Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

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

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

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

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

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

	Is this information correct?		If no, please provide the correct information here:
	Yes	No	
The proper name of your hospital is: TidalHealth Peninsula Regional	◉	○	
Your hospital's ID is: 210019	◉	○	
Your hospital is part of the hospital system called TidalHealth.	◉	○	
The primary Narrative contact at your hospital is Rita Mecca	○	◉	Henry Nyce
The primary Narrative contact email address at your hospital is rita.mecca@tidalhealth.org	○	◉	Henry.nyce@tidalhealth.org
The primary Financial contact at your hospital is Rebecca Righter	○	◉	Cindy Sapp
The primary Financial email at your hospital is rebecca.righter@tidalhealth.org	○	◉	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.

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

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

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

- [x] 21792
- [x] 21804
- [x] 21811
- [x] 21829
- [x] 21841
- [x] 21842
- [x] 21862
- [x] 21863
- [x] 21864

- [x] 21813
- [x] 21822
- [x] 21843
- [x] 21851
- [x] 21872

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.
- [x] Other. Please describe.

Historically, TidalHealth Peninsula Regional has used this three county area of Somerset County, Wicomico County and Worcester County as its CBSA.

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

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

https://online.fliphtml5.com/cxbl/pjhj/#p=1

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										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/Population Health Director (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Board of Directors or Board Committee (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (system level)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☑	The Board of Trustees receives a copy of the Community Healt Assessment and the Implementation Strategy Plan to review, and approve. There are also periodic updates to action plans, m and progress updates.
Clinical Leadership (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☑	Those identified in the preceding positions (nurses, social work make up the Community Benefit Task Force. Others from Beh Health, Marketing, and Planning were also participants in the Co Benefit Task Force.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Physician(s)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Nurse(s)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Social Workers	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Hospital Advisory Board	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Other (specify) Behavioral Health, Marketing, Planning, Diabetes Department, Emergency Department, Cardiac Rehab, Pediatric Endocrinology and Employee Health and Wellness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Participants in each of these departments used their knowled unique expertise to contribute to the CHNA.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:

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

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

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	The Board of Trustees receives a copy of the Community Benefits Repo (financial and narrative) with a presentation at their monthly educatior session. Following the education session, the Board fully accepts the Community Benefit Report through the passing of a resolution.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

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

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

Q48. Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. Please use the table below to tell us about the external partners involved in your most recent CHNA. In the first column, select and describe the external participants. In the second column, select the level of community engagement for each

participant. In the third column, select the recommended practices that each stakeholder was engaged in. The Maryland Hospital Association worked with the HSCRC to develop this list of eight recommended practices for engaging patients and communities in the CHNA process.

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

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

Local Govt. Organizations -- Please list the organizations here:	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
Wicomico County Executive	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐
Faith-Based Organizations	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐
School - K-12 -- Please list the schools here: Wicomico High School	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐
School - Colleges, Universities, Professional Schools -- Please list the schools here: Salisbury University and University of Maryland Eastern Shore	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐
Behavioral Health Organizations -- Please list the organizations here: Lower Shore Enterprises and Lower Shore Clinic	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐
Social Service Organizations -- Please list the organizations here: MAC, Inc.	☑	☑	☐	☑	☐	☐	☐	☑	☑	☑	☑	☐	☐	☑
Post-Acute Care Facilities -- please list the facilities here: Salisbury Rehabilitation and Skilled Nursing Center - Genesis, Deers Head and Peninsula Home Care	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here: HOPE Inc. and HALO	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐
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	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐

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

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

- (●) Yes
- ( ) No

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

11/07/2019

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

https://online.fliphtml5.com/cxbl/urjg/#p=1

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

TidalHealth Peninsula Regional Implmentation 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.

- [x] Health Conditions - Addiction
- [ ] Health Conditions - Arthritis
- [ ] Health Conditions - Blood Disorders
- [x] Health Conditions - Cancer
- [ ] Health Conditions - Chronic Kidney Disease
- [ ] Health Conditions - Chronic Pain
- [ ] Health Conditions - Dementias
- [x] Health Conditions - Diabetes
- [ ] Health Conditions - Foodborne Illness
- [ ] Health Conditions - Health Care-Associated Infections
- [ ] Health Conditions - Heart Disease and Stroke
- [ ] Health Conditions - Infectious Disease
- [x] Health Conditions - Mental Health and Mental Disorders
- [ ] Health Conditions - Oral Conditions
- [ ] Health Conditions - Osteoporosis
- [x] 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
- [x] Health Behaviors - Drug and Alcohol Use
- [ ] Health Behaviors - Emergency Preparedness
- [ ] Health Behaviors - Family Planning
- [x] Health Behaviors - Health Communication
- [ ] Health Behaviors - Injury Prevention
- [x] Health Behaviors - Nutrition and Healthy Eating
- [x] Health Behaviors - Physical Activity
- [x] Health Behaviors - Preventive Care
- [ ] Health Behaviors - Safe Food Handling
- [ ] Health Behaviors - Sleep
- [ ] Health Behaviors - Tobacco Use
- [x] Health Behaviors - Vaccination
- [ ] Health Behaviors - Violence Prevention
- [x] Populations - Adolescents
- [x] Populations - Children
- [ ] Populations - Infants
- [ ] Populations – LGBT
- [ ] Populations - Men
- [x] Populations - Older Adults
- [ ] Populations - Parents or Caregivers
- [ ] Populations - People with Disabilities
- [x] Populations - Women
- [ ] Populations - Workforce
- [ ] Settings and Systems - Community
- [ ] Settings and Systems - Environmental Health
- [ ] Settings and Systems - Global Health
- [x] Settings and Systems - Health Care
- [ ] Settings and Systems - Health Insurance
- [ ] Settings and Systems - Health IT
- [ ] Settings and Systems - Health Policy
- [x] 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
- [x] Social Determinants of Health - Education Access and Quality
- [x] 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 Peninsula Regional Attachments.pdf
6.8MB
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	Community Opioid Addiction Team (COAT)	The primary goals of the COAT team are 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 COAT team's efforts impact overall reduction in admissions, readmissions and ED visits. The objective is to contact and provide linkage to treatment and other support services to community members dealing with substance abuse/addiction issues.	Number of people served Number of people served with a history of opioid disorder Number of Wicomico County residents linked to treatment Number of non-residents linked to treatment Number of attempts to contact people for 6-month follow-up Number of contacts made Number of navigation services provided	421 served 176 served with a history of Opioid Disorder 236 Wicomico County residents linked to treatment 42 non-residents linked to treatment Attempted contact with 234 people served for 6 month follow-up. Made contact with 56 people served. Of those contacted, 45 or 80.3% remained in recovery. 261 Navigation Services provided to 171 individuals
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

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	Healing Seated Yoga	A gentle seated yoga class for any ability that refreshes the mind and body of cancer patients and their caregivers.	Number of classes Number of participants	53 hour long classes 331 participants
Initiative B	What's Cooking	Using a Registered Dietician, teach cancer patients and their caregivers how to prepare healthy food dishes using fruits, vegetables, beans and healthy grains. The sessions also have nutritional topics to talk about and the participants can taste the dishes and ask questions of the Registered Dietician.	Number of classes	10 classes 44 participants The nutrition needs vary from person to person our team helps and develop unique nutritional guidelines for each individual. Through education patients are exhibiting better outcomes in strength and energy an most importantly feeling better.
Initiative C	Tai Chi Class	Improve the balance, stress levels, circulation, strength and focus of cancer patients by completing a graceful form of low impact exercise originating from the martial arts.	Number of classes	67 classes 164 participants have indicated that they feel more confident as Tai Chi helps them increase their light physical activity.
Initiative D	Prostate Cancer Support Group	Bi-monthly support group for patients and their caregivers who have been affected by prostate cancer	Number of classes Number of participants	6 classes 14 participants Participants have gained emotional support and energy from their peers. It has improved their psychological wellbeing, reduced anxiety and depression and overall improved the quality of life.
Initiative E	Food Distribution	As available, a share of organic vegetables are provided to cancer survivors.	Number of distributions Number of participants	14 distributions 175 participants Wholesome, clean, nutritious food to overcome outcomes disparities within the community in the fight against cancer. Food insecure patients often have worse treatment outcomes and poorer quality of life if we do not try and alleviate the impact of food insecurity.
Initiative F	Cancer Survivor and Caregiver Support Group	Weekly support group for current or past cancer patients and their caregivers to network, educate and enjoy fellowship	Number of classes Number of participants	9 sessions 19 participants Creation of a network of survivors and caregivers that provide hope, support and education
Initiative G	Cancer Thriving and Surviving	The goal is to provide cancer patients and their caregivers with the tools they need to live a healthier life with cancer.	Number of classes Number of participants	5 classes 13 participants
Initiative H	Skin Cancer Screenings	The goal is to bring attention to the high rate of skin cancer on the Delmarva Peninsula and stress the importance of early detection.	Number of screenings	Screenings delayed due to COVID-19 restrictions
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	Adult Diabetes Support Group	The primary objective is to provide support, networking, education, fellowship and to promote community unity to adults with diabetes and their caregivers.	Number of meetings Number of participants	Due to COVID the Adult Diabetes Support Group will meet in FY 2022.
Initiative B	Kids and Teen Diabetes Support Group	The primary objective is to provide support, networking, education, fellowship and to promote community unity to kids and teens with diabetes and their caregivers.	Number of meetings Number of participants	Transitioned this program to a local "home grown" community based Kids and Teens Diabetes Support Group.
Initiative C	Nutrition and Diabetes Education Community Education Presentations	The primary objective is to provide education and improve knowledge and awareness of presentation attendees.	Number of people given diabetes education Number of presentations Number of meetings	Live Healthy Wicomico - Several Meetings. Met with a Haitian population at their house of worship to provide diabetes education 45 people. Preceptor for local college UMES Dietetic Internship Program to educate on the importance of diabetes education in the local three County area.
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	PEARLS	The goal is to reduce the instances of depression in older adults through outreach and access to an evidence-based intervention program. Aligns with SIHIS measure to improve care transformation and care coordination. Also aligns with SHIP measure to reduce ED visits due to mental illness. The objective of the program is to increase the percent of program participants with a significant reduction of depression above the 2018 baseline of 50%.	Number of participants Number of participants with significant reduction in depression	143 enrolled 141 screened 71 with six or more sessions 51% total remission of depressive symptoms 59% achieved response

Initiative B	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 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	Opioid Intervention Team (OIT)	The primary goal of the Opioid Intervention Team (OIT) 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 OIT's efforts impact overall reduction in admissions, readmissions and ED visits. The objective of the initiative 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 OIT meetings held Number of community events held Number of Local Overdose Fatality Review Team meetings held Number of individuals attending CE trainings Number of post reaches through Facebook Number of resource mailers sent Number of digital advertising impressions Number of uses of OIT trailer Number of medication bags provided Number of people provided education via OIT trailer	15 OIT meetings held 16 community events held. 14 of these were narcan trainings 11 Local Overdose Fatality Review Team meetings held. 70 individuals attended CE trainings 76,103 post reaches were made via Facebook, 15,000 resource mailers were sent to residences in Wicomico County which included SUD resources, and 76,110 impressions were made by using digital advertising. OIT trailer was only deployed at 1 event in FY2021 due to COVID restrictions 60 medication bags provided 100 provided education via OIT trailer
Initiative B	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 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	MAC Stepping on Falls	Reduces rate of unintended injury and death caused by falls. Aligns with State Health Improvement Plan priority for "Health Living: Reduce fall-related death rate." Teaches older adults how to carry out healthy behaviors that prevent and reduce risk of falls and harm or injury caused by falls. Aligns with health system priority - effectiveness - by employing evidence-based prevention intervention for high risk population. Educate the older population on how strength and balancing exercises, medication management, home safety, footwear, vision and mobility are important in preventing falls.	Number of workshops Number of participants enrolled Number of participants completed Percentage of completion rate	8 workshops 64 participants enrolled 46 participants completed 72% completion rate
Initiative B	Remote Patient Monitoring	1)Reduce admissions and readmissions due to CHF, COPD, Diabetes; 2) Improve health of patients participating in the program; 3) Increase engagement with patient participants in monitoring and managing health conditions. The primary objective is to monitor Medicare patients who have been discharged from the hospital and diagnosed with CHF, COPD or Respiratory Failure in order to make sure patients adhere to protocols, medications and are engaged in their medical instructions. The Remote Patient Monitoring also is focused on reducing readmissions, increasing patient/caregiver engagement and early identification in changes to a patient's health status. A future goal of the program is to monitor diabetes, blood pressure and other health metrics that weren't captured in FY2019.	Reduced admissions and readmissions due to CHF, COPD and/or Diabetes Reduction of costs associated with these admissions or readmissions	Reduction of 298 visits in Pre/Post Analysis Savings of $1,887,342 in Pre/Post Analysis 132 patients in the program

Initiative C	MAC Chronic Disease Self-Management	Improve population health by increasing health literacy, access to evidence-based health education, and person-level self efficacy to manage chronic conditions (i.e. hypertension, diabetes). Aligns with internal health system strategic goals: - Access: Increases access to health prevention and promotion; Engagement: Engages community and individuals in preventing and managing chronic disease; Effectiveness: Evidence-based health education programming is effective in preventing and reducing rates of chronic disease and uncontrolled conditions such as diabetes and hypertension. Aligns with state health improvement plan priorities (SHIP): Quality preventative care - reduces ED visits because of diabetes, hypertension; reduces admissions and re-admissions. Aligns with SIHIS goals for Population Health - Diabetes. 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.	Number of workshops Number of participants enrolled Number of participants completed Percentage of completion rate	13 workshops 94 participants enrolled 79 participants completed 92% completion rate
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	COVID-19 Vaccine Clinics	Provide access to COVID-19 vaccinations for the community and prevent COVID-19 infections.	Number of vaccinations	44,519 COVID-19 Vaccines administered
Initiative B	Drive Thru Flu Shot Clinics	Increase access to influenza immunizations for the general public to protect them from getting the flu.	Number of vaccinations	7,100 community members vaccinated against the flu
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	SWIFT	The primary goals are 1) Increase access to care by deploying multi-disciplinary mobile care coordination team to homes of high risk patients to address medical, health and social needs. 2)Reduce EMS and ED utilization by connecting patients with high utilization to community-based resources and support. This intervention aligns with SIHIS goals tied to Hospital Quality - reducing avoidable admissions and readmissions; Care Transformation - improves care coordination for patients. The program also aligns with the SHPI measures for quality preventative care and access to health care measures. The primary objective is to reduce EMS and ED utilization by identifying and providing intervention to the highest ED utilizers. The SWIFT team works collaboratively with high utilizers to reduce overuse of emergency services and improve access to care by connecting these community members to area resources that address behavioral health, chronic disease health and other social determinants of health. The program also connects utilizers with more appropriate care settings such as primary care offices and FQHCs.	Number of face to face visits Number of phone calls/text/email encounters Number of visits reduced Amount of charges reduced	387 face to face visits 282 phone call/text/email encounters Reduction of 62 visits Reduction of $461,293 in charges
Initiative D	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 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.

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

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 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
- [x] 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.docx
33.1KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q60. Section III - CB Administration

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

- [x] Yes, by the hospital's staff
- [x] 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 Peninsula Regional's strategic plan through the three themes of Access, Effectiveness and Engagement. TidalHealth Peninsula Regional 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.

- [x] Diabetes - Reduce the mean BMI for Maryland residents
- [x] Opioid Use Disorder - Improve overdose mortality
- [ ] Maternal and Child Health - Reduce severe maternal morbidity rate
- [x] 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 Peninsula Regional'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 HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	○	○	
Anesthesiology	○	○	
Cardiology	○	○	
Dermatology	○	○	
Emergency Medicine	○	○	
Endocrinology, Diabetes & Metabolism	○	○	
Family Practice/General Practice	○	○	
Geriatrics	○	○	
Internal Medicine	○	○	
Medical Genetics	○	○	
Neurological Surgery	○	○	
Neurology	○	○	
Obstetrics & Gynecology	○	○	
Oncology-Cancer	○	○	
Ophthamology	○	○	
Orthopedics	○	○	
Otololaryngology	○	○	
Pathology	○	○	
Pediatrics	○	○	
Physical Medicine & Rehabilitation	○	○	
Plastic Surgery	○	○	
Preventive Medicine	○	○	
Psychiatry	○	○	
Radiology	○	○	
Surgery	○	○	
Urology	○	○	
Other. (Describe) Non-resident house staff and hospitalist	◉	○	Non-resident house staff and hospitalists

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.

TidalHealth Peninsula Regional the regional tertiary referral hospital located on the Delmarva Peninsula, serving a largely rural geographic area that has a combination of both urban and rural challenges. In general, the population TidalHealth Peninsula Regional serves in Wicomico, Worcester and Somerset Counties has lower median incomes, lower graduation rates, fewer college degrees, higher unemployment, lower quality housing and sicker patients, compared to the Maryland average. In comparison to the state of Maryland, al three counties have a higher percentage of families living in poverty. Availability of primary care services continues to be an issue due to a proportionally higher percentage of families not having personal transportation and that fact that several of our counties fall in Maryland's bottom quartile for primary care access. Residents rely on the Hospital as the tertiary referral center, to provide a full complement of primary care, specialty and sub-specialty services from chronic disease management to neurosurgery and everything in between. Addressing the full spectrum of services is challenging as six counties that TidalHalth Peninsula Regional serves has higher Medicare population percentages than the state of Maryland and the United States. As a percentage of the total population, both Worcester County and Sussex County have almost twice as many Medicare residents, at 28% of the population, in comparison to Maryland and the United States, which is approximately 6%. The U.S. Census Bureau projects that by 2030, the number of Medicare residents will exceed 20 percent; this growth in the number of older Americans is expected to increase total health care costs. The shortage of rural physicians is a complex issue, resulting from many of the preceding outlined factors. TidalHealth Peninsula Regional strives to provide access to quality health care services to the underserved rural communities on the Peninsula. Every three years, with the help of a consultant, a Medical Staff Development Plan is conducted to strategically and effectively plan for physician recruitment and retention, filling in specialty and primary care service gaps by geography. As evidenced by our Mission Driven Health Services submission, the Hospital subsidizes many specialties including but not limited to Medical Oncology, Endocrinology, Behavioral Health, Pulmonology, Neurosurgery, and Cardiac Surgery. Without these subsidies, access to these services would be limited or non-existent, and for our most needy populations like Somerset County, traveling across the Bay Bridge for services is not an option. For this reason, TidalHealth Peninsula Regional continues to appropriately provide the right balance of physician services for the

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-Uncompensated-Care-Policy-07-01-21.pdf
415.2KB
application/pdf

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

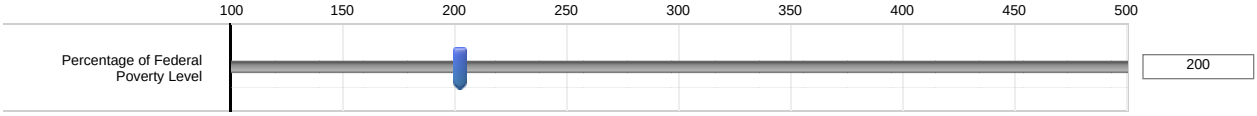
https://www.tidalhealth.org/sites/default/files/2021-07/Financial-Assistance-Uncompensated-Care-Policy-07-01-21.pdf

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

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

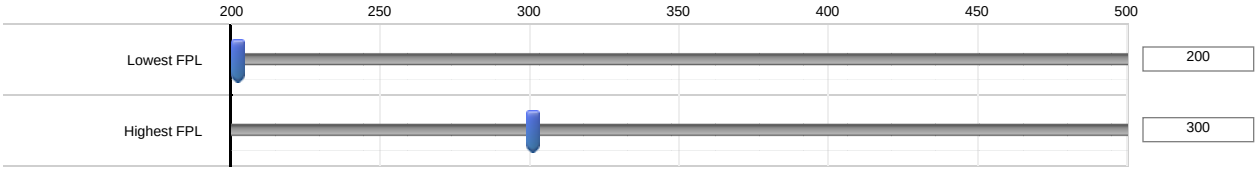
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



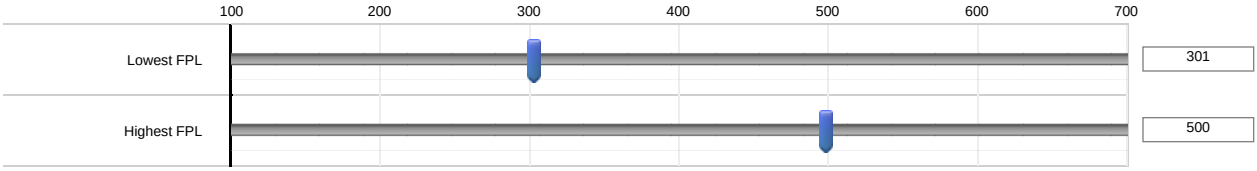
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

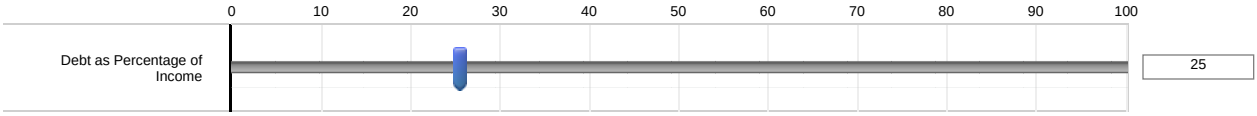


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health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

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



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



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

- [x] Federal corporate income tax

- [x] State corporate income tax
- [x] State sales tax
- [x] 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 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: GeoIP 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.

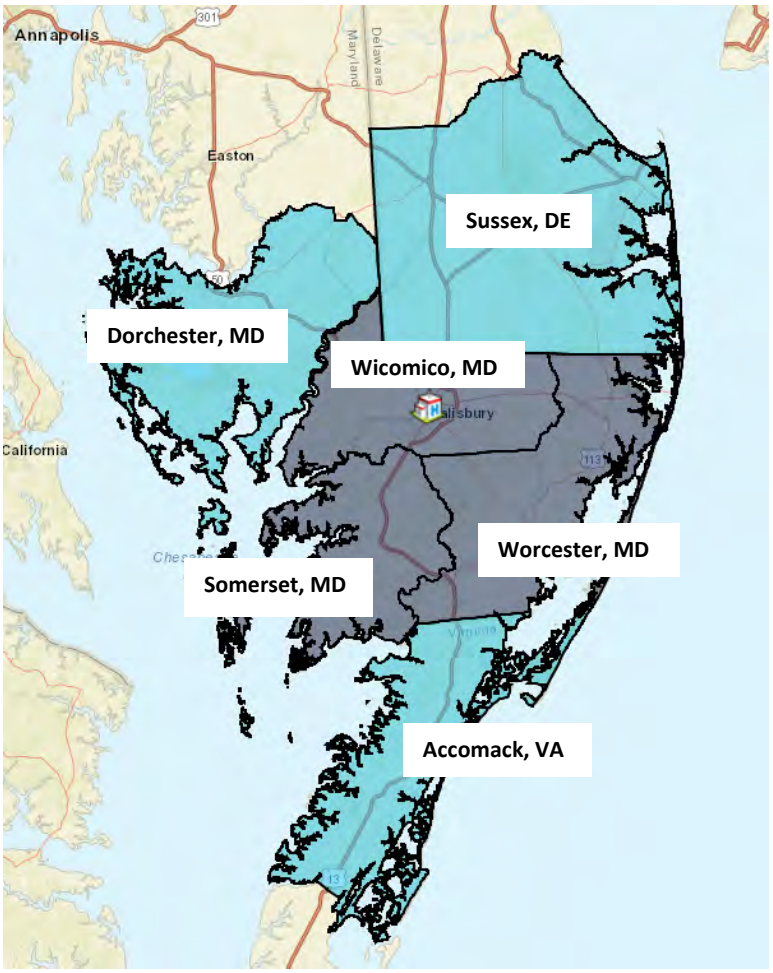
TidalHealth Demographics

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%
Total	185,198	100.0%	100.0%

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%
Total	**189,161**	**100.0%**	**100.0%**

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

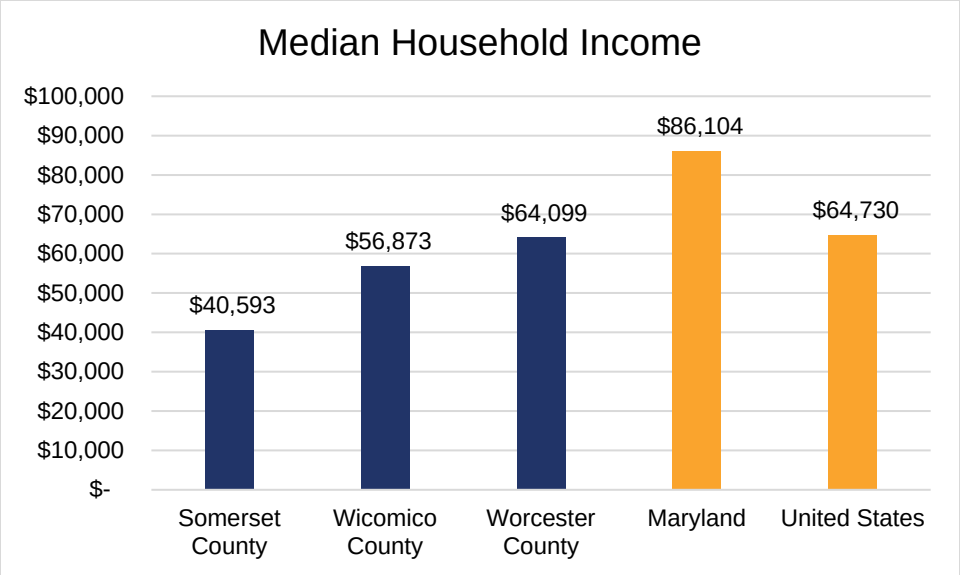
In a report prepared by the Office of Minority Health and Health Disparities of the Maryland Department of Health and Mental Hygiene, the largest disparities between Black and White people in the three lower counties for visit rates to the emergency department are for diabetes, asthma and hypertension.

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

Median Household Income within the CBSA

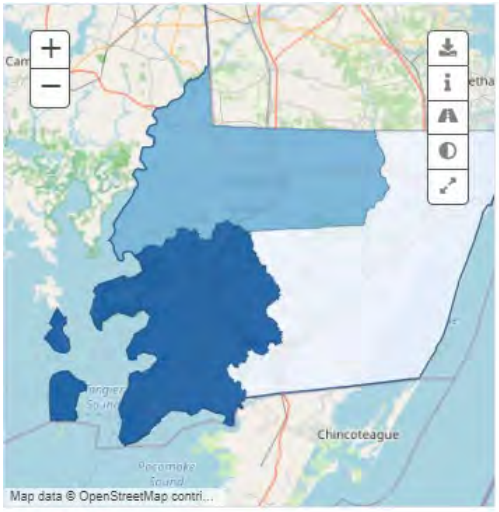
The median household income values in all three counties are lower than that of the state of Maryland. Somerset County has the lowest median household income in the Community Benefit Service Area with a value of $40,593. Worcester County has the highest median household income in the service area at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

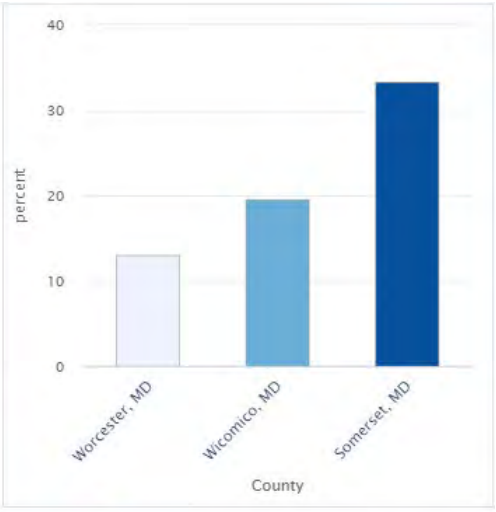
Source: ESRI ArcGIS



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



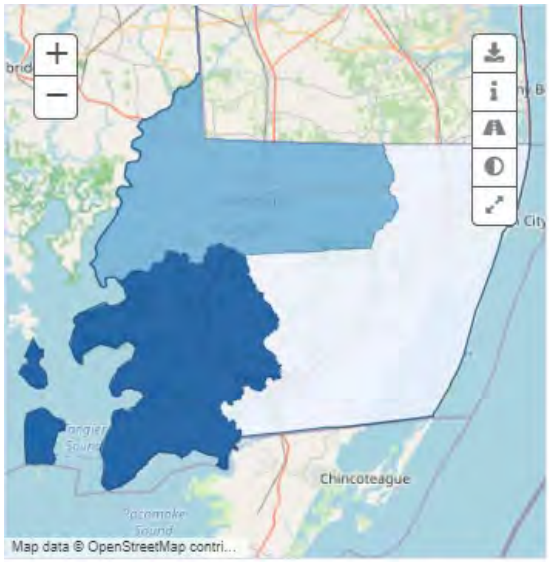


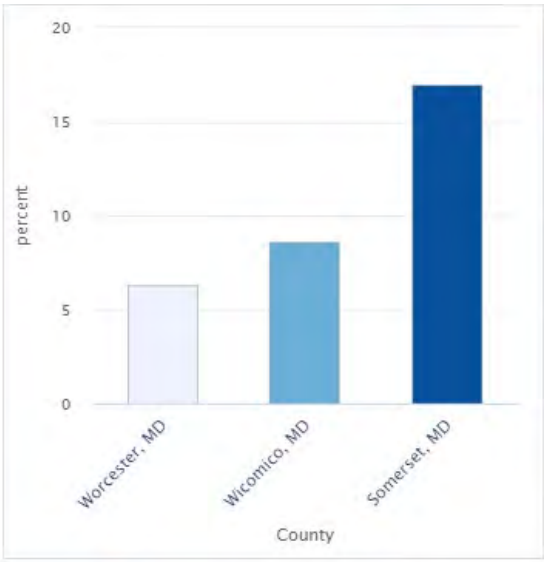
13.1% 19.6% 33.4% N/A

County	Source	Measurement Period	Percent
Worcester, MD	American Community Survey	2015-2019	13.1%
Wicomico, MD	American Community Survey	2015-2019	19.6%
Somerset, MD	American Community Survey	2015-2019	33.4%

Source: Healthy Communities Inc., 2021

Families Living Below Poverty



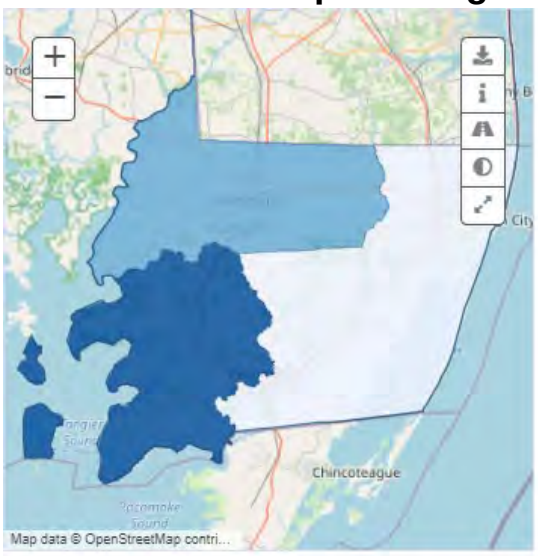


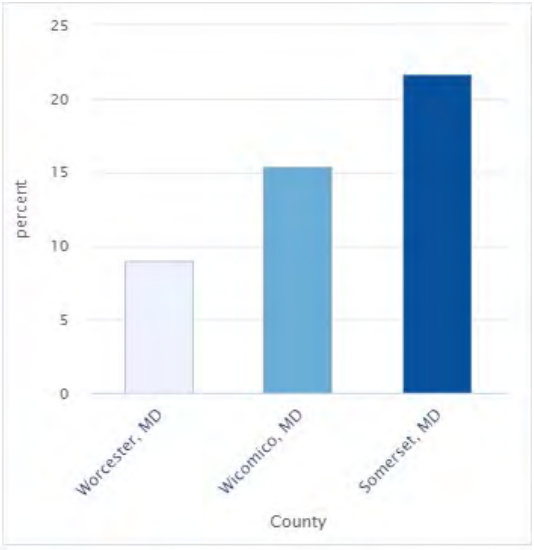
6.3% 8.6% 17.0% N/A

County	Source	Measurement Period	Percent	
Worcester, MD	American Community Survey	2015-2019	6.3%	
Wicomico, MD	American Community Survey	2015-2019	8.6%	
Somerset, MD	American Community Survey	2015-2019	17.0%	

Source: Healthy Communities Inc., 2021

People Living Below Poverty Level



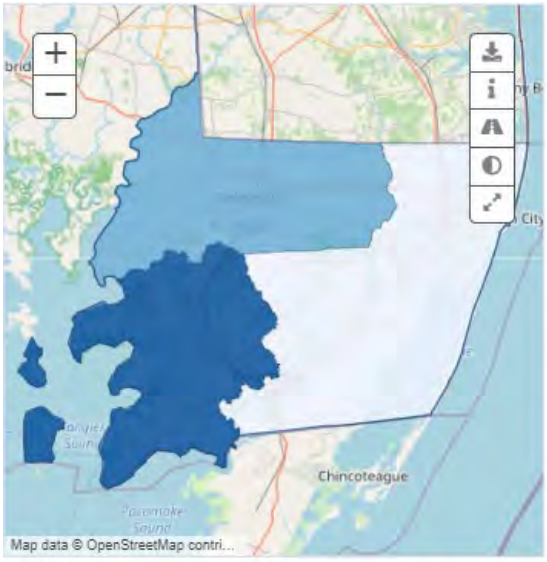


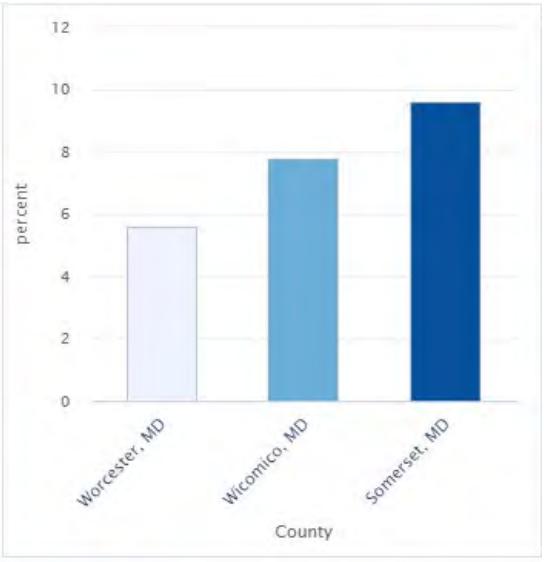
9.0% 15.4% 21.7% N/A

County	Source	Measurement Period	Percent	
Worcester, MD	American Community Survey	2015-2019	9.0%	○
Wicomico, MD	American Community Survey	2015-2019	15.4%	●
Somerset, MD	American Community Survey	2015-2019	21.7%	●

Source: Healthy Communities Inc., 2021

People 65+ Living Below Poverty Level





5.6% 7.8% 9.6% N/A

County	Source	Measurement Period	Percent	
Worcester, MD	American Community Survey	2015-2019	5.6%	○
Wicomico, MD	American Community Survey	2015-2019	7.8%	●
Somerset, MD	American Community Survey	2015-2019	9.6%	●

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;

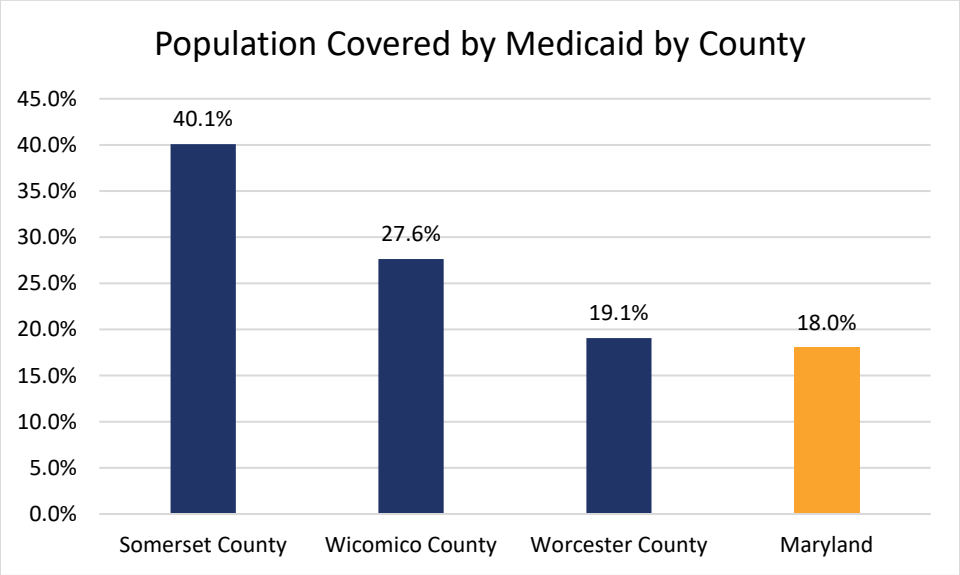
http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml

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.

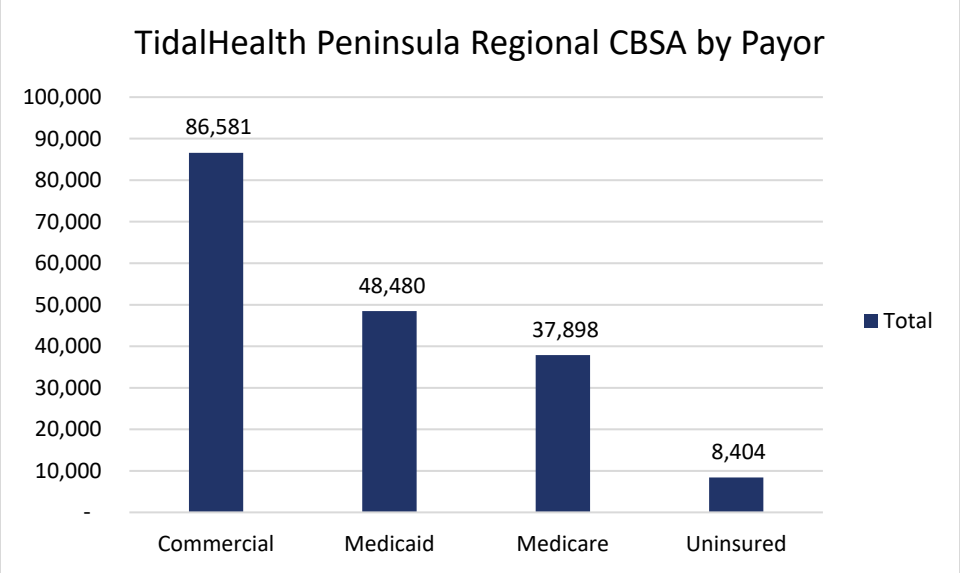
Percentage of Medicaid recipients by County within the CBSA

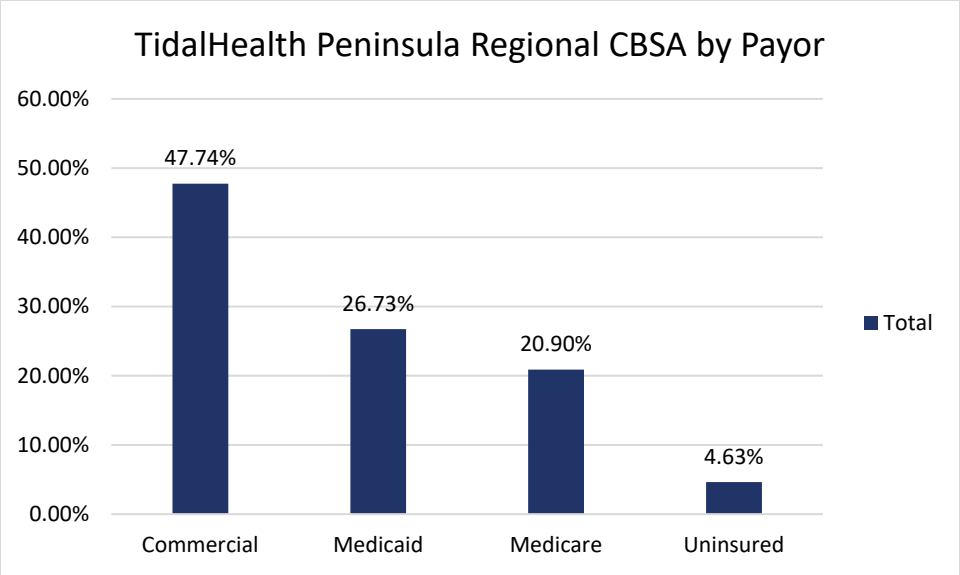
In comparison to the state of Maryland, TidalHealth Peninsula Regional's CBSA has a greater proportion of Medicaid recipients. Several of the poorer counties in Maryland, Wicomico County and Somerset County, have a substantially higher percentage of Medicaid recipients than the state of Maryland. The 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.

	Life Expectancy		
County	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.

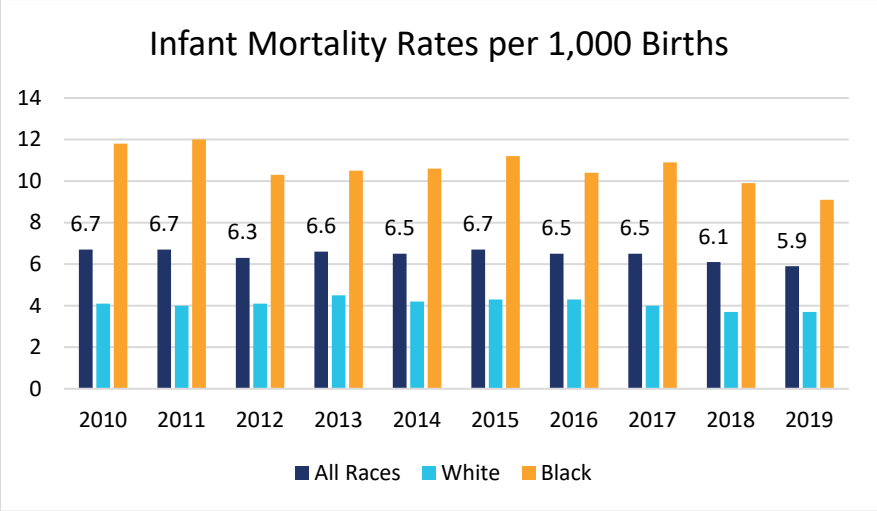
Worcester County

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

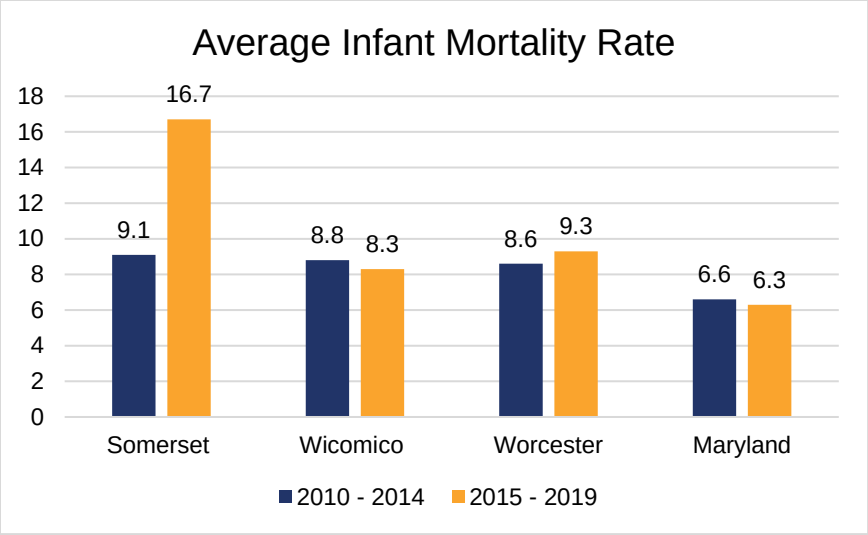
Blacks or African Americans in Somerset County had higher mortality rates than Whites for all-cause mortality and for five of top six causes of death.
The diabetes mortality rate for Blacks or African Americans was 2.4 times higher than for Whites; and the kidney disease mortality rate was 1.9 times 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

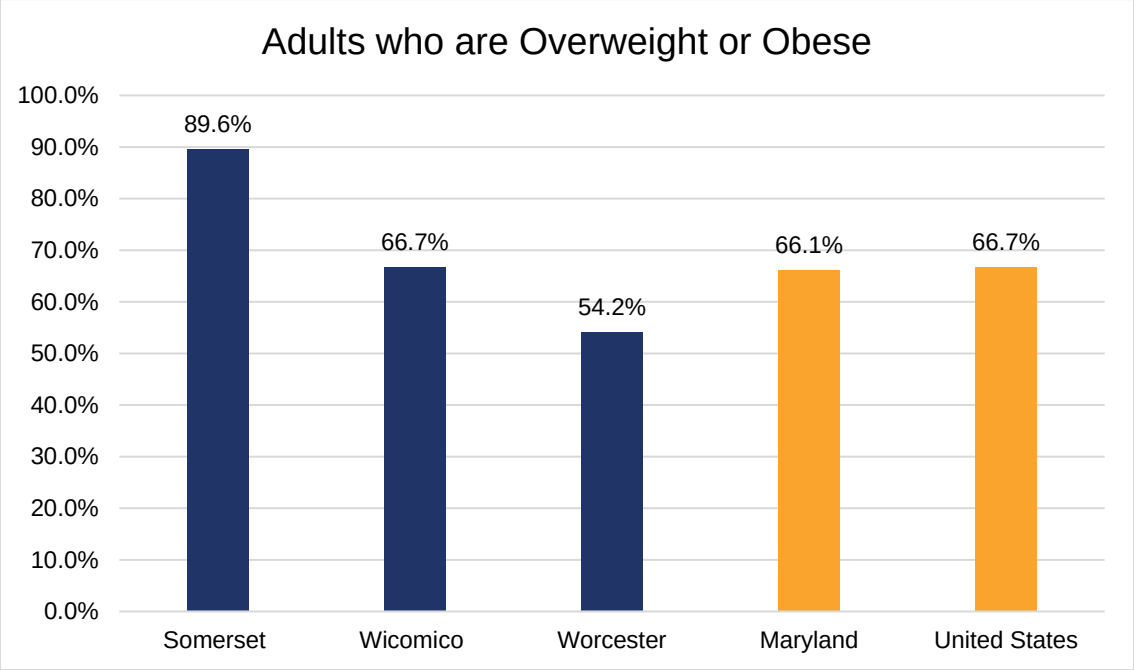
Access to Healthy Food

Healthy Food/Healthy Lifestyle Environmental Factors

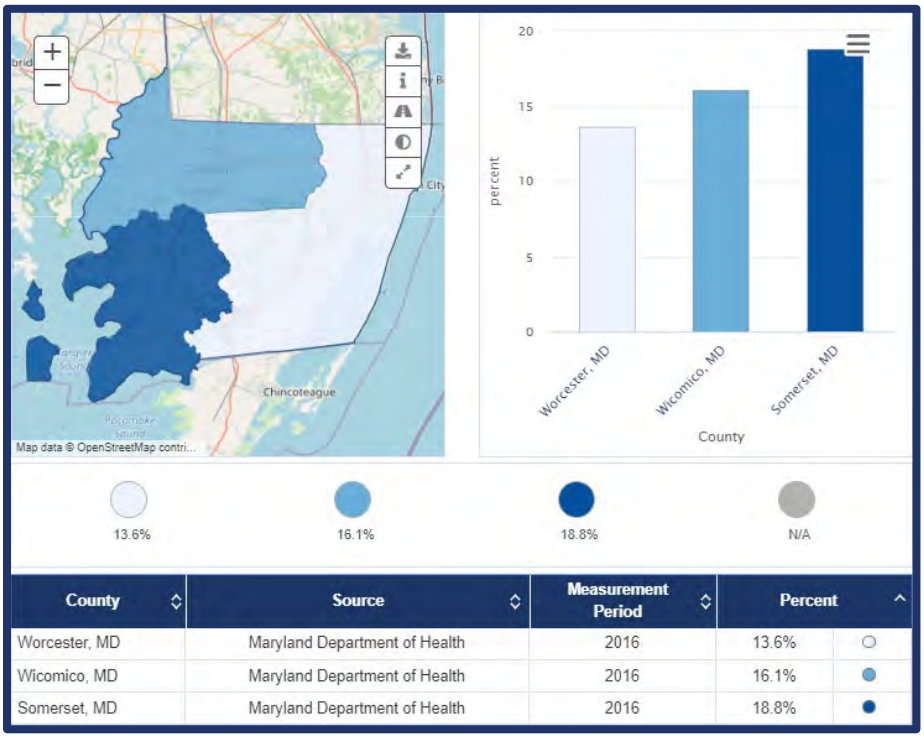
Obesity continues to be a health issue in Wicomico, Worcester and Somerset counties. Somerset County has a high percentage of adolescent obesity: 18.8% compared to the Maryland SHIP 2020 target of 16.1% and the Maryland state value of 12.6%. TidalHealth Peninsula Regional's CBSA has a higher percentage 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



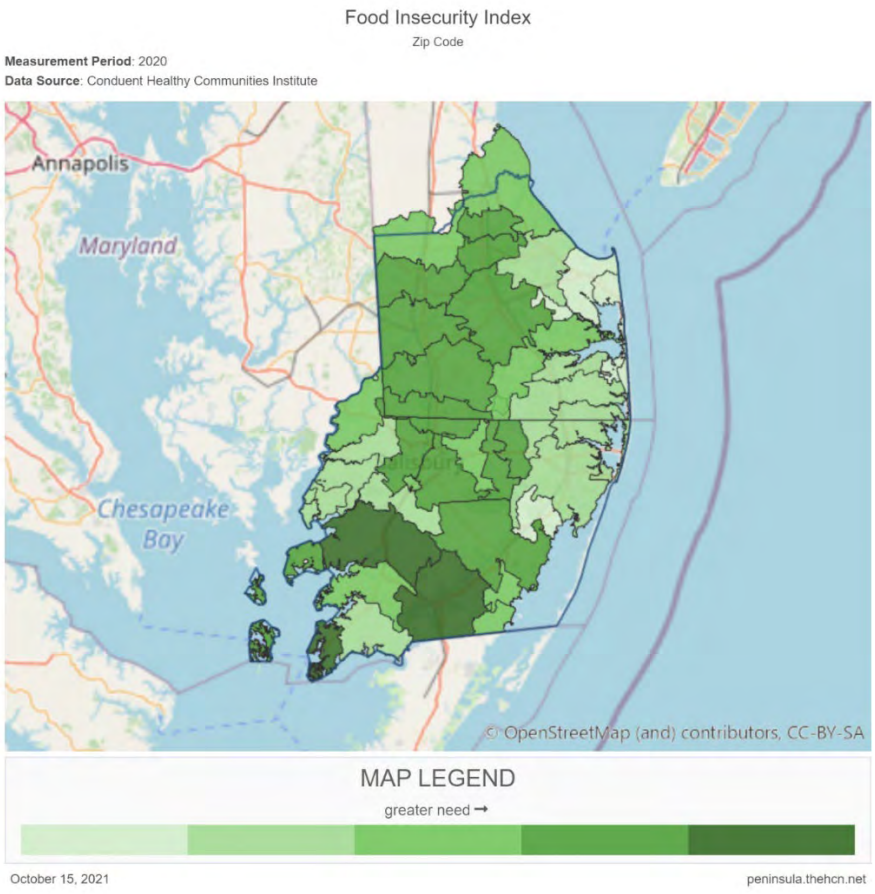
County	Source	Measurement Period	Percent
Worcester, MD	Maryland Department of Health	2016	13.6%
Wicomico, MD	Maryland Department of Health	2016	16.1%
Somerset, MD	Maryland Department of Health	2016	18.8%

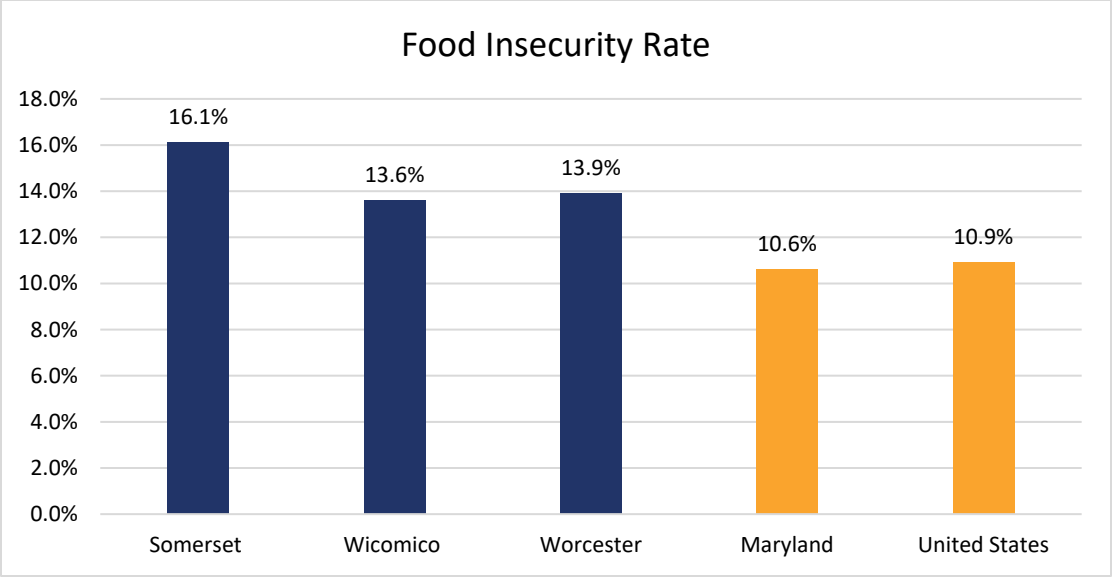
Source: Healthy Communities Inc., 2021

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.

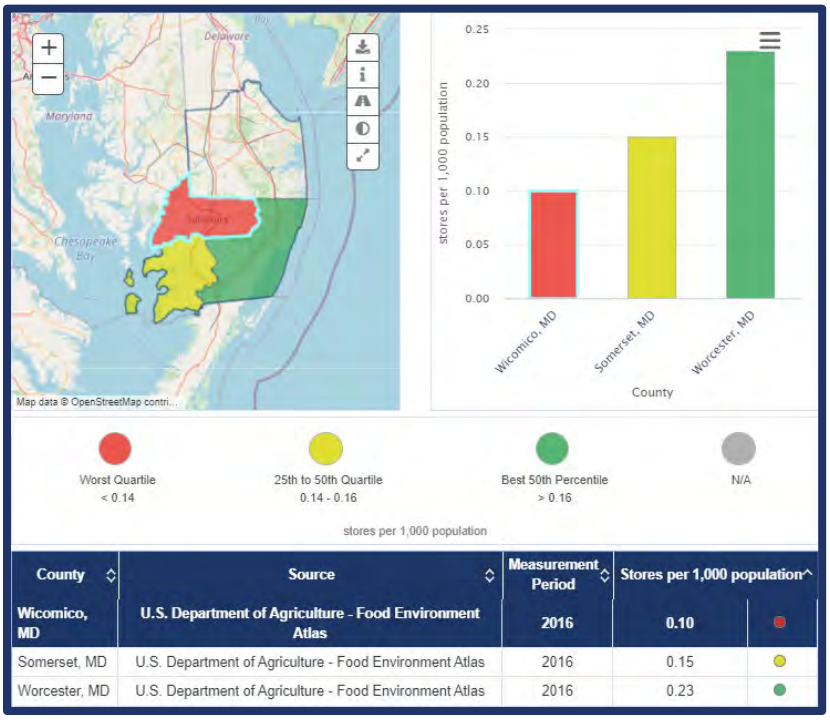




Grocery Store Density

There are strong correlations between the density of grocery stores in a neighborhood and the nutation 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.

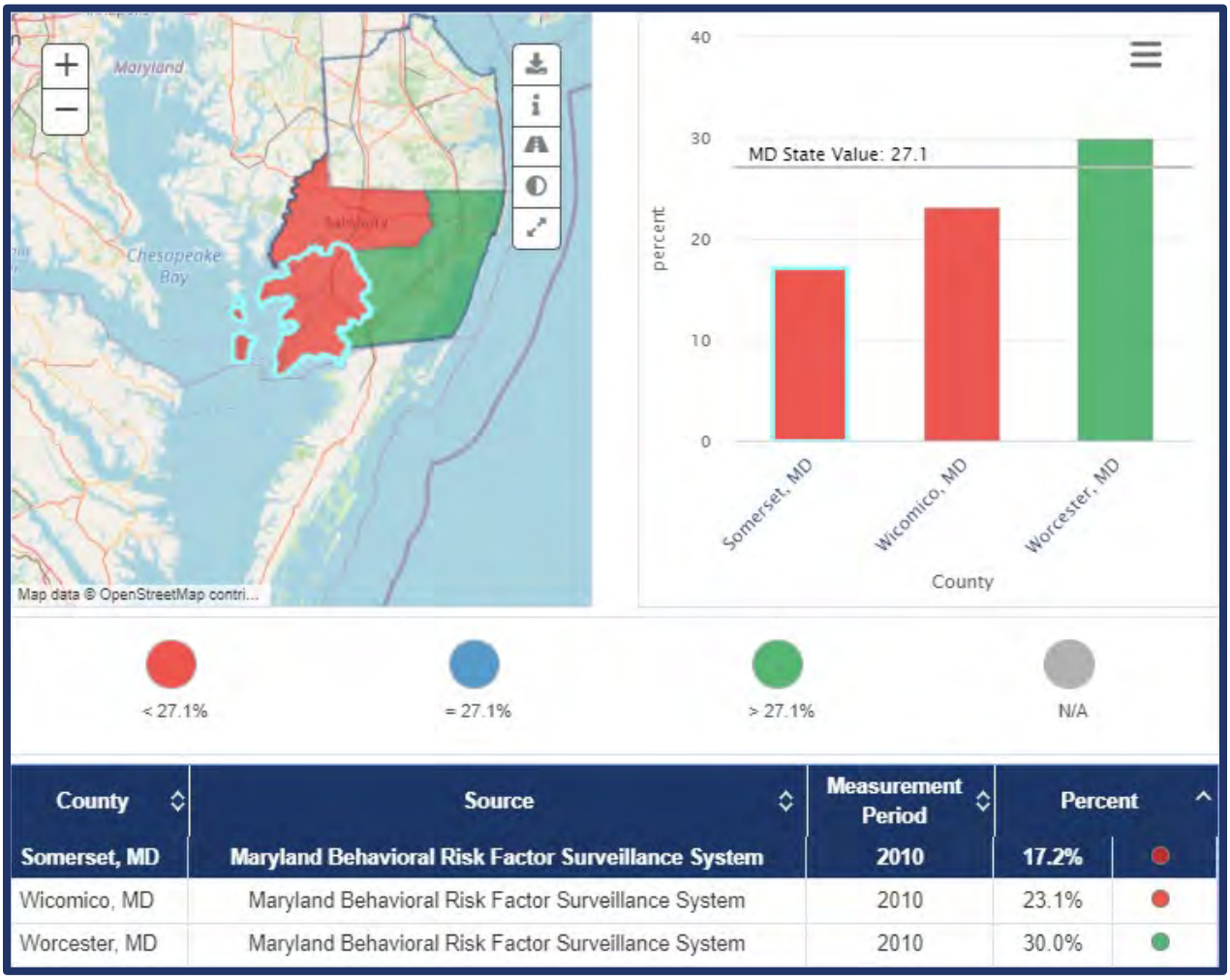
Wicomico County and Somerset County have low grocery store densities when compared to other Maryland counties, which can be a cause of having an unhealthy lifestyle. Combining these low grocery store densities with rural, poverty stricken areas, this creates severely low access to nutritious food.



County	Source	Measurement Period	Stores per 1,000 population
Wicomico, MD	U.S. Department of Agriculture - Food Environment Atlas	2016	0.10
Somerset, MD	U.S. Department of Agriculture - Food Environment Atlas	2016	0.15
Worcester, MD	U.S. Department of Agriculture - Food Environment Atlas	2016	0.23

Adult Fruit and Vegetable Consumption

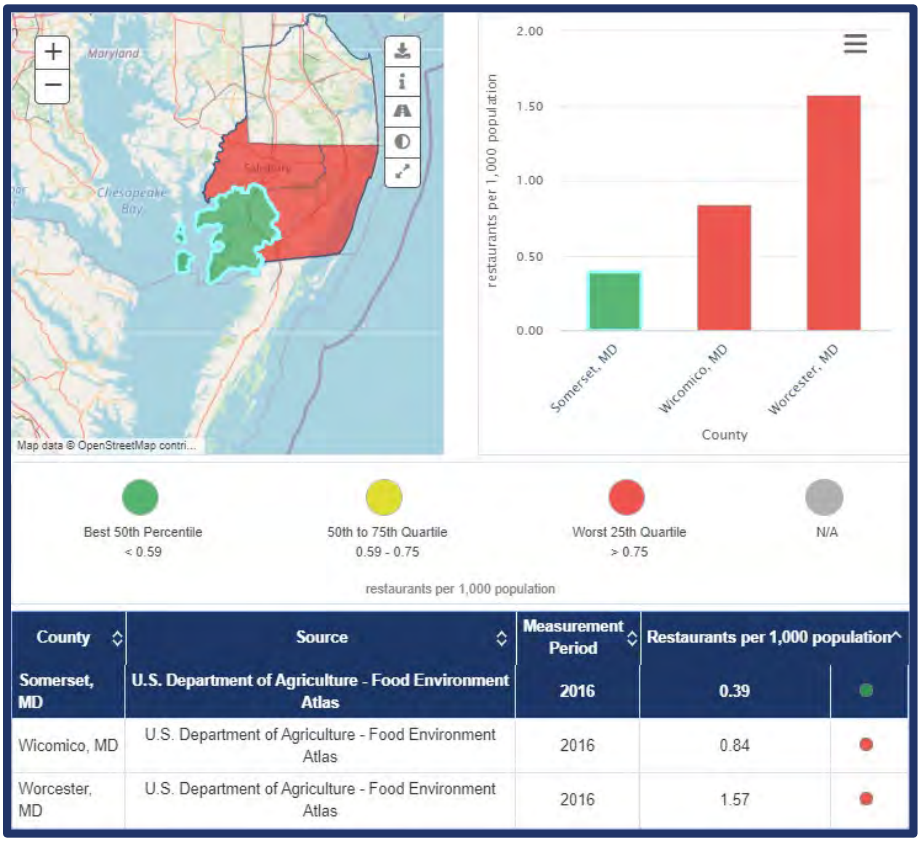
Based on the state of Maryland's most recent Behavioral Risk Factor Surveillance System, adults living in Wicomico County and Somerset County are not consuming adequate amounts of fruits and vegetables to maintain a healthy diet. This statistic indicates that an opportunity exists for education about 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.



County	Source	Measurement Period	Percent	
Somerset, MD	**Maryland Behavioral Risk Factor Surveillance System**	**2010**	**17.2%**	
Wicomico, MD	Maryland Behavioral Risk Factor Surveillance System	2010	23.1%	
Worcester, MD	Maryland Behavioral Risk Factor Surveillance System	2010	30.0%	

Fast Food Restaurant Density

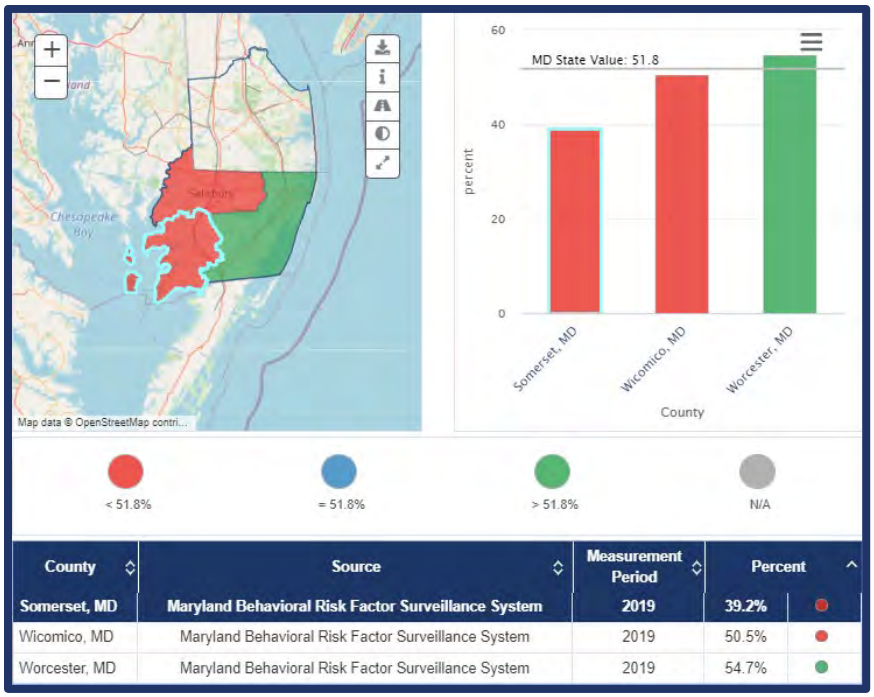
Based on the latest U.S. Department of Agriculture – Food Environment Atlas, TidalHealth Peninsula Regional's CBSA has a high number of fast food restaurants per 1,000 population in Wicomico County and Worcester County compared to United States counties. A high density of fast food restaurants leads 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 25th quartile in these rankings of 0.75 fast food restaurants per 1,000 population.



County	Source	Measurement Period	Restaurants per 1,000 population	
Somerset, MD	U.S. Department of Agriculture - Food Environment Atlas	2016	0.39	
Wicomico, MD	U.S. Department of Agriculture - Food Environment Atlas	2016	0.84	
Worcester, MD	U.S. Department of Agriculture - Food Environment Atlas	2016	1.57	

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.



County	Source	Measurement Period	Percent	
Somerset, MD	Maryland Behavioral Risk Factor Surveillance System	2019	39.2%	
Wicomico, MD	Maryland Behavioral Risk Factor Surveillance System	2019	50.5%	
Worcester, MD	Maryland Behavioral Risk Factor Surveillance System	2019	54.7%	

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

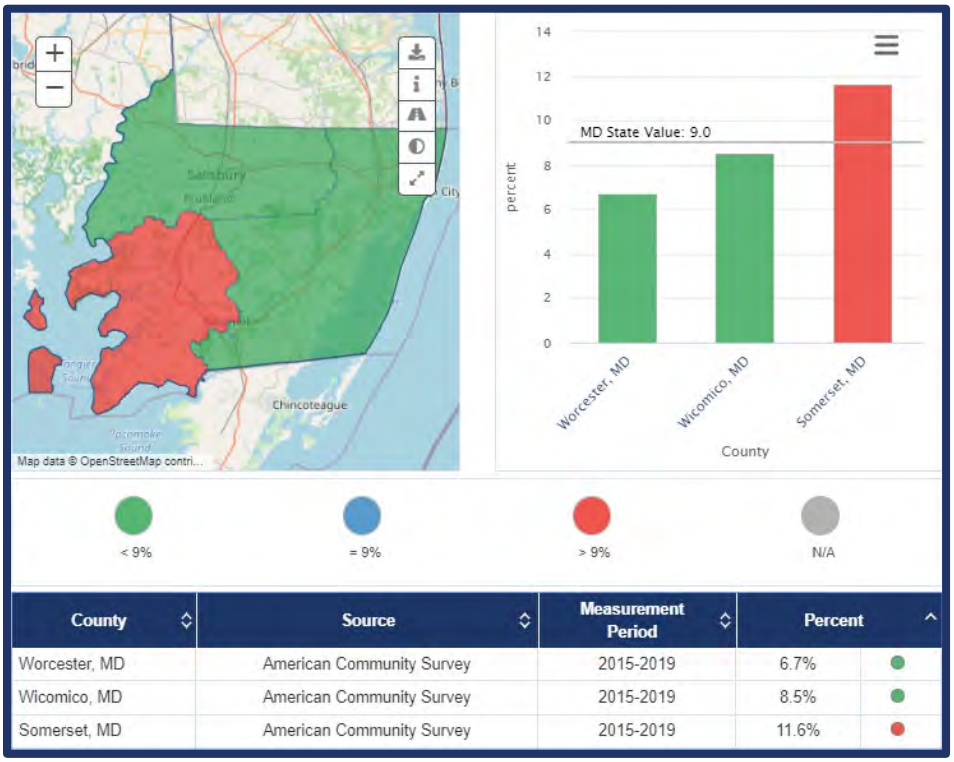
caregiver. A bus ticket or taxi fare is provided for those patients who are indigent or may lack a vehicle. TidalHealth Peninsula Regional's Patient Care Management Department manages these cases on a patient-by-patient basis.

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

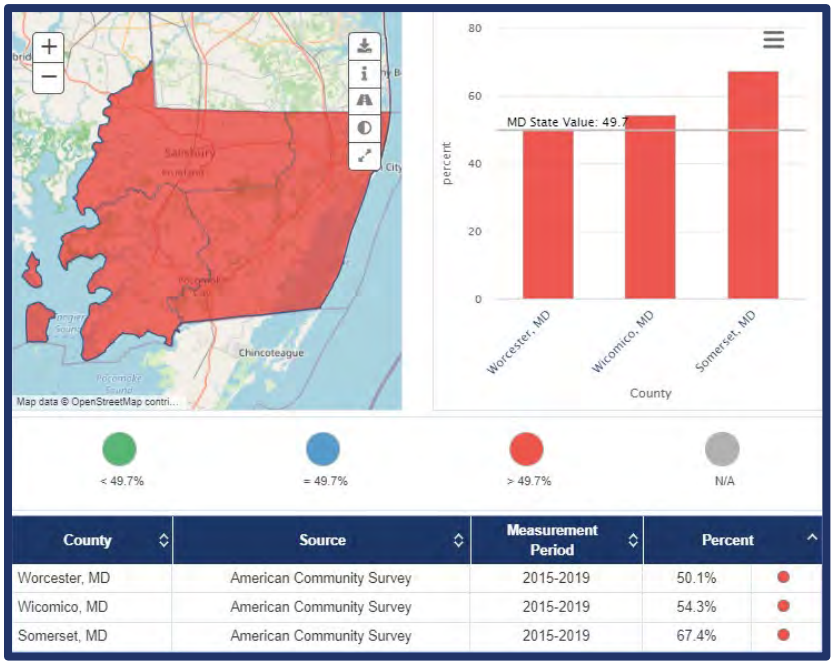
Vehicle ownership is directly related to the ability to travel. In general, people living in a household without a car and its independent transportation it offers will make fewer than half the number of journeys compared to households with a car. This lack of transportation limits their access to essential 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.



County	Source	Measurement Period	Percent
Worcester, MD	American Community Survey	2015-2019	6.7%
Wicomico, MD	American Community Survey	2015-2019	8.5%
Somerset, MD	American Community Survey	2015-2019	11.6%

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.

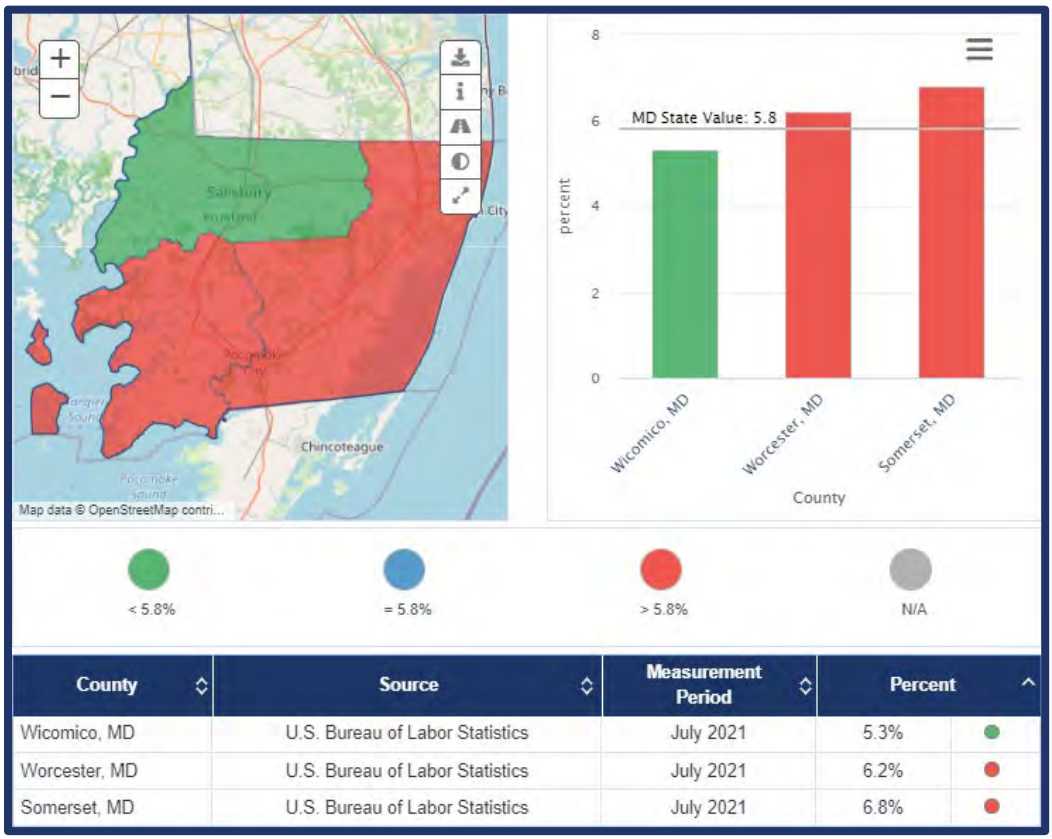


County	Source	Measurement Period	Percent
Worcester, MD	American Community Survey	2015-2019	50.1%
Wicomico, MD	American Community Survey	2015-2019	54.3%
Somerset, MD	American Community Survey	2015-2019	67.4%

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.



County	Source	Measurement Period	Percent	
Wicomico, MD	U.S. Bureau of Labor Statistics	July 2021	5.3%	
Worcester, MD	U.S. Bureau of Labor Statistics	July 2021	6.2%	
Somerset, MD	U.S. Bureau of Labor Statistics	July 2021	6.8%	

Sources:

Healthy Communities (HCI) 2021

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

PENINSULA REGIONAL MEDICAL CENTER

Public Health
Prevent. Promote. Protect.
Wicomico County Health Department

Public Health
Prevent. Promote. Protect.
SOMERSET COUNTY HEALTH DEPARTMENT

TABLE OF CONTENTS

SECTION 1

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.

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.

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, on the PRMC blog at prmcsalisbury.com, or on the Peninsula Regional website at 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:

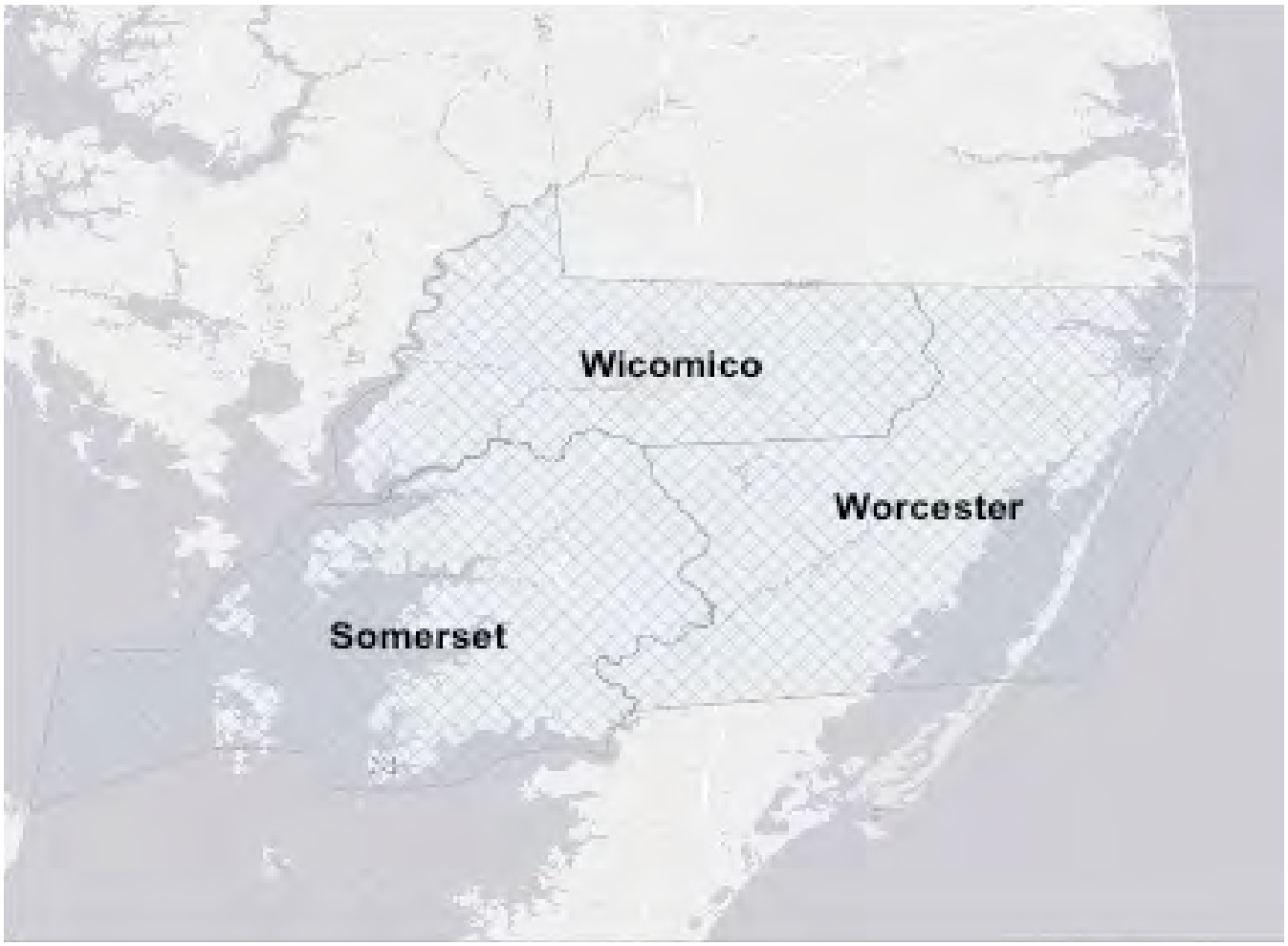
- Health Officer Lori Brewster MS, APRN/BC, LCADC
- Acting Physician Deputy Health Officer James Cockey, M.D.
- Administrative Deputy Health Officer Danielle Weber, RN, MS

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

SECTION 3

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.

SECTION 4

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.

SECTION 5

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 SCHD 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 SCHD 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

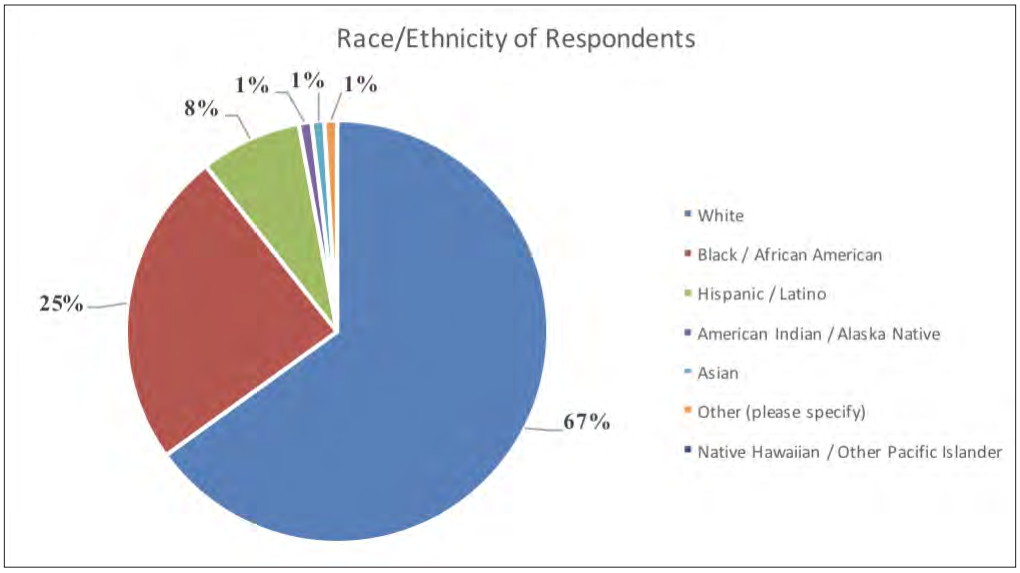
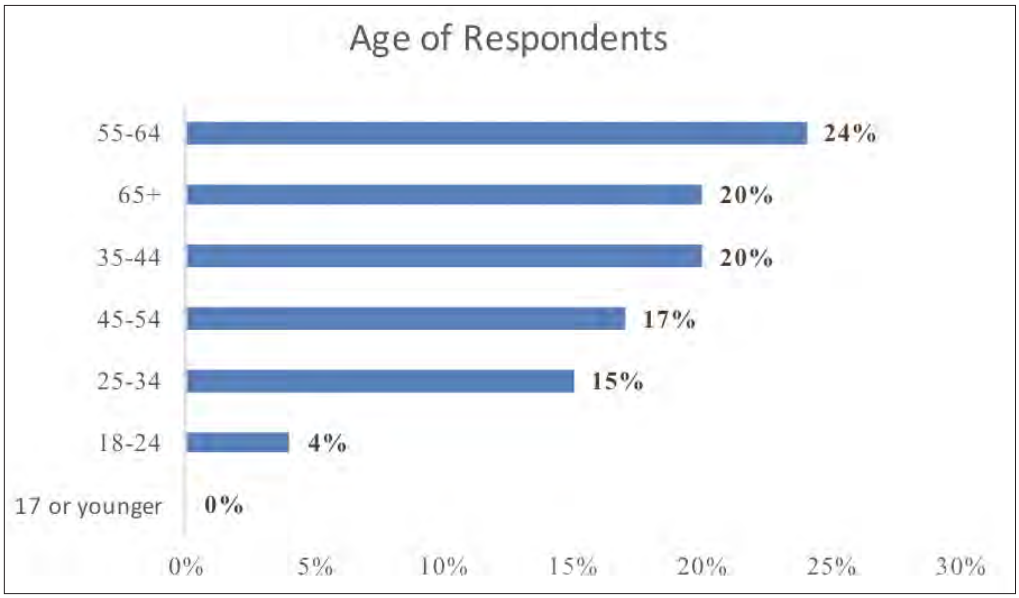


FIGURE 5. AGE OF COMMUNITY SURVEY RESPONDENTS



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

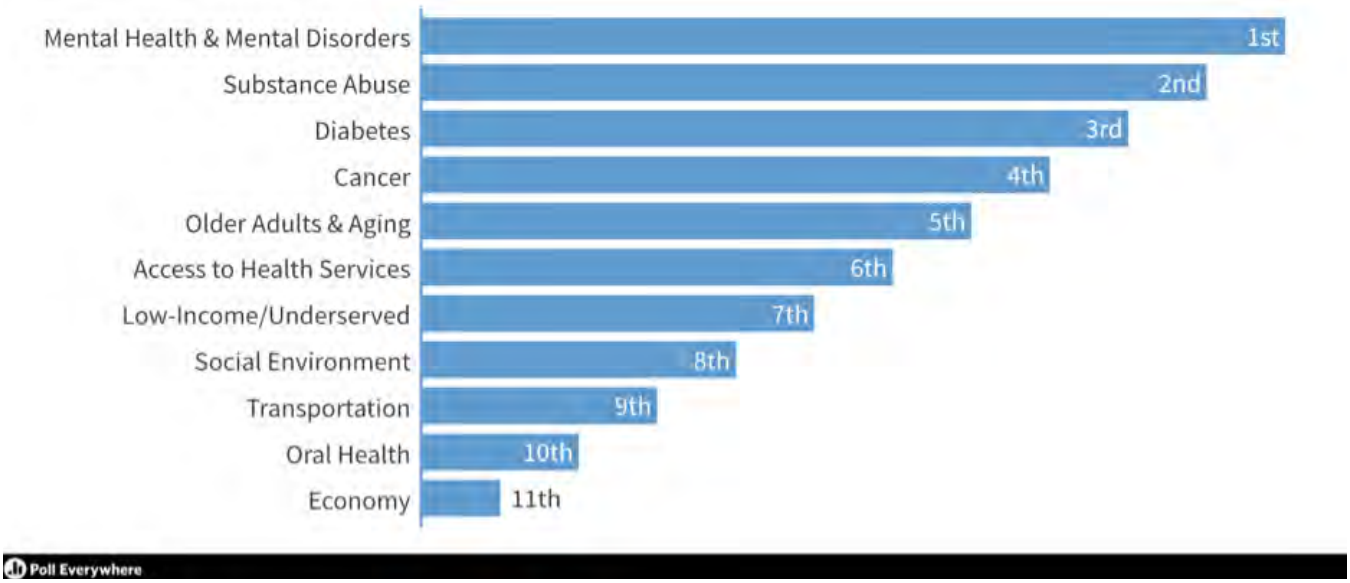
criteria set forth by PRMC project team. The criteria for prioritization can be seen in Figure 6 below:

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



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 were chose to participate and were influence 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.

SECTION 6

DEMOGRAPHICS

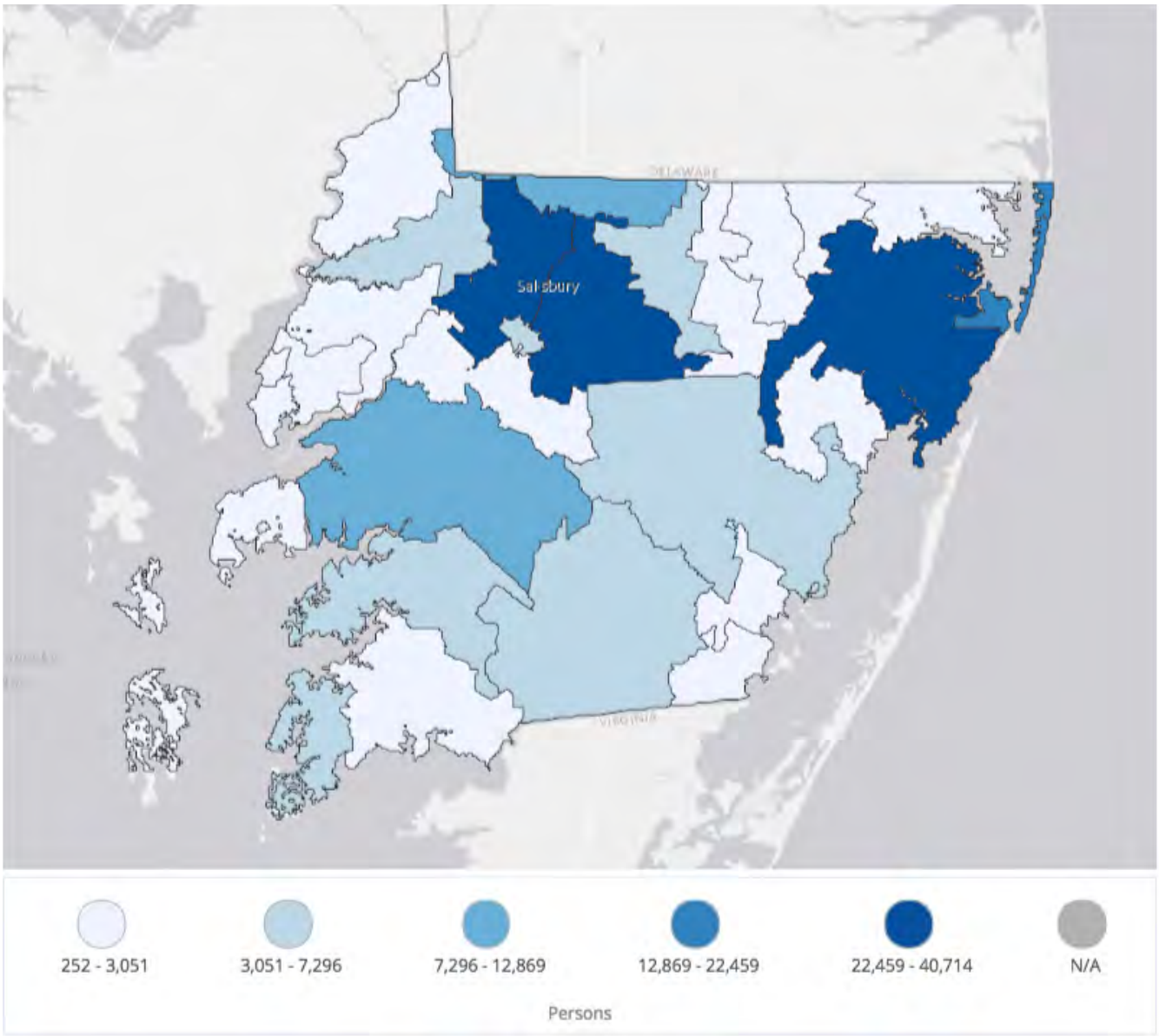
The demographics of a community significantly impact its health profile. Poverty, lack of a vehicle, and poor public transportation can limit the ability to access healthy foods and health services. Unsafe neighborhoods can make it difficult to get enough physical activity. Linguistic isolation can make 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.

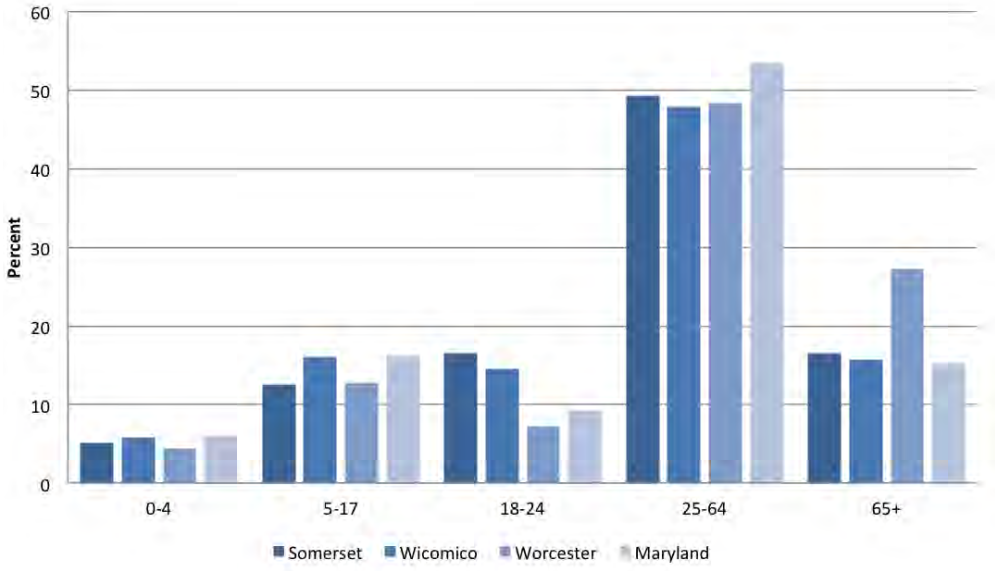
FIGURE 8. TRI-COUNTY SERVICE AREA POPULATION COUNT BY ZIP CODE



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.

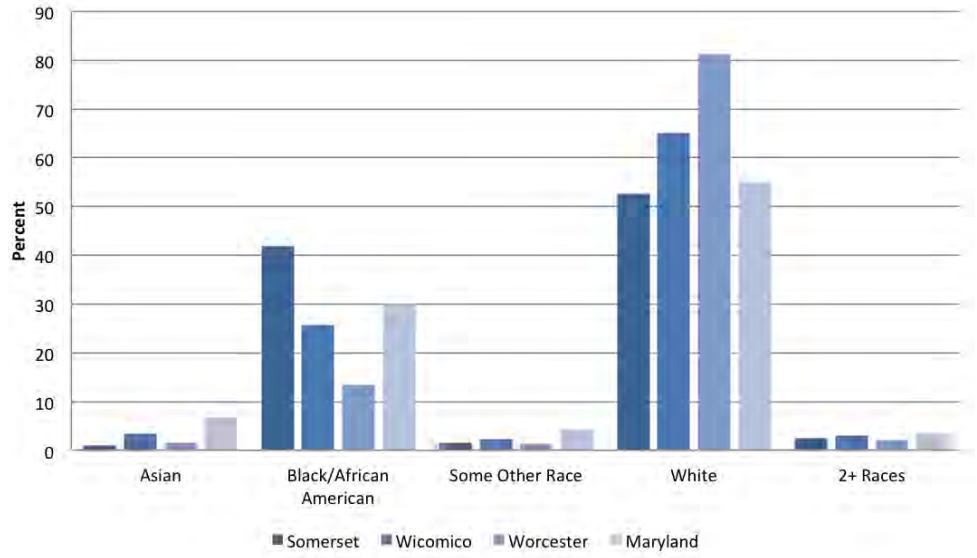
FIGURE 9. TRI-COUNTY SERVICE AREA DEMOGRAPHICS: AGE



6.1.3 RACIAL/ETHNICITY DIVERSITY

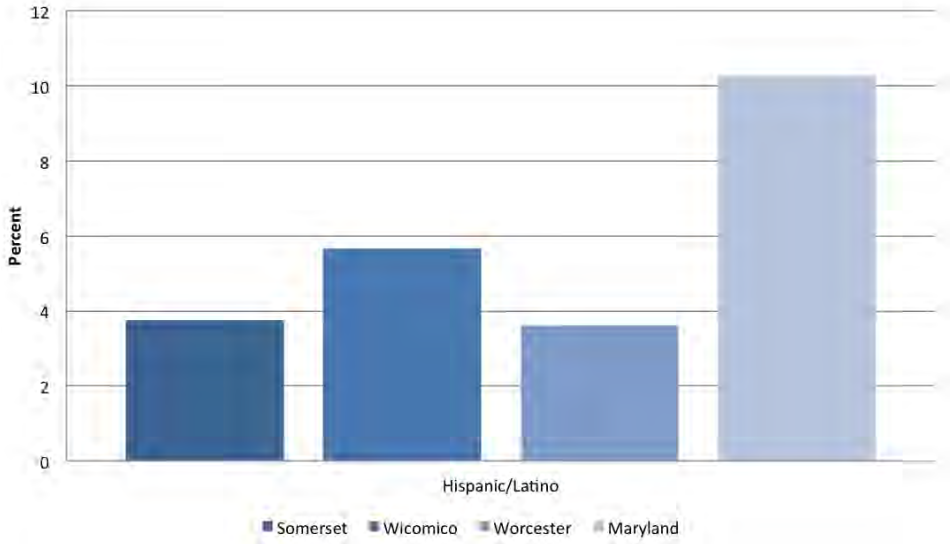
Worcester County has the highest percentage of people in the White race group (81.2%), whereas Somerset has the lowest percentage (52.6%). Both Worcester and Wicomico (65.1%) have a higher percentage of Whites than the state of Maryland as whole (55.1%). Somerset County has the largest proportion of 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

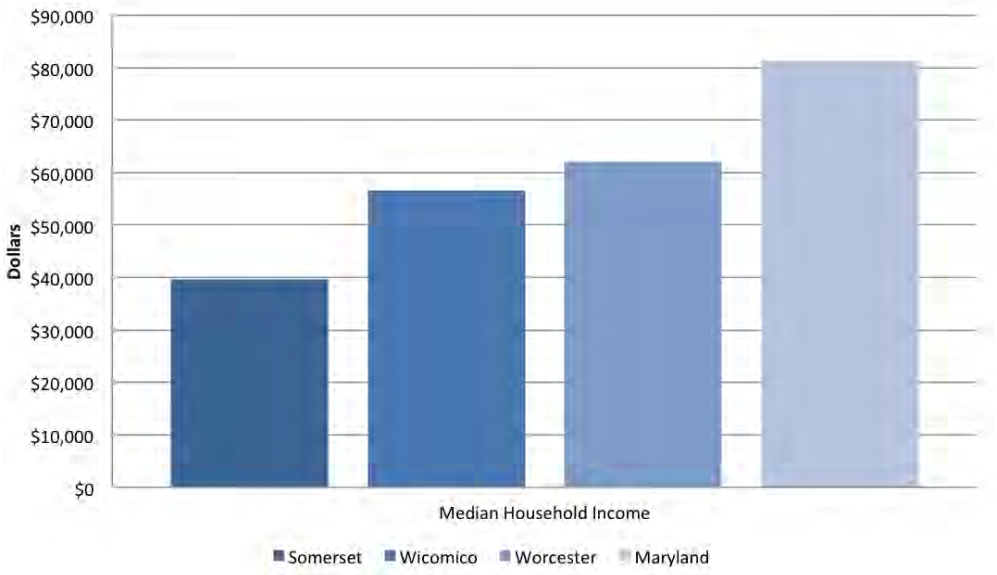
Healthy People 2020 defines social determinants of health as conditions in which people are born, grow, live, work, and age that affect a wide range of health outcomes and risks. The social determinants of health partly explain why some people are healthier than others, and generally why some people 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.

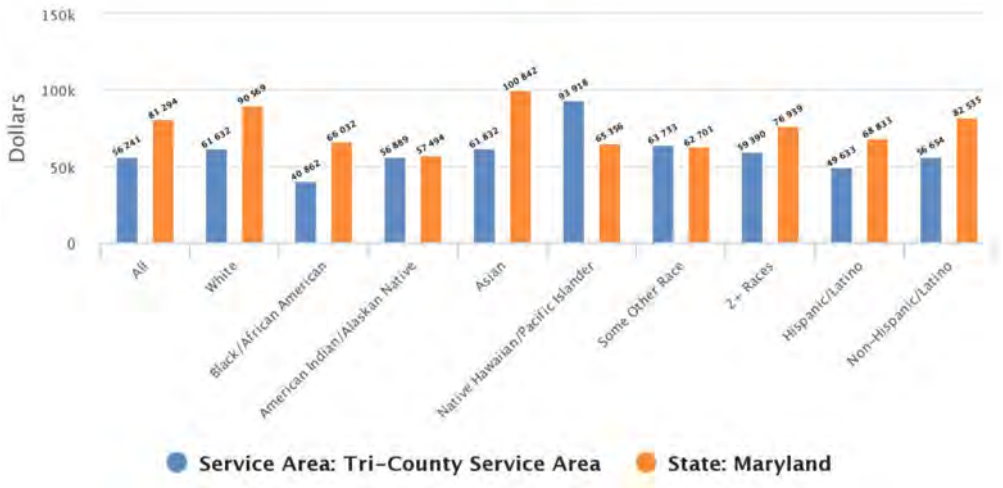
FIGURE 12. TRI-COUNTY SERVICE AREA MEDIAN HOUSEHOLD INCOME



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,

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

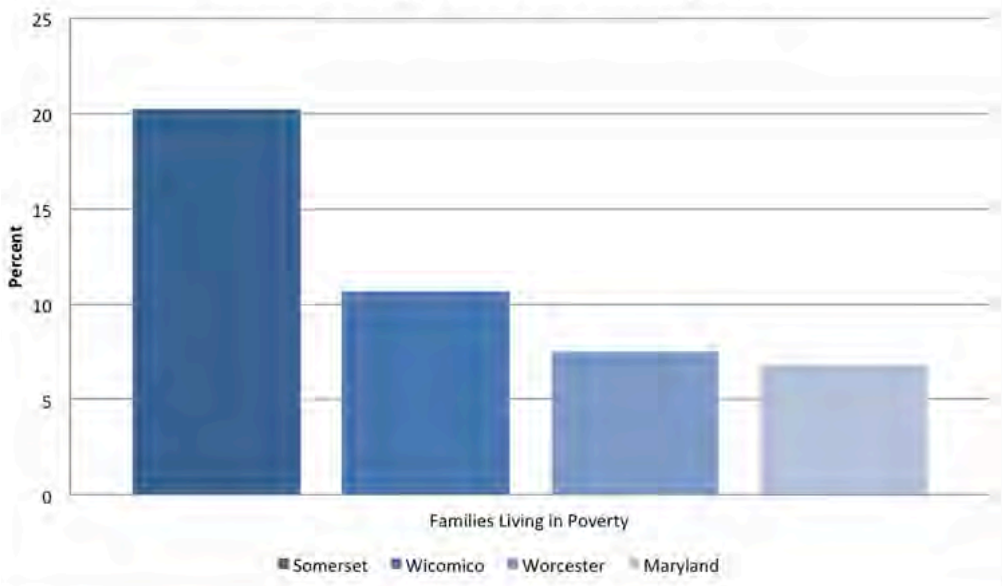
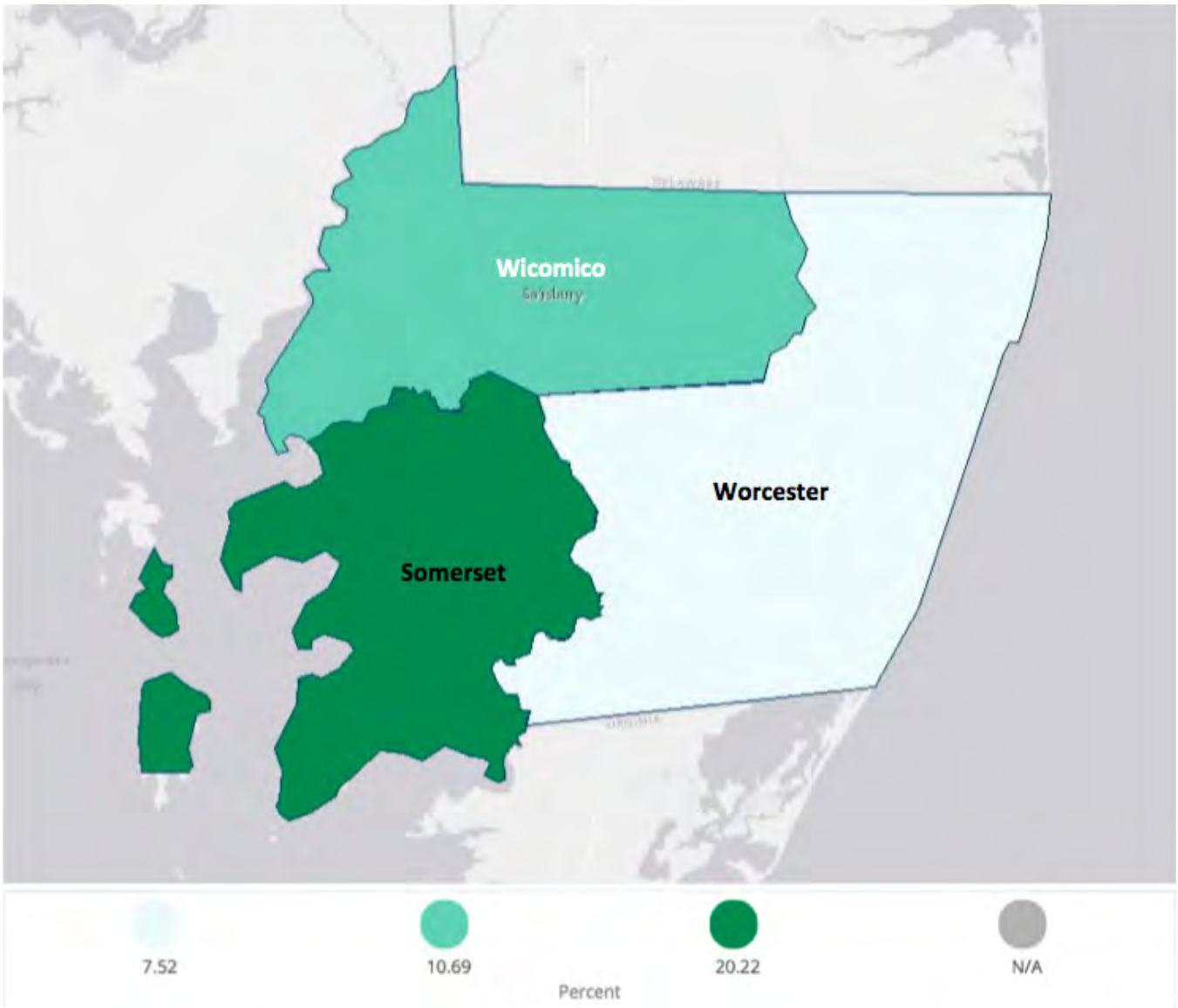


FIGURE 15. TRI-COUNTY SERVICE AREA MAP OF FAMILIES LIVING IN POVERTY



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

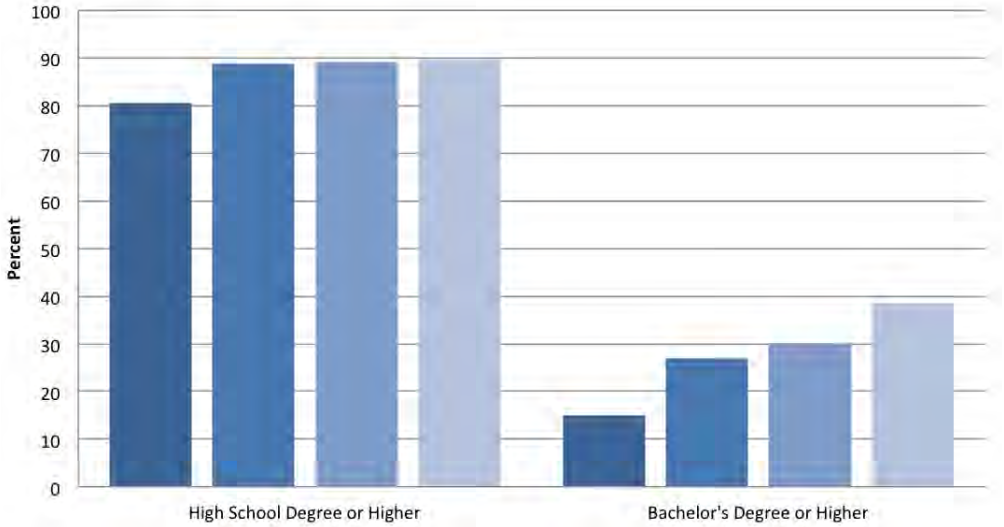
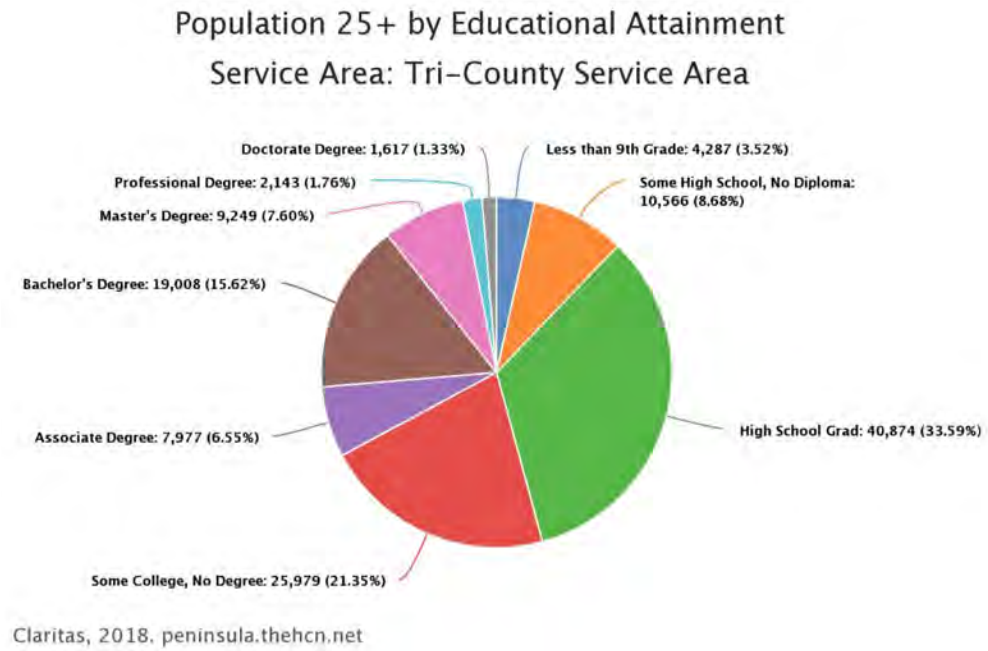


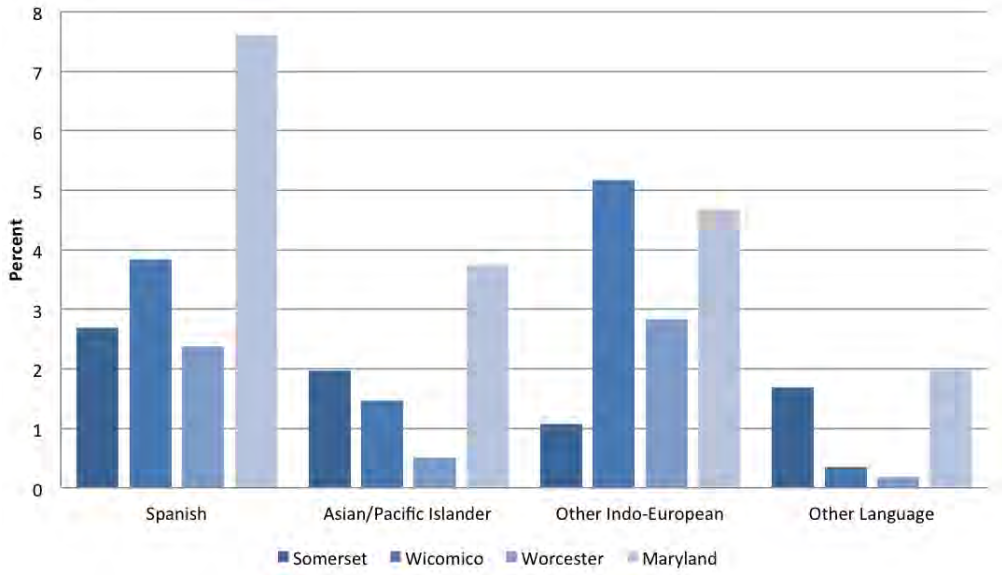
FIGURE 17. TRI-COUNTY SERVICE AREA EDUCATIONAL ATTAINMENT



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.

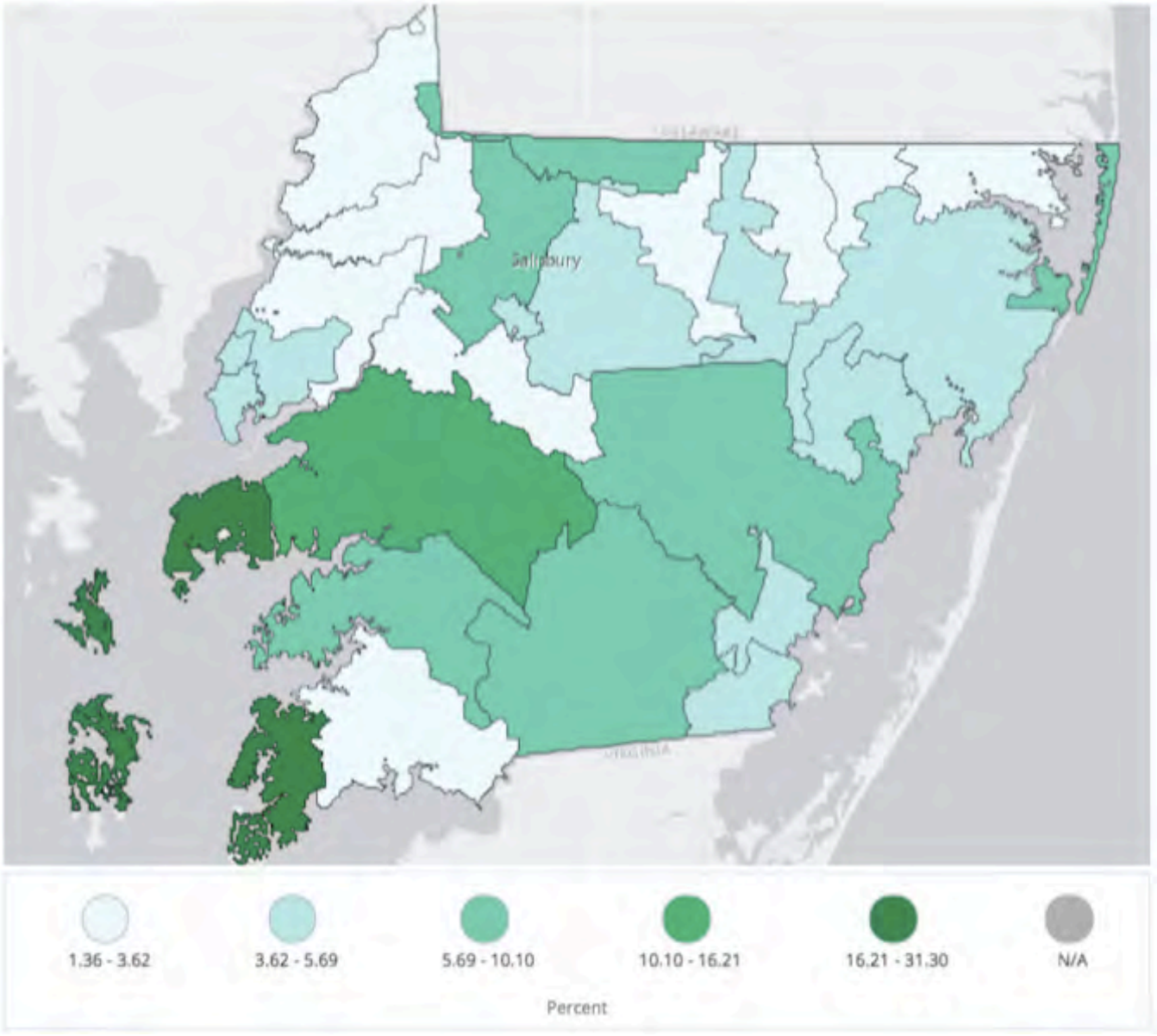
FIGURE 18. TRI-COUNTY SERVICE AREA LANGUAGE SPOKEN AT HOME



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

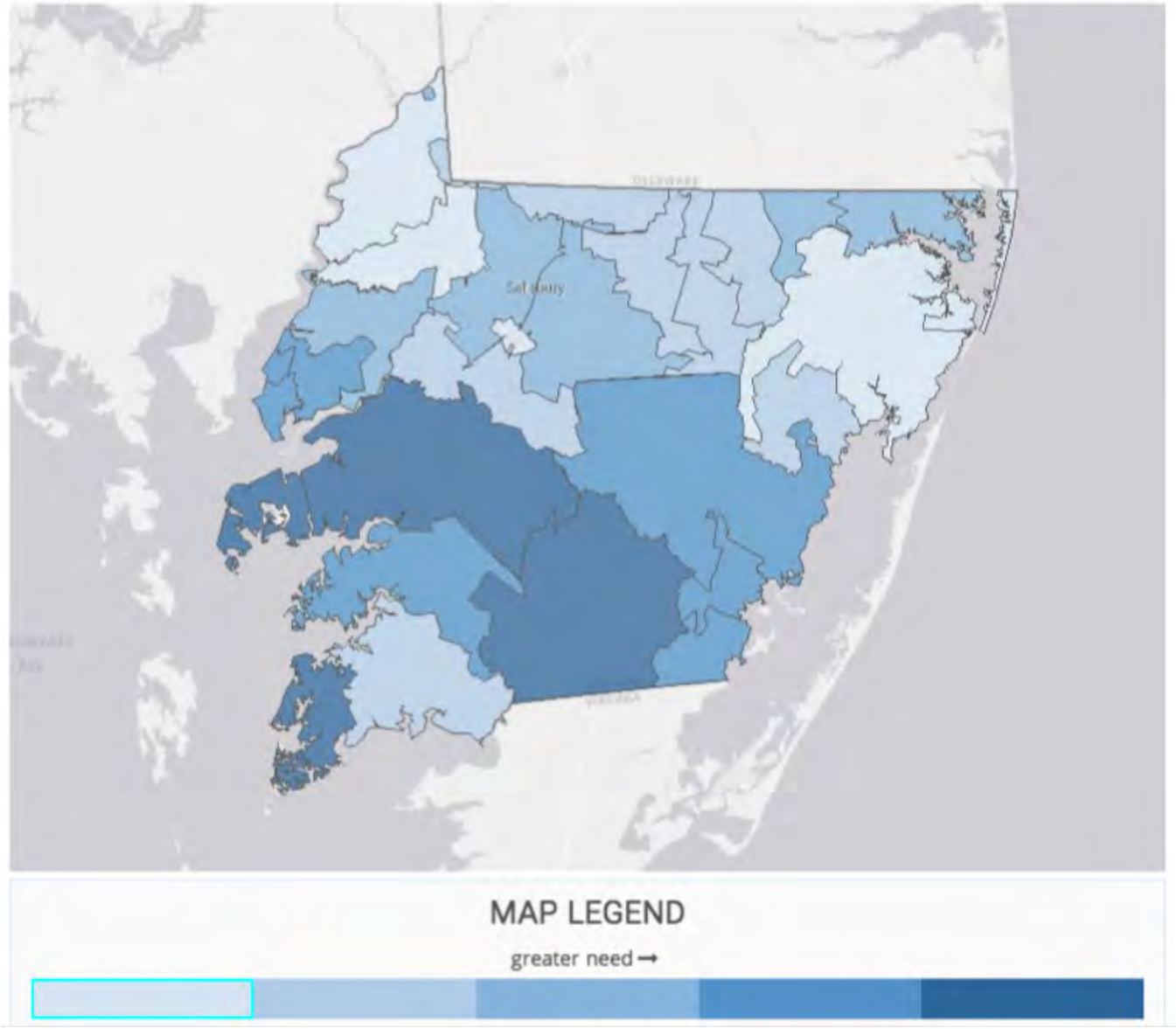


TABLE 1. SOCIONEEDS INDEX ZIP CODES OF HIGHEST NEED

ZIP CODES WITH HIGHEST SOCIOECONOMIC NEED

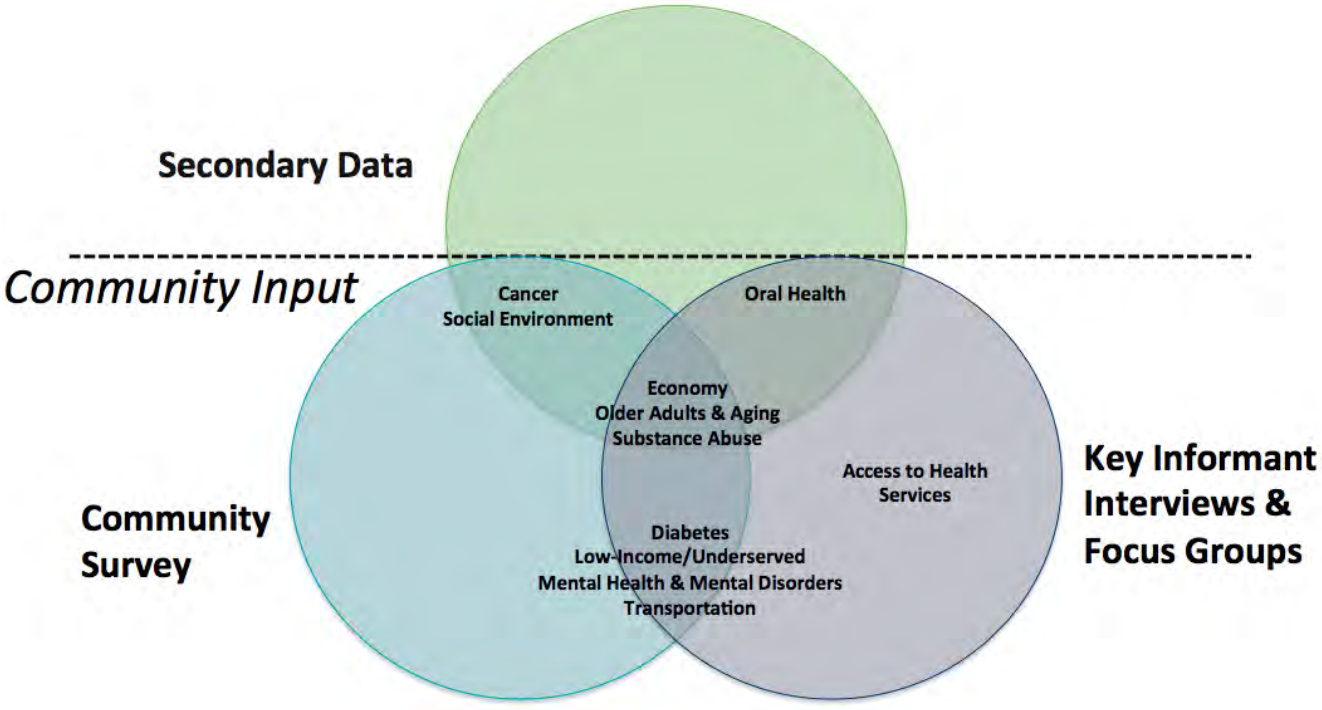
COUNTY	ZIP CODE	ZIP CODE INDEX SCORE
Somerset	21817	91.6
	21821	87.6
	21853	84.1
Wicomico	21814	76.5
Worcester	21851	86.7

SECTION 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



SECTION 8

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)[9]

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)[9]

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)[3]

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)[19]

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

Age-Adjusted Death Rate due to Cancer, 2010-2014 (deaths/100,000 population)[16]			
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	

Age-Adjusted Death Rate due to Lung Cancer, 2010-2014 (deaths/100,000 population)[16]			
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	

Age-Adjusted Death Rate due to Prostate Cancer, 2010-2014 (deaths/100,000 males)[16]			
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	

Lung and Bronchus Cancer Incidence Rate, 2010-2014 (cases/100,000 population)[16]			
MD Value: 58.1	U.S. Value: 61.2	HP2020 Target: ----	MD SHIP Target: ----
Somerset: 97.6	Wicomico: 75.6	Worcester: 69.2	

Oral Cavity and Pharynx Cancer Incidence Rate, 2010-2014 (cases/100,000 population)[16]			
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 SCHD 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

Age-Adjusted ER Rate due to Mental Health, 2014 (ER visits/100,000 population)[9]

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: -----	

Age-Adjusted Death Rate due to Suicide, 2012-2014 (deaths/100,000 population)[9]

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)	

Poor Mental Health: Average Number of Days, 2016

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."

SECTION 9

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."**

SECTION 10

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.

> **"Housing: If you can't have a stable living situation, you can't have a safe, healthy life."**

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.

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.

> **"There's no drive...to provide health care for all; it's providing the best health care possible for those that can pay."**

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.

SECTION 11

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.

SECTION 12

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 SCHD 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 SCHD 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.

SECTION 13

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.

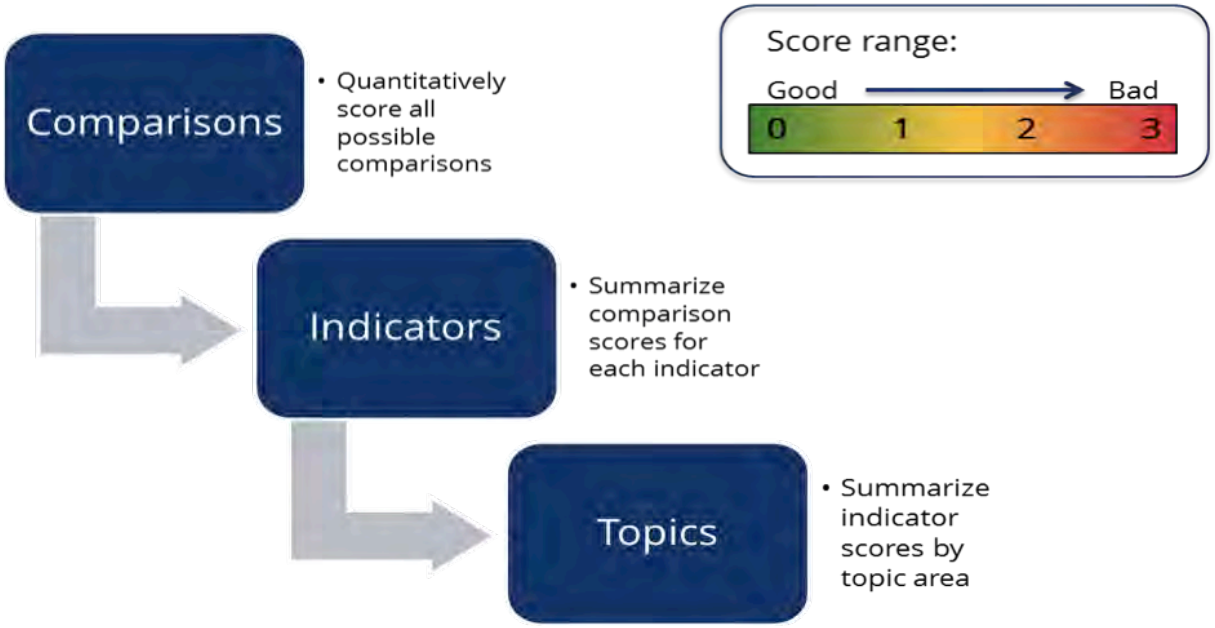
The following is a list of both local and national sources for which data is maintained for the Tri-County Service Area on the Creating Healthy Communities data dashboard.

- 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

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

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

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

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
2.48	Syphilis Incidence Rate	*cases/ 100,000 population*	15.5		8.5	8.7		*2016*	9
2.43	Chlamydia Incidence Rate	*cases/ 100,000 population*	877		509.6	497.3	431	*2016*	9
2.43	Tuberculosis Incidence Rate	*cases/ 100,000 population*	3.9	1	2.9	3		*2015*	9
2.35	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	46.5	11.4	16.1			*2015*	9
2.28	Gonorrhea Incidence Rate	*cases/ 100,000 population*	205.7		158.3	145.8		*2016*	9
2.25	Adults with Influenza Vaccination	*percent*	29.5	70	41.7		49.1	*2014*	9
2.00	HIV Incidence Rate: Aged 13+	*cases/ 100,000 population*	26.5		22.1		26.7	*2016*	9
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

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	*percent*	10.2	7.8	8.6	8.2	8	*2016*	9
2.48	Sudden Unexpected Infant Death Rate	*deaths/ 1,000 live births*	3.4	0.84	1	0.9	0.86	*2011-2015*	9
2.35	Infant Mortality Rate	*deaths/ 1,000 live births*	11.6	6	6.5		6.3	*2012-2016*	9
1.58	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15*	19.4		15.9	20.3	17.8	*2016*	9
0.58	Preterm Births	*percent*	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	*deaths/ 100,000 males*	38.1	21.8	26.7			*2005-2009*	16
1.85	Life Expectancy for Males	*years*	74.8		76.8	76.7		*2014*	7
0.75	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	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	*ER Visits/ 100,000 population*	5665.2		3442.6		3152.6	*2014*	9
2.25	Poor Mental Health: Average Number of Days	*days*	4.3		3.5	3.8		*2016*	4
2.05	Self-Reported Good Mental Health	*percent*	63.6		76.2			*2015*	8
1.95	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/ 100,000 populati*	228.7		194.1		199.4	*2014*	9
1.80	Adequate Social and Emotional Support	*percent*	80.7		82.9			*2010*	8
1.80	Frequent Mental Distress	*percent*	13.2		10.3	15		*2016*	4
1.35	Depression: Medicare Population	*percent*	14.5		15.4	16.7		*2015*	3
0.90	Mental Health Provider Rate	*providers/ 100,000 population*	216		216	214.3		*2017*	4
0.65	Alzheimer's Disease or Dementia: Medicare Population	*percent*	8.3		10.1	9.9		*2015*	3

SCORE	OLDER ADULTS & AGING	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
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 populati*	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

SCORE	ORAL HEALTH	UNITS	SOMERSET COUNTY	HP2020	MARYLAND	U.S.	MARYLAND SHIP 2017	MEASUREMENT PERIOD	Source
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

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.	#N/A	MEASUREMENT PERIOD	Source
2.70	Severe Housing Problems	*percent*	24.4		17.1	18.8		*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

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

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

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

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

SCORE	IMMUNIZATIONS & INFECTIOUS 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
2.33	Chlamydia Incidence Rate	*cases/ 100,000 population*	650.3		509.6	497.3	431	*2016*	9
2.18	Gonorrhea Incidence Rate	*cases/ 100,000 population*	226.2		158.3	145.8		*2016*	9
2.15	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	28.4	11.4	16.1			*2015*	9
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
1.20	HIV Incidence Rate: Aged 13+	*cases/ 100,000 population*	16.2		22.1		26.7	*2016*	9
0.93	Syphilis Incidence Rate	*cases/ 100,000 population*	1		8.5	8.7		*2016*	9
0.73	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	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	*deaths/ 1,000 live births*	9.4	6	6.5		6.3	*2012-2016*	9
2.13	Babies with Low Birth Weight	*percent*	9	7.8	8.6	8.2	8	*2016*	9
1.88	Preterm Births	*percent*	10.3	9.4	10	9.6		*2015*	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
0.48	Sudden Unexpected Infant Death Rate	*deaths/ 1,000 live births*	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	*deaths/ 100,000 males*	24.4	21.8	20.3	20.1		*2010-2014*	16
2.10	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	157.9		131.5	114.8		*2010-2014*	16
1.85	Life Expectancy for Males	*years*	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	*ER Visits/ 100,000 population*	6207.9		3442.6		3152.6	*2014*	9
2.13	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	12.2	10.2	9.2	12.7	9	*2012-2014*	9
2.05	Self-Reported Good Mental Health	*percent*	57.7		76.2			*2015*	8
1.95	Poor Mental Health: Average Number of Days	*days*	4		3.5	3.8		*2016*	4
1.80	Poor Mental Health: 14+ Days	*percent*	11.1		9.7			*2016*	8
1.50	Adequate Social and Emotional Support	*percent*	83.4		82.9			*2010*	8
1.50	Frequent Mental Distress	*percent*	11.9		10.3	15		*2016*	4
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
1.05	Mental Health Provider Rate	*providers/ 100,000 population*	231		216	214.3		*2017*	4
0.95	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/ 100,000 populati*	146.9		194.1		199.4	*2014*	9

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 populati*	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

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

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

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

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

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

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

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

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 populat*	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

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

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.

- O Somerset
- O Wicomico
- O Worcester
- O Other (please specify) _____

2. Do you work in the health field?

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

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.

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

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

[1]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 Fisrtcare Team), local churches, physicians and civic organizations are aware of the program and are referring patients.

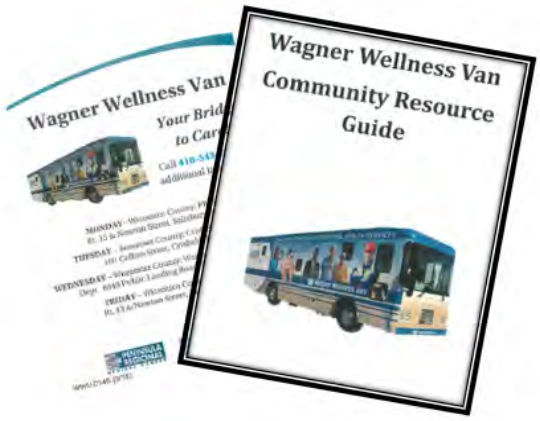
  In the last year, the partnership was successful in increasing the total number of educational classes available from 26 to 47, touching the lives of over 450 participants and their supporting caregivers. According to the surveys completed by participants agreed they had a better understanding of how 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

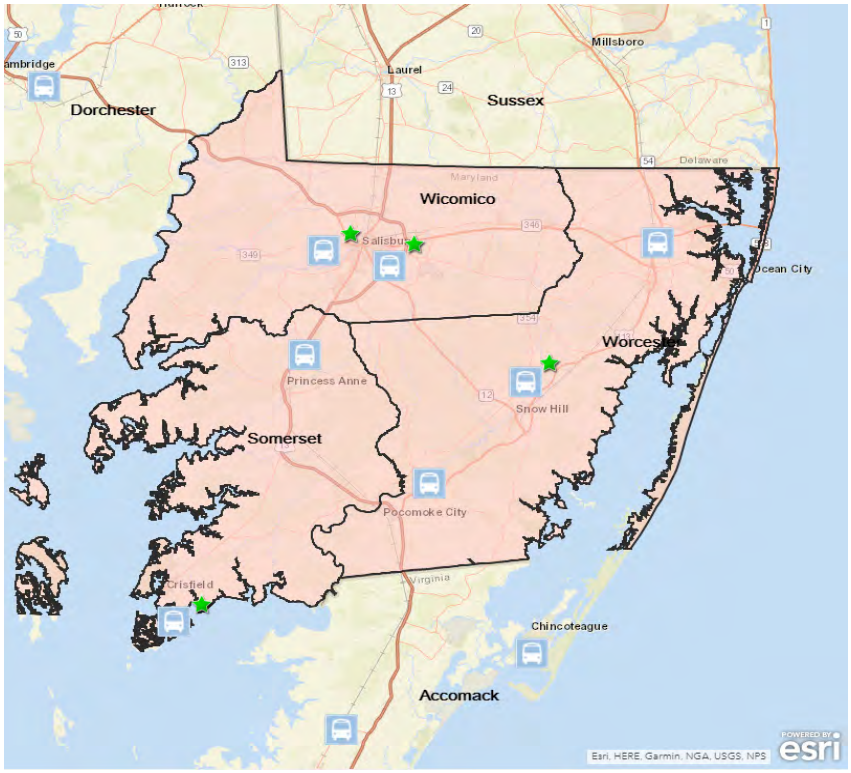
providing nutritional and healthy lifestyle counseling, in addition to medication compliance, to control diabetes and hypertension. Health screenings are performed on residents to help determine appropriate education, self-management class information, or referrals to community resources and services. 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.*



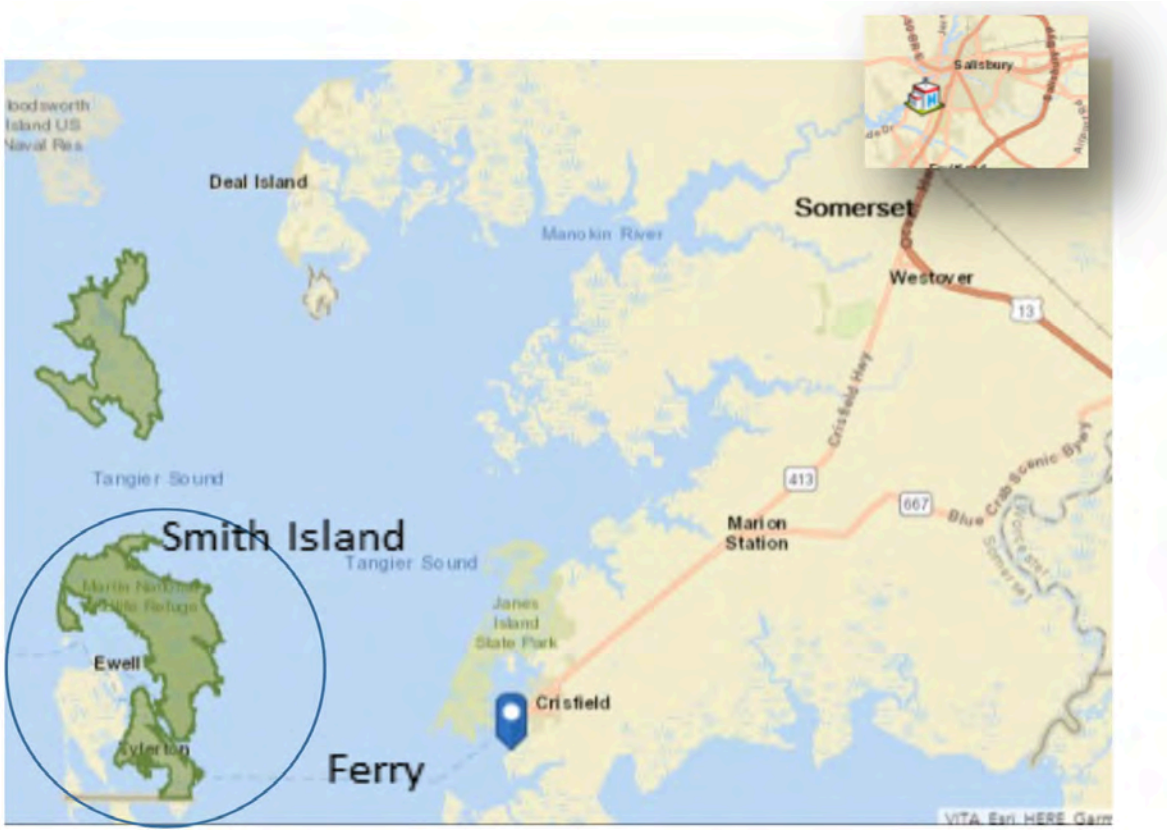
WAGNER WELLNESS VAN LOCATIONS



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.

[2]GOAL

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 though 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.

[3]GOAL

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

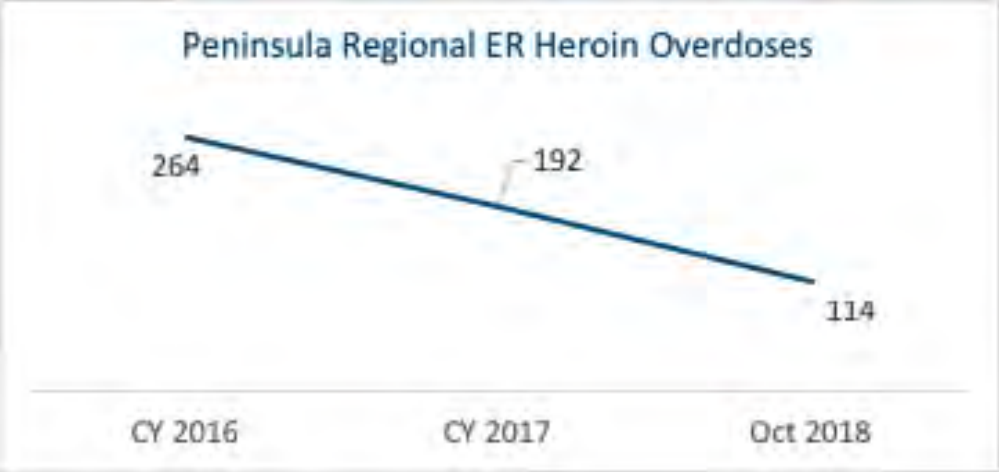
- ***Partner with local providers of Behavioral Health, such as the Lower Shore Clinic to help support long-term health.*** The CareWrap program was a hospital-community collaboration between PRMC and Lower Shore Clinic located in Salisbury, Maryland. The "Transitions Team" at Peninsula Regional targets 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 s 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

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

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 10th 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, SCHD 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

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 SCHD 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 SCHD, 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

ADMINISTRATIVE POLICY MANUAL

Subject: Financial Assistance / Uncompensated Care

Effective Date:	August 1981
Approved by:	President/CEO and Senior Vice President of Finance/CFO
Responsible Parties:	Senior Executive Director of Patient Financial Services
Revised Date:	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, 7/21
Reviewed Date:	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
Date Approved by Board:	
Key Words:	Financial Assistance, Federal Poverty Guidelines, Charity Care, Uncompensated

POLICY

In accordance with state and federal guidelines, 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. A patient's payment shall not exceed the amount generally billed (AGB). All hospital regulated services (which includes emergency and medically necessary care) at TidalHealth Peninsula Regional 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 Provider or in an unregulated area at TidalHealth Peninsula Regional or all services at TidalHealth Nanticoke Hospital will be charged the fee schedule plus the standard mark-up which is the AGB for TidalHealth. Self-pay patients, for all services not regulated by the HSCRC, will receive a discount to reduce charges to the amount TidalHealth would be reimbursed by Medicare which is the prospective method. For self-pay patients, the amount billed will not exceed the Medicare fee schedule for all unregulated services.

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: Anyone for whom the patient claims a personal exemption in a federal or State tax return. A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return, biological children, adopted children, or step-children. If the patient is a child, the household size is anyone for whom the patient's parents or guardians claim a personal exemption in a federal of State tax return. Biological parents, adopted parents, or stepparents or guardians, biological siblings, adopted siblings, or stepsiblings.
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, including 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 or TidalHealth Nanticoke.

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 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. Annual notification in the local newspaper.
f. The application is available in English, Spanish, and Creole. 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) for Maryland based on U.S. Census data. For Delaware, the hospital population considered was 5%.
g. 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.

Signs will be posted in various locations throughout TidalHealth to inform patients where to call or apply for Financial Assistance.

TidalHealth Peninsula Regional – Emergency Department, Frank B. Hanna Outpatient Center, Cardiac Rehab, Wound Care, L&D Waiting Area, Hospital Cancer Center, and Same Day Surgery Waiting Area.

TidalHealth McCready Pavilion – Lab and Radiology Waiting Area, Emergency Department, Clinic, and Physical Therapy.

TidalHealth Nanticoke – Outpatient Registration, Emergency Department, Mears Building, Wound Care and Cardiac Rehab Entrance, and Cancer 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). TidalHealth Patient Financial Services determines final approval for Financial Assistance. 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. Programs included are patients that:

- Live in a household with children enrolled in the free and reduced-cost meal program.
- Receive benefits through the federal Supplemental Nutrition Assistance Program.
- Receive benefits through the State's Energy Assistance Program.
- Receive benefits through the federal Special Supplemental Food Program for Women, Infants, and Children.
- Receive benefits from any other social service program as determined by the Department and the Commission.

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 Senior Executive Director of Revenue Cycle at 100 East Carroll Street, Salisbury, Maryland 21801-5493 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.
- One motor vehicle used for the transportation needs of the patient or any family member of the patient.
- Any resources excluded in determining financial eligibility under the Medical Assistance program under the Social Security Act.
- Prepaid higher education funds in a Maryland or Delaware 529 Program account.

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.

m. In accordance with state and federal guidelines, staff training records regarding this policy are maintained by the TidalHealth Training Coordinator.

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.

_____
Steven Leonard
President/CEO

_____
Bruce Ritchie
Senior Vice President of Finance/CFO

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

It is the intention of TidalHealth 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 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 services will appear on the same statement. Physician charges outside of TidalHealth are not included in the hospital bill and will be billed separately. Physician charges outside of TidalHealth 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/find-a-doctor.

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 TidalHealth Peninsula Regional, 100 East Carroll Street, Salisbury, Maryland 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 or the Registration Office of TidalHealth Nanticoke, 801 Middleford Road, Seaford, Delaware, 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, Spanish, and Creole.

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 the TidalHealth Financial Services Department at (877) 729-7762. You can obtain a copy of the TidalHealth Financial Assistance Policy at 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.dhmh.maryland.gov for information about the various Medicaid programs available. You may apply online for Maryland Medicaid at 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. For more information, if you are a Maryland resident, you may call the Department of Health and Mental Hygiene's Recipient Relations Hotline at 1 (800) 492-5231 or (410) 767-5800.

Delaware residents may obtain information online at dhss.delaware.gov or apply online at assist.dhss.delaware.gov. If you are a Delaware resident, call (302) 571-4900. Virginia residents may obtain information at dmas.Virginia.gov. To receive an application, call your local DSS office or the Area Agency on Aging, (AAA).

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 4:00 p.m., de lunes a viernes
- Acuda en persona a la oficina del consejero financiero (Localizado en el vestibulo Frank B. Hanna del Centro de attencion 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. Haga clic en Patients & Visitors (Pacientes y vistantes), luego en Patient Financial Services (Servicios financieros para pacientes) y después en Billing Information (Información de facturación)

Date: 5/16 (effective 11/01/16)
Reviewed:
Revised: 7/17, 7/18, 7/19, 7/20, 9/20, 7/21

From: Henry Nyce
To: Hilltop HCB Help Account
Cc: Logan Becker; Chris Hall
Subject: RE: Clarification Required - TidalHealth Peninsula Regional FY 21 Community Benefit Narrative
Date: Monday, May 23, 2022 8:40:40 AM

Report This Email

Thank you, and we will clarify and provide Hilltop with this information as quickly as possible within the next several weeks, as we work with our internal health team.

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

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Thursday, May 19, 2022 4:42 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; Henry Nyce <Henry.Nyce@tidalhealth.org>
Subject: Clarification Required - TidalHealth Peninsula Regional FY 21 Community Benefit Narrative

---

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.
- No response was given for Question 131 on page 22. Please provide a response.
- For Question 223 on page 26, your hospital indicated that physician subsidies were reported on its community benefit financial report. However, only “Other” physician gaps were selected on Question 218 on page 26 even though numerous itemized physician subsidies were listed on your hospital’s financial report. Please clarify in the narrative report which physician types had gaps in availability as well the type of subsidy for each. Additionally, please describe how each line-item subsidy from the financial report was determined to be necessary to meet patient demand in your service area.

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

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

Hilltop Request

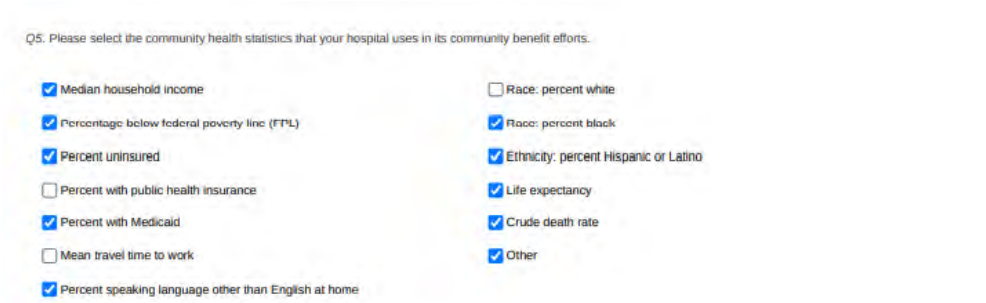
Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for TidalHealth Peninsula Regional. In reviewing the narrative, we encountered a few items that require clarification:

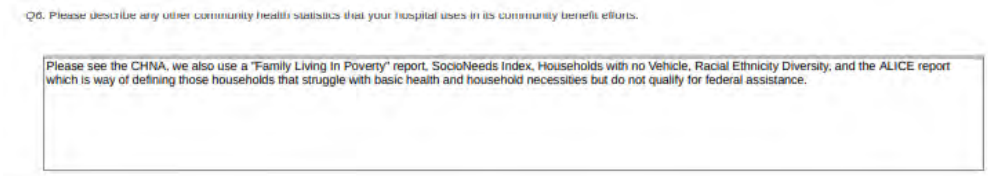
- Your response to Question 5 on page 1 indicated your hospital used "Other" community health statistics in its community benefit efforts. However, no description was provided of these other statistics. Please provide a description.

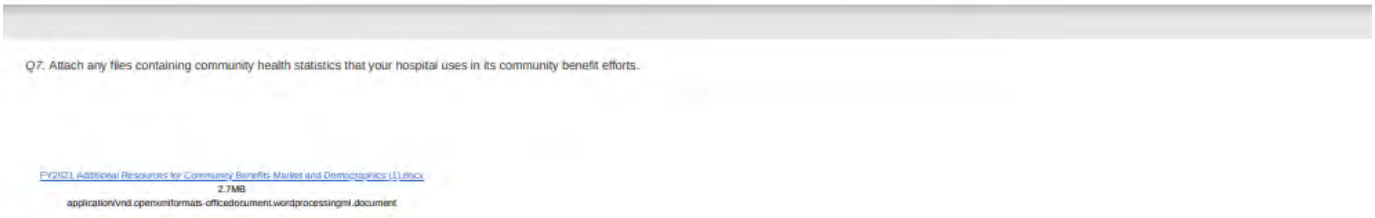
TidalHealth Response

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.







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.

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

From:	Henry Nyce
To:	Hilltop HCB Help Account
Cc:	Jenin Shah
Subject:	Revised Q218
Date:	Friday, July 29, 2022 4:08:44 PM
Attachments:	Q218 Revised.pdf

Report This Email

Thank you so much for your patience, attached you will find the revised TidalHealth Peninsula Regional physician subsidies report (Community Benefit Report Q218) that parallels the financial excel statement.

- For Question 223 on page 26, your hospital indicated that physician subsidies were reported on its community benefit financial report. However, only "Other" physician gaps were selected on Question 218 on page 26 even though numerous itemized physician subsidies were listed on your hospital's financial report

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

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

	Is there a gap resulting in a subsidy? Yes	No	What type of subsidy?
Allergy & Immunology	○	○	
Anesthesiology	○	○	
Cardiology	✓	○	Physician Recruit. meet Comm need
Dermatology	○	○	
Emergency Medicine	✓	○	Coverage & Emerg Dept Call
Endocrinology, Diabetes & Metabolism	✓	○	Physician Recruit meet comm need
Family Practice/General Practice	✓	○	Physician Recruit meet comm need
Geriatrics	○	○	
Internal Medicine	○	○	
Medical Genetics	○	○	
Neurological Surgery	✓	○	Physician Recruit meet comm need
Neurology	○	○	
Obstetrics & Gynecology	○	○	
Oncology-Cancer	✓	○	Physician Recruit meet comm need
Ophthamology	○	○	
Orthopedics	○	○	
Ololaryngology	○	○	
Pathology	○	○	
Pediatrics	✓	○	Physician Recruit meet comm need
Physical Medicine & Rehabilitation	○	○	
Plastic Surgery	○	○	
Preventive Medicine	○	○	
Psychiatry	✓	○	Physician Recruit meet comm need
Radiology	○	○	
Surgery	✓	○	Physician Recruit meet comm need
Urology	○	○	
Other (Describe) Non-resident house staff and hospitalist	◉	○	Non-resident house staff and hospitalists

Other Pulmonology — Physician Recruit meet comm need
Pain Management — ✓ ✓ ✓ ✓