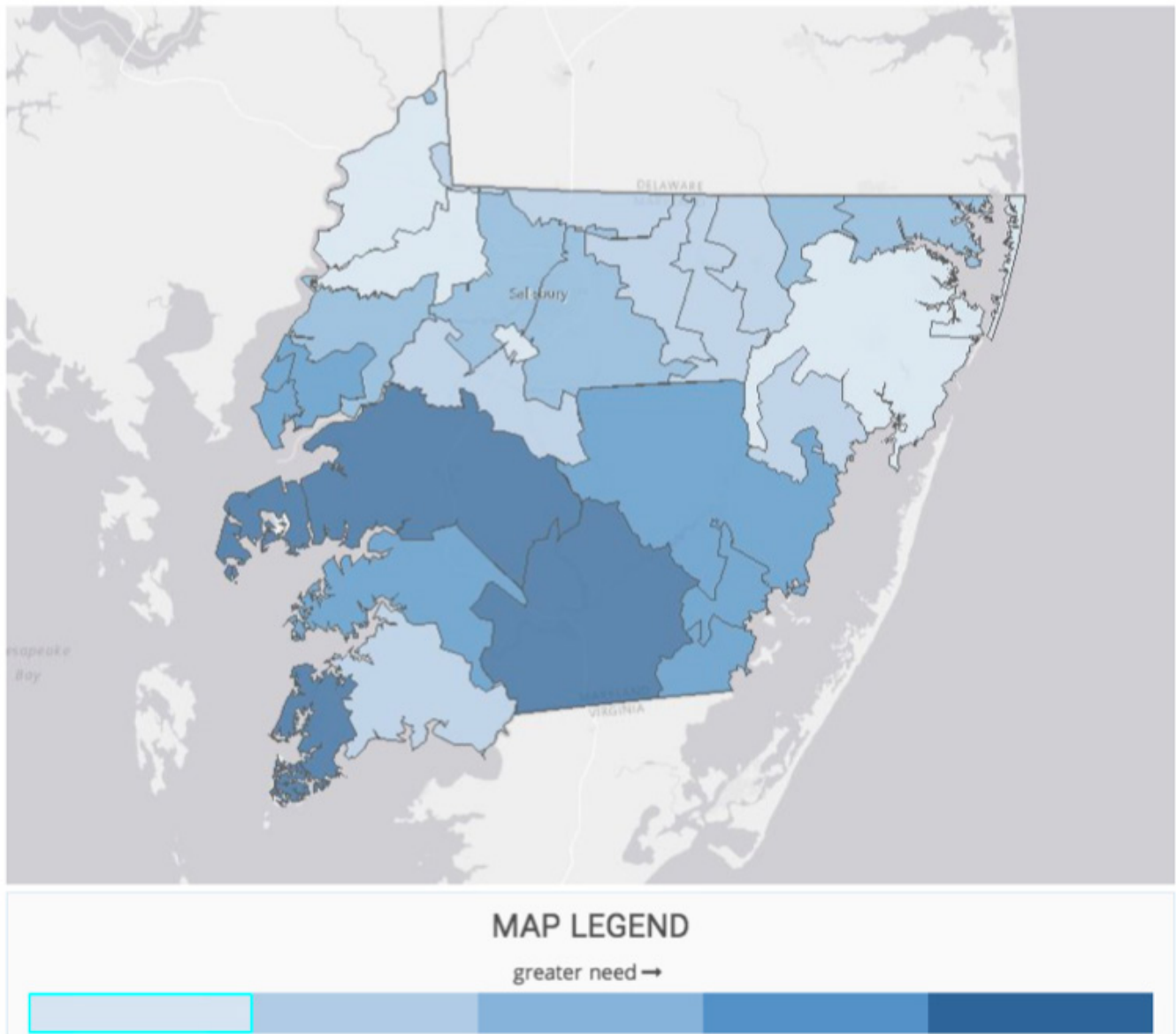
**FIGURE 19. TRI-COUNTY SERVICE AREA MAP OF HOUSEHOLDS WITHOUT A VEHICLE**



**6.2.6 SOCIONEEDS INDEX®**

Conduent Healthy Communities Institute developed the SocioNeeds Index® to easily compare multiple socioeconomic factors across geographies. This index incorporates estimates for six different social and economic determinants of health – income, poverty, unemployment, occupation, educational attainment, and linguistic barriers – that are associated with poor health outcomes including preventable hospitalizations and premature death. Within the Tri-County Service Area, zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map. The zip codes with the highest levels of socioeconomic need can be found for all counties in the service area in the table below. Three of the five zip codes with the highest index score, indicating most need, are in Somerset County. Understanding where there are communities with high socioeconomic need is important when determining where to focus prevention and outreach activities.

**FIGURE 20. SOCIONEEDS INDEX MAP FOR TRI-COUNTY SERVICE AREA**





**TABLE 1. SOCIONEEDS INDEX ZIP CODES OF HIGHEST NEED**

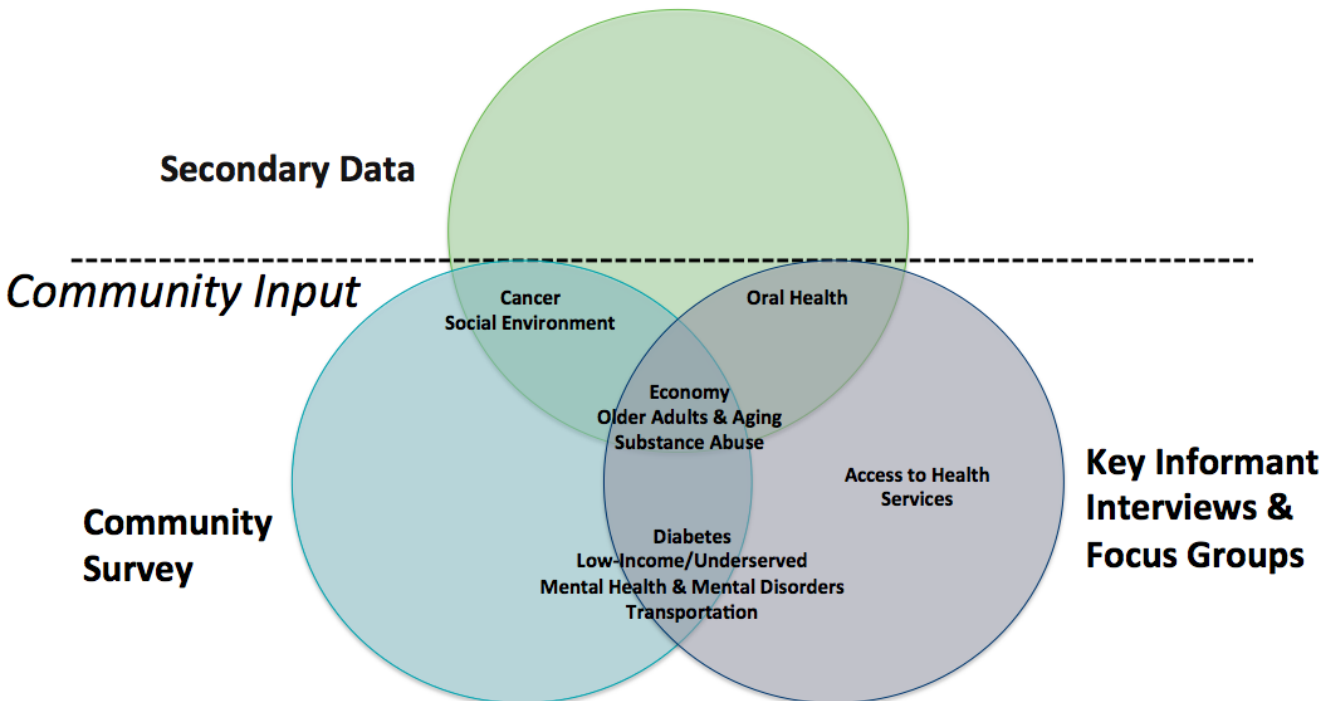
<b>ZIP CODES WITH HIGHEST SOCIOECONOMIC NEED</b>		
<b>COUNTY</b>	<b>ZIP CODE</b>	<b>ZIP CODE INDEX SCORE</b>
Somerset	21817	91.6
	21821	87.6
	21853	84.1
Wicomico	21814	76.5
Worcester	21851	86.7

# DATA SYNTHESIS



Primary and secondary data were collected, analyzed, and synthesized to identify the significant community health needs in the PRMC, WCHD, and SCHD Tri-County Service Area, and the results are shown in the figure below. Topic areas demonstrating strong evidence of need from secondary data and community input were determined to be significant health needs. In primary data, topic areas demonstrating strong evidence of need were the most commonly discussed health needs during key informant interviews and focus groups, as well as the highest ranked health needs, quality of life conditions of need, and most negatively affected subpopulation groups per the community survey. From the secondary data, topic areas demonstrating strong evidence of need were the top health need areas and the top quality of life need areas, as determined by the highest weighted data scoring results from across the entire Tri-County Service Area. Primary and secondary data for all topic areas shown in the figure below are discussed in further detail in this section.

FIGURE 21. DATA SYNTHESIS RESULTS



# PRIORITIZED SIGNIFICANT HEALTH NEEDS

## 8.1 DIABETES

The secondary data analysis for Diabetes resulted in a topic score of 1.53 on a scale of 0 to 3, indicating need slightly above average. Notably, the age-adjusted emergency room visit rate due to diabetes is higher in each of the counties in the Tri-County Service Area than the state of Maryland value of 204 ER visits per 100,000 population. Additionally, all three counties fail to meet the Maryland SHIP 2017 Target of 186.3 ER visits per 100,000 population. Further, both Somerset and Wicomico have higher percentages of their Medicare populations with diabetes than the state of Maryland and the entire U.S. average. Both of those counties also have lower percentages of this same Medicare population that monitors their diabetes. This lower percentage is those diabetic Medicare patients who have had a blood sugar test in the past year. Lastly, Somerset County has a very high death rate due to diabetes, with a value of 25.2 deaths per 100,000 population, higher than both the Maryland state and U.S. values.

TABLE 2. DIABETES-RELATED INDICATORS OF CONCERN

### Age-Adjusted Death Rate due to Diabetes, 2012-2014 (deaths/100,000 population)<sup>9</sup>

MD Value: 19.9	U.S. Value: 21.2	HP2020 Target: ----	MD SHIP Target: -----
Somerset: 25.2	Wicomico: 10.1	Worcester: 14.5	

### Age-Adjusted ER Rate due to Diabetes, 2014 (ER Visits/100,000 population)<sup>9</sup>

MD Value: 204.0	U.S. Value: ----	HP2020 Target: ----	MD SHIP Target: 186.3
Somerset: 253.8	Wicomico: 372.7	Worcester: 229.9	

### Diabetes: Medicare Population, 2015 (percent)<sup>3</sup>

MD Value: 29.1	U.S. Value: 26.5	HP2020 Target: ----	MD SHIP Target: ----
Somerset: 34.4	Wicomico: 31.5	Worcester: 25.9	

### Diabetic Monitoring: Medicare Population, 2014 (percent)<sup>19</sup>

MD Value: 85.0	U.S. Value: 85.2	HP2020 Target: ----	MD SHIP Target: ----
Somerset: 84.3	Wicomico: 83.5	Worcester: 89.5	

**COMMUNITY INPUT**

Community survey respondents ranked Diabetes as the third most important health issue in their community. Further, Diabetes as a topic or theme was mentioned 16 times by participants across all key informant interviews and focus groups. It was the eleventh most discussed topic in the key informant interviews. Concerns related to diabetes that were discussed by community input participants included the fact that many parts of the region do not have healthy eating options readily available, and many welfare cards do not cover fresh foods, such as fruits and vegetables. Additionally, participants discussed that even when diabetes is identified and diagnosed, it often goes unmanaged as people do not know how or cannot afford to take care of it regularly. This theme is reflected in the secondary data where it is seen that the ER rate due to diabetes is very high in the region, signifying that people are waiting until there is an emergency to treat their diabetes or are using the ER as primary care to manage their diabetes.

**“Sugary drinks are so available and fairly inexpensive... kids are bombarded with advertisements [for them].”**

**8.2 CANCER**

The secondary data analysis for Cancer resulted in a topic score of 1.77, the fourth highest scoring topic area for the Tri-County Service Area. This high score signifies worse performance and greater need for the topic area. Most notably, the age-adjusted death rate due to all cancers for all three counties in the service area failed to meet either the Healthy People 2020 (161.4 deaths per 100,000 population) or Maryland SHIP 2017 (147.4 deaths per 100,000 population) targets. Additionally, all three counties in the service area also failed to meet the Healthy People 2020 targets for both age-adjusted death rate due to lung cancer (45.5 deaths per 100,000 population) and age-adjusted death rate due to prostate cancer (21.8 deaths per 100,000 males). Further, Somerset County performed significantly worse than the other counties in terms of women ages 50 years and older who have had a mammogram in the past two years, while both Somerset and Wicomico counties had high values for age-adjusted death rate due to colorectal cancer and colorectal cancer incidence rate when compared to the Maryland and U.S. values. Both of those counties also failed to meet the Healthy People 2020 targets for the colorectal cancer measures (14.5 deaths per 100,000 population and 39.9 cases per 100,000 population). Worcester County, meanwhile, had a high age-adjusted death rate due to breast cancer, with a value of 28.9 deaths per 100,000 females that is higher than the Maryland and U.S. values and also fails to meet the Healthy People 2020 target of 20.7. Additional indicators that performed poorly across all three counties in the service area are shown in the table below.

TABLE 3. CANCER-RELATED INDICATORS OF CONCERN

<b>Age-Adjusted Death Rate due to Cancer, 2010-2014 (deaths/100,000 population)<sup>16</sup></b>			
MD Value: 165.3	U.S. Value: 166.1	HP2020 Target: 161.4	MD SHIP Target: 147.4
Somerset: 212.5	Wicomico: 200.9	Worcester: 181.8	
<b>Age-Adjusted Death Rate due to Lung Cancer, 2010-2014 (deaths/100,000 population)<sup>16</sup></b>			
MD Value: 43.2	U.S. Value: 44.7	HP2020 Target: 45.5	MD SHIP Target: -----
Somerset: 76.0	Wicomico: 57.3	Worcester: 56.6	
<b>Age-Adjusted Death Rate due to Prostate Cancer, 2010-2014 (deaths/100,000 males)<sup>16</sup></b>			
MD Value: 20.3	U.S. Value: 20.1	HP2020 Target: 21.8	MD SHIP Target: ----
Somerset: 38.1	Wicomico: 24.4	Worcester: 22.7	
<b>Lung and Bronchus Cancer Incidence Rate, 2010-2014 (cases/100,000 population)<sup>16</sup></b>			
MD Value: 58.1	U.S. Value: 61.2	HP2020 Target: ----	MD SHIP Target: ----
Somerset: 97.6	Wicomico: 75.6	Worcester: 69.2	
<b>Oral Cavity and Pharynx Cancer Incidence Rate, 2010-2014 (cases/100,000 population)<sup>16</sup></b>			
MD Value: 10.6	U.S. Value: 11.5	HP2020 Target: ----	MD SHIP Target: ----
Somerset: 14.7	Wicomico: 13.3	Worcester: 12.2	

**COMMUNITY INPUT**

Community Survey respondents ranked Cancer as the fifth most important health issue in their community according to survey results. Cancer was only discussed four times total across the key informant interviews and focus groups, however some clear themes related to this topic area came out of the discussions. Key informants and focus group participants mentioned that high smoking prevalence in the region is a huge contributor to cancer rates and that smoking cessation is crucial to combatting cancer incidence. Additionally, it was discussed how people in the community struggle in general with chronic conditions, and this is most notably displayed in high cancer rates.

**“A lot of non-profit organizations, like Women supporting Women, work on breast cancer [in the community].”**

**8.3 BEHAVIORAL HEALTH**

The topic areas of Mental Health & Mental Disorders and Substance Abuse ranked 1st and 2nd respectively in the prioritization process. The team at PRMC, WCHD, and SCHED elected to combine these two topic areas into one priority: Behavioral Health. A further discussion of the two topic areas follows.

**8.3.1 MENTAL HEALTH & MENTAL DISORDERS**

Secondary data scoring presented mental health & mental disorders as a slightly above average health need, with a topic score of 1.53. Wicomico and Somerset counties in particular seem to have significant need for additional mental health services, with indicators showing much poorer outcomes when compared to the state as a whole. There were 6,207.9 ER visits/100,000 population in Wicomico and 5,665.2 in Somerset, in comparison to 3,442.6 for the state of Maryland. There were also more suicide deaths in Wicomico County (12.2/100,000 population) when compared to the state of Maryland (9.2). In addition, residents of Somerset County suffered from more days of poor mental health per week (4.3) versus Maryland as a whole (3.5).

**TABLE 4. MENTAL HEALTH-RELATED INDICATORS OF CONCERN**

<b>Age-Adjusted ER Rate due to Mental Health, 2014 (ER visits/100,000 population)<sup>9</sup></b>			
MD Value: 3,442.6	U.S. Value: -----	HP2020 Target: -----	MD SHIP Target: 3,152.6
Somerset: 5,665.2	Wicomico: 6,207.9	Worcester: -----	

<b>Age-Adjusted Death Rate due to Suicide, 2012-2014 (deaths/100,000 population)<sup>9</sup></b>			
MD Value: 9.2	U.S. Value: 12.7	HP2020 Target: 10.2	MD SHIP Target: 9.0
Somerset: -----	Wicomico: 12.2	Worcester: 12.0 (2011-2013)	

<b>Poor Mental Health: Average Number of Days, 2016</b>			
MD Value: 3.5	U.S. Value: 3.8	HP2020 Target: -----	MD SHIP Target: ----
Somerset: 4.3	Wicomico: 4.0	Worcester: 3.7	

**COMMUNITY INPUT**

Although the secondary data analysis signaled that mental health & mental disorders was a topic of only average need, it was actually deemed the 2nd most important health issue from respondents of the community survey. Mental health was mentioned 29 times in the community survey in addition to 13 times in the focus groups. Through these numerous responses, it's clear that both focus group participants and community survey respondents agree that there is a lack of access to mental health care. Many believe that there remains a stigma on seeking and receiving care for mental health issues, exacerbating this problem. Some also noted that an overlap exists between the opioid epidemic and mental illness; a collaborative effort aimed at tackling substance abuse issues along with mental illness would be much more effective than dealing with each separately.

**“I don't know of anyone who is an addict without mental health issues.”**

**8.3.2 SUBSTANCE ABUSE**

Substance Abuse had strong signals from both the secondary and primary data. It was the number one ranked health need in the online community survey, indicating that this is a pressing need for members of the community. In the secondary data, we see concerning data around emergency room visits for alcohol and substance abuse, adult smoking, deaths due to alcohol-impaired driving, and deaths due to drug poisoning.

Particularly troubling, is the Age-Adjusted Emergency Room Rate due to Alcohol/Substance Abuse for Wicomico County, which is nearly double the rate for the state of Maryland. Alcohol-impaired driving deaths were high in Worcester County, more than 50% higher than the state and U.S. averages. Deaths due to drug poisoning in Worcester County were nearly double the U.S. rate and almost 30% higher than the Maryland state average. Adult smoking was high for all three service area counties, greater than the Maryland average. A table of the most concerning indicators is below.

TABLE 5. SUBSTANCE ABUSE-RELATED INDICATORS OF CONCERN

**Age-Adjusted ER Rate due to Alcohol/Substance Abuse, 2014 (ER visits/100,000 population)**

MD Value: 1591.3	U.S. Value: -----	HP2020 Target: -----	MD SHIP Target: 1400.9
Somerset: 1896.4	Wicomico: 2870.5	Worcester: 2296.8	

**Alcohol-Impaired Driving Deaths, 2012-2016 (percent)**

MD Value: 30.5	U.S. Value: 29.3	HP2020 Target: -----	MD SHIP Target: -----
Somerset: 30.0	Wicomico: 31.8	Worcester: 48.0	

**Death Rate due to Drug Poisoning, 2014-2016 (deaths/100,000 population)**

MD Value: 24.4	U.S. Value: 16.9	HP2020 Target: -----	MD SHIP Target: ----
Somerset: 25.8	Wicomico: 19.9	Worcester: 33.6	

**Adults who Smoke, 2016 (percent)**

MD Value: 13.4	U.S. Value: 17.1	HP2020 Target: 12.0	MD SHIP Target: 15.5
Somerset: 20.5	Wicomico: 17.3	Worcester: 20.9	

**COMMUNITY INPUT**

As mentioned before, Substance Abuse was the number one ranked health issue in the online community survey. Among focus groups and key informant interviews, Substance Abuse was in the top two most frequently mentioned subjects. Clearly, this topic area is of great concern and importance to members of the community.

In the focus group and key informant interview discussions, people repeatedly mentioned the growing and serious problem of opioid addiction. Others mentioned the lack of treatment beds for those suffering from substance abuse. Another theme was the overlap with substance abuse and mental health issues.

**“Many [addicts] were introduced through injury, then were prescribed drugs, then went to street drugs.”**

# NON-PRIORITIZED SIGNIFICANT HEALTH NEEDS



## 9.1 ACCESS TO HEALTH SERVICES

Access to Health Services ranked the lowest of all topic areas according to secondary data scoring with a data score of 1.44, signaling below average need. However, there are still some indicators of concern in the topic area, including primary care provider rate (31.1 providers per 100,000 population in Somerset County and 67.4 in Wicomico, compared to 88.0 for the state of Maryland as whole), adults who visited a dentist in the past year (57.9% in Wicomico County compared to 69.4% for Maryland and 66.4% for the U.S.), and adults who have had a routine checkup in the past year (69.5% in Worcester County compared to 88.2% for Maryland and 83.6% for the entire nation).

### COMMUNITY INPUT

Despite its low score in the secondary data analysis, Access to Health Services was one of the most important topic areas in the community input. This topic was mentioned 73 times in focus groups and 39 times in key informant interviews, by far the most discussed topic in both forms of primary qualitative data collection. It was also ranked as the 7th most important health issue by Community Survey respondents.

Participants in key informant interviews and focus groups discussed many themes related to the Access to Health Services topic area including a lack of specialists in the region, which forces people to travel many hours or wait many weeks for much need specialized care. Additionally, it was discussed how a lack of knowledge of and education on health care and services resources leads to the inability by many in the region to navigate these needed resources to access care. Lastly, participants mentioned a cultural theme where community members often wait until their health situation is in crises before seeking access to health care or services, often from the emergency department.

“People I know have to drive 2 to 2.5 hours after waiting 60 days to see a specialist.”

## 9.2 OLDER ADULTS & AGING

Older Adults & Aging ranked in the top 10 list of health needs resulting from secondary data analysis. It scored 1.65 indicating it was an above average and otherwise a topic area of concern. Related indicators include Chronic Kidney Disease in Medicare Population (21% of the Medicare population in Wicomico County and 21.3% in Somerset County as compared to a Maryland state value of 18.2%) and Hyperlipidemia in Medicare Population (56% of the Medicare population in Wicomico, 56.9% in Worcester, and 53.5% in Somerset counties as compares to the state value of 48.9% and the U.S. value of 44.6%).



**COMMUNITY INPUT**

Although Older Adults & Aging was not as significant in the secondary data, it was discussed in most Key Informant Interviews with a total of 11 mentions, which is one of the most frequently mentioned topics among all interviews. Out of those discussions with informants came the following themes:

- Lack of home support and follow-up care
- Increase in aging population and therefore increase in demand/need
- Lack of treatment options and availability

Additionally, community survey respondents ranked Older Adults as the second most negatively affected population, signaling the importance of this subgroup as they relate to top health needs in the community.

**“Older population is struggling more and more to afford care and medication.”**

**9.3 ORAL HEALTH**

Oral Health was sixth in the top ten list of health needs resulting from the secondary data analysis for the tri-county area with a score of 1.73. Top warning indicators were Age-Adjusted ER Visit Rate due to Dental Problems (1,886.7 ER visits per 1000,000 population in Wicomico County compared to 779.9 in the state of Maryland). Another concerning indicator was Adults who Visited a Dentist (57.9% of adults in Wicomico County visited a dentist in the past year as compared to 69.4% in the state of Maryland and 66.4% in the U.S.).

**COMMUNITY INPUT**

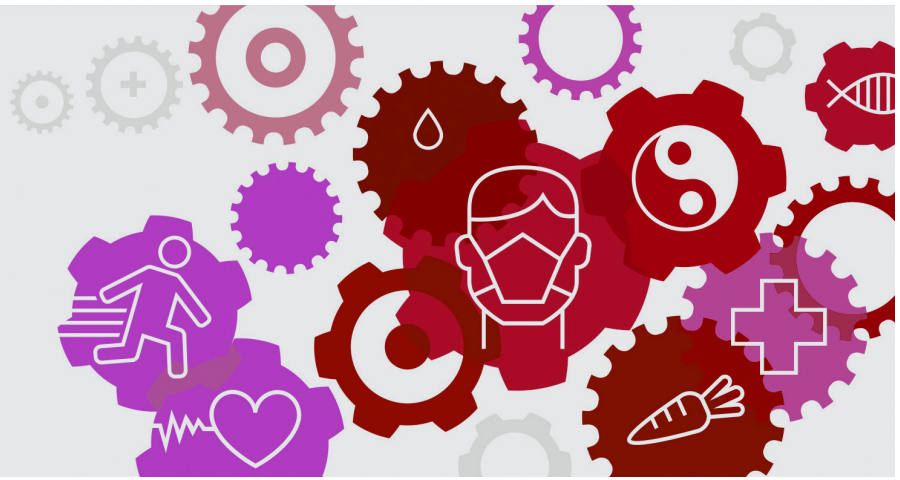
Oral Health was heavily discussed during the Focus Groups with a total of sixteen participant mentions. From those Focus Group talks came the following themes:

- Lack of accessible and affordable dental care
- Utilization of ER for dental problems
- Dental health coverage not enough

Key informant interviewees also spoke to the issues of dental insurance not covering most needed treatments, and difficulty accessing dentists or getting appointments.

**“Dental issues are becoming more serious.”**

# OTHER FINDINGS



Both secondary and primary data analysis results allude to issues surrounding barriers to health services, as well as other quality of life measures that impact the six significant health needs that were discussed above. The findings were consistent in both secondary and primary for the following four topics:

- Transportation
- Social Environment
- Economy
- Low Income/Underserved

## 10.1 TRANSPORTATION

Transportation is a topic that did not score extremely high in secondary data, but was mentioned repeatedly in the primary data, particularly the key informant and focus group discussions. The poorly scoring indicators related to commuting. The secondary data showed a large number of workers who drive alone to work in both Wicomico and Somerset counties, whereas the percent of workers commuting by public transportation was low for those same counties. Additionally, the percentage of households without a vehicle was high for Somerset County.

Themes that were mentioned in focus group and key informant interviews were issues around transportation for medical and dental appointments. The existing transportation options are time consuming and costly. The sub-populations of the elderly and migrant workers were mentioned as needing increased or enhanced transportation options.

“We need to offer free transportation to seniors for medical appointments.”

## 10.2 SOCIAL ENVIRONMENT

Social Environment rose to the top in secondary data due to concerning rates in the following warning indicators: People Living Below Poverty Level, Single-Parent Households, and People 65+ Living Alone.

Additionally, in primary data collection, 11 of 14 key informants spoke to issues around Social Environment stressing the lack of support in homes of the poor and vulnerable. There is need for more support including employment and housing, especially for those struggling. And stigma around behavioral health is apparent. Isolation was mentioned as being a problem due to the nature of the rural area in which the community resides.

In addition, Community Survey respondents also ranked Social Environment as the third most critical social determinant of health.

### 10.3 ECONOMY

Poor economic indicators across all three counties contributed to an above average topic score of 1.69. In particular, housing issues were prevalent across the tri-county area. Homeownership rates of 47.7% in Somerset and 28.3% in Worcester fell far short of the Maryland state value of 59.8%. Furthermore, 20.3% of households in Wicomico and 24.4% in Somerset had severe housing problems, when compared to only 17.1% for Maryland as a whole. Somerset seems to be disproportionately affected by economic issues, having a median household income of \$35,886 versus \$76,067 for the state of Maryland.

Economic conditions were also identified as the most critical social determinant of health by respondents of the community survey. Economic issues were mentioned 17 times in the focus groups along with 15 times in the community surveys. Participants noted that the high cost of living, including housing and healthy diet, resulted in less money to spend on health and health care. Specifically, the high cost of health insurance, medication, and specialty services contributed to the lack of health care access in these communities.

**“Housing: If you can’t have a stable living situation, you can’t have a safe, healthy life.”**

### 10.4 LOW INCOME/UNDERSERVED

As mentioned above, Somerset County is impacted to a greater degree by economic conditions than Wicomico and Worcester. This is supported by the secondary data, which shows just how poorly Somerset performs in its economic indicators. A significant amount of people in Somerset live below poverty level (25.1%), as compared to only 9.9% in Maryland as a whole. In addition, a fifth (19.8%) of Somerset residents have experienced food insecurity and a substantial majority (82.5%) of students are eligible for the free lunch program due to their financial status.

Community survey respondents and focus group participants were acutely aware of the health needs of the low-income population, mentioning them a total of 47 times. Overall, Somerset is the county in the region that can least afford health care due to low-income and uninsured populations. It was also noted that Haitian/Creole and Hispanic populations are the most underserved, signaling the potential for targeted interventions for these particular groups.

**“There’s no drive...to provide health care for all; it’s providing the best health care possible for those that can pay.”**

# A CLOSER LOOK AT HIGHLY IMPACTED POPULATIONS



An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations, and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined in the Tri-County Service Area.

For secondary data health indicators, Conduent Healthy Communities Institute's Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for each of the three counties, and the five indicators from each county with the highest race/ethnicity index value were found, with their associated subgroup with the negative disparity listed below.

**TABLE 6. NEGATIVE RACE/ETHNICITY DISPARITIES BY COUNTY**

Somerset	Wicomico	Worcester
Adults Unable to Afford to See a Doctor (Other Race)	Children with Asthma (Black)	People 65+ Living Below Poverty Level (Black, Asian, AIAN, Multiple Races)
People 65+ Living Below Poverty Level (White, Multiple Races)	Teen Birth Rate: 15-19 (Black, Hispanic/Latino)	Children with Asthma (Black)
Adults who Binge Drink (Black, Hispanic/Latino)	People 65+ Living Below Poverty Level (Black, Multiple Races, Hispanic/Latino)	Teen Birth Rate: 15-19 (Black)
Children with Asthma (Black, Other Race)	Workers Commuting by Public Transportation (White, Asian, AIAN, NHPI, Multiple Races, Other Race)	Workers Commuting by Public Transportation (White, AIAN, NHPI, Multiple Races, Other Race)
Families Living Below Poverty Level (Black, Asian, Multiple Races, Other Race, Hispanic/Latino)	Families Living Below Poverty Level (Black, Other Race, Hispanic/Latino)	People Living Below Poverty Level (Black, AIAN, Multiple Races)

Notably, the Black race group has high disparities for Children with Asthma in all three counties, while those who are of multiple races have high disparities in each county for People 65+ Living Below Poverty Level. Black and Hispanic/Latino racial/ethnic groups have high disparities for Families Living Below Poverty Level in two of the counties, while Blacks have high disparities for Teen Birth Rate for two of the three counties as well.

Additionally, the Index of Disparity found the subgroups with the most indicators for which there was a negative disparity, by county. The numbers listed in the below table next to the subgroup are the number of indicators for which that

subgroup has a negative disparity. Gender disparities (male versus female) are shown at the bottom in a similar fashion. As can be seen, the Black race group has the most negative disparities for each county, with the Hispanic/Latino population also having many negative disparities across the service area. For gender, males actually had slightly more negative disparities compared to females, particularly in Wicomico County.

TABLE 7. NUMBER OF INDICATORS WITH NEGATIVE SUB-POPULATION DISPARITIES PER COUNTY

Somerset		Wicomico		Worcester	
Black	14	Black	17	Black	18
Hispanic/Latino	12	Hispanic/Latino	13	Multiple Races	9
Multiple Races	11	Other Race	9	Hispanic/Latino	6
Other Race	11	Multiple Races	8	Other Race	5
White	10	White	6	Asian	5
Asian	6	Asian	3	White	4
Female	8	Male	12	Male	8
Male	7	Female	3	Female	5

In the primary data collection process, participants were asked which racial, ethnic, or other special subpopulation groups were most negatively impacted in their communities. Immigrant communities, particularly the Hispanic and Haitian/Creole populations, were cited frequently as being largely affected by health and socioeconomic issues.

In regards to mental health and substance abuse topics, adolescents and young white males were cited as the subgroups being most negatively affected by these issues.

# CONCLUSION



This community health needs assessment utilized a comprehensive set of secondary data and primary data to determine the greatest health needs in the Tri-County Service Area. The findings of this report will be used to identify the best strategies to improve the health of the area through the development of new programs, enhancing existing programs, and building new partnerships. While the priority areas of Diabetes, Cancer, and Behavioral Health were identified as the top priority areas for PRMC, WCHD, and SCHED they are not the only topics that will be addressed in the coming years. PRMC remains committed to supporting existing program and strategies to improve the health for all the residents of Wicomico, Worcester, and Somerset counties, while WCHD and SCHED remain committed to supporting efforts in Wicomico and Somerset counties. Please send your feedback and comments to the Community Relations Department via [community.relations@peninsula.org](mailto:community.relations@peninsula.org).

# APPENDICES

## 13.1 SECONDARY DATA

### 13.1.1 SECONDARY DATA SOURCES

The main source for the secondary data, or data that has been previously collected, is Peninsula Regional Medical Center’s Creating Healthy Communities data platform, a publicly available data platform that is maintained by Peninsula Regional Medical Center and Conduent Healthy Communities Institute.

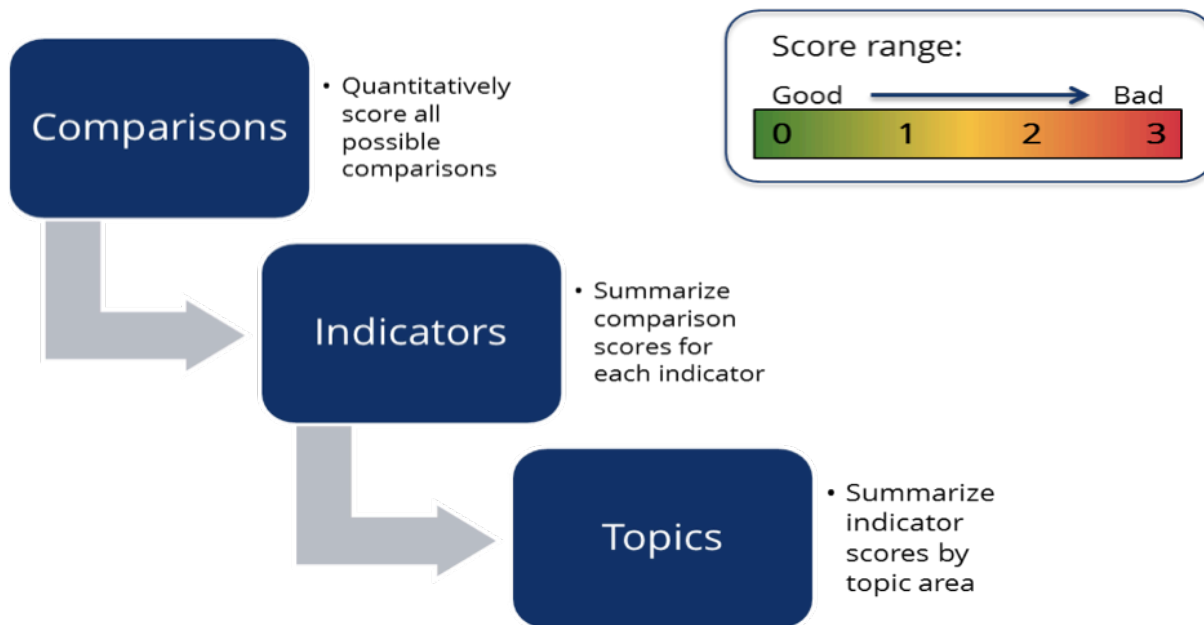
The following is a list of both local and national sources for which data is maintained for the Tri-County Service Area on the Creating Healthy Communities data dashboard.

- American Community Survey
- American Lung Association
- Centers for Medicare & Medicaid Services
- County Health Rankings
- Fatality Analysis Reporting System
- Feeding America
- Institute for Health Metrics and Evaluation
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Department of Health
- Maryland Department of the Environment
- Maryland Governor’s Office for Children
- Maryland Governor’s Office of Crime Control & Prevention
- Maryland State Board of Elections
- Maryland State Department of Education
- Maryland Youth Risk Behavior Survey
- National Cancer Institute
- National Center for Education Statistics
- Small Area Health Insurance Estimates
- The Dartmouth Atlas of Health Care
- U.S. Bureau of Labor Statistics
- U.S. Census — County Business Patterns
- U.S. Department of Agriculture — Food Environment Atlas
- U.S. Environmental Protection Agency

## 13.1.2 SECONDARY DATA SCORING DETAILED METHODOLOGY

Data Scoring is done in three stages:

FIGURE 22. DATA SCORING METHODOLOGY STEPS



For each indicator, each county in the Tri-County Service Area (Somerset, Wicomico, Worcester) is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time.

Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.

## 13.1.3 COMPARISONS

**Comparison to a Distribution of County Values: Within State and Nation**

For ease of interpretation and analysis, indicator data on the data platform is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state of Maryland or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons (“in the red”) scored high, whereas indicators with good comparisons (“in the green”) scored low.



**Comparison to Values: State, National, and Targets**

The three Tri-County counties are also compared to the state of Maryland value, the national value, and target values. Targets values include the nation-wide Healthy People 2020 (HP2020) goals as well as Maryland State Health Improvement Process (SHIP) 2017 targets. Healthy People 2020 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. The goal of the Maryland State Health Improvement Process (SHIP) objectives is to advance the health of Maryland residents. The SHIP 2017 target objectives align with the Healthy People 2020 objectives. For all value comparisons, the scoring depends on whether each county value is better or worse than the comparison value, as well as how close each county value is to the target value.

**Trend Over Time**

The Mann-Kendall statistical test for trend was used to assess whether each of the three county values is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for each county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

**Missing Values**

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the data platform, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

**Indicator Scoring**

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated and the indicator is excluded from the data scoring results.

**Topic Scoring**

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas, if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if that topic area includes at least three indicators.

## 13.1.4 SECONDARY DATA SCORING RESULTS

## SOMERSET DATA SCORING APPENDIX

SCORE	ACCESS TO HEALTH SERVICES	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.40	Primary Care Provider Rate	providers/ 100,000 population	31		88	75.5		2015	4
2.10	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	62		89.1	81.2		2017	4
1.68	Adults who have had a Routine Checkup	percent	85.7		88.2	83.6		2016	8
1.68	Children with Health Insurance	percent	95.6	100	96.6			2016	18
1.58	Adults with Health Insurance	percent	89.1	100	91.6			2016	18
1.53	Persons with Health Insurance	percent	90.8	100	93			2016	18
1.50	Adolescents who have had a Routine Checkup: Medicaid Population	percent	55.1		55.3		57.4	2016	9
1.48	Adults who Visited a Dentist	percent	69.1		69.4	66.4		2016	8
1.30	People with a Usual Primary Care Provider	percent	87.5		84.8		83.9	2016	9
0.90	Mental Health Provider Rate	providers/ 100,000 population	216		216	214.3		2017	4
0.80	Children who Visited a Dentist	percent	71.3		63.9		64.6	2016	9
0.75	Uninsured Emergency Department Visits	percent	7.2		11		14.7	2014	9
0.68	Adults Unable to Afford to See a Doctor	percent	6.7		10.1	13.1		2014	8
0.30	Dentist Rate	dentists/ 100,000 population	147		75.7	67.4		2016	4
SCORE	CANCER	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.85	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	76	45.5	43.2	44.7		2010-2014	16
2.70	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	14.7		10.6	11.5		2010-2014	16
2.60	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	212.5	161.4	165.3	166.1	147.4	2010-2014	16
2.45	Colorectal Cancer Incidence Rate	cases/ 100,000 population	52.7	39.9	37.3	39.8		2010-2014	16
2.33	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	38.1	21.8	26.7			2005-2009	16
2.30	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	97.6		58.1	61.2		2010-2014	16
2.15	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	16.4	14.5	14.4	14.8		2010-2014	16
1.95	Mammogram in Past 2 Years: 50+	percent	58.5		66.3			2016	8
1.90	Cancer: Medicare Population	percent	8.5		8.6	7.8		2015	3
1.75	Pap Test in Past 3 Years	percent	93.7	93	95.1			2016	8
1.65	Colon Cancer Screening: Sigmoidoscopy or Colonoscopy	percent	73.7		73.8			2016	8
0.75	Prostate Cancer Incidence Rate	cases/ 100,000 males	110.4		131.5	114.8		2010-2014	16
0.50	Breast Cancer Incidence Rate	cases/ 100,000 females	103.8		131	123.5		2010-2014	16
0.25	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	19.3	20.7	24.5	22.6		2006-2010	16

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SCORE	CHILDREN'S HEALTH	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.50	Child Food Insecurity Rate	percent	27.2		16.3	19.3		2015	6
2.20	Blood Lead Levels in Children	percent	0.7		0.3		0.28	2016	10
1.95	Child Abuse Rate	cases/ 1,000 children	23.2		7.3			2015	11
1.95	Children with Asthma	percent	25.1		16.1			2013	8
1.68	Children with Health Insurance	percent	95.6	100	96.6			2016	18
1.20	Children with Low Access to a Grocery Store	percent	2.6					2015	22
0.80	Children who Visited a Dentist	percent	71.3		63.9		64.6	2016	9
0.50	Food Insecure Children Likely Ineligible for Assistance	percent	9		41	34.1		2015	6
SCORE	DIABETES	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Diabetes: Medicare Population	percent	34.4		29.1	26.5		2015	3
2.18	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	25.2		19.9	21.2		2010-2012	9
2.05	Age-Adjusted ER Rate due to Diabetes	ER Visits/ 100,000 population	253.8		204		186.3	2014	9
1.85	Diabetic Monitoring: Medicare Population	percent	84.3		85	85.2		2014	19
1.03	Adults with Diabetes	percent	9.5		10.2	10.5		2016	8
SCORE	ECONOMY	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Homeownership	percent	47.7		59.8	55.9		2012-2016	1
2.70	People Living Below Poverty Level	percent	25.1		9.9	15.1		2012-2016	1
2.70	Severe Housing Problems	percent	24.4		17.1	18.8		2010-2014	4
2.50	Child Food Insecurity Rate	percent	27.2		16.3	19.3		2015	6
2.50	Children Living Below Poverty Level	percent	39.1		13.3	21.2		2012-2016	1
2.50	Families Living Below Poverty Level	percent	20.6		6.8	11		2012-2016	1
2.50	Food Insecurity Rate	percent	19.8		11.4	13.7		2015	6
2.50	Median Household Income	dollars	35886		76067	55322		2012-2016	1
2.50	People Living 200% Above Poverty Level	percent	52.6		77	66.4		2012-2016	1
2.50	Students Eligible for the Free Lunch Program	percent	82.5		39.9	42.6		2015-2016	17
2.40	Unemployed Workers in Civilian Labor Force	percent	8.2		4.5	4.1		March 2018	20
2.30	Homeowner Vacancy Rate	percent	4.5		1.7	1.8		2012-2016	1
2.30	Per Capita Income	dollars	17143		37756	29829		2012-2016	1
2.30	Renters Spending 30% or More of Household Income on Rent	percent	57.7		50.5	47.3		2012-2016	1
2.25	People 65+ Living Below Poverty Level	percent	10.7		7.7	9.3		2012-2016	1
2.20	Households with Cash Public Assistance Income	percent	3		2.5	2.7		2012-2016	1
2.10	Low-Income and Low Access to a Grocery Store	percent	12					2015	22
1.60	SNAP Certified Stores	stores/ 1,000 population	0.8					2016	22
0.80	Affordable Housing	percent	89.3		46.1		54.4	2014	9
0.50	Food Insecure Children Likely Ineligible for Assistance	percent	9		41	34.1		2015	6
0.50	Youth not in School or Working	percent	0.2		2.3	2.4		2012-2016	1

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SCORE	EDUCATION	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.50	People 25+ with a Bachelor's Degree or Higher	percent	14		38.4	30.3		2012-2016	1
2.25	People 25+ with a High School Degree or Higher	percent	79.2		89.6	87		2012-2016	1
1.75	High School Graduation	percent	86	87	87.7		95	2017	14
1.65	4th Grade Students Proficient in Reading	percent	85.5		86.3			2014	14
1.65	8th Grade Students Proficient in Reading	percent	73		76.9			2014	14
1.20	School Readiness at Kindergarten Entry	percent	57		45		85.5	2016-2017	14
0.95	Student-to-Teacher Ratio	students/teacher	13.6		15	17.7		2015-2016	17
SCORE	ENVIRONMENT	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Severe Housing Problems	percent	24.4		17.1	18.8		2010-2014	4
2.50	Food Environment Index		6.1		9.1	7.7		2018	4
2.25	Access to Exercise Opportunities	percent	49.2		93	83.1		2018	4
2.20	Blood Lead Levels in Children	percent	0.7		0.3		0.28	2016	10
2.10	Low-Income and Low Access to a Grocery Store	percent	12					2015	22
1.95	Households with No Car and Low Access to a Grocery Store	percent	5					2015	22
1.80	Recreation and Fitness Facilities	facilities/ 1,000 population	0					2014	22
1.65	People with Low Access to a Grocery Store	percent	22.7					2015	22
1.60	Liquor Store Density	stores/ 100,000 population	15.5		20	10.5		2015	21
1.60	SNAP Certified Stores	stores/ 1,000 population	0.8					2016	22
1.35	Grocery Store Density	stores/ 1,000 population	0.2					2014	22
1.35	People 65+ with Low Access to a Grocery Store	percent	1.9					2015	22
1.20	Children with Low Access to a Grocery Store	percent	2.6					2015	22
1.20	Fast Food Restaurant Density	restaurants/ 1,000 population	0.4					2014	22
0.95	Farmers Market Density	markets/ 1,000 population	0.12					2016	22
0.83	Drinking Water Violations	percent	0		16.2			FY 2013-14	4
SCORE	ENVIRONMENTAL & OCCUPATIONAL HEALTH	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.28	Adults with Asthma	percent	20.4		14.1	14		2016	8
2.20	Blood Lead Levels in Children	percent	0.7		0.3		0.28	2016	10
2.00	Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	78.7		68.3		62.5	2014	9
1.95	Children with Asthma	percent	25.1		16.1			2013	8
1.90	Asthma: Medicare Population	percent	8.7		7.9	8.2		2015	3

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SCORE	EXERCISE, NUTRITION, & WEIGHT	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.50	Child Food Insecurity Rate	percent	27.2		16.3	19.3		2015	6
2.50	Food Environment Index		6.1		9.1	7.7		2018	4
2.50	Food Insecurity Rate	percent	19.8		11.4	13.7		2015	6
2.43	Adults with a Healthy Weight	percent	20.2		35.1	35.2	36.6	2014	9
2.25	Access to Exercise Opportunities	percent	49.2		93	83.1		2018	4
2.23	Adults who are Obese	percent	43.2	30.5	30.1	29.9		2016	8
2.15	Adolescents who are Obese	percent	17.5	16.1	11.5		10.7	2014	9
2.10	Low-Income and Low Access to a Grocery Store	percent	12					2015	22
1.95	Adult Fruit and Vegetable Consumption	percent	17.2		27.1			2010	8
1.95	Households with No Car and Low Access to a Grocery Store	percent	5					2015	22
1.93	Adults who are Overweight or Obese	percent	72.7		68.1	65.2		2016	8
1.80	Recreation and Fitness Facilities	facilities/ 1,000 population	0.04					2014	22
1.65	People with Low Access to a Grocery Store	percent	22.7					2015	22
1.60	SNAP Certified Stores	stores/ 1,000 population	0.8					2016	22
1.43	Adults Engaging in Regular Physical Activity	percent	42.1	20.1	48	20.5		2013	8
1.35	Grocery Store Density	stores/ 1,000 population	0.2					2014	22
1.35	People 65+ with Low Access to a Grocery Store	percent	1.9					2015	22
1.20	Children with Low Access to a Grocery Store	percent	2.6					2015	22
1.20	Fast Food Restaurant Density	restaurants/ 1,000 population	0.4					2014	22
0.95	Farmers Market Density	markets/ 1,000 population	0.1					2016	22
0.55	Workers who Walk to Work	percent	4.5	3.1	2.4	2.8		2012-2016	1
0.50	Food Insecure Children Likely Ineligible for Assistance	percent	9		41	34.1		2015	6
SCORE	HEART DISEASE & STROKE	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.40	High Blood Pressure Prevalence	percent	57.5	26.9	45			2016	8
2.40	Hypertension: Medicare Population	percent	66.9		59.2	55		2015	3
2.33	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	286.2		166.9	167	166.3	2014-2016	9
2.33	High Cholesterol Prevalence	percent	57.7	13.5	35.9	36.3		2015	8
2.05	Stroke: Medicare Population	percent	4.4		4.5	4		2015	3
1.80	Heart Failure: Medicare Population	percent	14.2		12.4	13.5		2015	3
1.80	Hyperlipidemia: Medicare Population	percent	53.5		48.9	44.6		2015	3
1.80	Ischemic Heart Disease: Medicare Population	percent	28.6		26	26.5		2015	3
1.35	Age-Adjusted ER Rate due to Hypertension	ER Visits/ 100,000 population	239.3		252.2		234	2014	9
1.15	Atrial Fibrillation: Medicare Population	percent	7.6		8	8.1		2015	3
0.78	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	28.5	34.8	36.5	37		2011-2013	9

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SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.48	Syphilis Incidence Rate	<i>cases/ 100,000 population</i>	15.5		8.5	8.7		2016	9
2.43	Chlamydia Incidence Rate	<i>cases/ 100,000 population</i>	877		509.6	497.3	431	2016	9
2.43	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	3.9	1	2.9	3		2015	9
2.35	Salmonella Infection Incidence Rate	<i>cases/ 100,000 population</i>	46.5	11.4	16.1			2015	9
2.28	Gonorrhea Incidence Rate	<i>cases/ 100,000 population</i>	205.7		158.3	145.8		2016	9
2.25	Adults with Influenza Vaccination	<i>percent</i>	29.5	70	41.7		49.1	2014	9
2.00	HIV Incidence Rate: Aged 13+	<i>cases/ 100,000 population</i>	26.5		22.1		26.7	2016	9
1.53	Adults 65+ with Pneumonia Vaccination	<i>percent</i>	76.7	90	75.4	73.4		2016	8
0.73	Adults 65+ with Influenza Vaccination	<i>percent</i>	69.3		61.6	58.6		2016	8
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.58	Babies with Low Birth Weight	<i>percent</i>	10.2	7.8	8.6	8.2	8	2016	9
2.48	Sudden Unexpected Infant Death Rate	<i>deaths/ 1,000 live births</i>	3.4	0.84	1	0.9	0.86	2011-2015	9
2.35	Infant Mortality Rate	<i>deaths/ 1,000 live births</i>	11.6	6	6.5		6.3	2012-2016	9
1.58	Teen Birth Rate: 15-19	<i>live births/ 1,000 females aged 15-</i>	19.4		15.9	20.3	17.8	2016	9
0.58	Preterm Births	<i>percent</i>	7.1	9.4	10	9.6		2015	9
SCORE	MEN'S HEALTH	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.33	Age-Adjusted Death Rate due to Prostate Cancer	<i>deaths/ 100,000 males</i>	38.1	21.8	26.7			2005-2009	16
1.85	Life Expectancy for Males	<i>years</i>	74.8		76.8	76.7		2014	7
0.75	Prostate Cancer Incidence Rate	<i>cases/ 100,000 males</i>	110.4		131.5	114.8		2010-2014	16
SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.25	Age-Adjusted ER Rate due to Mental Health	<i>ER Visits/ 100,000 population</i>	5665.2		3442.6		3152.6	2014	9
2.25	Poor Mental Health: Average Number of Days	<i>days</i>	4.3		3.5	3.8		2016	4
2.05	Self-Reported Good Mental Health	<i>percent</i>	63.6		76.2			2015	8
1.95	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	<i>hospitalizations/ 100,000 populati</i>	228.7		194.1		199.4	2014	9
1.80	Adequate Social and Emotional Support	<i>percent</i>	80.7		82.9			2010	8
1.80	Frequent Mental Distress	<i>percent</i>	13.2		10.3	15		2016	4
1.35	Depression: Medicare Population	<i>percent</i>	14.5		15.4	16.7		2015	3
0.90	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	216		216	214.3		2017	4
0.65	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	8.3		10.1	9.9		2015	3

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SCORE		UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
	<b>OLDER ADULTS &amp; AGING</b>								
2.70	Chronic Kidney Disease: Medicare Population	percent	21.3		18.2	18.1		2015	3
2.70	Diabetes: Medicare Population	percent	34.4		29.1	26.5		2015	3
2.50	People 65+ Living Alone	percent	30.8		26	26.4		2012-2016	1
2.40	Hypertension: Medicare Population	percent	66.9		59.2	55		2015	3
2.35	COPD: Medicare Population	percent	14.3		9.9	11.2		2015	3
2.25	People 65+ Living Below Poverty Level	percent	10.7		7.7	9.3		2012-2016	1
2.05	Stroke: Medicare Population	percent	4.4		4.5	4		2015	3
1.95	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	hospitalizations/ 100,000 population	228.7		194.1		199.4	2014	9
1.90	Asthma: Medicare Population	percent	8.7		7.9	8.2		2015	3
1.90	Cancer: Medicare Population	percent	8.5		8.6	7.8		2015	3
1.85	Diabetic Monitoring: Medicare Population	percent	84.3		85	85.2		2014	19
1.80	Heart Failure: Medicare Population	percent	14.2		12.4	13.5		2015	3
1.80	Hyperlipidemia: Medicare Population	percent	53.5		48.9	44.6		2015	3
1.80	Ischemic Heart Disease: Medicare Population	percent	28.6		26	26.5		2015	3
1.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	30		30	30		2015	3
1.53	Adults 65+ with Pneumonia Vaccination	percent	76.7	90	75.4	73.4		2016	8
1.35	Depression: Medicare Population	percent	14.5		15.4	16.7		2015	3
1.35	People 65+ with Low Access to a Grocery Store	percent	1.9					2015	22
1.15	Atrial Fibrillation: Medicare Population	percent	7.6		8	8.1		2015	3
0.73	Adults 65+ with Influenza Vaccination	percent	69.3		61.6	58.6		2016	8
0.65	Alzheimer's Disease or Dementia: Medicare Population	percent	8.3		10.1	9.9		2015	3
0.65	Osteoporosis: Medicare Population	percent	4.3		5.7	6		2015	3
	<b>ORAL HEALTH</b>								
2.70	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	14.7		10.6	11.5		2010-2014	16
2.28	Adults with No Tooth Extractions	percent	33.7		57.9	56.9		2016	8
2.25	Age-Adjusted ER Visit Rate due to Dental Problems	ER Visits/ 100,000 population	1227.2		779.7		792.8	2014	9
1.48	Adults who Visited a Dentist	percent	69.1		69.4	66.4		2016	8
0.80	Children who Visited a Dentist	percent	71.3		63.9		64.6	2016	9
0.30	Dentist Rate	dentists/ 100,000 population	147		75.7	67.4		2016	4

SECTION 13 APPENDICES

SCORE	OTHER CHRONIC DISEASES	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Chronic Kidney Disease: Medicare Population	percent	21.3		18.2	18.1		2015	3
1.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	30		30	30		2015	3
0.65	Osteoporosis: Medicare Population	percent	4.3		5.7	6		2015	3
							#N/A		
SCORE	PREVENTION & SAFETY	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Severe Housing Problems	percent	24.4		17.1	18.8	#N/A	2010-2014	4
2.65	Pedestrian Death Rate	deaths/ 100,000 population	3.8	1.4	0.9	1.5		2013	5
2.25	Death Rate due to Drug Poisoning	deaths/ 100,000 population	25.8		24.4	16.9		2014-2016	4
1.53	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	33.7	36.4	26.6	39.7		2012-2014	9
1.45	Pedestrian Injuries	injuries/ 100,000 population	23.2	20.3	42.5		35.6	2014	9
SCORE	PUBLIC SAFETY	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.65	Pedestrian Death Rate	deaths/ 100,000 population	3.8	1.4	0.9	1.5		2013	5
1.95	Child Abuse Rate	cases/ 1,000 children	23.2		7.3			2015	11
1.60	Domestic Violence Offense Rate	offenses/ 100,000 population	500.6		508.4		445	2015	9
1.50	Alcohol-Impaired Driving Deaths	percent	30		30.5	29.3		2012-2016	4
1.45	Pedestrian Injuries	injuries/ 100,000 population	23.2	20.3	42.5		35.6	2014	9
1.13	Violent Crime Rate	crimes/ 100,000 population	323.9		471.3	373.7		2015	12
SCORE	RESPIRATORY DISEASES	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.85	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	75.5	45.5	43.2	44.7		2010-2014	16
2.43	Tuberculosis Incidence Rate	cases/ 100,000 population	3.9	1	2.9	3		2015	9
2.35	COPD: Medicare Population	percent	14.3		9.9	11.2		2015	3
2.30	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	97.6		58.1	61.2		2010-2014	16
2.28	Adults with Asthma	percent	20.4		14.1	14		2016	8
2.25	Adults with Influenza Vaccination	percent	29.5	70	41.7		49.1	2014	9
2.00	Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	78.7		68.3		62.5	2014	9
1.95	Children with Asthma	percent	25.1		16.1			2013	8
1.90	Asthma: Medicare Population	percent	8.7		7.9	8.2		2015	3
1.53	Adults 65+ with Pneumonia Vaccination	percent	76.7	90	75.4	73.4		2016	8
0.73	Adults 65+ with Influenza Vaccination	percent	69.3		61.6	58.6		2016	8



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SCORE	SOCIAL ENVIRONMENT	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Homeownership	percent	47.7		59.8	55.9		2012-2016	1
2.70	People Living Below Poverty Level	percent	25.1		9.9	15.1		2012-2016	1
2.50	Children Living Below Poverty Level	percent	39.1		13.3	21.2		2012-2016	1
2.50	Median Household Income	dollars	35886		76067	55322		2012-2016	1
2.50	People 25+ with a Bachelor's Degree or Higher	percent	14		38.4	30.3		2012-2016	1
2.50	People 65+ Living Alone	percent	30.8		26	26.4		2012-2016	1
2.40	Single-Parent Households	percent	54.5		34.2	33.6		2012-2016	1
2.30	Per Capita Income	dollars	17143		37756	29829		2012-2016	1
2.25	People 25+ with a High School Degree or Higher	percent	79.2		89.6	87		2012-2016	1
1.95	Child Abuse Rate	cases/ 1,000 children	23.2		7.3			2015	11
1.85	Voter Registration	percent	60.3		83.6			2016	13
1.53	Persons with Health Insurance	percent	90.8	100	93			2016	18
1.15	Mean Travel Time to Work	minutes	24		32.4	26.1		2012-2016	1
0.50	Youth not in School or Working	percent	0.2		2.3	2.4		2012-2016	1

SCORE	SUBSTANCE ABUSE	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.58	Adults who Smoke	percent	20.5	12	13.4	17.1	15.5	2016	8
2.25	Adolescents who Use Tobacco	percent	27.5	21	16.4		15.2	2014	9
2.25	Age-Adjusted ER Rate due to Alcohol/Substance Abuse	ER visits/ 100,000 population	1896.4		1591.3		1400.9	2014	9
2.25	Death Rate due to Drug Poisoning	deaths/ 100,000 population	25.8		24.4	16.9		2014-2016	4
2.00	Teens who Smoke: High School Students	percent	16.5	16	8.7			2014	15
1.60	Liquor Store Density	stores/ 100,000 population	15.5		20	10.5		2015	21
1.50	Alcohol-Impaired Driving Deaths	percent	30		30.5	29.3		2012-2016	4
0.68	Adults who Binge Drink	percent	10.8	24.2	15.4	16		2014	8
0.53	Age-Adjusted Death Rate due to Drug Use	deaths/ 100,000 population	0	11.3	12.1	12.7	12.6	2008-2010	9

SCORE	TEEN & ADOLESCENT HEALTH	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.25	Adolescents who Use Tobacco	percent	27.5	21	16.4		15.2	2014	9
2.15	Adolescents who are Obese	percent	17.5	16.1	11.5		10.7	2014	9
2.00	Teens who Smoke: High School Students	percent	16.5	16	8.7			2014	15
1.58	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15+	19.4		15.9	20.3	17.8	2016	9
1.50	Adolescents who have had a Routine Checkup: Medicaid Population	percent	55.1		55.3		57.4	2016	9

SCORE	TRANSPORTATION	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Households without a Vehicle	percent	12.4		9.2	9		2012-2016	1
2.25	Workers who Drive Alone to Work	percent	82.3		73.7	76.4		2012-2016	1
2.05	Workers Commuting by Public Transportation	percent	1.3	5.5	8.9	5.1		2012-2016	1
1.95	Households with No Car and Low Access to a Grocery Store	percent	5					2015	22
1.30	Solo Drivers with a Long Commute	percent	34.5		48.7	34.7		2012-2016	4
1.15	Mean Travel Time to Work	minutes	24		32.4	26.1		2012-2016	1
0.55	Workers who Walk to Work	percent	4.5	3.1	2.4	2.8		2012-2016	1

SCORE	WOMEN'S HEALTH	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
1.95	Mammogram in Past 2 Years: 50+	percent	58.5		66.3			2016	8
1.85	Life Expectancy for Females	years	79.4		81.4	81.5		2014	7
1.75	Pap Test in Past 3 Years	percent	93.7	93	95.1			2016	8
0.50	Breast Cancer Incidence Rate	cases/ 100,000 females	103.8		131	123.5		2010-2014	16
0.25	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	19.3	20.7	24.5	22.6		2006-2010	16

## WICOMICO DATA SCORING APPENDIX

SCORE	ACCESS TO HEALTH SERVICES	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.18	Adults who Visited a Dentist	percent	57.9		69.4	66.4		2016	8
2.10	Primary Care Provider Rate	providers/ 100,000 population	67		88	75.5		2015	4
1.73	Persons with Health Insurance	percent	91.9	100	93			2016	18
1.70	Children who Visited a Dentist	percent	61.7		63.9		64.6	2016	9
1.68	Adults Unable to Afford to See a Doctor	percent	11.5		9.9	12		2016	8
1.68	Adults with Health Insurance	percent	90.2	100	91.6			2016	18
1.58	Adults who have had a Routine Checkup	percent	86.9		88.2	83.6		2016	8
1.53	Children with Health Insurance	percent	96.3	100	96.6			2016	18
1.35	People with a Usual Primary Care Provider	percent	85.1		84.8		83.9	2016	9
1.25	Adolescents who have had a Routine Checkup: Medicaid Population	percent	57.3		55.3		57.4	2016	9
1.05	Mental Health Provider Rate	providers/ 100,000 population	231		216	214.3		2017	4
0.90	Uninsured Emergency Department Visits	percent	9.9		11		14.7	2014	9
0.75	Dentist Rate	dentists/ 100,000 population	80		75.7	67.4		2016	4
0.30	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	185		89.1	81.2		2017	4
SCORE	CANCER	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.40	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	200.9	161.4	165.3	166.1	147.4	2010-2014	16
2.40	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	13.3		10.6	11.5		2010-2014	16
2.30	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	24.4	21.8	20.3	20.1		2010-2014	16
2.10	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	17.8	14.5	14.4	14.8		2010-2014	16
2.10	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	57.3	45.5	43.2	44.7		2010-2014	16
2.10	Breast Cancer Incidence Rate	cases/ 100,000 females	133.7		131	123.5		2010-2014	16
2.10	Prostate Cancer Incidence Rate	cases/ 100,000 males	157.9		131.5	114.8		2010-2014	16
2.00	Cancer: Medicare Population	percent	8.7		8.6	7.8		2015	3
1.95	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	75.6		58.1	61.2		2010-2014	16
1.75	Colorectal Cancer Incidence Rate	cases/ 100,000 population	41.8	39.9	37.3	39.8		2010-2014	16
1.50	Mammogram in Past 2 Years: 50+	percent	68		66.3			2016	8
1.30	Pap Test in Past 3 Years	percent	95.9	93	95.1			2016	8
1.20	Colon Cancer Screening: Sigmoidoscopy or Colonoscopy	percent	80.3		73.8			2016	8
0.85	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	20.4	20.7	22.8	21.2		2010-2014	16
0.45	Cervical Cancer Incidence Rate	cases/ 100,000 females	6.3	7.3	6.5	7.5		2010-2014	16

SECTION 13 APPENDICES

SCORE	CHILDREN'S HEALTH	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.20	Blood Lead Levels in Children	percent	0.4		0.3		0.28	2016	10
1.80	Children with Low Access to a Grocery Store	percent	6.4					2015	22
1.70	Child Food Insecurity Rate	percent	20.7		16.3	19.3		2015	6
1.70	Children who Visited a Dentist	percent	61.7		63.9		64.6	2016	9
1.53	Children with Health Insurance	percent	96.3	100	96.6			2016	18
1.20	Child Abuse Rate	cases/ 1,000 children	5.6		7.3			2015	11
1.05	Children with Asthma	percent	9.7		16.1			2013	8
0.65	Food Insecure Children Likely Ineligible for Assistance	percent	25		41	34.1		2015	6
SCORE	DIABETES	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.20	Diabetes: Medicare Population	percent	31.5		29.1	26.5		2015	3
2.00	Age-Adjusted ER Rate due to Diabetes	ER Visits/ 100,000 population	372.7		204		186.3	2014	9
1.95	Diabetic Monitoring: Medicare Population	percent	83.5		85	85.2		2014	19
1.18	Adults with Diabetes	percent	9.6		10.2	10.5		2016	8
0.53	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	10.1		19.2	21.1		2012-2014	9
SCORE	ECONOMY	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.35	Severe Housing Problems	percent	20.3		17.1	18.8		2010-2014	4
2.35	Students Eligible for the Free Lunch Program	percent	55.8		39.9	42.6		2015-2016	17
2.25	Unemployed Workers in Civilian Labor Force	percent	6.4		4.5	4.1		March 2018	20
2.10	Homeownership	percent	54.6		59.8	55.9		2012-2016	1
2.00	Food Insecurity Rate	percent	14.6		11.4	13.7		2015	6
2.00	Households with Cash Public Assistance Income	percent	3		2.5	2.7		2012-2016	1
2.00	People Living Below Poverty Level	percent	16.3		9.9	15.1		2012-2016	1
2.00	Per Capita Income	dollars	26498		37756	29829		2012-2016	1
1.95	Low-Income and Low Access to a Grocery Store	percent	8.9					2015	22
1.85	People Living 200% Above Poverty Level	percent	64.6		77	66.4		2012-2016	1
1.80	Renters Spending 30% or More of Household Income on Rent	percent	51.5		50.5	47.3		2012-2016	1
1.70	Child Food Insecurity Rate	percent	20.7		16.3	19.3		2015	6
1.70	Children Living Below Poverty Level	percent	21.1		13.3	21.2		2012-2016	1
1.70	Families Living Below Poverty Level	percent	10.5		6.8	11		2012-2016	1
1.70	Median Household Income	dollars	53508		76067	55322		2012-2016	1
1.50	Homeowner Vacancy Rate	percent	1.9		1.7	1.8		2012-2016	1
1.10	People 65+ Living Below Poverty Level	percent	7.5		7.7	9.3		2012-2016	1
1.10	SNAP Certified Stores	stores/ 1,000 population	1					2016	22
0.80	Affordable Housing	percent	85.6		46.1		54.4	2014	9
0.65	Food Insecure Children Likely Ineligible for Assistance	percent	25		41	34.1		2015	6
0.60	Youth not in School or Working	percent	1.8		2.3	2.4		2012-2016	1

SECTION 13 APPENDICES

SCORE	EDUCATION	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.05	High School Graduation	percent	83.8	87	87.7		95	2017	14
1.80	4th Grade Students Proficient in Reading	percent	85.3		86.3			2014	14
1.80	8th Grade Students Proficient in Reading	percent	70.4		76.9			2014	14
1.55	People 25+ with a Bachelor's Degree or Higher	percent	27.4		38.4	30.3		2012-2016	1
1.50	School Readiness at Kindergarten Entry	percent	47		45		85.5	2016-2017	14
1.20	People 25+ with a High School Degree or Higher	percent	88.6		89.6	87		2012-2016	1
0.90	Student-to-Teacher Ratio	students/ teacher	13.6		15	17.7		2015-2016	17
SCORE	ENVIRONMENT	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.35	Severe Housing Problems	percent	20.3		17.1	18.8		2010-2014	4
2.20	Blood Lead Levels in Children	percent	0.4		0.3		0.28	2016	10
2.00	Food Environment Index		7.3		9.1	7.7		2018	4
1.95	Grocery Store Density	stores/ 1,000 population	0.1					2014	22
1.95	Low-Income and Low Access to a Grocery Store	percent	8.9					2015	22
1.90	Fast Food Restaurant Density	restaurants/ 1,000 population	0.8					2014	22
1.80	Children with Low Access to a Grocery Store	percent	6.4					2015	22
1.80	People 65+ with Low Access to a Grocery Store	percent	4					2015	22
1.80	People with Low Access to a Grocery Store	percent	26.7					2015	22
1.65	Farmers Market Density	markets/ 1,000 population	0.03					2016	22
1.60	Recognized Carcinogens Released into Air	pounds	73686					2016	23
1.50	Households with No Car and Low Access to a Grocery Store	percent	2.4					2015	22
1.50	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1					2014	22
1.43	Drinking Water Violations	percent	1.7		16.2			FY 2013-14	4
1.40	PBT Released	pounds	0					2014	23
1.20	Access to Exercise Opportunities	percent	84.7		93	83.1		2018	4
1.10	SNAP Certified Stores	stores/ 1,000 population	1					2016	22
0.50	Liquor Store Density	stores/ 100,000 population	5.9		20	10.5		2015	21
SCORE	ENVIRONMENTAL & OCCUPATIONAL HEALTH	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.20	Blood Lead Levels in Children	percent	0.4		0.3		0.28	2016	10
2.00	Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	91.5		68.3		62.5	2014	9
1.90	Asthma: Medicare Population	percent	8.6		7.9	8.2		2015	3
1.08	Adults with Asthma	percent	12.5		14.1	14		2016	8
1.05	Children with Asthma	percent	9.7		16.1			2013	8

## SECTION 13 APPENDICES

SCORE	EXERCISE, NUTRITION, & WEIGHT	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.08	Adults with a Healthy Weight	percent	31.3		35.1	35.2	36.6	2014	9
2.00	Food Environment Index		7.3		9.1	7.7		2018	4
2.00	Food Insecurity Rate	percent	14.6		11.4	13.7		2015	6
1.95	Grocery Store Density	stores/ 1,000 population	0.1					2014	22
1.95	Low-Income and Low Access to a Grocery Store	percent	8.9					2015	22
1.90	Fast Food Restaurant Density	restaurants/ 1,000 population	0.8					2014	22
1.80	Adult Fruit and Vegetable Consumption	percent	23.1		27.1			2010	8
1.80	Children with Low Access to a Grocery Store	percent	6.4					2015	22
1.80	People 65+ with Low Access to a Grocery Store	percent	4					2015	22
1.80	People with Low Access to a Grocery Store	percent	26.7					2015	22
1.73	Adults who are Obese	percent	31.4	30.5	30.1	29.9		2016	8
1.73	Adults who are Overweight or Obese	percent	70.1		68.1	65.2		2016	8
1.70	Child Food Insecurity Rate	percent	20.7		16.3	19.3		2015	6
1.70	Workers who Walk to Work	percent	2.3	3.1	2.4	2.8		2012-2016	1
1.65	Farmers Market Density	markets/ 1,000 population	0					2016	22
1.50	Households with No Car and Low Access to a Grocery Store	percent	2.4					2015	22
1.50	Recreation and Fitness Facilities	facilities/ 1,000 population	0.09					2014	22
1.45	Adolescents who are Obese	percent	11.9	16.1	11.5		10.7	2014	9
1.28	Adults Engaging in Regular Physical Activity	percent	45.6	20.1	48	20.5		2013	8
1.20	Access to Exercise Opportunities	percent	84.7		93	83.1		2018	4
1.10	SNAP Certified Stores	stores/ 1,000 population	1					2016	22
0.65	Food Insecure Children Likely Ineligible for Assistance	percent	25		41	34.1		2015	6
SCORE	HEART DISEASE & STROKE	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.50	Hyperlipidemia: Medicare Population	percent	56		48.9	44.6		2015	3
2.30	Hypertension: Medicare Population	percent	65.6		59.2	55		2015	3
2.30	Stroke: Medicare Population	percent	5.2		4.5	4		2015	3
2.23	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	245.1		166.9	167	166.3	2014-2016	9
2.18	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	40.5	34.8	38.4	37.2		2014-2016	9
2.10	Atrial Fibrillation: Medicare Population	percent	8.8		8	8.1		2015	3
2.00	Age-Adjusted ER Rate due to Hypertension	ER Visits/ 100,000 population	383.7		252.2		234	2014	9
1.90	High Blood Pressure Prevalence	percent	49.4	26.9	45			2016	8
1.80	Heart Failure: Medicare Population	percent	14.1		12.4	13.5		2015	3
1.50	Ischemic Heart Disease: Medicare Population	percent	27.9		26	26.5		2015	3
1.43	High Cholesterol Prevalence	percent	33.7	13.5	35.9	36.3		2015	8

SECTION 13 APPENDICES

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.43	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	3.9	1	2.9	3		2015	9
2.35	Adults with Influenza Vaccination	<i>percent</i>	34.3	70	41.7		49.1	2014	9
2.33	Chlamydia Incidence Rate	<i>cases/ 100,000 population</i>	650.3		509.6	497.3	431	2016	9
2.18	Gonorrhea Incidence Rate	<i>cases/ 100,000 population</i>	226.2		158.3	145.8		2016	9
2.15	Salmonella Infection Incidence Rate	<i>cases/ 100,000 population</i>	28.4	11.4	16.1			2015	9
1.68	Adults 65+ with Influenza Vaccination	<i>percent</i>	59.8		61.6	58.6		2016	8
1.58	Adults 65+ with Pneumonia Vaccination	<i>percent</i>	74.8	90	75.4	73.4		2016	8
1.20	HIV Incidence Rate: Aged 13+	<i>cases/ 100,000 population</i>	16.2		22.1		26.7	2016	9
0.93	Syphilis Incidence Rate	<i>cases/ 100,000 population</i>	1		8.5	8.7		2016	9
0.73	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	8.3		16	15.2		2012-2014	9
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.35	Infant Mortality Rate	<i>deaths/ 1,000 live births</i>	9.4	6	6.5		6.3	2012-2016	9
2.13	Babies with Low Birth Weight	<i>percent</i>	9	7.8	8.6	8.2	8	2016	9
1.88	Preterm Births	<i>percent</i>	10.3	9.4	10	9.6		2015	9
1.03	Teen Birth Rate: 15-19	<i>live births/ 1,000 females aged 15-</i>	16.9		15.9	20.3	17.8	2016	9
0.48	Sudden Unexpected Infant Death Rate	<i>deaths/ 1,000 live births</i>	0.8	0.84	1	0.9	0.86	2011-2015	9
SCORE	MEN'S HEALTH	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.30	Age-Adjusted Death Rate due to Prostate Cancer	<i>deaths/ 100,000 males</i>	24.4	21.8	20.3	20.1		2010-2014	16
2.10	Prostate Cancer Incidence Rate	<i>cases/ 100,000 males</i>	157.9		131.5	114.8		2010-2014	16
1.85	Life Expectancy for Males	<i>years</i>	74.8		76.8	76.7		2014	7
SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.40	Age-Adjusted ER Rate due to Mental Health	<i>ER Visits/ 100,000 population</i>	6207.9		3442.6		3152.6	2014	9
2.13	Age-Adjusted Death Rate due to Suicide	<i>deaths/ 100,000 population</i>	12.2	10.2	9.2	12.7	9	2012-2014	9
2.05	Self-Reported Good Mental Health	<i>percent</i>	57.7		76.2			2015	8
1.95	Poor Mental Health: Average Number of Days	<i>days</i>	4		3.5	3.8		2016	4
1.80	Poor Mental Health: 14+ Days	<i>percent</i>	11.1		9.7			2016	8
1.50	Adequate Social and Emotional Support	<i>percent</i>	83.4		82.9			2010	8
1.50	Frequent Mental Distress	<i>percent</i>	11.9		10.3	15		2016	4
1.40	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	9.8		10.1	9.9		2015	3
1.30	Depression: Medicare Population	<i>percent</i>	15.3		15.4	16.7		2015	3
1.05	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	231		216	214.3		2017	4
0.95	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	<i>hospitalizations/ 100,000 populat</i>	146.9		194.1		199.4	2014	9

SECTION 13 APPENDICES

SCORE	OLDER ADULTS & AGING	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Chronic Kidney Disease: Medicare Population	percent	21		18.2	18.1		2015	3
2.50	Hyperlipidemia: Medicare Population	percent	56		48.9	44.6		2015	3
2.30	Hypertension: Medicare Population	percent	65.6		59.2	55		2015	3
2.30	Stroke: Medicare Population	percent	5.2		4.5	4		2015	3
2.20	Diabetes: Medicare Population	percent	31.5		29.1	26.5		2015	3
2.13	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	8.6	7.2	8.5	8.5	7.7	2012-2014	9
2.10	Atrial Fibrillation: Medicare Population	percent	8.8		8	8.1		2015	3
2.00	Cancer: Medicare Population	percent	8.7		8.6	7.8		2015	3
1.95	Diabetic Monitoring: Medicare Population	percent	83.5		85	85.2		2014	19
1.90	Asthma: Medicare Population	percent	8.6		7.9	8.2		2015	3
1.85	COPD: Medicare Population	percent	12.2		9.9	11.2		2015	3
1.80	Heart Failure: Medicare Population	percent	14.1		12.4	13.5		2015	3
1.80	People 65+ with Low Access to a Grocery Store	percent	4					2015	22
1.75	People 65+ Living Alone	percent	26.8		26	26.4		2012-2016	1
1.68	Adults 65+ with Influenza Vaccination	percent	59.8		61.6	58.6		2016	8
1.58	Adults 65+ with Pneumonia Vaccination	percent	74.8	90	75.4	73.4		2016	8
1.50	Ischemic Heart Disease: Medicare Population	percent	27.9		26	26.5		2015	3
1.40	Alzheimer's Disease or Dementia: Medicare Population	percent	9.8		10.1	9.9		2015	3
1.30	Depression: Medicare Population	percent	15.3		15.4	16.7		2015	3
1.10	People 65+ Living Below Poverty Level	percent	7.5		7.7	9.3		2012-2016	1
1.05	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	28.8		30	30		2015	3
0.95	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	hospitalizations/ 100,000 population	146.9		194.1		199.4	2014	9
0.95	Osteoporosis: Medicare Population	percent	5.1		5.7	6		2015	3
SCORE	ORAL HEALTH	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.40	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	13.3		10.6	11.5		2010-2014	16
2.20	Age-Adjusted ER Visit Rate due to Dental Problems	ER Visits/ 100,000 population	1886.7		779.7		792.8	2014	9
2.18	Adults who Visited a Dentist	percent	57.9		69.4	66.4		2016	8
1.70	Children who Visited a Dentist	percent	61.7		63.9		64.6	2016	9
1.18	Adults with No Tooth Extractions	percent	58.3		57.9	56.9		2016	8
0.75	Dentist Rate	dentists/ 100,000 population	80		75.7	67.4		2016	4
SCORE	OTHER CHRONIC DISEASES	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Chronic Kidney Disease: Medicare Population	percent	21		18.2	18.1		2015	3
1.05	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	28.8		30	30		2015	3
0.95	Osteoporosis: Medicare Population	percent	5.1		5.7	6		2015	3

SECTION 13 APPENDICES

SCORE	PREVENTION & SAFETY	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.35	Severe Housing Problems	percent	20.3		17.1	18.8		2010-2014	4
2.13	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	8.6	7.2	8.5	8.5	7.7	2012-2014	9
2.08	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	39.2	36.4	30.5	43.2		2014-2016	9
1.70	Pedestrian Injuries	injuries/ 100,000 population	36.1	20.3	47.1		35.6	2015	9
1.60	Death Rate due to Drug Poisoning	deaths/ 100,000 population	19.9		24.4	16.9		2014-2016	4
0.55	Pedestrian Death Rate	deaths/ 100,000 population	0	1.4	0.9	1.5		2013	5
SCORE	PUBLIC SAFETY	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.40	Domestic Violence Offense Rate	offenses/ 100,000 population	782.5		508.4		445	2015	9
1.78	Violent Crime Rate	crimes/ 100,000 population	467.1		471.3	373.7		2015	12
1.70	Pedestrian Injuries	injuries/ 100,000 population	36.1	20.3	47.1		35.6	2015	9
1.65	Age-Adjusted Death Rate due to Homicide	deaths/ 100,000 population	7.1	5.5	8.4	5.6		2008-2010	9
1.65	Alcohol-Impaired Driving Deaths	percent	31.8		30.5	29.3		2012-2016	4
1.20	Child Abuse Rate	cases/ 1,000 children	5.6		7.3			2015	11
0.55	Pedestrian Death Rate	deaths/ 100,000 population	0	1.4	0.9	1.5		2013	5
SCORE	RESPIRATORY DISEASES	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.43	Tuberculosis Incidence Rate	cases/ 100,000 population	3.9	1	2.9	3		2015	9
2.35	Adults with Influenza Vaccination	percent	34.3	70	41.7		49.1	2014	9
2.10	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	57.3	45.5	43.2	44.7		2010-2014	16
2.00	Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	91.5		68.3		62.5	2014	9
1.95	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	75.6		58.1	61.2		2010-2014	16
1.90	Asthma: Medicare Population	percent	8.6		7.9	8.2		2015	3
1.85	COPD: Medicare Population	percent	12.2		9.9	11.2		2015	3
1.68	Adults 65+ with Influenza Vaccination	percent	59.8		61.6	58.6		2016	8
1.58	Adults 65+ with Pneumonia Vaccination	percent	74.8	90	75.4	73.4		2016	8
1.08	Adults with Asthma	percent	12.5		14.1	14		2016	8
1.05	Children with Asthma	percent	9.7		16.1			2013	8
0.73	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	8.3		16	15.2		2012-2014	9



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SCORE	SOCIAL ENVIRONMENT	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.10	Homeownership	percent	54.6		59.8	55.9		2012-2016	1
2.10	Single-Parent Households	percent	39.3		34.2	33.6		2012-2016	1
2.00	People Living Below Poverty Level	percent	16.3		9.9	15.1		2012-2016	1
2.00	Per Capita Income	dollars	26498		37756	29829		2012-2016	1
1.85	Voter Registration	percent	74.7		83.6			2016	13
1.75	People 65+ Living Alone	percent	26.8		26	26.4		2012-2016	1
1.73	Persons with Health Insurance	percent	91.9	100	93			2016	18
1.70	Children Living Below Poverty Level	percent	21.1		13.3	21.2		2012-2016	1
1.70	Median Household Income	dollars	53508		76067	55322		2012-2016	1
1.55	People 25+ with a Bachelor's Degree or Higher	percent	27.4		38.4	30.3		2012-2016	1
1.20	Child Abuse Rate	cases/ 1,000 children	5.6		7.3			2015	11
1.20	People 25+ with a High School Degree or Higher	percent	88.6		89.6	87		2012-2016	1
0.65	Mean Travel Time to Work	minutes	21.7		32.4	26.1		2012-2016	1
0.60	Youth not in School or Working	percent	1.8		2.3	2.4		2012-2016	1

SCORE	SUBSTANCE ABUSE	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.40	Age-Adjusted ER Rate due to Alcohol/Substance Abuse	ER visits/ 100,000 population	2870.5		1591.3		1400.9	2014	9
2.33	Age-Adjusted Death Rate due to Drug Use	deaths/ 100,000 population	16.2	11.3	15.2	14.6	12.6	2012-2014	9
2.28	Adults who Smoke	percent	17.3	12	13.4	17.1	15.5	2016	8
1.75	Adolescents who Use Tobacco	percent	21.5	21	16.4		15.2	2014	9
1.65	Alcohol-Impaired Driving Deaths	percent	31.8		30.5	29.3		2012-2016	4
1.60	Death Rate due to Drug Poisoning	deaths/ 100,000 population	19.9		24.4	16.9		2014-2016	4
1.50	Teens who Smoke: High School Students	percent	12.7	16	8.7			2014	15
1.08	Adults who Binge Drink	percent	14.5	24.2	16	16.9		2016	8
0.50	Liquor Store Density	stores/ 100,000 population	5.9		20	10.5		2015	21

SCORE	TEEN & ADOLESCENT HEALTH	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
1.75	Adolescents who Use Tobacco	percent	21.5	21	16.4		15.2	2014	9
1.50	Teens who Smoke: High School Students	percent	12.7	16	8.7			2014	15
1.45	Adolescents who are Obese	percent	11.9	16.1	11.5		10.7	2014	9
1.25	Adolescents who have had a Routine Checkup: Medicaid Population	percent	57.3		55.3		57.4	2016	9
1.03	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15+	16.9		15.9	20.3	17.8	2016	9

SCORE	TRANSPORTATION	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.40	Workers who Drive Alone to Work	percent	83.7		73.7	76.4		2012-2016	1
2.00	Workers Commuting by Public Transportation	percent	0.8	5.5	8.9	5.1		2012-2016	1
1.70	Workers who Walk to Work	percent	2.3	3.1	2.4	2.8		2012-2016	1
1.50	Households with No Car and Low Access to a Grocery Store	percent	2.4					2015	22
0.95	Households without a Vehicle	percent	7		9.2	9		2012-2016	1
0.85	Solo Drivers with a Long Commute	percent	24.4		48.7	34.7		2012-2016	4
0.65	Mean Travel Time to Work	minutes	21.7		32.4	26.1		2012-2016	1

SCORE	WOMEN'S HEALTH	UNITS	WICOMICO COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.10	Breast Cancer Incidence Rate	cases/ 100,000 females	133.7		131	123.5		2010-2014	16
2.05	Life Expectancy for Females	years	79.1		81.4	81.5		2014	7
1.50	Mammogram in Past 2 Years: 50+	percent	68		66.3			2016	8
1.30	Pap Test in Past 3 Years	percent	95.9	93	95.1			2016	8
0.85	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	20.4	20.7	22.8	21.2		2010-2014	16
0.45	Cervical Cancer Incidence Rate	cases/ 100,000 females	6.3	7.3	6.5	7.5		2010-2014	16

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WORCESTER DATA SCORING APPENDIX

SCORE	ACCESS TO HEALTH SERVICES	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.28	Adults who have had a Routine Checkup	percent	69.5		88.2	83.6		2016	8
2.23	Adults Unable to Afford to See a Doctor	percent	14.1		9.9	12		2016	8
1.98	Adults who Visited a Dentist	percent	64		69.4	66.4		2016	8
1.95	People with a Usual Primary Care Provider	percent	78.3		84.8		83.9	2016	9
1.85	Dentist Rate	dentists/ 100,000 population	54		76		67	2016	4
1.80	Adolescents who have had a Routine Checkup: Medicaid Population	percent	52.1		55.3		57.4	2016	9
1.70	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	72		89	81		2017	4
1.38	Persons with Health Insurance	percent	92.7	100	93			2016	18
1.33	Children with Health Insurance	percent	95.9	100	96.6			2016	18
1.30	Children who Visited a Dentist	percent	64.5		63.9		64.6	2016	9
1.25	Mental Health Provider Rate	providers/ 100,000 population	200		216	214		2017	4
1.03	Adults with Health Insurance	percent	91.7	100	91.6			2016	18
0.90	Primary Care Provider Rate	providers/ 100,000 population	82		88	76		2015	4
0.75	Uninsured Emergency Department Visits	percent	7.6		11		14.7	2014	9
SCORE	CANCER	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.65	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	28.9	20.7	22.8	21.2		2010-2014	16
2.15	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	56.6	45.5	43.2	44.7		2010-2014	16
2.15	Cancer: Medicare Population	percent	9.1		8.6	7.8		2015	3
2.10	Breast Cancer Incidence Rate	cases/ 100,000 females	135.6		131	123.5		2010-2014	16
2.05	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	22.7	21.8	20.3	20.1		2010-2014	16
2.00	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	69.2		58.1	61.2		2010-2014	16
1.95	Colon Cancer Screening: Sigmoidoscopy or Colonoscopy	percent	65.5		73.8			2016	8
1.95	Prostate Cancer Incidence Rate	cases/ 100,000 males	137.8		131.5	114.8		2010-2014	16
1.75	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	181.8	161.4	165.3	166.1	147.4	2010-2014	16
1.70	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	12.2		10.6	11.5		2010-2014	16
1.35	Mammogram in Past 2 Years: 50+	percent	70.3		66.3			2016	8
1.15	Pap Test in Past 3 Years	percent	97.5	93	95.1			2016	8
0.90	Colorectal Cancer Incidence Rate	cases/ 100,000 population	36.6	39.9	37.3	39.8		2010-2014	16
0.15	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	12	14.5	14.4	14.8		2010-2014	16

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SCORE	CHILDREN'S HEALTH	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.15	Child Food Insecurity Rate	percent	22.6		16.3	19.3		2015	6
1.95	Child Abuse Rate	cases/ 1,000 children	14.1		7.3			2015	11
1.80	Children with Asthma	percent	18.5		16.1			2013	8
1.35	Children with Low Access to a Grocery Store	percent	3.4					2015	22
1.33	Children with Health Insurance	percent	95.9	100	96.6			2016	18
1.30	Children who Visited a Dentist	percent	64.5		63.9		64.6	2016	9
1.25	Blood Lead Levels in Children	percent	0.2		0.3		0.28	2016	10
1.15	Food Insecure Children Likely Ineligible for Assistance	percent	28		41	34.1		2015	6
SCORE	DIABETES	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.18	Adults with Diabetes	percent	12.9		10.2	10.5		2016	8
1.70	Age-Adjusted ER Rate due to Diabetes	ER Visits/ 100,000 population	229.9		204		186.3	2014	9
1.00	Diabetes: Medicare Population	percent	25.9		29.1	26.5		2015	3
0.68	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	14.5		19.2	21.1		2012-2014	9
0.60	Diabetic Monitoring: Medicare Population	percent	89.5		85	85.2		2014	19
SCORE	ECONOMY	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.50	Homeownership	percent	28.3		59.8	55.9		2012-2016	1
2.40	Unemployed Workers in Civilian Labor Force	percent	10.9		4.5	4.1		Mar-18	20
2.30	Homeowner Vacancy Rate	percent	3.4		1.7	1.8		2012-2016	1
2.15	Child Food Insecurity Rate	percent	22.6		16.3	19.3		2015	6
2.00	Youth not in School or Working	percent	2.7		2.3	2.4		2012-2016	1
1.65	Food Insecurity Rate	percent	13		11.4	13.7		2015	6
1.60	Median Household Income	dollars	57227		76067	55322		2012-2016	1
1.45	Families Living Below Poverty Level	percent	7.7		6.8	11		2012-2016	1
1.45	People Living 200% Above Poverty Level	percent	72.2		77	66.4		2012-2016	1
1.45	Severe Housing Problems	percent	16.5		17.1	18.8		2010-2014	4
1.35	Low-Income and Low Access to a Grocery Store	percent	4.3					2015	22
1.35	Per Capita Income	dollars	32988		37756	29829		2012-2016	1
1.30	SNAP Certified Stores	stores/ 1,000 population	1					2016	22
1.20	Renters Spending 30% or More of Household Income on Rent	percent	45.5		50.5	47.3		2012-2016	1
1.15	Food Insecure Children Likely Ineligible for Assistance	percent	28		41	34.1		2015	6
1.10	Children Living Below Poverty Level	percent	13.9		13.3	21.2		2012-2016	1
1.10	People Living Below Poverty Level	percent	10.2		9.9	15.1		2012-2016	1
1.05	Affordable Housing	percent	56.9		46.1		54.4	2014	9
1.05	People 65+ Living Below Poverty Level	percent	6.9		7.7	9.3		2012-2016	1
0.95	Students Eligible for the Free Lunch Program	percent	38.2		39.9	42.6		2015-2016	17
0.80	Households with Cash Public Assistance Income	percent	2.1		2.5	2.7		2012-2016	1

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SCORE	EDUCATION	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
1.40	People 25+ with a Bachelor's Degree or Higher	percent	29.9		38.4	30.3		2012-2016	1
1.20	4th Grade Students Proficient in Reading	percent	94.4		86.3			2014	14
1.20	High School Graduation	percent	91.8	87	87.7		95	2017	14
1.20	School Readiness at Kindergarten Entry	percent	56		45		85.5	2016-2017	14
1.10	People 25+ with a High School Degree or Higher	percent	89.6		89.6	87		2012-2016	1
1.05	8th Grade Students Proficient in Reading	percent	85.6		76.9			2014	14
0.70	Student-to-Teacher Ratio	students/ teacher	11.4		15	17.7		2015-2016	17
SCORE	ENVIRONMENT	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.40	Liquor Store Density	stores/ 100,000 population	33		20	10.5		2015	21
1.95	People 65+ with Low Access to a Grocery Store	percent	5.8					2015	22
1.85	Fast Food Restaurant Density	restaurants/ 1,000 population	1.6					2014	22
1.55	Food Environment Index		8		9.1	7.7		2018	4
1.50	Households with No Car and Low Access to a Grocery Store	percent	2.1					2015	22
1.50	People with Low Access to a Grocery Store	percent	20.7					2015	22
1.45	Severe Housing Problems	percent	16.5		17.1	18.8		2010-2014	4
1.35	Annual Ozone Air Quality	grade	D					2008-2010	2
1.35	Children with Low Access to a Grocery Store	percent	3.4					2015	22
1.35	Low-Income and Low Access to a Grocery Store	percent	4.3					2015	22
1.30	Grocery Store Density	stores/ 1,000 population	0.3					2014	22
1.30	SNAP Certified Stores	stores/ 1,000 population	1					2016	22
1.25	Blood Lead Levels in Children	percent	0.2		0.3		0.28	2016	10
1.10	Farmers Market Density	markets/ 1,000 population	0.06					2016	22
1.05	Access to Exercise Opportunities	percent	92.3		93	83.1		2018	4
1.05	Recreation and Fitness Facilities	facilities/ 1,000 population	0.21					2014	22
0.83	Drinking Water Violations	percent	0		16.2			FY 2013-14	4
SCORE	ENVIRONMENTAL & OCCUPATIONAL HEALTH	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.13	Adults with Asthma	percent	15.5		14.1	14		2016	8
1.80	Children with Asthma	percent	18.5		16.1			2013	8
1.50	Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	64.1		68.3		62.5	2014	9
1.25	Blood Lead Levels in Children	percent	0.2		0.3		0.28	2016	10
0.70	Asthma: Medicare Population	percent	6.4		7.9	8.2		2015	3

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SCORE	EXERCISE, NUTRITION, & WEIGHT	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.63	Adults who are Obese	percent	40	30.5	30.1	29.9		2016	8
2.15	Child Food Insecurity Rate	percent	22.6		16.3	19.3		2015	6
1.95	People 65+ with Low Access to a Grocery Store	percent	5.8					2015	22
1.88	Adults who are Overweight or Obese	percent	72.4		68.1	65.2		2016	8
1.85	Fast Food Restaurant Density	restaurants/ 1,000 population	1.6					2014	22
1.80	Adolescents who are Obese	percent	13.5	16.1	11.5		10.7	2014	9
1.65	Food Insecurity Rate	percent	13		11.4	13.7		2015	6
1.55	Food Environment Index		8		9.1	7.7		2018	4
1.50	Households with No Car and Low Access to a Grocery Store	percent	2.1					2015	22
1.50	People with Low Access to a Grocery Store	percent	20.7					2015	22
1.35	Children with Low Access to a Grocery Store	percent	3.4					2015	22
1.35	Low-Income and Low Access to a Grocery Store	percent	4.3					2015	22
1.30	Grocery Store Density	stores/ 1,000 population	0.3					2014	22
1.30	SNAP Certified Stores	stores/ 1,000 population	1					2016	22
1.28	Adults with a Healthy Weight	percent	36.2		35.1	35.2	36.6	2014	9
1.15	Food Insecure Children Likely Ineligible for Assistance	percent	28		41	34.1		2015	6
1.10	Farmers Market Density	markets/ 1,000 population	0.06					2016	22
1.05	Access to Exercise Opportunities	percent	92.3		93	83.1		2018	4
1.05	Adult Fruit and Vegetable Consumption	percent	30		27.1			2010	8
1.05	Recreation and Fitness Facilities	facilities/ 1,000 population	0.21					2014	22
0.85	Workers who Walk to Work	percent	2.9	3.1	2.4	2.8		2012-2016	1
0.83	Adults Engaging in Regular Physical Activity	percent	51.9	20.1	48	20.5		2013	8
SCORE	HEART DISEASE & STROKE	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.50	Atrial Fibrillation: Medicare Population	percent	9.6		8	8.1		2015	3
2.33	High Cholesterol Prevalence	percent	46.2	13.5	35.9	36.3		2015	8
2.30	Hyperlipidemia: Medicare Population	percent	56.9		48.9	44.6		2015	3
2.20	Stroke: Medicare Population	percent	4.6		4.5	4		2015	3
2.15	Hypertension: Medicare Population	percent	64.4		59.2	55		2015	3
2.13	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	186.9		166.9	167	166.3	2014-2016	9
2.10	High Blood Pressure Prevalence	percent	55.8	26.9	45			2016	8
1.85	Age-Adjusted ER Rate due to Hypertension	ER Visits/ 100,000 population	286.2		252.2		234	2014	9
1.78	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	37.3	34.8	38.4	37.2		2014-2016	9
1.10	Heart Failure: Medicare Population	percent	12.2		12.4	13.5		2015	3
0.90	Ischemic Heart Disease: Medicare Population	percent	25.8		26	26.5		2015	3

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SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.35	Salmonella Infection Incidence Rate	<i>cases/ 100,000 population</i>	32.8	11.4	16.1			2015	9
1.78	Adults 65+ with Pneumonia Vaccination	<i>percent</i>	72	90	75.4	73.4		2016	8
1.55	Adults with Influenza Vaccination	<i>percent</i>	42.6	70	41.7		49.1	2014	9
1.43	Gonorrhea Incidence Rate	<i>cases/ 100,000 population</i>	124.3		158.3	145.8		2016	9
1.28	Adults 65+ with Influenza Vaccination	<i>percent</i>	63.6		61.6	58.6		2016	8
1.23	Syphilis Incidence Rate	<i>cases/ 100,000 population</i>	5.8		8.5	8.7		2016	9
1.15	HIV Incidence Rate: Aged 13+	<i>cases/ 100,000 population</i>	6.6		22.1		26.7	2016	9
1.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	13.3		16	15.2		2012-2014	9
0.68	Chlamydia Incidence Rate	<i>cases/ 100,000 population</i>	359.4		509.6	497.3	431	2016	9
0.58	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	0	1	2.9	3		2015	9
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.55	Infant Mortality Rate	<i>deaths/ 1,000 live births</i>	9.6	6	6.5		6.3	2012-2016	9
2.33	Sudden Unexpected Infant Death Rate	<i>deaths/ 1,000 live births</i>	2	0.84	1	0.9	0.86	2011-2015	9
1.73	Preterm Births	<i>percent</i>	9.9	9.4	10	9.6		2015	9
0.98	Teen Birth Rate: 15-19	<i>live births/ 1,000 females aged 15</i>	14.9		15.9	20.3	17.8	2016	9
0.63	Babies with Low Birth Weight	<i>percent</i>	6	7.8	8.6	8.2	8	2016	9
SCORE	MEN'S HEALTH	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.05	Age-Adjusted Death Rate due to Prostate Cancer	<i>deaths/ 100,000 males</i>	22.7	21.8	20.3	20.1		2010-2014	16
1.95	Prostate Cancer Incidence Rate	<i>cases/ 100,000 males</i>	137.8		131.5	114.8		2010-2014	16
1.10	Life Expectancy for Males	<i>years</i>	77.2		76.8	76.7		2014	7
SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.05	Self-Reported Good Mental Health	<i>percent</i>	61.8		76.2			2015	8
1.93	Age-Adjusted Death Rate due to Suicide	<i>deaths/ 100,000 population</i>	12	10.2	9	12.5	9	2011-2013	9
1.50	Adequate Social and Emotional Support	<i>percent</i>	83.3		82.9			2010	8
1.35	Frequent Mental Distress	<i>percent</i>	11.1		10.3	15		2016	4
1.35	Poor Mental Health: Average Number of Days	<i>days</i>	3.7		3.5	3.8		2016	4
1.25	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	200		216	214		2017	4
1.05	Poor Mental Health: 14+ Days	<i>percent</i>	6.9		9.7			2016	8
0.90	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	<i>hospitalizations/ 100,000 populati</i>	146.1		194.1		199.4	2014	9
0.70	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	7.1		10.1	9.9		2015	3
0.50	Depression: Medicare Population	<i>percent</i>	12.2		15.4	16.7		2015	3

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SCORE	OLDER ADULTS & AGING	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.50	Atrial Fibrillation: Medicare Population	percent	9.6		8	8.1		2015	3
2.30	Hyperlipidemia: Medicare Population	percent	56.9		48.9	44.6		2015	3
2.20	Stroke: Medicare Population	percent	4.6		4.5	4		2015	3
2.15	Cancer: Medicare Population	percent	9.1		8.6	7.8		2015	3
2.15	Hypertension: Medicare Population	percent	64.4		59.2	55		2015	3
1.95	People 65+ with Low Access to a Grocery Store	percent	5.8					2015	22
1.78	Adults 65+ with Pneumonia Vaccination	percent	72	90	75.4	73.4		2016	8
1.65	People 65+ Living Alone	percent	24.9		26	26.4		2012-2016	1
1.50	Chronic Kidney Disease: Medicare Population	percent	16.6		18.2	18.1		2015	3
1.50	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	29.1		30	30		2015	3
1.28	Adults 65+ with Influenza Vaccination	percent	63.6		61.6	58.6		2016	8
1.10	Heart Failure: Medicare Population	percent	12.2		12.4	13.5		2015	3
1.05	People 65+ Living Below Poverty Level	percent	6.9		7.7	9.3		2012-2016	1
1.00	Diabetes: Medicare Population	percent	25.9		29.1	26.5		2015	3
0.90	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	hospitalizations/ 100,000 population	146.1		194.1		199.4	2014	9
0.90	Ischemic Heart Disease: Medicare Population	percent	25.8		26	26.5		2015	3
0.75	Osteoporosis: Medicare Population	percent	4.6		5.7	6		2015	3
0.70	Alzheimer's Disease or Dementia: Medicare Population	percent	7.1		10.1	9.9		2015	3
0.70	Asthma: Medicare Population	percent	6.4		7.9	8.2		2015	3
0.60	Diabetic Monitoring: Medicare Population	percent	89.5		85	85.2		2014	19
0.50	Depression: Medicare Population	percent	12.2		15.4	16.7		2015	3
0.30	COPD: Medicare Population	percent	8.9		9.9	11.2		2015	3
SCORE	ORAL HEALTH	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.20	Age-Adjusted ER Visit Rate due to Dental Problems	ER Visits/ 100,000 population	1441.5		779.7		792.8	2014	9
1.98	Adults who Visited a Dentist	percent	64		69.4	66.4		2016	8
1.85	Dentist Rate	dentists/ 100,000 population	54		76	67		2016	4
1.70	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	12.2		10.6	11.5		2010-2014	16
1.63	Adults with No Tooth Extractions	percent	53		57.9	56.9		2016	8
1.30	Children who Visited a Dentist	percent	64.5		63.9		64.6	2016	9
SCORE	OTHER CHRONIC DISEASES	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
1.50	Chronic Kidney Disease: Medicare Population	percent	16.6		18.2	18.1		2015	3
1.50	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	29.1		30	30		2015	3
0.75	Osteoporosis: Medicare Population	percent	4.6		5.7	6		2015	3

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SCORE	PREVENTION & SAFETY	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Death Rate due to Drug Poisoning	deaths/ 100,000 population	33.6		24.4	16.9		2014-2016	4
2.65	Pedestrian Death Rate	deaths/ 100,000 population	5.8	1.4	0.9	1.5		2013	5
2.15	Pedestrian Injuries	injuries/ 100,000 population	54.3	20.3	47.1		35.6	2015	9
1.63	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	34.8	36.4	30.5	43.2		2014-2016	9
1.45	Severe Housing Problems	percent	16.5		17.1	18.8		2010-2014	4
SCORE	PUBLIC SAFETY	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.70	Alcohol-Impaired Driving Deaths	percent	48		30.5	29.3		2012-2016	4
2.65	Pedestrian Death Rate	deaths/ 100,000 population	5.8	1.4	0.9	1.5		2013	5
2.15	Pedestrian Injuries	injuries/ 100,000 population	54.3	20.3	47.1		35.6	2015	9
1.95	Child Abuse Rate	cases/ 1,000 children	14.1		7.3			2015	11
1.90	Domestic Violence Offense Rate	offenses/ 100,000 population	558.8		508.4		445	2015	9
0.88	Violent Crime Rate	crimes/ 100,000 population	281.2		471.3	373.7		2015	12
SCORE	RESPIRATORY DISEASES	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.15	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	56.6	45.5	43.2	44.7		2010-2014	16
2.13	Adults with Asthma	percent	15.5		14.1	14		2016	8
2.00	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	69.2		58.1	61.2		2010-2014	16
1.80	Children with Asthma	percent	18.5		16.1			2013	8
1.78	Adults 65+ with Pneumonia Vaccination	percent	72	90	75.4	73.4		2016	8
1.55	Adults with Influenza Vaccination	percent	42.6	70	41.7		49.1	2014	9
1.50	Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	64.1		68.3		62.5	2014	9
1.28	Adults 65+ with Influenza Vaccination	percent	63.6		61.6	58.6		2016	8
1.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	13.3		16	15.2		2012-2014	9
0.70	Asthma: Medicare Population	percent	6.4		7.9	8.2		2015	3
0.58	Tuberculosis Incidence Rate	cases/ 100,000 population	0	1	2.9	3		2015	9
0.30	COPD: Medicare Population	percent	8.9		9.9	11.2		2015	3



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SCORE	SOCIAL ENVIRONMENT	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.50	Homeownership	percent	28.3		59.8	55.9		2012-2016	1
2.00	Youth not in School or Working	percent	2.7		2.3	2.4		2012-2016	1
1.95	Child Abuse Rate	cases/ 1,000 children	14.1		7.3			2015	11
1.90	Single-Parent Households	percent	35.3		34.2	33.6		2012-2016	1
1.65	People 65+ Living Alone	percent	24.9		26	26.4		2012-2016	1
1.60	Median Household Income	dollars	57227		76067	55322		2012-2016	1
1.40	People 25+ with a Bachelor's Degree or Higher	percent	29.9		38.4	30.3		2012-2016	1
1.38	Persons with Health Insurance	percent	92.7	100	93			2016	18
1.35	Mean Travel Time to Work	minutes	24.5		32.4	26.1		2012-2016	1
1.35	Per Capita Income	dollars	32988		37756	29829		2012-2016	1
1.10	Children Living Below Poverty Level	percent	13.9		13.3	21.2		2012-2016	1
1.10	People 25+ with a High School Degree or Higher	percent	89.6		89.6	87		2012-2016	1
1.10	People Living Below Poverty Level	percent	10.2		9.9	15.1		2012-2016	1
1.10	Voter Registration	percent	89.6		83.6			2016	13
SCORE	SUBSTANCE ABUSE	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.78	Adults who Smoke	percent	20.9	12	13.4	17.1	15.5	2016	8
2.70	Alcohol-Impaired Driving Deaths	percent	48		30.5	29.3		2012-2016	4
2.70	Death Rate due to Drug Poisoning	deaths/ 100,000 population	33.6		24.4	16.9		2014-2016	4
2.40	Liquor Store Density	stores/ 100,000 population	33		20	10.5		2015	21
2.20	Age-Adjusted ER Rate due to Alcohol/Substance Abuse	ER visits/ 100,000 population	2296.8		1591.3		1400.9	2014	9
2.13	Adults who Binge Drink	percent	19.9	24.2	16	16.9		2016	8
1.95	Adolescents who Use Tobacco	percent	22.5	21	16.4		15.2	2014	9
1.88	Age-Adjusted Death Rate due to Drug Use	deaths/ 100,000 population	15.6	11.3	15.2	14.6	12.6	2012-2014	9
1.75	Teens who Smoke: High School Students	percent	14.7	16	8.7			2014	15
SCORE	TEEN & ADOLESCENT HEALTH	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
1.95	Adolescents who Use Tobacco	percent	22.5	21	16.4		15.2	2014	9
1.80	Adolescents who are Obese	percent	13.5	16.1	11.5		10.7	2014	9
1.80	Adolescents who have had a Routine Checkup: Medicaid Population	percent	52.1		55.3		57.4	2016	9
1.75	Teens who Smoke: High School Students	percent	14.7	16	8.7			2014	15
0.98	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15-	14.9		15.9	20.3	17.8	2016	9
SCORE	TRANSPORTATION	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
1.70	Workers Commuting by Public Transportation	percent	2.3	5.5	8.9	5.1		2012-2016	1
1.50	Households with No Car and Low Access to a Grocery Store	percent	2.1					2015	22
1.50	Households without a Vehicle	percent	7.1		9.2	9		2012-2016	1
1.40	Workers who Drive Alone to Work	percent	80.5		73.7	76.4		2012-2016	1
1.35	Mean Travel Time to Work	minutes	24.5		32.4	26.1		2012-2016	1
1.00	Solo Drivers with a Long Commute	percent	30.6		48.7	34.7		2012-2016	4
0.85	Workers who Walk to Work	percent	2.9	3.1	2.4	2.8		2012-2016	1
SCORE	WOMEN'S HEALTH	UNITS	WORCESTER COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.65	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	28.9	20.7	22.8	21.2		2010-2014	16
2.10	Breast Cancer Incidence Rate	cases/ 100,000 females	135.6		131	123.5		2010-2014	16
1.35	Mammogram in Past 2 Years: 50+	percent	70.3		66.3			2016	8
1.25	Life Expectancy for Females	years	81.4		81.4	81.5		2014	7
1.15	Pap Test in Past 3 Years	percent	97.5	93	95.1			2016	8

## 13.2 COMMUNITY INPUT

### 13.2.1 KEY INFORMANT INTERVIEW QUESTIONS

#### Peninsula Regional Medical Center and Wicomico and Somerset County Health Departments Key Informant Interview Guide

Q1. Could you tell me a little bit about yourself, your background, and your organization?

Q2. What is your vision for a healthy \_\_\_\_\_ community?

Q3. What are the major health needs/issues you see in the community?

(Probes: How would you rank these issues in your community (top priority to lowest priority) and why? What do you think contributes to the health needs you see?)

Q4a. *Data Gaps:*

- Disabilities
- Family Planning
- Men's Health
- Other Chronic Diseases
- Vision

Q4b: We have found that there is limited publically available data about [topic area] for \_\_\_\_\_ County, which may make it difficult to assess the extent of the community need. Could you please help fill in some of our data gaps by telling me a little about how [topic area] is impacting the community?

Q5. What are the barriers to receiving care and for building a healthy community?

Q6. Who in your community appears to struggle most with these issues you've identified and how does it impact their lives?

Q7. Could you tell me about some of the strengths and resources in your community that address these issues, such as groups, initiatives, services, or programs? Please name them.

Q8. What advice do you have for a group developing a plan to address the needs you've mentioned today?

Q8. Given all that we have discussed so far, what are the top 3 health needs that should be addressed in your community? Please list them in order of 1st - 2nd - 3rd.

Q9. Is there anything else you'd like us to note?

### 13.2.2 FOCUS GROUP QUESTIONS

#### Community Health Status

Q1. How would you rate the health status of the community: Excellent, Very Good, Good, Fair, Poor, or Don't Know/Not Sure? Why did you give it this rating?

[Probe: do you think that this community is doing better or worse than those immediately surrounding it and why?]

#### Priorities

Q2. What are the top 3 priorities for this community in terms of health needs and why? Be sure to rank your answers, with one being the most important priority.

[Probe: If you were on a grant committee to allocate funds — how would you choose to allocate funds/resources — what would you select — based on the communities need?]

### **Health Needs/Issues**

Q3. How do these issues impact different types of people/populations?  
[Probe: Do these issues vary by age, gender, race and/or ethnicity? How about for low-income or uninsured people?]

### **Barriers**

Q4. Now we'd like to discuss barriers. What are the barriers to receiving services in the community?  
[Probe: What might prevent someone in this community from accessing care? Examples include lack of transportation, lack of health insurance coverage, language/cultural barriers, etc.]

### **Resources**

Q5. Next we'd like to focus on resources. What do you see as the community's best resources?  
[Probes: What organization or community agency do you see taking a strong leadership role at improving health in your community? Could you tell me about some of the strengths in your community in terms of resources/services/programs/initiatives that address the issues you see? Are individuals in your service area likely to use preventative healthcare?)]

Q6. To what extent are people utilizing these resources? Are there gaps in services or health information?  
[Probe: Where do people get their health information in this community?]

### **Role of Hospital / Health Department**

Q7a. What do you think the role of a hospital has in addressing these needs we have discussed so far? How can [the hospital] better partner with the community to improve health?  
[Probe: How does [the hospital] respond to the health needs that have been discussed?]

Q7b. What do you think the role of a health department has in addressing these needs we have discussed so far? How can [the health department] better partner with the community to improve health?  
[Probe: How does [the health department] respond to the health needs that have been discussed?]

### **Wrap Up Questions**

Q8. What needs to happen to make your vision of a healthy community a reality?  
[Probe: Who needs to be involved in these efforts? How can these efforts be sustained?]

Q9. Is there anything else you thought about that we didn't get to discuss?

## 13.2.3 ONLINE COMMUNITY SURVEY

**Peninsula Regional Medical Center and Wicomico and Somerset County Health Departments Community Survey****1. Please tell us what county you live in.**

- Somerset
- Wicomico
- Worcester
- Other (please specify) \_\_\_\_\_

**2. Do you work in the health field?**

- Health professional
- Not a health professional

**3. What do you think are reasons that prevent you or others in your community from getting the health services they need? Check all that apply.**

- No health insurance
- No transportation
- High cost
- Local doctors not “in-network” for health insurance plan
- Doctors are too far from home or work
- Unable to get appointment with a physician
- Specific/needed services not available
- Language barriers
- Other (please specify) \_\_\_\_\_

**4. Please select the most important health issue(s) in your community from this list of health topics. (Select up to 5)**

- Access to Health Services
- Cancer
- Diabetes
- Heart Disease & Stroke
- Immunization & Infectious Diseases
- Injury, Violence & Safety
- Maternal, Fetal, & Infant Health
- Mental Health & Mental Disorders
- Obesity/Overweight
- Oral Health
- Reproductive Health (family planning)
- Respiratory/Lung Diseases (asthma, COPD, etc.)
- Sexual Health (HIV, STD/I, etc.)
- Substance Abuse (alcohol, tobacco, e-cigs, drugs, etc.)
- Other (please specify) \_\_\_\_\_

**5. Please select the population(s) below who is (are) most negatively affected by poor health outcomes in your community. (Select up to 5)**

- Children
- Teen and Adolescent
- Low income populations
- Lesbian, Gay, Bisexual, and Transgender
- Mothers and Infants
- Men
- Older Adults
- Persons with Disabilities

- Racial or Ethnic Populations
- Refugees
- Women
- Other (please specify) \_\_\_\_\_

**6. What are the conditions of daily life that have the most impact on your community? (Select up to 3)**

- Economy (housing, etc.)
- Education
- Employment (jobs, etc.)
- Environmental Quality (exposure to secondhand smoke, etc.)
- Language Barriers
- Physical Activity and Exercise
- Transportation
- Social Environment (living situation, neighborhood, family structure, etc.)
- Other (please specify) \_\_\_\_\_

**7. Is there anything else you would like us to know about your community? Please feel free to tell us below.**

---

**8. What is your gender identity?**

- Female
- Male
- Transgender
- Gender non-conforming
- Other (please specify) \_\_\_\_\_

**9. What is your age?**

- 17 or younger
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

**10. Select your race/ethnicity.**

- White
- Hispanic / Latino
- Black / African American
- American Indian / Alaska Native
- Asian
- Native Hawaiian / Other Pacific Islander
- Other (please specify) \_\_\_\_\_

### 13.3 COMMUNITY RESOURCES

RESOURCES	URL
Worcester County Health Department	<a href="http://www.worcesterhealth.org/">http://www.worcesterhealth.org/</a>
Lower Shore Clinic, Inc.	<a href="https://www.lowershoreclinic.org/">https://www.lowershoreclinic.org/</a>
Health and Outreach Point of Entry (HOPE Inc.)	<a href="https://helpandoutreach.wordpress.com/">https://helpandoutreach.wordpress.com/</a>
TGM Group LLC	<a href="http://www.tgmgroupllc.com/">http://www.tgmgroupllc.com/</a>
Chesapeake Health Care	<a href="https://chesapeakehc.org/">https://chesapeakehc.org/</a>
Somerset County Health Department	<a href="https://somesethealth.org/">https://somesethealth.org/</a>
Wicomico County Health Department	<a href="http://www.wicomicohealth.org/index.aspx?pagelid=1">http://www.wicomicohealth.org/index.aspx?pagelid=1</a>
Deer's Head Hospital Center – Maryland Dept. of Health	<a href="https://health.maryland.gov/deershead/Pages/Home.aspx">https://health.maryland.gov/deershead/Pages/Home.aspx</a>
MAC, Inc.	<a href="https://macinc.org/">https://macinc.org/</a>
Genesis HealthCare	<a href="http://www.genesisihcc.com/">http://www.genesisihcc.com/</a>
CoreLife	<a href="https://corelifemd.com/">https://corelifemd.com/</a>
Peninsula Regional Medical Center	<a href="https://www.peninsula.org/">https://www.peninsula.org/</a>
Salisbury University	<a href="https://www.salisbury.edu/">https://www.salisbury.edu/</a>
SOAR Program	<a href="https://soarworks.prainc.com/states/maryland">https://soarworks.prainc.com/states/maryland</a>
Center for Clean Start – Worcester County Health Dept.	<a href="http://www.worcesterhealth.org/contact-us/7-c4cs-center-for-clean-start">http://www.worcesterhealth.org/contact-us/7-c4cs-center-for-clean-start</a>
Area Health Education Center	<a href="https://www.esahec.org/">https://www.esahec.org/</a>
Hartley Hall Nursing Home and Rehabilitation Center	<a href="https://www.hartleyhall.org/">https://www.hartleyhall.org/</a>
Atlantic General Hospital	<a href="https://www.atlanticgeneral.org/">https://www.atlanticgeneral.org/</a>
Wagner Wellness Van	<a href="https://www.peninsula.org/deparment/wagner-wellness-van">https://www.peninsula.org/deparment/wagner-wellness-van</a>
Wor-Wic Community College	<a href="https://www.worwic.edu/">https://www.worwic.edu/</a>
Eastern Shore	<a href="https://www.unitedway4us.org/">https://www.unitedway4us.org/</a>

**13.4 PRIORITIZATION TOOLKIT****PRMC, WCHD & SCHD HEALTH NEEDS PRIORITIZATION**

OCTOBER 24, 2018

This packet will help you assess each of the pressing health needs identified by HCI's data analysis, and how each of those health needs relate to the criteria set forth by Peninsula Regional Medical Center and Wicomico and Somerset County Health Departments for prioritizing health needs in the Tri-County Service Area. For each health need you will score how well you believe the health need meets the criteria. We will then submit all final ranking results into Poll Everywhere, a software which will collate results and instantaneously show the group's collective ranking of the most pressing health needs in the service area.

**INSTRUCTIONS**

On the following page, score each health need for how well it meets each criteria:

**1=does not meet criteria through 3=meets criteria**

1. Add total scores for each health need and write total in "Total Health Topic Score" column.
2. Write the total scores for each topic in the table below.
3. Assign ranking to health needs based on total score, with highest score receiving a ranking of 1. If you have tie scores for health topics, break the tie by assigning rank as you see best fit.

<b>Health Topics</b> <i>(listed alphabetically)</i>	<b>Rank</b>
Access to Health Services	
Cancer	
Diabetes	
Economy	
Low-Income/Underserved	
Mental Health & Mental Disorders	
Older Adults & Aging	
Oral Health	
Social Environment	
Substance Abuse	
Transportation	

SECTION 13 APPENDICES

Health Need	Importance of problem to the community	Alignment with Maryland SHIP 2017 objectives	Opportunities for partnership	Addresses disparities of subgroups	Existing resources / programs to address the problem	TOTAL
Access to Health Services						
Cancer						
Diabetes						
Economy						
Low-Income / Underserved						
Mental Health & Mental Disorders						
Older Adults & Aging						
Oral Health						
Social Environment						
Substance Abuse						
Transportation						



## 13.5 IMPACT SINCE PRIOR CHNA

Below is a progress report for the successful implementation of multiple community health initiatives, as prioritized by three urgent health care themes selected as part of the 2016 Peninsula Regional CHNA (Community Health Needs Assessment) and the Implementation Strategy Plan 2016-2019.

### THEMES

- Chronic Care Management (*Emphasis on Diabetes*)
- Exercise, Nutrition and Weight
- Behavioral Health

### GOAL

**Improve the health through identification, education and self-management of residents with chronic disease within the CBSA (Community Benefits Service Area) with an emphasis on the diabetes population.**

- ***Peninsula Regional Medical Center continues our partnership with MAC, Inc. Area Agency on Aging*** to assist with the management of chronic diseases. Members and residents can participate in a wide variety of evidence based classes, exercise classes and wellness programs, including fall prevention. These programs are designed to assist with the management of chronic diseases, providing the participants awareness and education on controlling their **diabetes**, hypertension, and pain, giving the aging population a higher quality of life and sense of independence, ultimately keeping them healthy, strong, and out of the hospital.

Point of entry into these ongoing programs originates from many different providers and other outreach programs that are working locally in unison. Peninsula Regional's Wagner Wellness Van, SWIFT (Salisbury Wicomico Integrated Firstcare Team), local churches, physicians and civic organizations are aware of the program and are referring patients.

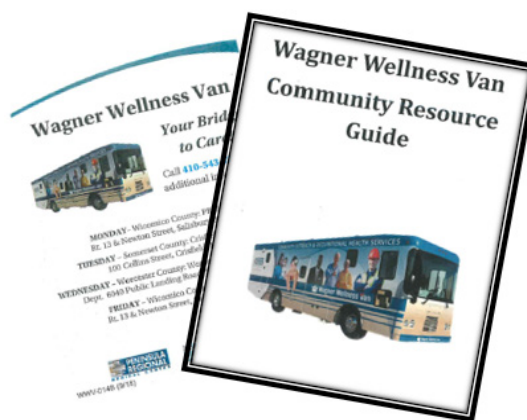
In the last year, the partnership was successful in increasing the total number of educational classes available from 26 to 47, touching the lives of over 450 participants and their supporting caregivers. According to the surveys completed by participants agreed they had a better understanding of how to manage the symptoms of their chronic diseases, but they also set action plans for moving forward and felt more motivated to take control of their health.

- The Wagner Wellness Van is a mobile clinic that visits local shelters, churches, and other areas in PRMC's Community Benefits Service Area where underserved residents can receive non-emergency medical care, chronic care management, and healthy lifestyles education. The van visits areas where the social determinants of health indicate the greatest amount of need. It provides care in areas with a higher prevalence of ER visits, lower median incomes, indigent population, access issues, communication barriers, and overall poor health outcomes. There has been improved control of diabetes and hypertension. The Wagner Wellness Van strives to educate patients by

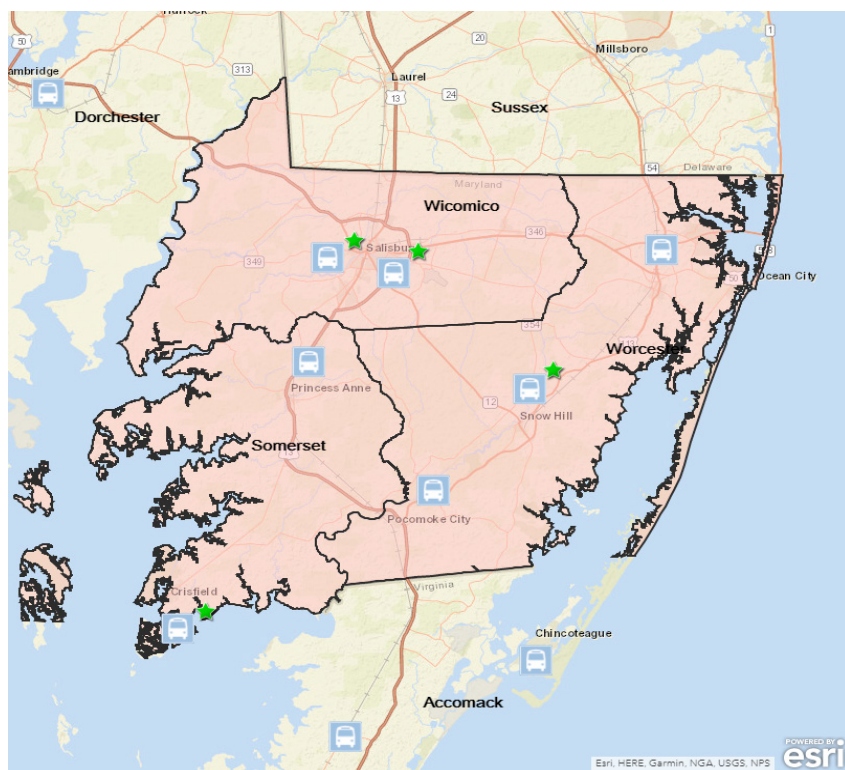
providing nutritional and healthy lifestyle counseling, in addition to medication compliance, to control diabetes and hypertension. Health screenings are performed on residents to help determine appropriate education, self-management class information, or referrals to community resources and services. These screenings include pre-diabetes, hypertension and obesity. When warranted, drug and alcohol misuse screenings are also conducted, and counseling is available. If a resident is at risk for diabetes, an A1C screening is performed to further assist with diagnosis and treatment.

The Wagner Wellness Van visits multiple local towns and counties throughout the week; green stars represent daily bus locations, the bus icon identifies van visits to health fairs, heart screenings, and other community events. The Van in FY 2018 provided 845 hypertension screenings, 392 diabetes screenings and 340 referrals to a primary care physician.

*The Wagner Wellness Van promotes a Tri-County Community Resource Guide distributed to residents that visit the Van. This multipage guide provides names, location and phone numbers for low or no cost transportation, local shelters, social services, Health Departments, medical assistance, Veterans Services, prescription aid, etc.*



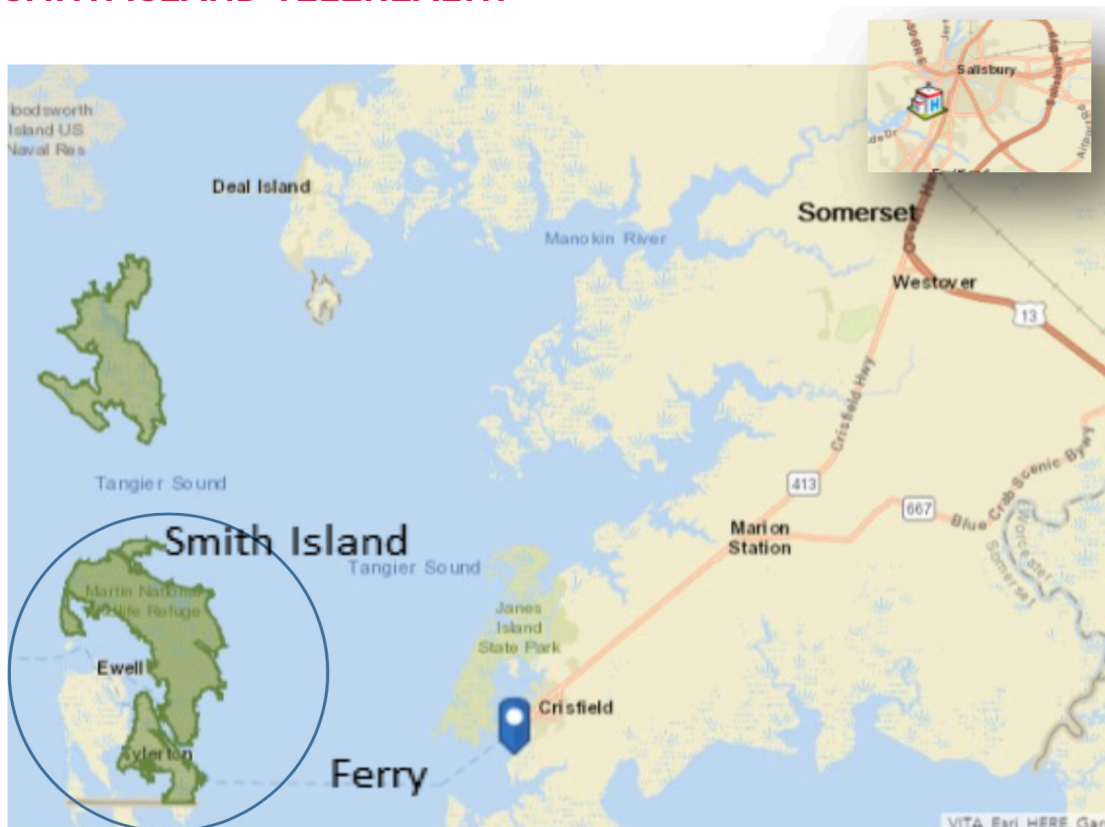
## WAGNER WELLNESS VAN LOCATIONS



Over the last several years Peninsula Regional has added several other initiatives that complement the chronic disease management and diabetes theme.

- Smith Island Telehealth** Smith Island is known for its Watermen, Smith Island cake, exceptional seafood, and being isolated with limited contact from mainland visitors. For this reason, Peninsula Regional Medical Center created a partnership with McCready Health, MAC – Area Agency on Aging, Somerset County Health Department, and Crisfield Clinic. The goal of the partnership is to improve the health of Smith Island residents, with the target of effectively reducing potentially avoidable ED utilization. The program was led by the Smith Island Community Health Staff which provides chronic disease education, management and connects residents of Smith Island via telehealth for primary care physician visits. In FY 2018, there were 98 patients served out of the possible 250 residents of Smith Island.

## SMITH ISLAND TELEHEALTH



Community health workers play an integral role in changing Island residents' health behaviors and actions; these embedded health facilitators are able to effectively bridge relationships with the residents of Smith Island. These facilitators are essentially a personal health coach that assist residents with medication management, timely compliance, ultimately helping guide residents through prescribed health care plans. Flu shots were administered ensuring the residents of Smith Island were protected during the flu season effectively reducing ED visits. Since Inception the partnership has had great successes, for example, there has been substantial reductions in A1C levels in residents diagnosed with diabetes;

a prime example of the “Triple Aim” improving health, providing access, chronic disease education, and reducing the probability of a future Emergency Department visit. Residents are learning how to self-manage their chronic diseases and are being exposed to the principles of leading a healthy lifestyles. As a result of program and intervention McCready Hospital experienced a 5% reduction in ED utilization for patients with a Smith Island zip code from October 2017 to June 2018.

## SMITH ISLAND



- SWIFT — The Salisbury-Wicomico Integrated FirstCare Team is a partnership between the Salisbury Fire Department and Peninsula Regional Medical Center, has earned the MIEMSS Executive Director’s Award for Excellence in EMS. The team of a Salisbury paramedic and PRMC nurse provides home visits for individuals who are frequent users of 911. This initiative identifies social determinants that contribute to the negative health outcomes of the patient and the subsequent high utilization of EMS services and the PRMC’s Emergency Room. With identification of these single or multiple social determinants, solutions can be provided to these patients which can take the form of coaching, matching the patient to local health resources, or chronic disease management. This program meets the patients where they are at and provides

coaching and direction in the management of their life and health.

SWIFT has a lead dedicated Emergency Medical Technician Paramedic (EMT-P) who acts as the point person to identify the long-term needs of patients, make necessary referrals, and enroll interested frequent users into the SWIFT program. Those enrolled in the SWIFT program had called EMS for assistance 296 times pre-enrollment and only 194 times post enrollment, a 34.5% reduction in annual 911 calls and an overall ER reduction rate of 37%. Since SWIFT's implementation, of those enrolled in the program there has been an average 35% reduction of 911 calls and a 20%-35% decrease in ER visits on a month-to-month basis.

## **2GOAL**

**Increase awareness of and engagement in healthy lifestyle behaviors.**

***To promote longer and healthier lifestyles and prevent chronic maladies, Peninsula Regional is committed to aiding the community through awareness, education, and resources via the following initiatives.***

- ***Partner with Local Leaders, YMCA, United Way, Eastern Shore Regional Library and Wicomico County Schools towards Public Awareness and Resources*** with the goal to reduce the number of child and adolescents/adults in Wicomico, Worcester and Somerset who are considered overweight and present a healthy lifestyle of nutrition and exercise opportunities; Peninsula Regional's Diabetes Education Department has a working relationship with the YMCA and conducts educational sessions about diabetes on site several times a year. Nutrition, exercise, obesity and diabetes are a top priority community health issue, as referrals are forthcoming from PRMC clinicians to the YMCA for obese pediatric and adult patients.

The Diabetes and Education Department at Peninsula Regional continues to impact the community through promotion of nutrition, weight loss and diabetes health literacy by interacting with the community through health fairs, school visitation, workshops, mobile clinic, and civic organizations.

To address obesity, Peninsula Regional also participates in Tri County Diabetes Alliance and Live Healthy Wicomico. Groups meet monthly or every other month to develop partnerships to address prevention and treatment of diabetes, obesity and other health issues. Projects include promoting lifestyle changes for disease prevention, team work in community, and awareness of pre-diabetes and diabetes and services available in the community. Susan Cottongim from PRMC is serving as co-chair for the TCDA.

- Peninsula Regional Medical Center has partnered with Children's National Health System, based in Washington, DC, to bring nationally recognized pediatric endocrinology services to the Delmarva Peninsula. Medical Nutrition Therapy Services are provided by Peninsula Regional Registered Licensed Dietitians. Pediatric overweight and diabetes patients and family meet with the dietitian to manage diabetes, high blood pressure, high cholesterol, early kidney disease, weight loss management and healthy eating habits. Support groups are

available and meet bi-monthly for children and teens with diabetes to discuss in a non-judgmental environment – a place where peers can share healthy lifestyle tips, challenges of living with diabetes, weight loss and nutrition tips, all under the careful leadership of a registered dietitian. The pediatric support groups meet every other month and have a typical attendance of 5-10 students. Students are encouraged and taught how to manage their diabetes, eat healthy and participate in exercise programs and activities offered by the YMCA. At any time we are coordinating care between 130-150 elementary students, junior high students and high school students. Peninsula Regional’s team educates and advocates for children in need of specialty care by working with the tri-county area school nurses to develop each patient’s diabetes management plan for the school year. Telemedicine connectivity with Children’s DC provides the 24/7 accessibility of on call physicians, as well as providing scheduled telemedicine consults for endocrinology and diabetes care. Another fun aspect has been the increased volume of Children attending a “Diabetes Camp” where participation has increased from 1 participant to 11 in five years.

- To expand our “Healthy Living” message, Peninsula Regional sponsors and participates in many community-based health fairs providing nutrition education, weight loss, diabetes assessment, multiple screenings and health literacy. Participation in health fairs include underserved areas like Smith Island, an island on the Chesapeake Bay with a population of only 250, a Haitian Creole Health Fair, Healthfest and screenings at the Governor’s Basketball Challenge at the Civic Center in Wicomico County. Transforming the culture through participation and sponsorship of healthy lifestyles and screenings, meeting residents at community events located throughout the tri-county area.

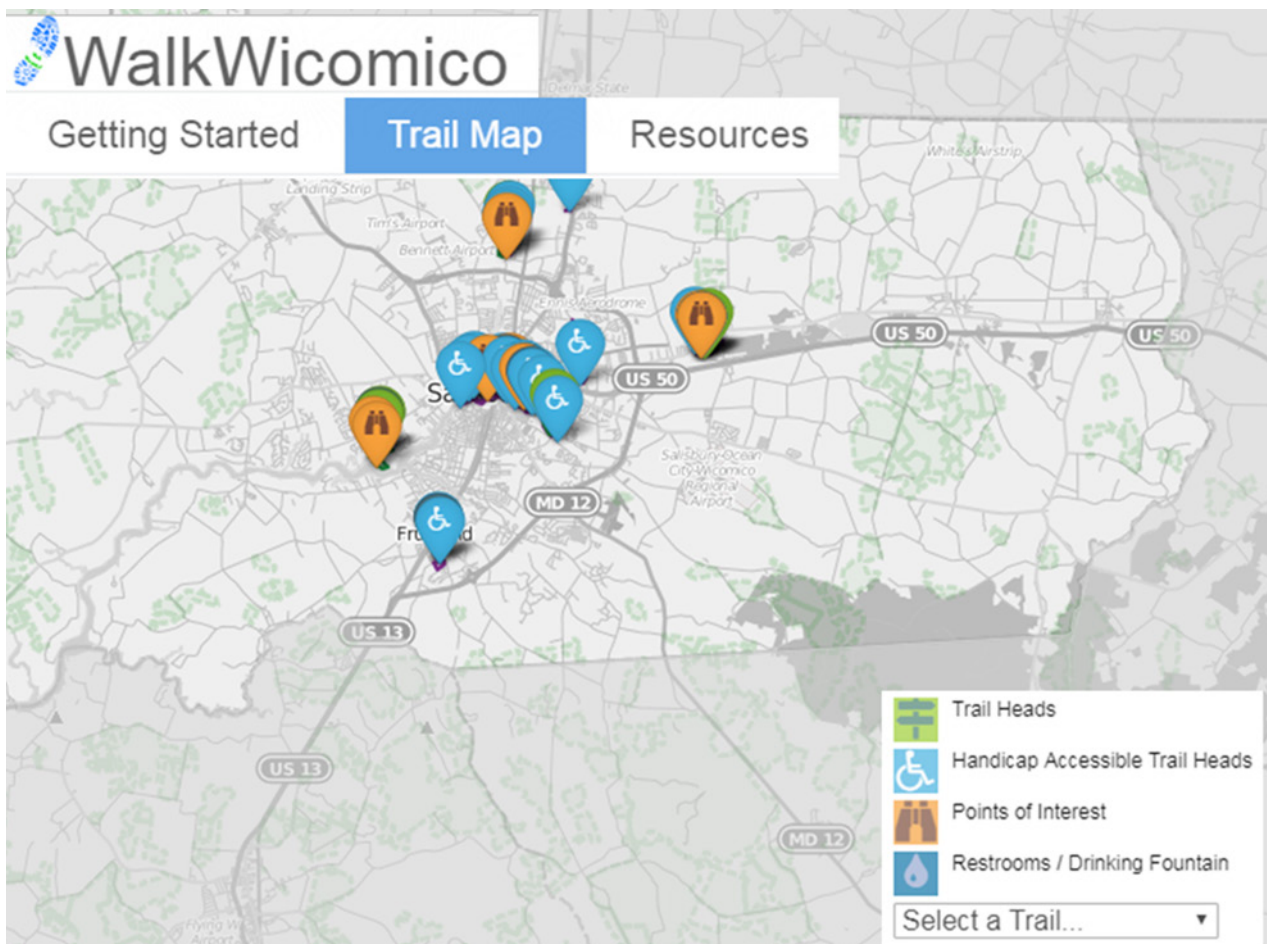
### POPULATION HEALTH

- Cholesterol, HDL, Triglycerides
- Resting 12-Lead EKG
- Body Fat / Mass Index
- Blood Pressure Testing
- Pulse Oximetry Testing
- 10-Year Risk Analysis
- Review Current Medications
- Follow-up Care Plan
- Exercise/Nutrition



- **WalkWicomico promotes walking Trails, personal challenges, and avenues to enjoy the outdoors** — the primary objective is to increase awareness of and engagement in healthy lifestyle behaviors promoting exercise to help with weight loss, increase energy, reduce risk of chronic disease and make people feel happier. “WalkWicomico” is primarily targeting those that reside in the county (pop. 100,000+); however, it would also be an attraction for adjacent counties including visitors.

Peninsula Regional as a participant has a common goal to transform the community’s culture by providing education, guidance and resources towards promoting exercise through walkability as an integral part of a healthy lifestyle. The Coalition’s initiatives included creating a website and phone app specific to walking in Wicomico County; communicating with the community via social media; working with civic organizations, churches, local businesses, towns, county health departments, and other groups to encourage local walkability. Walk Wicomico has marked walking routes, increased the number of walking routes, participated in and launched walking events, and is engaged with decision makers through input and feedback about making walking safer easier and more accessible.



## MILESTONES

- ✓ As of this report, Facebook has 193 followers and Instagram, 116. Along with motivational/educational/interactive posts, event flyers are now being shared on social media.
- ✓ WalkWicomico 1 Billion Steps Challenge team walked 6,342,425 steps, with a final rank of 164 out of 398.
- ✓ Website available will full updates on times, places, and events!
- ✓ Walk MD Day Challenge (most steps walked in 24 hours) was sent to all Wicomico County HMBs which included the Wicomico County Health Dept. (9,480 employees in 33 businesses).
- ✓ WalkWicomico and the city of Fruitland coordinated a community walk in the hope of getting parents and siblings to walk. The city took responsibility for the planning and promotion of the walk and is providing water. The partner secured pretzels.

### <sup>3</sup>GOAL

**Improve the access to and coordination of care for residents with behavioral health and/or substance abuse issues.**

- ***Partner with local providers of Behavioral Health, such as the Lower Shore Clinic to help support long-term health.*** The CareWrap program was a hospital-community collaboration between PRMC and Lower Shore Clinic located in Salisbury, Maryland. The “Transitions Team” at Peninsula Regional targets patients that have a high risk for returning to the hospital within 30 days of discharge. Once identified, those individuals are referred to the CareWrap program. The goal is to reduce hospital readmissions by helping patients’ access primary care and behavioral health services, and to help fill other social determinants of health gaps to ensure a smooth transition to health stabilization.

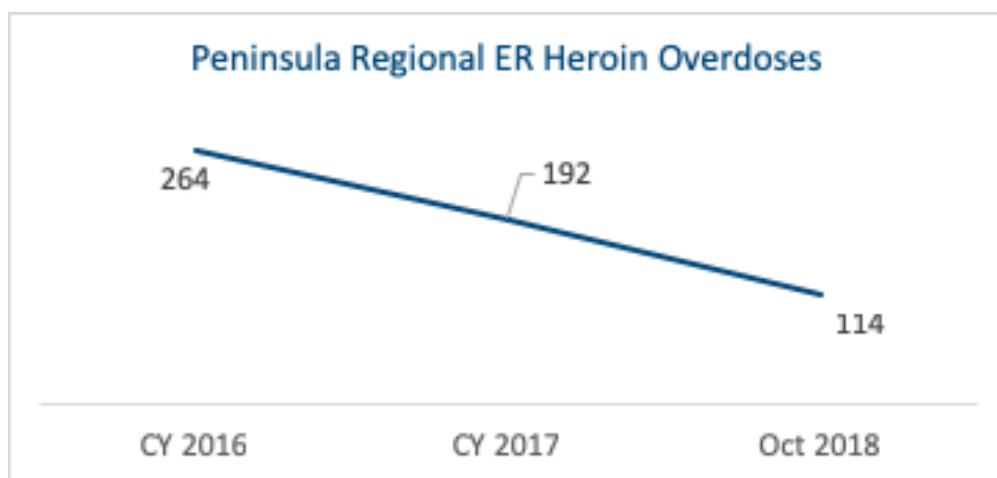
Community Health Workers link patients to community resources and access to the healthcare system to eliminate and/or minimize social determinants of health. Examples include: obtaining housing, medications, transportation and linking to entitled financial assistance or helping find employment. The CareWrap team provides weekly status updates on all patients. This team discusses participant progress as well as identifying barriers and works toward solutions. In Fiscal Year 2018 the program ended, however it has been replaced by participation in C.O.A.T (Community Outreach Addictions Team) provides similar transition services to those struggling with social determinants of health; triple issue addiction, behavioral and primary care access issues.

- ***C.O.A.T (Community Outreach Addictions Team) is a partnership between Peninsula Regional Medical Center, the Wicomico County Health Department, the State’s Attorney’s Office, the Salisbury City Government, and the Wicomico County Sheriff’s Office.*** C.O.A.T is an opioid intervention task force that goes and speaks with drug dependent residents of Wicomico County and the surrounding areas. The team consists of peer mentors who were previously addicted to drugs. These mentors talk to those struggling with addiction



and encourage them to enroll in treatment. The collaboration begins in the Peninsula Regional's ER; a patient arrives at the ER as an overdose or suffering from addiction symptoms. The PRMC staff calls the 24/7 hotline number to have a C.O.A.T Team Member visit with the patient, this peer mentor helps to provide a smooth transition to treatment services that link the patient with local behavioral health and addiction resources in the community. Most recently, the C.O.A.T program has expanded to the Labor and Delivery department of the hospital to engage pregnant women and substance exposed newborns.

Since inception C.O.A.T has been successful in reducing heroin overdoses, in 2016 PRMC ER experienced 264 heroin overdoses, compared to 192 overdose in CY 2017. This declining trend has continued into CY 2018; through October 2018, PRMC has experienced 114 heroin overdoses which is an average reduction of 11 overdoses per month. Wicomico County has experienced a 42% reduction in opioid-related deaths compared to Maryland has a 12% reduction in opioid-related deaths.



- PRMC has taken steps to curb the abuse of opioids from a medication prescribing vantage. Using EMR (Electronic Medical Record) system applications PRMC has reduced high opioid medication utilization using a systems based approach. This approach includes calculation of the total daily dose of opioids, morphine equivalent calculations, and non-opioid alternative medication suggestions. PRMC has experienced a reduction in opioid prescriptions below the national average. The opioid prescription percentage from June 2017 to May 2018 was 9.3% for PRMC vs a Peer Hospitals which had an average percentage of 15.22%.

## **ACKNOWLEDGEMENTS**

Peninsula Regional thanks all participants and partners that made it possible to make great strides in creating programs that deliver population health. They have provided expertise and allocated resources to meet those urgent health care needs within our community.

We value your commitment, and let's continue making Delmarva a healthier place to live.

### **THANK YOU!**

- Wicomico County Health Department
- Wicomico County Local Health Improvement Coalition
- The City of Salisbury
- YMCA
- Crisfield Clinic
- Chesapeake Health Care
- SWIFT
- Salisbury Fire Department/EMS
- Atlantic General Hospital
- Worcester County Health Department
- Somerset County Health Department
- Faith Based Organizations
- McCready Memorial Hospital
- MAC (Maintaining Active Citizens)
- Local Colleges/ and Schools
- C.O.A.T
- National Kidney Foundation
- CareWrap
- Wagner Wellness Van
- Peninsula Regional Employees
- Post-Acute Care Facilities
- HALO
- WalkWicomico (Coalition)
- Lower Shore Clinic
- Wicomico County Sheriff's Office
- Resource and Recovery Center

# 2019 – 2021 Implementation Strategy Plan for Peninsula Regional Medical Center

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## Community Health Improvement Plan for Somerset County Health Department and Wicomico County Health Department



 **PENINSULA  
REGIONAL**  
MEDICAL CENTER



**2019 – 2021 Implementation Strategy Plan**  
for Peninsula Regional Medical Center  
and  
**Community Health Improvement Plan**  
for Somerset County Health Department and Wicomico County Health  
Department

**Introduction**

Peninsula Regional Medical Center (PRMC), in partnership with Somerset County Health Department (SCHD) and Wicomico County Health Department (WiCHD), is pleased to share our Implementation Strategy Plan, which follows the development of the 2019 Community Health Needs Assessment (CHNA). In accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements, this plan was approved by the Board of Trustees of PRMC on November 7, 2019. This document also serves as the Community Health Improvement Plan for the health departments and was approved by the Somerset Local Health Improvement Coalition (LHIC) on November 12, 2019, and approved by the Wicomico LHIC on December 6, 2019.

After a thorough review of the health status in our community through the CHNA, we identified areas that we could address using our resources, expertise, and community partners.

The following are the prioritized health needs that will be addressed:

- Behavioral Health (Mental Health and Mental Disorders as well as Substance Abuse)
- Diabetes
- Cancer (Focus Areas: Breast, Colorectal, Cervical, Lung, Skin)

This Implementation Strategy summarizes the plans for PRMC, SCHD, and WiCHD to develop and/or collaborate on community benefit programs that address the prioritized health needs identified in the 2019 CHNA.

PRMC provides additional support for community benefit activities in the community that lie outside the scope of the programs and activities outlined in this Implementation Strategy. However, those additional activities will not be explored in detail in this document.

Additionally, this document includes the significant health needs that the partnership will not be addressing and why.

**PRMC, SCHD, and WiCHD**

PRMC is the 10<sup>th</sup> largest hospital in Maryland with 266 acute care beds, and the region's largest, most advanced tertiary care facility, which has been meeting the healthcare needs of Delmarva Peninsula residents since 1897. Its 3,300 physicians, staff, and volunteers provide

safe, compassionate, and affordable care designed to exceed the expectations of the nearly 500,000 patients who rely on the Medical Center team each year for inpatient, outpatient, diagnostic, sub-acute and emergency/trauma services. It is the region's oldest healthcare institution with the most experienced team of healthcare professionals. It also infuses over \$500 million annually into its regional economy, and is the recipient of over 125 national awards, recognitions, and certifications in the past half-decade for the care it offers patients and the outcomes they experience.

SCHD's mission is "Dedicated to serving the Public by preventing illness, promoting wellness and protecting the health of our community." The Health Department continues to evolve with the changes in the healthcare system and is currently in the planning stage of the Public Health Accreditation process.

WiCHD's mission is "To maximize the health and wellness of all members of the community through collaborative efforts." The public health department, accredited by the Public Health Accreditation Board on March 8, 2016, has expanded over the years to meet changing needs of the community and continually works toward protecting the health and environment of the people of Wicomico County.

PRMC, SCHD, and WiCHD service areas are jointly defined by Somerset, Wicomico, and Worcester counties in the state of Maryland. These three counties are referred to as the Tri-County service area. Additionally, the service area includes the 43 zip codes and associated census places and census tracts within those three counties.

## **Community Health Needs Assessment**

In December 2018, PRMC, SCHD, and WiCHD published their 2019 CHNA. The CHNA Report provides an overview of significant health needs in the Tri-County service area. This CHNA report was developed to provide an overview of the health needs in the Tri-County service area, including Somerset, Wicomico, and Worcester counties in Maryland. PRMC, SCHD, and WiCHD partnered with Conduent Healthy Communities Institute (HCI) to conduct the CHNA. The goal of this report is to offer a meaningful understanding of the greatest health needs across the Tri-County service area, as well as to guide planning efforts to address those needs. Special attention has been given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

The CHNA findings are drawn from an analysis of an extensive set of secondary data (over 100 indicators from national and state data sources) and in-depth primary data from community health leaders and organizations that serve the community at large, as well as non-health professionals and community members. The main source for the secondary data, or data that has been previously collected, is the Peninsula Regional Medical Center Creating Healthy Communities platform, a publicly available data platform that is embedded on the main PRMC website. That platform can be found here: <https://www.peninsula.org/community/creating-healthy-communities>.

## Priorities

On October 24, 2018, PRMC, SCHD and WiCHD came together to prioritize the significant health needs in a session facilitated by Conduent HCI consultants. Using a prioritization matrix, participants voted on the most critical needs while considering the following criteria:

- Importance of problem to the community
- Alignment with Maryland State Health Improvement Process (SHIP) 2017 objectives
- Opportunity for partnership
- Addresses disparities of subgroups
- Existing resources/programs to address the problem

The following three topics were selected as the top priorities:

- Behavioral Health (Mental Health and Mental Disorders as well as Substance Abuse)
- Diabetes
- Cancer (Focus Areas: Breast, Colorectal, Cervical, Skin)

No one organization can address all the health needs identified in its community. PRMC, SCHD, and WiCHD are committed to serving the community by adhering to their mission, and using their skills, expertise, and resources to provide a range of community benefit programs. This Implementation Strategy does not include specific plans to address other significant health needs including: Access to Health Services, Older Adults & Aging, and Oral Health.

These needs were not selected because they did not meet the prioritization criteria as strongly as the selected topics. PRMC, SCHD, and WiCHD have other programs in these areas, but they are not the focus of this report.

## Implementation Strategy Design Process

In April 2018, PRMC contracted with Conduent HCI to facilitate the Implementation Strategy process. PRMC, SCHD, and WiCHD assembled an internal team and created an inventory of existing programs in the chosen priority areas. Conduent HCI reviewed the inventory for those with an evidence base and those most applicable for community benefit. Conduent HCI also conducted research into additional evidence-based programs for consideration by the internal team. As a result, PRMC, SCHD, and WiCHD are committed to a portfolio of new and existing programs to create positive change for the prioritized health needs of their community.

### PRMC, SCHD, and WiCHD Internal Team

Stakeholder	Organization/Title
Chris Hall	PRMC, Vice President, Strategy
Kathryn Fiddler	PRMC, Vice President, Population Health

Henry Nyce	PRMC, Data Analyst
Logan Becker	PRMC, Planning Analyst
Rachel Blades	PRMC, Data Analyst, Population Health
Stephanie Elliott	PRMC, Director, Community Health Initiatives
Lori Brewster	WiCHD, SCHED Health Officer
Lisa Renegar	WiCHD, Health Planner, Office of Planning
Danielle Weber	SCHD, Administrative Deputy Health Officer

**Priority Areas**

**Behavioral Health**

**Goal:** Address behavioral issues in the Tri-County service area by reducing the instances of opioid-related deaths

**Goal:** Address behavioral issues in the Tri-County service area by targeting seniors suffering with minor to major depression

**Strategies:**

- Collaboratively address the opioid crisis in the Tri-County service area with an emphasis on prevention, treatment, resources, and enforcement
- Provide peer support for people who have overdosed or sought help for opioid addiction issues
- Address depression in adults 50 years or older through skill building, problem solving, and socialization activities

**Objectives and Anticipated Impact:**

- Work collaboratively to address policy, develop education, and raise community awareness in the fight against opioid use and continue to reduce instances of heroin overdose each year
  - **Evaluation Measures**
    - Monthly data from ED visits on opioid overdoses collected and reported to the county
    - # of individuals Narcan trained
    - # of individuals exposed to educational messaging
    - # of prescription drug deactivation bags distributed in the community



- # of educational/training events
  - # of OIT meetings held
  - # of informational campaigns
  - # of schools with Go Purple Clubs
  - # of school-based educational Go Purple events
- Utilizing the Community Outreach Addictions Team (C.O.A.T.), contact and provide linkage to treatment and other support services to community members dealing with substance abuse issues
  - **Evaluation Measures**
    - # of contact attempts
    - # of opioid users contacted
    - # linked to treatment
    - % of those who receive treatment and remain in recovery for 6 months and beyond
    - # supported through navigation services (increased access to insurance, primary care physicians, and social service benefits)
- Reduce the instances of depression in older adults through outreach and access to an evidence-based intervention program. Increase percent of program participants with a significant reduction of depression above the 2018 baseline of 50%
  - **Evaluation Measures**
    - # of community members enrolled
    - % of enrollees with reduction in level of depression maintained over 12 months
    - % of enrollees achieving remission of depression symptoms for at least 6 months

**Recommended Policy Change:**

- Align and integrate prevention and treatment efforts among public and private agencies
- Design communications that help people understand detection, management, and decreased stigma of mental illness and their associated risk factors

**PRMC System Resource Contributions:**

- PRMC staff
- Data Collection
- Vehicles/Transportation
- Phone Service
- Staff training and materials as needed

**Alignment Opportunities:**

- PRMC, as part of a regional partnership with Atlantic General Hospital in Worcester County, SCHD and WiCHD, are collaborating with the Maryland Health Service Cost Review Commission to develop a regional approach to behavioral health for FY 2021. Work in these three areas will be incorporated into this Tri-County Regional Partnership and updated in this document in 2021
- WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health

*PRMC and WiCHD will build off the successful efforts that were included for this program in their 2016 Implementation Strategy Plan*

**Activities:**

- Train peer support specialists
- Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction, as well as other substance abuse issues
- Provide connections to resources including treatment options
- Provide peer outreach to high-risk areas of the community
- Maintain ongoing communications about metrics between PRMC and C.O.A.T. team
- Evaluate expansion to Somerset County

**Program Owner:**

- Wicomico County Health Department

**Program Collaborators:**

- PRMC
- Somerset County Health Department
- Hudson Health Services, Inc.
- Lower Shore Clinic, Inc.
- Wicomico County Sheriff's Department
- Tri-County community Primary Care Physicians
- Law Enforcement
- EMS
- Office of the State's Attorney General
- Numerous other community providers assist with resources and access to program services

## **1. Wicomico County Opioid Intervention Team and Somerset County Opioid United Team**

### **Activities:**

- Bring awareness, education, and resources to the community to work toward eliminating opioid abuse
- Target awareness activities and campaigns to the community and schools
- Participation in drug awareness coalitions
- Narcan training for community members
- Develop and implement an Opioid Intervention Team educational trailer for parents, guardians, and adults. This is a mock teenage bedroom set up to show possible red flags for unhealthy behavior and/or substance use
- Coordinate and host first responder dinner to help address compassion fatigue
- Work with community partners to coordinate the Go Purple Awareness Campaign

### **Program Owners:**

- Wicomico County Health Department
- Somerset County Health Department

### **Program Collaborators:**

- PRMC
- Wicomico County Executive's Office
- Wicomico County Department of Emergency Services
- Wicomico County State's Attorney
- Wicomico County Sheriff's Office
- Maryland State Police Barrack E
- Fruitland Police Department
- Salisbury Police Department
- Maryland Natural Resources Police
- Pittsville Police Department
- Delmar Police Department
- Hudson Health Services, Inc.
- Maryland Coalition of Families
- Clarion Call Restoration Ministries
- MAC, Inc.
- Peninsula Addictions and Mental Health
- J. David Collins and Associates
- Second Wind, Inc.
- Focus Point Behavioral Health
- United Way of the Lower Eastern Shore
- SonRise Church
- Recovery Resource Center

- City of Salisbury Fire Department
- High Intensity Drug Trafficking Area (HIDTA) Program
- Eastern Shore Psychological Center
- Wor-Wic Community College
- Salisbury University
- Wicomico County Public Schools/Board of Education
- BNJ Health Services
- St. James AME Methodist Church
- Department of Social Services
- Department of Parole and Probation
- Sante Group/Mobile Crisis
- Life Crisis Center
- Community Behavioral Health
- Deer's Head Hospital Center
- Comcast Spotlight
- Lower Shore Clinic, Inc.
- DKH Recovery House
- Somerset County Emergency Services
- Crisfield Police Department
- Somerset County Sheriff's Office
- McCready Health
- Somerset County Department of Social Services
- Princess Anne Police Department
- Department Parole & Probation
- Crisfield Drug Free Community
- University of Maryland Eastern Shore
- Somerset Circuit Court
- Somerset Recovery Court
- Somerset County Public Schools

## **2. Program to Encourage Active and Rewarding Lives (PEARLS)**

### **Activities:**

- Raise awareness of this free program through targeted outreach to clinicians caring for older adults, as well as senior centers and other local organizations serving older community members
- Provide engaging and impactful curriculum in an easy-to-learn approach through flexible one-on-one visits at locations convenient for the community member being served

### **Program Owner:**

- PRMC

**Program Collaborators:**

- MAC, Inc.

### 3. ER Utilization Reduction and Access Improvement

**Activities:**

- SWIFT—a mobile integrated health team makes home-based visits to individuals utilizing 911 at least five times over a six-month period for non-life-threatening medical reasons. The team provides physical, mental, and safety assessments, and screens for social determinants of health. Based on their assessment, patients are referred for appropriate care interventions such as primary care providers, medical specialists, in home providers, financial and social resources, as well as other community resources as necessary.

**Program Owner:**

- PRMC

**Program Collaborators:**

- City of Salisbury
  - Wicomico County Health Department
- 

## Diabetes

**Goal:** Improve health of people with diabetes or pre-diabetes in the Tri-County service area

**Strategies:**

- Offer Evidence-Based Chronic Disease Self-Management Classes (CDSM) throughout the Tri-County service area
- Expand access to diabetes screening, education, and resources throughout the Tri-County service area with the Wagner Wellness Van mobile clinic services
- Provide a free evidence-based weight loss, nutrition, and physical activity program for women and children in Wicomico and Somerset Counties

**Objectives and Anticipated Impact:**

- By December 2020, increase the number of 6-week educational classes with identified diabetes patients and their supporting caregivers from 26 to 52 per year
  - **Evaluation Measures:**
    - # of 6-week classes
    - # of people reached
    - Class completion rate
    - % knowledge change

- By partnering with other community stakeholders, the Community Wellness Program will increase access to diabetes screening, education, and connection to community resources. This program, which includes the Wagner Wellness Van outreach, provides health outreach events that are both large-scale and small-scale, and can be aimed toward the general public or a targeted population or geographic area.
  - **Evaluation Measures:**
    - # of screenings provided
    - Number of A1C's checked
    - # of community members referred for diabetes education
    - # of community members referred to their PCP
  
- Starting in September 2019 and ending in June 2021 SCALE's expected outcomes include: 80% of adult participants will report weight loss of at least 5% of their total body weight from baseline; 20% of adults participants will report a drop-in hemoglobin A1C by 0.2 point or more; 20% of adult participants will report a decrease in blood pressure (diastolic and systolic) by 5 points or more; demonstrated behavior change and improved health status
  - **Evaluation Measures:**
    - Weight loss
    - A1C levels
    - BP rate
    - % knowledge change
    - % participants reporting improved health status

**Recommended Policy Changes:**

- Increase access to fresh fruits and vegetables through community-based initiatives
- Increase active time in early childcare care site and schools including physical education

**PRMC System Resource Contributions:**

- Staff
- Data
- Marketing materials
- Training materials
- Mobile van
- Phone service
- Staff training and materials as needed

**Alignment Opportunities:**

- WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health

## Programs to Address Diabetes

### 1. Chronic Disease Self-Management (CDSM) Classes

*PRMC will build off the successful efforts that were included for this program in its 2016 Implementation Strategy Plan*

#### Activities:

- Target and identify patients who have diabetes and their caregivers through self-referral or provider referral
- Train Community Peer Trainers and PRMC Community Health Workers to conduct classes
- Offer classes in English, Spanish and American Sign Language
- Explore the possibility to offer classes in Haitian-Creole, Korean and Mandarin languages, based on availability of peer trainers in these languages
- Offer 6-week classes at least weekly
- Educate participants on diabetes self-management and have them set and track personal goals weekly and share goals with their providers
- Partner with MAC, Inc. to collect data on pre and post A1C values
- Connect with the statewide Health Information Exchange to make referrals between providers' office and MAC, Inc. for all CDSM classes

#### Program Owners:

- MAC, Inc.

#### Program Collaborators:

- PRMC

### 2. Wagner Wellness Van Expansion

*PRMC and WiCHD will build off the successful efforts that were included for this program in its 2016 Implementation Strategy Plan*

#### Activities:

- Outreach to communities utilizing a Nurse Practitioner (NP) to provide primary care services
- Provide screenings for diabetes (other screenings provided as well)
- Identify need for and make referrals to community resources for health education programs
- Ensure those people identified as diabetic or pre-diabetic are referred for primary care follow up
- Track rate of successful PCP follow up for all referrals
- Identify barriers to accessing PCP follow up and work towards future solutions

**Program Owners:**

- PRMC

**Program Collaborators:**

- Wicomico, Somerset and Worcester County Health Departments
- HOPE
- HALO
- Salisbury Urban Ministries
- St. James AME
- St. Peter's Lutheran
- Resource and Recovery Center
- Atlantic Club
- Marion Pharmacy
- MAC, Inc.
- National Kidney Foundation
- Wicomico County Schools
- Maryland Food Bank
- Various other community and faith-based organizations

**3. Sustainable Change and Lifestyle Enhancement (SCALE)**

**Activities:**

- Target outreach to overweight women of child-bearing age (up to age 55) and overweight children ages 7 – 17
- Offer education and activities to encourage healthier eating and physical activity
- Provide support through cooking demonstrations, grocery store tours, walks and better access to fresh, healthy food

**Program Owners:**

- Wicomico County Health Department
- Somerset County Health Department

**Program Collaborators:**

- PRMC
- YMCA
- University of Maryland Eastern Shore
- Wicomico County Detention Center
- HOPE
- Community Health Providers



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## **Cancer**

**Goal:** Improve cancer prevention, and early detection and intervention/treatment of cancer to provide the best possible outcomes in the Tri-County Area for colorectal, breast, cervical, lung and skin cancer.

### **Strategies:**

- Partner with WiCHD and SCHED to expand cancer screening
- Utilize cancer rate data to identify neighborhoods with high cancer incidence rates for targeted education and screening activities
- Collaborate with local school district(s) and colleges/universities to integrate skin cancer prevention education within student health curricula

### **Objectives and Anticipated Impact:**

- Working in partnership with the WiCHD and SCHED, offer additional cancer prevention programs and screening options for low-income community members, and connect those who need it to treatment
- Increase knowledge of at-risk activities for cancer, importance of healthy behaviors in prevention of cancer and importance of screening activities
  - **Evaluation Measures:**
    - # of screenings conducted
    - % follow up post positive screening
    - # of patients connected to treatment
    - % knowledge increase of cancer prevention

### **Recommended Policy Changes:**

- Design culturally competent communications that help people understand the importance of screening for early detection
- Engage communities with health disparities to modify risky behaviors and to access resources for prevention

### **PRMC System Resource Contributions:**

Providers for screening

### **Programs in Support of the Strategies**

#### **1. Wagner Wellness Van expansion**

### **Activities**

- Clinical breast exams
- Skin cancer screening
- Education
- Referral for cancer screenings

**Program Owner:**

- PRMC

**Program Collaborators:**

- Wicomico County Health Department
- Somerset County Health Department

**Alignment Opportunities**

- WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health









## FY 2021 Community Benefit Attachments

Attachment A - FY 2021 Progress Update Implementation Strategy Plan for TidalHealth Peninsula Regional and Community Health Improvement Plan (CHIP) for Wicomico County Health Department and Somerset County Health Department

**Attachment A**

**FY 2021 Progress Update**

**Implementation Strategy Plan**

**for TidalHealth Peninsula**

**Regional and**

**Community Health**

**Improvement Plan (CHIP) for**

**Wicomico County Health**

**Department and Somerset**

**County Health Department**



# Fiscal Year 2021 Progress Update

## Implementation Strategy Plan for TidalHealth Peninsula Regional

### Community Health Improvement Plan for Somerset County Health Department and Wicomico County Health Department

*Presented to the Wicomico County Local Health Improvement Coalition  
August 6, 2021*

Program	Page
Community Outreach Addictions Team (COAT)	1
Opioid Teams Somerset and Wicomico Counties	5
Sustainable Change and Lifestyle Enhancement (SCALE) Program	6
PEARLS	7
ER Utilization Reduction & Access Improvement Wagner Wellness Van; SWIFT; and Smith Island Telemedicine	7
Chronic Disease Self-Management Classes (CDSM)	8
Wagner Wellness Van Expansion – Cancer Prevention	9

**COMMUNITY OUTREACH ADDICTIONS TEAM (COAT)**  
Wicomico County Health Department

FY 2021 COAT Data Evaluation Measures		
	Unduplicated # Served / % of Total*	
Wicomico County Residents	323	76.72%
Non-Residents	98	23.28%
Total	421	100.00%

FY 2021 COAT Data Evaluation Measures						
Total # Outreach Services	# Served Reporting History of Opioid Use / % of Total*	Unduplicated # Linked to Treatment / % Unduplicated Linked to Treatment	6 Month Follow-Up # Attempted to Contact / # Contacted	6 Month Follow-Up # Remaining in Recovery/ % Remaining in Recovery**	Duplicated # Receiving Navigation Services*	# of Navigation Services Provided*
1,561	176 41.81%	236 56.06%	234 56	45 80.36%	171	261

\* Data is not comparable to previous years due to a changes in data collection and data operationalization that began January 2020.  
\*\*This measure assesses progress of individuals served the prior fiscal year. Data collection began January 2020. Six months of data will be reported in the FY21 report.

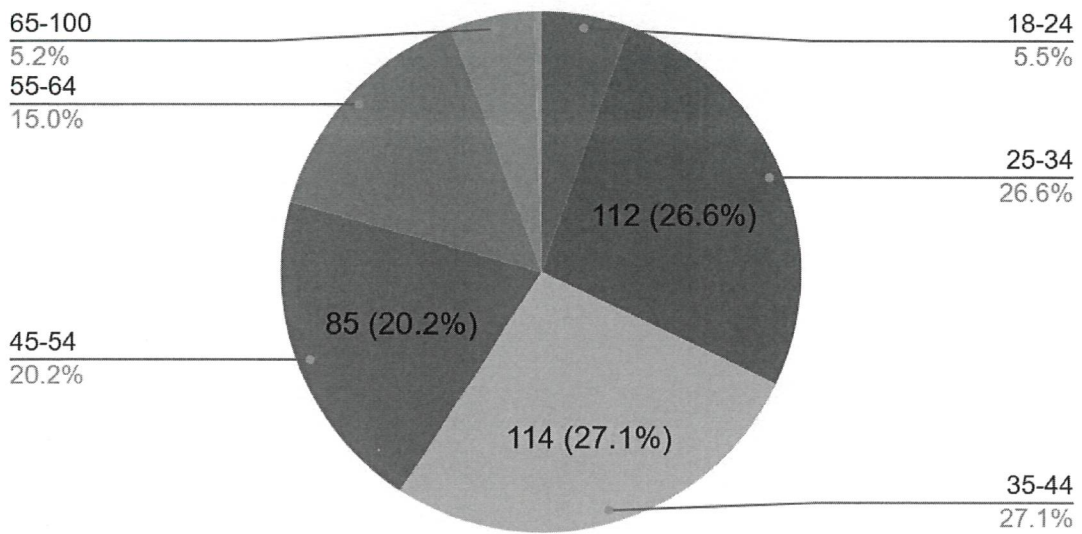
FY2021 COAT Navigation Services*			
Type of Assistance	# Served by Assistance Type	# of Services Provided	Average # of Services Per Person
Insurance Assistance	19	19	1.00
Transportation	21	63	3.00
Food Assistance	1	1	1.00
Housing	10	13	1.30
Financial Assistance	2	2	1.00
Medical Linkage/Referrals	6	7	1.17
Other (e.g. Support Meeting Schedule, Resource Information, Treatment Resources, etc.)	112	156	1.39

\* Data is not comparable to previous years due to a changes in data collection and data operationalization that began January 2020.

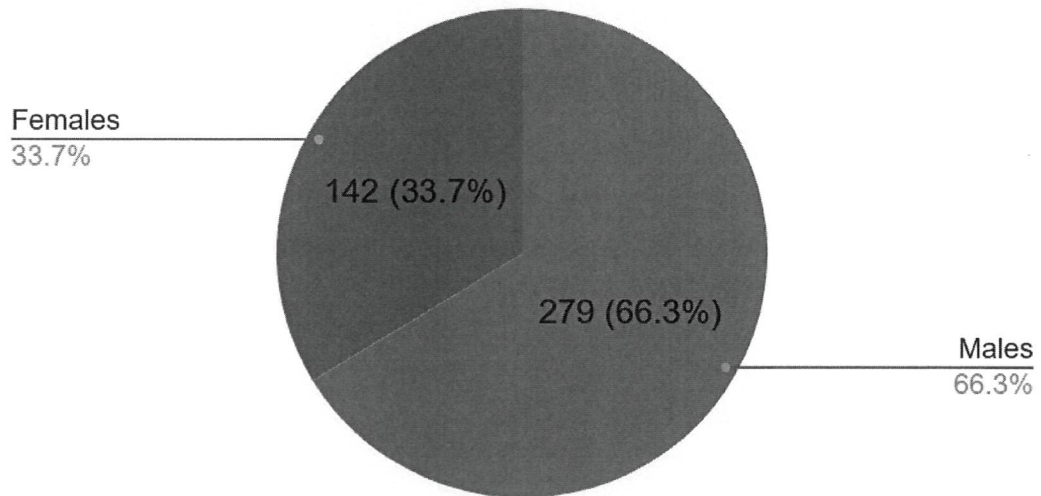
**NOTES**

- **# Served by Assistance Type** is the unduplicated number of individuals receiving the type of service. However, # served may be duplicated across the types of assistance, as an individual may receive more than one type of assistance.
- **# of Service Provided** is the total # of times staff provided the service, which may include providing individuals with the same type of assistance multiple times.

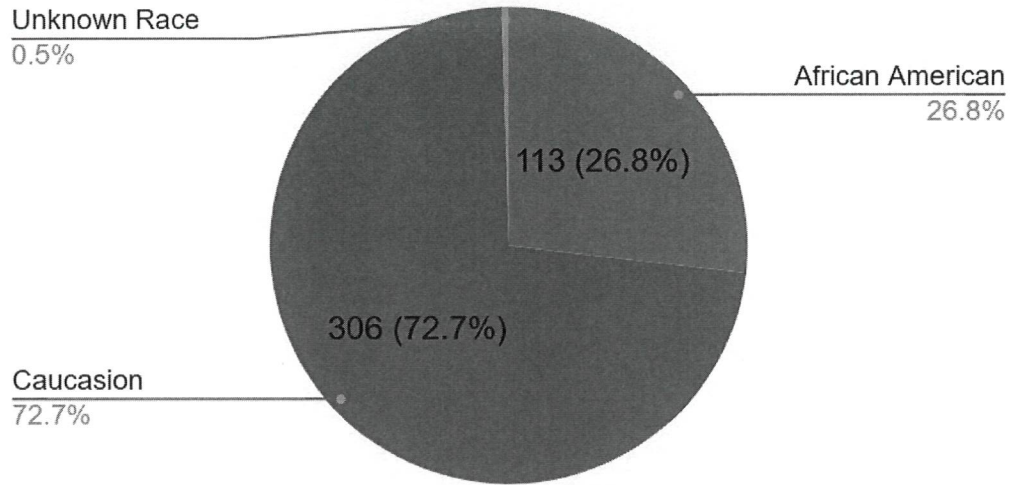
### FY21 COAT Data Total by Age



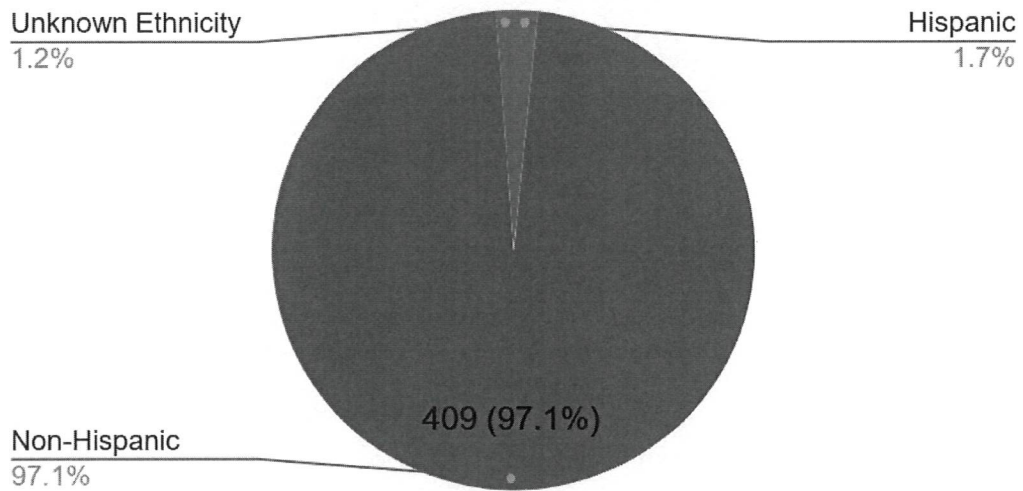
### FY21 COAT Data Individuals Served by Gender



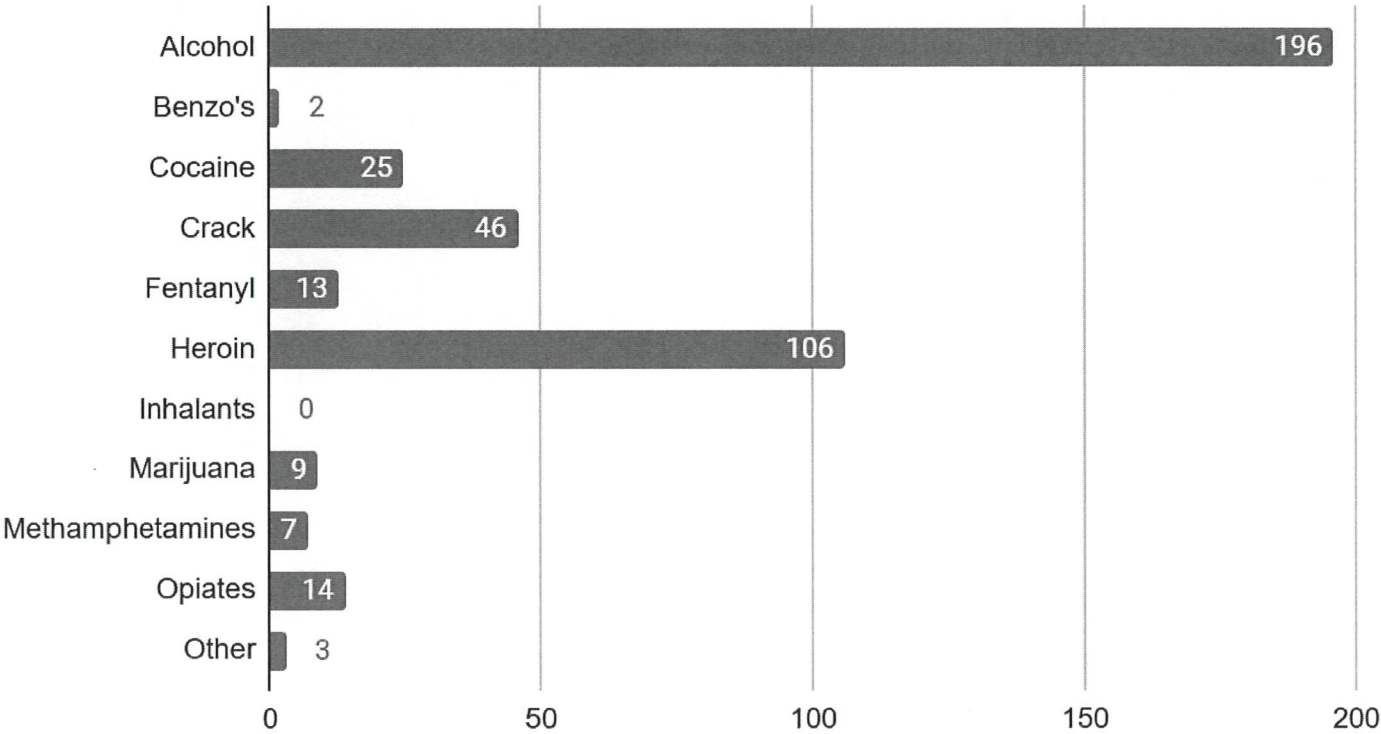
### FY21 COAT Data Individuals Served by Race



### FY21 COAT Data Individuals Served by Ethnicity



# FY21 COAT Data Individuals Served by Drug of Choice



## Opioid Teams

Somerset County Health Department & Wicomico County Health Department

<b>Somerset County Opioid United Team (SCOUT) FY 2021 Data Evaluation Measures</b>	
# of individuals exposed to opioid related messaging through an advertising "campaign"	306,389 Shore Birds stadium 50,000 fans, Clear Channel Billboard 106,389 impressions, The Voice radio station 150,000 listeners
# of individuals attending community events held in schools	0
# of individuals attending educational/training events held in the community	0 * Bags provided that advertised Somerset OIT grant with educational information to the increasing food pantries that popped up do to COVID-19
# of additional officer hours dedicated to opioid related calls and initiative	368.75 Hours
% of overdose cases shared by Law Enforcement with the Health Department	100%

<b>Wicomico County Opioid Intervention Team (OIT) FY 2021 Data Evaluation Measures</b>	
# of OIT meetings held	15
# of community events where Opioid Coordinator was present and providing education to the community	16
# of Local Overdose Fatality Review Team (LORFT) meetings attended	11
# of individuals who attend CE (continuing education) trainings planned by OIT Coordinator	70
FY21 # of individuals exposed to messaging via tv, radio, or social media	76,103 post reaches were made via Facebook, 15,000 resource mailers were sent to residences in Wicomico County which included SUD resources and 76.11k impressions were made by utilizing digital advertising
# of times the OIT Educational Trailer is deployed	1
# of Medication Disposal Bags provided to community members	60
# of individuals provided education via OIT trailer	100
# of first responders who attended dinner and received education.	Dinner not held due to COVID-19. 24 Appreciation Baskets delivered to each local agency in lieu of dinner.

**Sustainable Change and Lifestyle Enhancement (SCALE) Program**  
Somerset County Health Department & Wicomico County Health Department

<b>FY 2021 Sustainable Change and Lifestyle Enhancement (SCALE) Program Data Evaluation Measures</b>			
	<b>Somerset</b>	<b>Wicomico</b>	<b>Total for Somerset &amp; Wicomico</b>
<b># of adults enrolled in SCALE program</b>	14	8	22
<b>% of adults with weight loss of at least 5% of their baseline body weight</b>	57%	95%	76%
<b>% knowledge change</b>	100%	100%	100%
<b>% reporting improved health status</b>	85%	50%	67.5%
<b># of adults diagnosed as overweight or obese</b>	10	7	17
<b># of adults diagnosed as overweight or obese with improved BMI or weight loss</b>	2	7	9
<b># of adults with an increase in healthy lifestyle choices.</b>	100%	100%	100%
<i>Notes: Both counties held groups virtually due to COVID-19. Virtual meetings were challenging. In December 2020, Wicomico's health educator position became vacant. Beginning in January 2021, Somerset County Health Department provided classes in both Somerset and Wicomico counties.</i>			

**PEARLS  
MAC, Inc.**

<b>FY 2021 PEARLS Data Evaluation Measures</b>	
# of community members screened	141
# of community members enrolled	143
# who attended 6 or more sessions	71
% of enrollees with reduction in level of depression maintained over 12 months	59%
% of enrollees achieving remission of depression symptoms for at least 6 months	51%

**ER Utilization Reduction and Access Improvement  
(Wagner Wellness Van, SWIFT, and Smith Island Telemedicine)  
TidalHealth Peninsula Regional**

<b>FY 2021 Data Evaluation Measures</b>	
# of Labs	126
# of Tele Visits	32
# Office Visits	68
# Med Refills	42
# BP Checks	48
# COVID tests	55
# Flu Shots	58
# Pneumonia	3

*Note: On the Wagner Wellness Van No A1cs were done due to licensing constraints during the pandemic emergency. 11 people were referred to their PCP for elevated blood pressures during this time.*



## Chronic Disease Self-Management Classes (CDSM)

TidalHealth Peninsula Regional

FY 2021 CDSM Data Evaluation Measures	
# of Workshops	13
# Enrolled	94
# Completed	79
% Completed	92%

## Wagner Wellness Van Expansion – Cancer Prevention

TidalHealth Peninsula Regional

*No screening events were done with the cancer program during this time period because of the pandemic; however, the American Cancer Society screening handout was distributed to thousands of individuals who came to the COVID vaccination clinics*

## **FY2021 Community Benefit Narratives**

### **Community Benefit Narratives**

#### **Community Wellness Program**

The Community Wellness Program utilizes a mobile health van called the Wagner Wellness Van to build on partnerships throughout the community to identify and outreach to vulnerable and at-risk populations in Wicomico, Worcester, and Somerset counties. The Wellness team hosted screening events in all three counties, several days a week including at local migrant camps, Haitian community centers, schools, Smith Island, shelters, and churches. The strong commitment and trust built by the team proved significant in TidalHealth's ability to provide community-based education, information, testing, and vaccination in response to the COVID-19 pandemic.

In FY2021, the Community Wellness team supported several community endeavors through the fiscal year. The COVID-19 pandemic was still active in our community and the Community Wellness team shifted its focus to the COVID-19 vaccination clinics held at TidalHealth Peninsula Regional's campus, the Wicomico Youth and Civic Center, and community-based settings including homebound vaccinations. The team is led by a nurse practitioner and includes a social worker, community health workers and registered nurse. The mobile, multidisciplinary team continued to encounter with patients to provide social determinants of health screening and address barriers to optimum health and quality of life. Flu shots were provided in underserved communities. During these events and daily community outreach missions, the team provided flu vaccines, connected patients to primary care providers and provided referrals to various community partners and agencies for housing, faith, utilities, healthcare, and many other social determinants of health.

Once the coronavirus pandemic took hold of the community, the needs of residents changed, and the SWIFT and Wagner Wellness Van mobile teams adapted to meet the changing needs of vulnerable and disadvantaged residents most impacted by the pandemic. The staff were critical for mass community-based COVID-19 testing and vaccinations throughout the region. The teams were recruited to participate in a regional, grassroots task force organized to bring together agencies, organizations, and services to better meet the needs of vulnerable populations at a time when so many lost their employment, income, and access to brick-and-mortar programs. Again, the programs adapted to the needs of the community and provided health services, education, and outreach to pop-up resource fairs in the hardest hit communities. This work continues as the pandemic continues to affect communities.

#### **Smith Island Telehealth**

TidalHealth supports primary care, health education, prevention, and telehealth to the approximately 300 residents of the remote Smith Island in Somerset County. Without this partnership, Smith Island would have no direct access to health care. A team of providers including a physician, nurse practitioner and pharmacist, visit the island on average every other week. New primary care provider appointments are offered to community members without a PCP. Telehealth acute visits occur through a nurse practitioner at TidalHealth. A medical assistant resides on the island to provide ongoing support for chronic disease prevention and management, medication management, referrals and follow-up post discharge and ED visits. TidalHealth partnered with the Maryland Department of Health and National Guard to provide COVID testing and vaccinations to residents on the island in fiscal 2021.

### **Somerset County Opioid United Team (OIT and SCOUT)**

The Somerset County Opioid United Team is a program that targets the population of Somerset County who is struggling with addiction and their families and friends. The team consist of several community partners and stakeholders that bring awareness of the harms of opioid and other substances that affect not only the user, but also affect the family and friends of these users. Educational seminars are conducted at local schools, and clubs are formed at these schools to help bring education to other students about the dangers of substance abuse and the toll it takes on family and friends. There is also a substantial awareness campaign during Opioid Awareness Month in Somerset County. The team meets with local businesses and local government to set up opioid awareness campaigns that provide education to residents. Secure prescription drug drop boxes are located around Wicomico and Somerset counties as well as at TidalHealth McCreedy Pavilion to have residents safely dispose of their unwanted or expired opioids and limit the inappropriate use of these drugs in the community. The team also educates and trains community members on how to properly administer Narcan, the medicine used to treat someone with an opioid overdose. The overarching strategy of this team is to combat the current opioid epidemic affecting the local community and engage the community in helping reduce opioid use by increasing awareness.

### **TRIBE**

TRIBE stands for Tri-County Behavioral Health Engagement. This newly formed collaboration is a regional partnership between TidalHealth Peninsula Regional, Atlantic General Hospital and nine behavioral health community partner agencies in Somerset, Wicomico, and Worcester counties. The immediate goal is to design behavioral health crisis stabilization centers or behavioral health urgent care centers within the Tri-County area. The primary objectives of this program are to reduce ED utilization, hospital admissions to both TidalHealth Peninsula Regional and Atlantic General Hospital and readmissions for individuals experiencing behavioral health issues in the Tri-County area. TRIBE met throughout the year to discuss and identify gaps and fragmentation of services in the area with the goal of providing more seamless and “real time” behavioral health urgent care and behavioral health care services.

### **Wagner Wellness Van Expansion**

The Wagner Wellness Van helps to provide health outreach events that are both large-scale and small-scale that are aimed at the public or a targeted population or geographic area. The Wagner Wellness Van partnered with both the Somerset County Health Department and the Wicomico County Health Departments to increase access to diabetes screening, education, and connection to other community resources. The Wagner Wellness Van also offered additional cancer prevention programs and screenings options for low-income community members and connected those that needed it to treatment. The Wagner Wellness Van is vitally important for reaching communities that otherwise could not afford or would not seek healthcare.



## ADMINISTRATIVE POLICY MANUAL

### Subject: Financial Assistance / Uncompensated Care

<b>Effective Date:</b>	August 1981
<b>Approved by:</b>	President/CEO and Senior Vice President of Finance/CFO
<b>Responsible Parties:</b>	Senior Executive Director of Patient Financial Services
<b>Revised Date:</b>	12/86, 6/88, 3/90, 3/91, 7/93, 7/94, 8/98, 12/05, 8/08, 5/10, 10/10, 12/14, 7/16, 11/16, 7/17, 7/18, 7/19, 7/20, 9/20
<b>Reviewed Date:</b>	8/83, 12/85, 2/88, 6/92, 8/95, 7/96, 9/97, 6/00, 6/01, 10/02, 10/04, 12/11, 12/12, 12/13
<b>Key Words:</b>	Financial Assistance, Federal Poverty Guidelines, Charity Care, Uncompensated

### POLICY

TidalHealth will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their medical bill. For purposes of this policy, TidalHealth shall include TidalHealth Peninsula Regional, TidalHealth McCready Pavilion, TidalHealth Primary Care, and TidalHealth Specialty Care. A patient's payment shall not exceed the amount generally billed (AGB). All hospital regulated services (which includes emergency and medically necessary care) will be charged consistently as established by the Health Services Cost Review Commission (HSCRC) which equates to the amounts generally billed (AGB) method. All patients seen by a TidalHealth Primary Care or Specialty Care provider or in an unregulated area will be charged the fee schedule plus the standard mark-up. The AGB for TidalHealth Primary Care or Specialty Care and other services not regulated by the HSCRC equates to the Medicare fee-for-service amount under the prospective method. A 50% discount will be applied to all self-pay unregulated services and patients seen by a TidalHealth Primary Care or Specialty Care provider. The 50% discount reduces the patient responsibility to the AGB. If the patient qualifies for financial assistance, this 50% discount will be granted prior to the application of the financial assistance write-off.

TidalHealth may use outsource vendors to provide patient collection and/or pre-collection services. Vendors act in accordance with TidalHealth policies and wherever policy notates employee, financial services department, or other such wording – vendor and/or vendor employees are included without such notation.

#### Definitions:

- a. **Elective Care:** Care that can be postponed without harm to the patient or that is not medically necessary. An appropriate clinical or physician representative will be contacted for consultation in determining the patient status.
- b. **Medical Necessity:** Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.

- c. Immediate Family: A family unit is defined to include all individuals taken as 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 will be considered.
- d. 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.
- e. Medical Debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs for medical costs billed by TidalHealth.
- f. Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

TidalHealth will provide free medically necessary care to patients with family income at or below 200% of the federal poverty level. Patients qualifying for financial assistance based on income at or below 200% of the federal poverty level have no cost for their care and therefore pay less than AGB.

TidalHealth will provide reduced-cost medically necessary care to low-income patients with family income between 200% and 300% of the Federal poverty level.

TidalHealth will provide reduced-cost medically necessary care to low-income patients with family income between 301% and 500% of the Federal poverty level who have a medical hardship as defined by Maryland Law. Medical hardship is medical debt, incurred by a family over a 12 month period that exceeds 25% of the family income.

Other healthcare fees and professional fees that are not provided by TidalHealth are not included in this policy. Pre-planned service may only be considered for financial assistance when the service is medically necessary. As an example, cosmetic surgery is excluded. Inpatient, outpatient, emergency services, and services rendered by TidalHealth are eligible.

TidalHealth's financial assistance is provided only to bills related to services provided at TidalHealth or at a TidalHealth site including services provided by physicians employed by TidalHealth. To determine if your physician's services are covered by the TidalHealth financial assistance program, please see the roster of providers that deliver emergency and other medically necessary care, indicating which providers are covered under the policy and which are not. The list of providers is updated quarterly and available on the TidalHealth website. If you prefer, you may contact any financial counselor or patient accounting representative by calling (410) 912-4974, or in person at TidalHealth Peninsula Regional.

## **PROCEDURE**

If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies. In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, TidalHealth will provide care at reduced or zero cost. When no third party assistance is available to cover the total bill and the patient indicates that they have insufficient funds, Financial Assistance (FA) will be offered. The Maryland State Uniform Financial Assistance application, Financial Assistance Policy, Patient Collection Practice Policy, and plain language summary, can be obtained by one of the following ways:

- a. Available free of charge and upon request by calling (410) 543-7436 or (877) 729-7762.
- b. Are located in the registration areas.
- c. Downloaded from the TidalHealth website:  
<https://www.tidalhealth.org/patientforms>  
<https://www.tidalhealth.org/patientbills>
- d. The plain language summary is inserted in the Admission packet and with all patient statements.
- e. Through signs posted in the main registration areas.
- f. Annual notification in the local newspaper.
- g. The application is available in English and Spanish. No other language constitutes a group that is 5% or more, or more than 1,000 residents (whichever is less) of the population in our primary service area (Worcester, Wicomico and Somerset Counties) based on U.S. Census data.
- h. For patients who have difficulty in filling out an application, the information can be taken orally by calling (410) 912-6957 or in person at the Financial Counselor's Office located in the Frank B. Hanna Outpatient Center.

The patient's income will be compared to current Federal Poverty Guidelines (on file with the Collection Coordinator). The Collection Coordinator representative will consult with the patient as needed to make assessment of eligibility.

- a. 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.
- b. If the application is incomplete, all ECA efforts will remain on hold for a reasonable amount of time and assistance will be provided to the patient in order to get the application completed. If there is not a phone contact to call, a written notice that describes the additional information and/or documentation required will be mailed which includes a phone contact to call for assistance.
- c. Preliminary eligibility will be made within 2 business days based upon receipt of sufficient information to determine probable eligibility. A letter will be mailed to patients notifying them of their eligibility status. Following preliminary approval, patients must submit a completed application and any supporting documentation requested (if not done previously). Upon final approval, a financial assistance discount will be applied to the patient's responsibility.
- d. Patients who are beneficiaries/recipients of certain means-tested social services programs are deemed to have presumptive eligibility at 100% and are FA eligible without the completion of an application or submission of supporting documentation. It is the responsibility of the patient to notify TidalHealth that they are in a means-tested program. This information may also be obtained from an outsourced vendor or other means available to TidalHealth.
- e. A patient that has qualified for Maryland Medical Assistance is deemed to automatically qualify for Financial Assistance (FA) at 100%. The amount due from a patient on these accounts may be written off to FA with verification of Medicaid eligibility. Standard documentation requirements are waived.

- f. TidalHealth may automatically approve Financial Assistance for accounts ready to be sent to a collection agency that are identified as Poverty based on the propensity to pay score.
- g. If the application is ineligible, normal dunning processes will resume, which includes notifying the agency if applicable to proceed with ECA efforts. A copy of TidalHealth's Collections Policy may be obtained by calling (410) 543-7436 or (877) 729-7762 and is available on the website listed above.
- h. The patient may request reconsideration by submitting a letter to the Director of Patient Financial Services indicating the reason for the request.
- i. Only income and family size will be considered in approving applications for FA unless one of the following three scenarios occurs:
  - The amount requested is greater than \$50,000
  - The tax return shows a significant amount of interest income, or the patient states they have been living off of their savings accounts
  - Documentation indicates significant wealth
- j. If one of the above three scenarios are applicable, liquid assets may be considered including:
  - Checking and savings accounts
  - Stocks and bonds
  - CD's
  - Money market or any other financial accounts for the past three months
  - Last year's tax return
  - A credit report may also be reviewed

The following assets are excluded:

- The first \$10,000 of monetary assets
- Up to \$150,000 in a primary residence
- Certain retirement benefits such as a 401-K 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 be required to pay taxes and/or penalties by cashing in the benefit.

If the balance due is sufficient to warrant it and the assets are suitable, a lien may be placed on the assets for the amount of the bill. Collection efforts will consist of placement of the lien which will result in payment to TidalHealth upon sale or transfer of the asset. Refer to the TidalHealth Collection policy on filing liens.

- k. If TidalHealth 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.
- l. We do not request or provide waivers, written or oral, expressing patient does not wish to apply for assistance.

#### Collection Coordinator

- a. If eligible, and under \$2,500, the account will be written off to FA when the "Request for Financial Assistance" form is finalized. A copy is retained in the patient's electronic file. If eligible, and the balance is \$2,500 or above, the Collection Coordinator will obtain the appropriate adjustment signature(s).

- b. TidalHealth will review only those accounts where the patient or guarantor inquire about FA, based on mailing in an application, or in the normal working of the account there is indication that the patient may be eligible. Any patient/customer service representative, financial counselor, or collection representative may begin the application process.
- c. Once a request has been approved, service eight months before the approval and twelve months after the approval may be included in the adjustment. All encounters included with the application must reference the original encounter number where the electronic image of the application is stored. Service dates outside this twenty month window may be included if approved by a Supervisor, Manager, or Director. Any amount exceeding \$5 that has already been collected from the patient or guarantor for approved dates of service shall be refunded to the patient if the determination is made within two years of the date of care.
- d. TidalHealth will communicate with the patient using the method preferred by the patient including electronic communications, telephone or mail.

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Steven Leonard  
President/CEO

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Bruce Ritchie  
Senior Vice President of Finance/CFO



## PLAIN LANGUAGE SUMMARY

### **Financial Assistance Policy**

It is the intention of TidalHealth Peninsula Regional, TidalHealth McCready Pavilion, TidalHealth Primary Care, and TidalHealth Specialty Care to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost for emergency and medically necessary care.

Patients requiring elective services may, through consultation with their physician, have their procedure postponed until such time as the patient is able to make full payment or meet the established deposit. Elective procedure patients who, according to their diagnosis and/or their physician, cannot have their procedure postponed will be helped with obtaining assistance from agencies. If no assistance is available, and the patient requests, the account will be reviewed for possible financial assistance.

TidalHealth Primary Care and TidalHealth Specialty Care physician charges are not included in the hospital bill and are billed separately, with the exception of self-pay balances. Self-pay balances for TidalHealth Peninsula Regional, TidalHealth Primary Care and TidalHealth Specialty Care services will appear on the same statement. Physician charges outside of TidalHealth Primary Care and TidalHealth Specialty Care are not included in the hospital bill and will be billed separately. Physician charges outside of TidalHealth Primary Care and TidalHealth Specialty Care are not covered by TidalHealth's financial assistance policy. A list of providers that deliver emergency and other medically necessary care at TidalHealth is provided on the website at [www.tidalhealth.org/primaryandspecialtycare](http://www.tidalhealth.org/primaryandspecialtycare) indicating which providers are covered under TidalHealth's financial assistance policy and which are not, or you may call (410) 912-4974.

In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, the patient may be eligible for financial assistance.

### **Eligibility Determination Process**

1. Interview patient and/or family.
2. Obtain annual gross income.
3. Determine eligibility (*preliminary eligibility within 2 business days*).
4. Screen for possible referral to external charitable programs.
5. If the patient and/or family refuse to disclose financial resources or cooperate, the patient will be subject to standard collection efforts. No Extraordinary Collection Actions (ECA) will be taken for at least 120 days from the first post-discharge billing statement.
6. All applications received within 240 days of the first post-discharge billing statement will be reviewed. ECA actions will be suspended until the application has been processed.
7. The determination of eligibility (*approval or denial*) shall be made in a timely manner.

### **How to Apply**

- Applications can be taken orally by calling (410) 912-6957 between 8:00 a.m. and 5:00 p.m., Monday through Friday
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:00 a.m. and 4:00 p.m., Monday through Friday
- Mailing a request for an application to TidalHealth Peninsula Regional, PO Box 2498, Salisbury, MD 21802-2498

- On the internet at:  
<https://www.tidalhealth.org/patientforms>  
<https://www.tidalhealth.org/patientbills>
- Applications are available in English and in Spanish

### **Qualifications**

TidalHealth compares the patient's income to the Federal Poverty Guidelines. In order to process your application we require the following information:

- An independent third party to verify your household income (one of the following)
  - a. Recent pay stub showing current and year-to-date earnings
  - b. Most recent tax return showing your Adjusted Gross Income or W-2 form
  - c. Written documentation of Social Security benefits, SSI disability, VA benefits, etc.
  - d. If no income, a letter from an independent source such as a clergy or neighbor verifying no income
- Completed application

This information, and any information obtained from external sources, is used to determine your eligibility for financial assistance. The more information provided, the easier it is for us to determine your financial need. TidalHealth may request a credit report to support a patient's application for assistance.

### **Need Assistance?**

If, at any time, you have questions about obtaining financial assistance, your medical bill, your rights and obligations with regard to the bill, or applying for the Medical Assistance Program, please contact TidalHealth Peninsula Regional's Financial Services Department at (410) 912-6957 or (877) 729-7762. You can obtain a copy of the TidalHealth Financial Assistance Policy at [www.tidalhealth.org/financialassistance](http://www.tidalhealth.org/financialassistance).

### **Medical Assistance Program**

To find out if you are eligible for Maryland Medical Assistance or other public assistance, please apply at your local Department of Social Services (DSS) office, or you may visit [mmcp.dhmd.maryland.gov](http://mmcp.dhmd.maryland.gov) for information about the various Medicaid programs available. You may apply online for Maryland Medicaid at [marylandhealthconnection.gov](http://marylandhealthconnection.gov). If you are applying for assistance for a child or are pregnant, you may apply for the Maryland Children's Health Program (MCHP). If you are only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your local Department of Social Services (DSS) for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. Delaware residents may obtain information online at [dhss.delaware.gov](http://dhss.delaware.gov) or apply online at [assist.dhss.delaware.gov](http://assist.dhss.delaware.gov). Virginia residents may obtain information at [dmas.Virginia.gov](http://dmas.Virginia.gov). To receive an application, call your local DSS office or the Area Agency on Aging, (AAA). For more information, you may call the Department of Health and Mental Hygiene's Recipient Relations Hotline at 1 (800) 492-5231 or (410) 767-5800.

### **Patients' Rights and Obligations**

Rights:

- Prompt notification of their preliminary eligibility determination for financial assistance.
- Guidance from TidalHealth on how to apply for financial assistance and other programs which may help them with the payment of their medical bill.
- Receipt of financial assistance for all services not payable by another program that meet the qualifications of TidalHealth's Financial Assistance Policy.
- TidalHealth will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their medical bill.

**Obligations:**

- Submit complete and accurate information on the Uniform Financial Assistance Application in use in the state of Maryland.
- Attach supporting documentation and return the form to TidalHealth Peninsula Regional in a timely manner.
- Make payment in full or establish a payment plan for services not qualified under TidalHealth's Financial Assistance Policy.

**Cómo hacer la solicitud**

- Llame al (410) 912-6957 o (877) 729-7762 entre las 8:00 a.m. y las 5:00 p.m., de lunes a viernes
- Acuda en persona a la oficina del consejero financiero (Localizado en el vestíbulo Frank B. Hanna del Centro de atención de Pacientes Externos) entre las 8:00 a.m. y las 4:00 p.m., de lunes a viernes
- A través de Internet, visite [www.tidalhealth.org](http://www.tidalhealth.org). Haga clic en Patients & Visitors (Pacientes y visitantes), luego en Patient Financial Services (Servicios financieros para pacientes) y después en Billing Information (Información de facturación)



MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION

977

Information About You

Name: First Middle Last

Social Security Number US Citizen Yes No

Marital Status: Single Married Separated Permanent Resident: Yes No

Home Address

City State Zip Code Country

Employer Name Phone

Work Address

City State Zip Code

Household Members:

Table with 3 columns: Name, Age, Relationship. Multiple rows for household members.

Have you applied for Medical Assistance? Yes No. If yes, what was the date you applied? If yes, what was the determination

Do you receive any state or County Assistance? Yes No

TidalHealth Peninsula Regional - Patient Accounts 100 East Carroll Street Salisbury, MD 21801

**I. Family Income**

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/Pension Benefits	_____
Social Security Benefits	_____
Public Assistance Benefits	_____
Disability Benefits	_____
Unemployment Benefits	_____
Veterans Benefits	_____
Alimony	_____
Rental Property Income	_____
Strike Benefits	_____
Military Allotment	_____
Farm or Self-Employment	_____
Other Income Source	_____
<b>Total</b>	_____

**II. Liquid Assets**

	Current Balance
Checking Account	_____
Savings Account	_____
Stocks, Bonds, CD, or Money Market	_____
Other Accounts	_____
<b>Total</b>	_____

**III. Other Assets**

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____	Approximate Value _____
Automobile	Make _____ Year _____	Approximate Value _____
Additional Vehicle	Make _____ Year _____	Approximate Value _____
Additional Vehicle	Make _____ Year _____	Approximate Value _____
Other Property		Approximate Value _____
	<b>Total</b>	_____

**IV. Monthly Expense**

	Amount
Rent or Mortgage	_____
Utilities	_____
Car Payment(s)	_____
Credit Card(s)	_____
Car Insurance	_____
Health Insurance	_____
Other Medical Expenses	_____
Other Expenses	_____
<b>Total</b>	_____

Do you have any other unpaid medical Bills?                      Yes      No

For what service? \_\_\_\_\_

If you have arranged a payment plan, what is the monthly payment? \_\_\_\_\_

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within 10 days.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**2020 Federal Poverty Guidelines**

Updated 02/05/2020

(with name update 9/01/2020)

If your family size is:	And, your family income is at or below:		
Family Size	200% Federal Poverty Guideline	201% up to 300% Federal Poverty Guideline	301% - 500% Federal Poverty Guideline with <u>Medical Hardship</u>
1	\$25,520	\$38,280	\$63,800
2	\$34,480	\$51,720	\$86,200
3	\$43,440	\$65,160	\$108,600
4	\$52,400	\$78,600	\$131,000
5	\$61,360	\$92,040	\$153,400
6	\$70,320	\$105,480	\$175,800
7	\$79,280	\$118,920	\$198,200
8	\$88,240	\$132,360	\$220,600
You receive a discount off TidalHealth bills of:	<b>100%</b>	<b>50%</b>	<b>25%</b>

**From:** [Hilltop HCB Help Account](#)  
**To:** [Hilltop HCB Help Account](#); [Henry Nyce](#)  
**Subject:** Clarification Required - TidalHealth McCready Pavilion FY 21 Community Benefit Narrative  
**Date:** Thursday, May 19, 2022 4:40:54 PM  
**Attachments:** [TidalHealth McCready Pavilion\\_HCBNarrative\\_FY2021\\_20211216.pdf](#)

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Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for TidalHealth McCready Pavilion. In reviewing the narrative, we encountered a few items that require clarification:

- Your response to Question 5 on page 1 indicated your hospital used “Other” community health statistics in its community benefit efforts. However, no description was provided of these other statistics. Please provide a description.
- Please provide a response to question 131 on page 22.

Please provide all clarifying answers as a response to this message.

**From:** [Henry Nyce](#)  
**To:** [Hilltop HCB Help Account](#)  
**Cc:** [Logan Becker](#)  
**Subject:** Clarification of CB  
**Date:** Thursday, June 2, 2022 10:26:24 AM  
**Attachments:** [Hilltop clarification to CB TidalHealth.docx](#)

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[Report This Email](#)

Hilltop HCB Help Account,

Attached you will find clarification to several questions of TidalHealth's FY 2021 Community Benefit Narrative Report.

- Question 5, page 1
- Question 131, page 22

We are currently working on clarifying question 223 on page 26 (physician subsidies) and will submit that over the next several weeks.

Thank you, and if you have any questions please call.

**Henry Nyce**  
Manager of Planning & Business Dev.  
Strategy & Business Development

**TidalHealth**  
100 East Carroll Street  
Salisbury, MD 21801

**O** 410-543-7404

**F** 410-543-7144

Please note, my e-mail has changed to:

[Henry.nyce@TidalHealth.org](mailto:Henry.nyce@TidalHealth.org)

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## Hilltop Request

Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for TidalHealth Peninsula Regional. In reviewing the narrative, we encountered a few items that require clarification:

- Your response to Question 5 on page 1 indicated your hospital used “Other” community health statistics in its community benefit efforts. However, no description was provided of these other statistics. Please provide a description.

## TidalHealth Response

*Page 1, Question 5. Other Health Statistics reviewed within TidalHealth’s CBSA include: cancer statistics, children’s health, economy, education, environmental and occupational health, health and nutrition, heart disease, maternal and infant health, behavioral health, older adults, oral health, prevention and safety, public safety, social environment, transportation, women’s health and teen and adolescent health.*

*In addition, we also had attached a file “FY2021 Additional Resources to Community Benefits Market and Demographics” to the original submission that included other statistics we continue to use as part of our CBSA evaluation toolkit.*

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

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Median household income                              | <input type="checkbox"/> Race: percent white                              |
| <input checked="" type="checkbox"/> Percentage below federal poverty line (FPL)          | <input checked="" type="checkbox"/> Race: percent black                   |
| <input checked="" type="checkbox"/> Percent uninsured                                    | <input checked="" type="checkbox"/> Ethnicity: percent Hispanic or Latino |
| <input type="checkbox"/> Percent with public health insurance                            | <input checked="" type="checkbox"/> Life expectancy                       |
| <input checked="" type="checkbox"/> Percent with Medicaid                                | <input checked="" type="checkbox"/> Crude death rate                      |
| <input type="checkbox"/> Mean travel time to work  | <input checked="" type="checkbox"/> Other                                 |
| <input checked="" type="checkbox"/> Percent speaking language other than English at home |   |

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

Please see the CHNA, we also use a “Family Living In Poverty” report, SocioNeeds Index, Households with no Vehicle, Racial Ethnicity Diversity, and the ALICE report which is way of defining those households that struggle with basic health and household necessities but do not qualify for federal assistance.

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

[FY2021 Additional Resources for Community Benefits Market and Demographics \(1\).docx](#)  
2.7MB  
application/vnd.openxmlformats-officedocument.wordprocessingml.document

## Hilltop Request

- No response was given for Question 131 on page 22. Please provide a response.

## TidalHealth Response

Please see TidalHealth's selected five checkmarks below for Question 131, page 22.

### HillTop

Q131.

In your most recently completed CHNA, the following community health needs were identified: **Health Conditions - Addiction, Health Conditions - Cancer, Health Conditions - Diabetes, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Overweight and Obesity, Health Behaviors - Drug and Alcohol Use, Health Behaviors - Health Communication, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Physical Activity, Health Behaviors - Preventive Care, Health Behaviors - Vaccination, Populations - Adolescents, Populations - Children, Populations - Older Adults, Populations - Women, Settings and Systems - Health Care, Settings and Systems - Hospital and Emergency Services, Social Determinants of Health - Education Access and Quality, Social Determinants of Health - Health Care Access and Quality**  
Other:

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

- |  |   |
|--|---|
| <input type="checkbox"/> Access to Health Services: Health Insurance                       | <input type="checkbox"/> Heart Disease and Stroke                       |
| <input type="checkbox"/> Access to Health Services: Practicing PCPs                        | <input type="checkbox"/> HIV  |
| <input type="checkbox"/> Access to Health Services: Regular PCP Visits                     | <input type="checkbox"/> Immunization and Infectious Diseases           |
| <input type="checkbox"/> Access to Health Services: ED Wait Times                          | <input type="checkbox"/> Injury Prevention                              |
| <input type="checkbox"/> Access to Health Services: Outpatient Services                    | <input type="checkbox"/> Lesbian, Gay, Bisexual, and Transgender Health |
| <input type="checkbox"/> Adolescent Health   | <input type="checkbox"/> Maternal and Infant Health                     |
| <input type="checkbox"/> Arthritis, Osteoporosis, and Chronic Back Conditions              | <input type="checkbox"/> Nutrition and Weight Status                    |
| <input type="checkbox"/> Behavioral Health, including Mental Health and/or Substance Abuse | <input type="checkbox"/> Older Adults                                   |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Oral Health                                    |
| <input type="checkbox"/> Children's Health   | <input type="checkbox"/> Physical Activity                              |
| <input type="checkbox"/> Chronic Kidney Disease  | <input type="checkbox"/> Respiratory Diseases                           |
| <input type="checkbox"/> Community Unity   | <input type="checkbox"/> Sexually Transmitted Diseases                  |
| <input type="checkbox"/> Dementias, including Alzheimer's Disease                          | <input type="checkbox"/> Sleep Health                                   |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Telehealth                                     |
| <input type="checkbox"/> Disability and Health   | <input type="checkbox"/> Tobacco Use                                    |
| <input type="checkbox"/> Educational and Community-Based Programs                          | <input checked="" type="checkbox"/> Violence Prevention                 |
| <input type="checkbox"/> Environmental Health  | <input type="checkbox"/> Vision   |
| <input checked="" type="checkbox"/> Family Planning  | <input type="checkbox"/> Wound Care                                     |
| <input checked="" type="checkbox"/> Food Safety  | <input type="checkbox"/> Housing & Homelessness                         |
| <input checked="" type="checkbox"/> Global Health  | <input type="checkbox"/> Transportation                                 |
| <input type="checkbox"/> Health Communication and Health Information Technology            | <input checked="" type="checkbox"/> Unemployment & Poverty              |
| <input type="checkbox"/> Health Literacy   | <input type="checkbox"/> Other Social Determinants of Health            |
| <input type="checkbox"/> Health-Related Quality of Life & Well-Being                       | <input type="checkbox"/> Other (specify) <input type="text"/>           |