Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

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

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

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

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

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

	Is this information correct? Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: UM Shore Regional Health	◉	○	
Your hospital's ID is: Dorchester - 210010, Chestertown - 210030, Easton - 210037	◉	○	Note: Dorchester closed Sept. 30 2021
Your hospital is part of the hospital system called University of Maryland Medical System.	◉	○	
The primary Narrative contact at your hospital is Kathleen Mcgrath, Donna Jacobs	◉	○	
The primary Narrative contact email address at your hospital is kfmcgrath@umm.edu; optimaloutcomesmd@gmail.com	◉	○	
The primary Financial contact at your hospital is Anna D'Acunzi	◉	○	
The primary Financial email at your hospital is adacunzi@umm.edu	◉	○	

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

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

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

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

http://www.countyhealthrankings.org/

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

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

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

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

- [ ] 21609
- [ ] 21629
- [x] 21632
- [ ] 21636
- [x] 21639
- [ ] 21640
- [ ] 21641
- [ ] 21643
- [ ] 21649
- [x] 21655
- [ ] 21657
- [ ] 21660

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.

- [x] 21613
- [ ] 21622
- [ ] 21626
- [ ] 21627
- [x] 21631
- [ ] 21632
- [ ] 21634
- [x] 21643
- [ ] 21648
- [ ] 21655
- [ ] 21659
- [ ] 21664
- [ ] 21669
- [ ] 21672
- [ ] 21675
- [ ] 21677
- [ ] 21835
- [ ] 21869

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.

- [ ] 21610
- [x] 21620
- [ ] 21635
- [ ] 21645
- [ ] 21650
- [x] 21651
- [x] 21661
- [ ] 21667
- [x] 21678
- [ ] 21690
- [ ] 21797
- [ ] 21930

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.

- [ ] 21607
- [x] 21617
- [ ] 21619
- [ ] 21620
- [ ] 21623
- [ ] 21628
- [ ] 21638
- [ ] 21640
- [ ] 21644
- [ ] 21649
- [ ] 21651
- [ ] 21656
- [ ] 21657
- [ ] 21658
- [ ] 21666
- [x] 21668
- [ ] 21670
- [ ] 21679

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

This question was not displayed to the respondent.

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.

- [x] 21601
- [ ] 21653
- [ ] 21665

- [ ] 21612
- [ ] 21624
- [ ] 21625
- [ ] 21647
- [ ] 21652
- [ ] 21654
- [ ] 21657
- [ ] 21662
- [x] 21663
- [x] 21671
- [x] 21673
- [ ] 21676
- [ ] 21679

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.
- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.
- [x] Based on patterns of utilization. Please describe.

  Zipcodes checked reflects 60%of admissions for SRH

- [x] Other. Please describe.

  Shore Regional Health’s service area is defined as the Maryland counties of
  Caroline, Dorchester, Talbot, Queen Anne’s and Kent. The five counties of the Mid-Shore comprise 20% of the landmass of the State of Maryland and 2% of the population.SMC at Easton is situated at the center of the midshore area and thus serves a large rural geographical area (all 5 counties of the mid-shore). SMC at Dorchester is located approximately 18 miles from Easton and primarily serves Dorchester County and portions of Caroline County. UMC at Chestertown serves the residents of Kent County, portions of Queen Anne’s and Caroline
  Counties and the surrounding areas

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

https://www.umms.org/shore/about/mission

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)

5/25/2022

Q41. Please provide a link to your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

https://www.umms.org/shore/-/media/files/um-shore/community/community-health-reports/chna-2022.pdf

Q42. Please upload your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

CHNA Board Approved 5.25.2022.pdf
3.7MB
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)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☑	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
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)	☐	☐	☐	☑	☑	☐	☐	☐	☐	☐	
	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)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	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 initiatives	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 initiatives	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 initiatives	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 initiatives	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 initiatives	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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	

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

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

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

Refer to the FY 2022 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is 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: UM Chestertown, UM Dorchester	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
	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: Caroline, Dorchester, Kent, Talbot, Queen Anne's	☑	☑	☑	☐	☐	☐	☑	☑	☑	☑	☑	☐	☐	☐
	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: Mid Shore 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
Faith-Based Organizations	☑	☑	☑	☐	☐	☐	☑	☑	☑	☑	☑	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here: Mid Shore Behavioral Health	☑	☑	☑	☐	☐	☐	☑	☑	☑	☑	☑	☐	☐	☐
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other -- If any other people or organizations were involved, please list them 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

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.

5/25/2022

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

https://www.umms.org/shore/-/media/files/um-shore/community/community-health-reports/chip-2022.pdf

Q53. Please upload your hospital's CHNA implementation strategy.

Community Health Implementation Plan 5.25.2022.pdf
829KB
application/pdf

Q54. 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.

Q55. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q56. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q57. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q58.
Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q59. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q60. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

HEALTH DISPARITIES Overall, the five counties of the Mid-Shore, (Caroline, Dorchester, Kent, Queen Anne's, Talbot) face significant health disparities that accentuate the need for access to quality health care. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities. Within the Mid-Shore the economic condition varies significantly. County Health Rankings reveals large disparities between counties for health outcomes and the social factors that impact health, such as poverty. The impact of these challenges are compounded by the barriers already present, such as limited public transportation options and fewer choices to acquire healthy food. COUNTY HEALTH RANKINGS Robert Wood Johnson Foundation Health Outcomes for 2022 Caroline: 22, Dorchester:21, Kent:16, Queen Anne's:9, Talbot:10 (Ranking is based on 24 counties including Baltimore City) in health outcomes that indicate the overall health of the county). Social & Economic Factors: Caroline:18, Dorchester:22, Kent:16, Queen Anne's:6, Talbot:11 on Social and economic factors, such as income, education, employment, community safety, and social support that can significantly affect how well and how long we live) Food Insecure: Caroline 12.1%, Dorchester 15.8%, Kent 11.5%, Queen Anne's 7.5%, Talbot10.5% Children in Poverty: Caroline 20%, Dorchester 27%, Kent 19%, QA 9%, Talbot 15% (Source: URL: http://www.mdfoodsystemmap.org) Pre-COVID. Additional challenges for the Mid Shore include limited access to affordable high speed broadband services, a shortage of affordable housing, an inadequate supply of skilled workers, and low per capita income. Because addressing health disparities and inequities is essential for public health to progress, UM Shore Regional Health works in partnership with public sector agencies, health care providers and community-based partners. Through a variety of community building activities, UM Shore Regional Health promotes health equity in the community it serves and to increase the trust in communities that may have long-term been distrusting—communities who have been marginalized and sometimes even harmed by past public health actions. These activities include: active engagement and collaboration with local Health Departments, Mid Shore Behavioral Health, Opioid Task Force, Chambers of Commerce, and Faith-based organizations that work to improve the quality of life for the residents of the Mid-Shore. UM SRH provides on-going services that are fundamental to addressing the identified community health needs that demonstrate the extent to which our commitment to serve our community is integrated into our care delivery model. UM SRH Community Health and Outreach initiatives addressing health disparities and inequities include: • Facilitate listening sessions and Town Hall meetings to understand needs of the community • Health Literacy series- monthly presentation on a specific health topic. Our clinical experts take questions from families using the Ask Me 3® approach to better understand health conditions such as diabetes, asthma and cancer and what is needed to stay healthy. • Food Insecurity - partnership with Maryland Food Bank of the Eastern Shore, including food drives and distribution to local food pantries. • Screenings and Support Groups offered in all five counties. Health and Education Events include: (1) High blood pressure and heart disease; (2) Diabetes; (3) Cancer; (4) Stroke; (5) Hospice services and palliative care; (6) Obesity, exercise and nutrition We have a strong focus on treating patients with chronic conditions. UM Shore Regional Health works to coordinate care, ensure smooth transitions and promote disease self-management strategies at every step of a patient's journey – whether at home, in the community, or within our hospital. We operate specialized clinics to enable access to routine outpatient care. Our transitional care services help patients newly diagnosed or those that have had a recent hospitalization transition safely back to the community. Transitional nurse navigators provide patients with disease education and self-management strategies, connect them to primary care providers and specialists, and help them overcome any barriers to making follow up appointments. Urgent care to address off hours visits and low acuity emergencies is also available. Resources are embedded throughout the hospital and in the community so that every patient receives the same high level of care coordination. Care managers are embedded within our emergency department and hospital, and provide in-home visits as needed. Community health workers reach out to patients who are identified in need of critical resources and need additional support to access care. Close relationships are maintained with skilled nursing facilities and home health agencies so that transfers from the hospital to these facilities are smooth, and the highest quality of care is constantly delivered. Strong relationships exist with local emergency medical service (EMS) providers through our mobile integrated health program, which delivers effective and efficient care to patients outside of the hospital. Nurses and community health workers function outside traditional emergency response roles, with a focus on maintaining individuals' health at their homes while also providing convenient access to care in the community. Additional care partners include primary care providers, specialists, local department of health, office on aging and other community based partners. We are proud to serve our community and appreciate our partners who allow us to fulfill our mission. We will always do what is right for the patient, no matter where they are in their health journey, and will always strive to have our patients receive care in the community they reside. As a part of the University of Maryland Medical System (UMMS) we are shaping a new paradigm in care delivery to address health care.

Q61. 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:

- [ ] None
- [ ] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [x] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q62. If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q63. Section III - CB Administration

Q64. 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
- [x] Yes, by a third-party auditor
- [ ] No

Q65. Please describe the third party audit process used.

Ernst and Young

Q66. Does your hospital conduct an internal audit of the community benefit narrative?

- [x] Yes
- [ ] No

Q67. Please describe the community benefit narrative audit process.

University of Maryland Shore Regional Health's Narrative Review Process: The Community Health Planning Council, which is responsible for recommending and developing programs and services that carry out the mission of UM SRH to enhance the health of local communities reviews the narrative. The narrative is then reviewed by (1) senior leadership, (2) UM SRH Strategic Planning Committee, (3) Senior Vice President, Government, Regulatory Affairs and Community Health, University of Maryland Medical System and ultimately submitted to (4) UM SRH Board for approval

Q68. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- [x] Yes
- [ ] No

Q69. Please explain:

This question was not displayed to the respondent.

Q70. Does the hospital's board review and approve the annual community benefit narrative report?

- [x] Yes
- [ ] No

Q71. Please explain:

This question was not displayed to the respondent.

Q72. Does your hospital include community benefit planning and investments in its internal strategic plan?

- [x] Yes
- [ ] No

Q73. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

The Community Benefit investments are incorporated in the Shore Regional Health (SRH) Strategic Plan which supports the efforts currently underway in Maryland, to strengthen primary care and coordinate hospital care with community care; map and track preventable disease and health costs; develop public-private coalitions for improved health outcomes; and establish Regional Partnerships. UM SRH's Strategic Plan provides the framework for improved care coordination to improve care delivery for our community. Development of community benefit initiatives and investments to support identified needs is ongoing and will continue to be updated to reflect progress and changes.

Q74. If available, please provide a link to your hospital's strategic plan.

Q75. 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

Diabetes Prevention and Management Programs offered to community
•Provide classes, program, speakers, events to improve health & wellness
•Expand diabetes/pre-diabetes educational classes- State Diabetes
•Provide education specialist(s) needed to support wellness programing

- [x]

Opioid Use Disorder - Improve overdose mortality

• Expand screening, brief intervention, and referral to treatment (SBIRT) and buprenorphine induction.
• Distribute Naloxone to patients who receive treatment in the emergency department (ED) for a non-fatal overdose.
• Connect with Regional Partnership on plans to expand behavioral health crisis infrastructure in the community

- [ ] Maternal and Child Health - Reduce severe maternal morbidity rate

- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

- [ ] None of the Above

Q76. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q77. Section IV - Physician Gaps & Subsidies

Q78. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ( ) No
- (•) Yes

Q79. 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	(•)	( )	Physician recruitment to meet community need
Cardiology	(•)	( )	Physician recruitment to meet community need
Dermatology	( )	(•)	
Emergency Medicine	(•)	( )	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	(•)	( )	Physician recruitment to meet community need
Family Practice/General Practice	(•)	( )	Physician recruitment to meet community need
Geriatrics	( )	(•)	
Internal Medicine	( )	(•)	
Medical Genetics	( )	(•)	
Neurological Surgery	( )	(•)	
Neurology	(•)	( )	Physician recruitment to meet community need
Obstetrics & Gynecology	(•)	( )	Physician recruitment to meet community need
Oncology-Cancer	(•)	( )	Physician recruitment to meet community need
Ophthalmology	( )	(•)	
Orthopedics	( )	(•)	
Otolaryngology	(•)	( )	Physician recruitment to meet community need

Pathology	○	◉	
Pediatrics	◉	○	Physician recruitment to meet community need
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	○	◉	
Psychiatry	◉	○	Physician recruitment to meet community need
Radiology	○	◉	
Surgery	◉	○	Physician recruitment to meet community need
Urology	◉	○	Physician recruitment to meet community need
Other. (Describe) Digestive Health, Pulmonary Care, Acute Rehab, Wound Care, Palliative	○	◉	Physician recruitment to meet community need

Q80. 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.

For residents of the five counties of the mid-shore, Access to Care has consistently been a top priority identified in the Community Health Needs Assessment (CHNA). The challenges to access care due to availability of primary care and specialty physicians is well documented in the white paper, UNDERSTANDING AND ADDRESSING THE NEEDS OF MARYLAND'S VULNERABLE RURAL HOSPITALS AND THEIR COMMUNITIES. The number and availability of physicians and Advanced Practice Providers (APPs, including nurse practitioners, physician assistants, midwives) whose practices are open to new patients and/or who have reasonable wait times to schedule such care have a profound impact on the health of the population served by UM SRH. To address Access to Care and as part of our ongoing strategic planning process and Community Health Implementation Plan (CHIP), UM SRH regularly evaluates the supply/demand and need for additional physicians and succession planning. UM SRH is the primary provider of specialty and emergency services within the midshore. In 2020, a consultant group was engaged to create a Medical Staff Development Plan; identifying gaps in physicians and physician specialties for our service area. The plan is based on service area profiles, access, medical market profiles, physician interviews, and community needs assessment. UM SRH developed a detailed recruitment/retention and succession action plan. The plan has identified the following needs and is actively engaged in recruitment and retention efforts for the following specialties; Neurology, Otolaryngology, Primary Care, Psychiatry, Rheumatology, General Surgery, Endocrinology, Medical oncology, Urology, Gastroenterology, Cardiology, Pulmonology & OBGYN. As a consequence of the challenges outlined above, within UM SRH, investments in hiring and retaining physicians and APPs are on the rise and occurring at a significant cost to the health system.

Q81. Please attach any files containing further information and data justifying physician subsidies at your hospital.

Q82. Section VI - Financial Assistance Policy (FAP)

Q83. Upload a copy of your hospital's financial assistance policy.

UM SRH Financial Assistance Policy.pdf
325KB
application/pdf

Q84. Provide the link to your hospital's financial assistance policy.

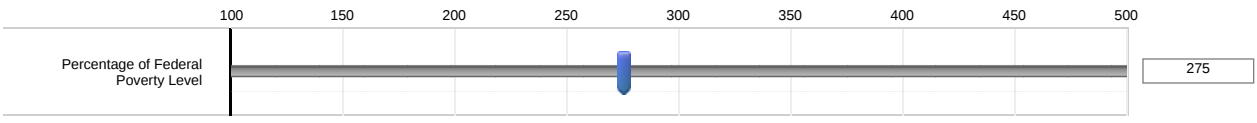
https://www.umms.org/shore/patients-visitors/for-patients/financial-assistance

Q85. 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:

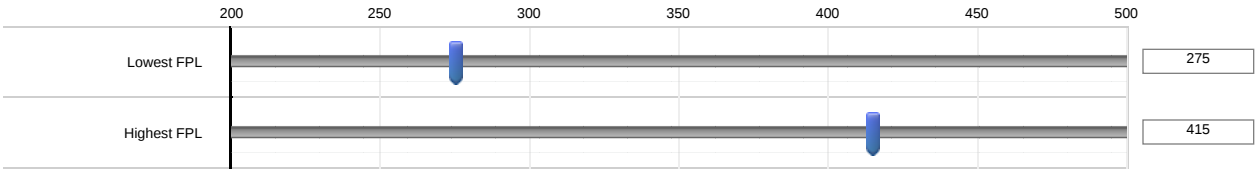
Q86. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



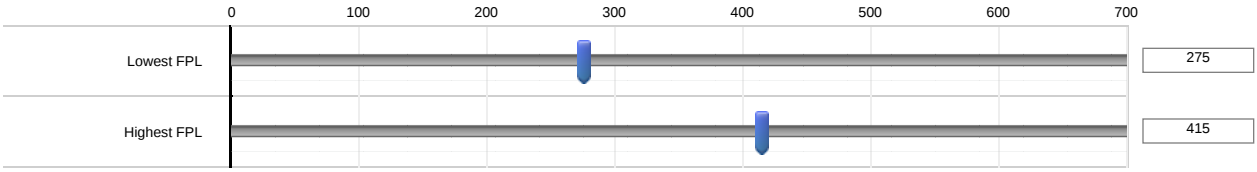
Q87. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

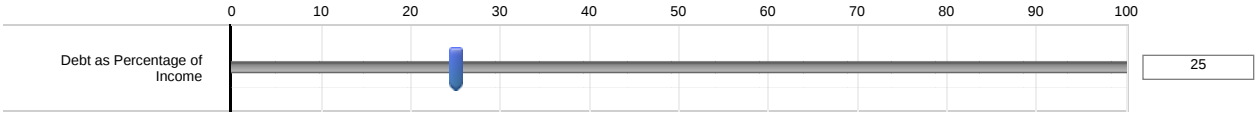


Q88. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health 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.



Q89. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q90. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable 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)

Q91. Summary & Report Submission

Q92.

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: (41.2591, -95.8517)

Source: GeoIP Estimation

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Community Health Needs Assessment & Implementation Plan

FY2023-FY2025

Board Approved
5/25/2022

Table of Contents

Executive Summary

Overview

University of Maryland Shore Regional Health (UM Shore Regional Health) is a regional, nonprofit, medical delivery care network formed on July 1, 2013, through the consolidation of two University of Maryland Medical System (UMMS) partner entities, the former Shore Health and the former Chester River Health. As a member of UMMS, UM Shore Regional Health is able to enhance its various clinical programs and facilities and facilitate physician recruitment, bringing world-class medical care to the residents of Maryland's Mid-Shore region.

The UM Shore Regional Health network serves the Mid-Shore region, which includes Caroline, Dorchester, Kent, Queen Anne's and Talbot counties. In addition to its two hospitals — University of Maryland Shore Medical Centers at Chestertown and Easton — UM Shore Regional Health includes two freestanding emergency centers in Cambridge and Queenstown, and UM Shore Medical Pavilions at Cambridge, Chestertown, Denton, Easton and Queenstown, and a broad array of inpatient and outpatient services in locations throughout the five-county region. UM Shore Regional Health also provides urgent care services in Denton, Easton and Kent Island through UM Urgent Care.

The organization's affiliate, UM Shore Medical Group, employs physicians and advanced practice providers who provide care in office and clinical locations in towns throughout the five-county region, including Cambridge, Centreville, Chestertown, Denton, Easton, Galena and Queenstown.

As the regional health care network serving Caroline, Dorchester, Kent, Queen Anne’s and Talbot counties on Maryland’s Eastern Shore, University of Maryland Shore Regional Health (UM SRH) provides inpatient and outpatient health care services for residents in this predominantly rural, 2,000 square mile region. With more than 2,500 employees, board members and volunteers, and a medical staff that includes 382 credentialed medical staff members, UM SRH works with various

community partners to provide quality health care and to fulfill the organization's mission of Creating Healthier Communities Together.

In FY2020, UM SRH provided care for 8,409 inpatient admissions, 7,784 outpatient surgical cases, and 70,420 emergency department visits. Beyond Shore Regional Health Medical Center facilities, 18,000 hours of community health services were provided through education and outreach programs, screenings, and support groups. In addition, UM SRH provided additional support to the community with COVID-19 PPE, food distribution and COVID-19 safety information. UM SRH provides a community outreach section on the UM SRH public web site to announce upcoming community health events and activities in addition to posting the triennial Community Health Needs Assessment (CHNA).
/www.umms.org/shore/-/media/files/um-shore/community/community-health-needs-

Our Mission and Vision

UM SRH's organization's mission and vision statements set the framework for the community benefit program. As University of Maryland Shore Regional Health expands the regional healthcare network, we have explored and renewed our mission, vision and values to reflect a changing health care environment and our communities' needs with input from physicians, team members, patients, health officers, community leaders, volunteers and other stakeholders.

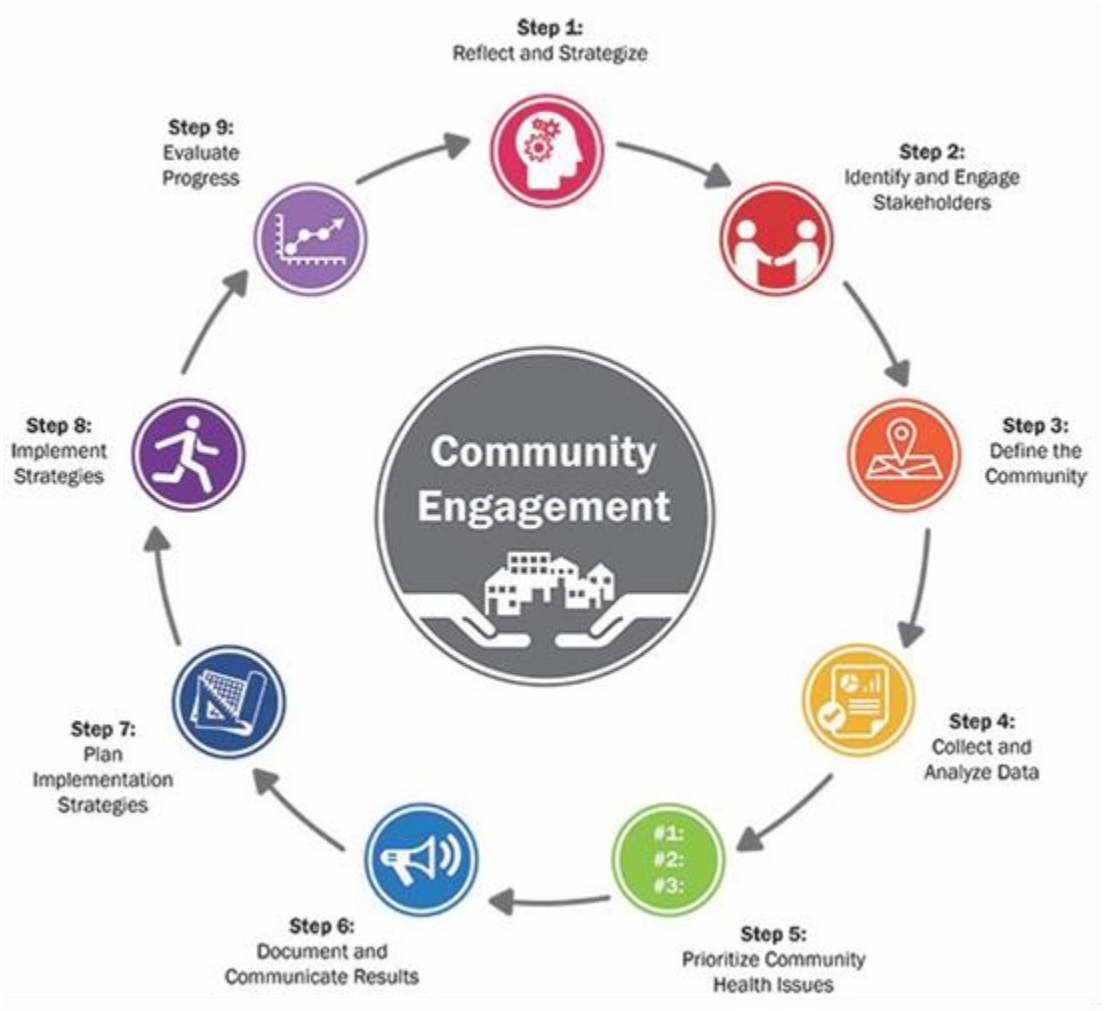
The Strategic Plan supports our **Mission**, **Creating Healthier Communities Together**, and our **Vision**, to be the **region's leader in patient centered health care**. Our goal is to provide quality health care services that are comprehensive, accessible, and convenient, and that address the needs of our patients, their families and our wider communities.

Process

I. Establishing the Assessment and Infrastructure

To complete a comprehensive assessment of the needs of the community, the Association for Community Health Improvement's (ACHI) 9-step Community Health Assessment Process was utilized as an organizing methodology. UM SRH Community Health Planning Leadership served as the lead team to conduct the Community Health Needs Assessment (CHNA) with input from UM SRH Strategic Planning Committee, The University of Maryland Medical System (UMMS) Community Health Improvement Committee, community leaders, the public, health experts, and the five health departments that serve the Mid-Shore. UM SRH adopted the following ACHI 9-step process (See Figure 1) to lead the assessment process and the additional 5-component assessment (See Figure 2) and engagement strategy to lead the data collection methodology.

Figure 1 - ACHI 9-Step Community Health Assessment Process



According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public. For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following: (1) A description of the process used to conduct the assessment ; (2) With whom the hospital has worked; (3) How the hospital took into account input from community members and public health experts; (4) A description of the community served; and (5) A description of the health needs identified through the assessment process.

Figure 2 – 5-Step Assessment & Engagement Model

Data was collected from the five major areas illustrated above to complete a comprehensive assessment of the community's needs. Data presented in Section III of this document. UM SRH participates in a wide variety of local coalitions including, several sponsored by Local Health Departments (Caroline, Dorchester, Kent, Queen Anne's, Talbot Counties), Cancer Coalition, Tobacco Coalition, Opioid Taskforce, Rural Health Collaborative, Rural Health Association as well as partnerships with many community- based organizations like American Cancer Society (ACS), American Diabetes Association (ADA) and American Heart Association (AHA), to name a few.

II. Defining the Purpose and Scope

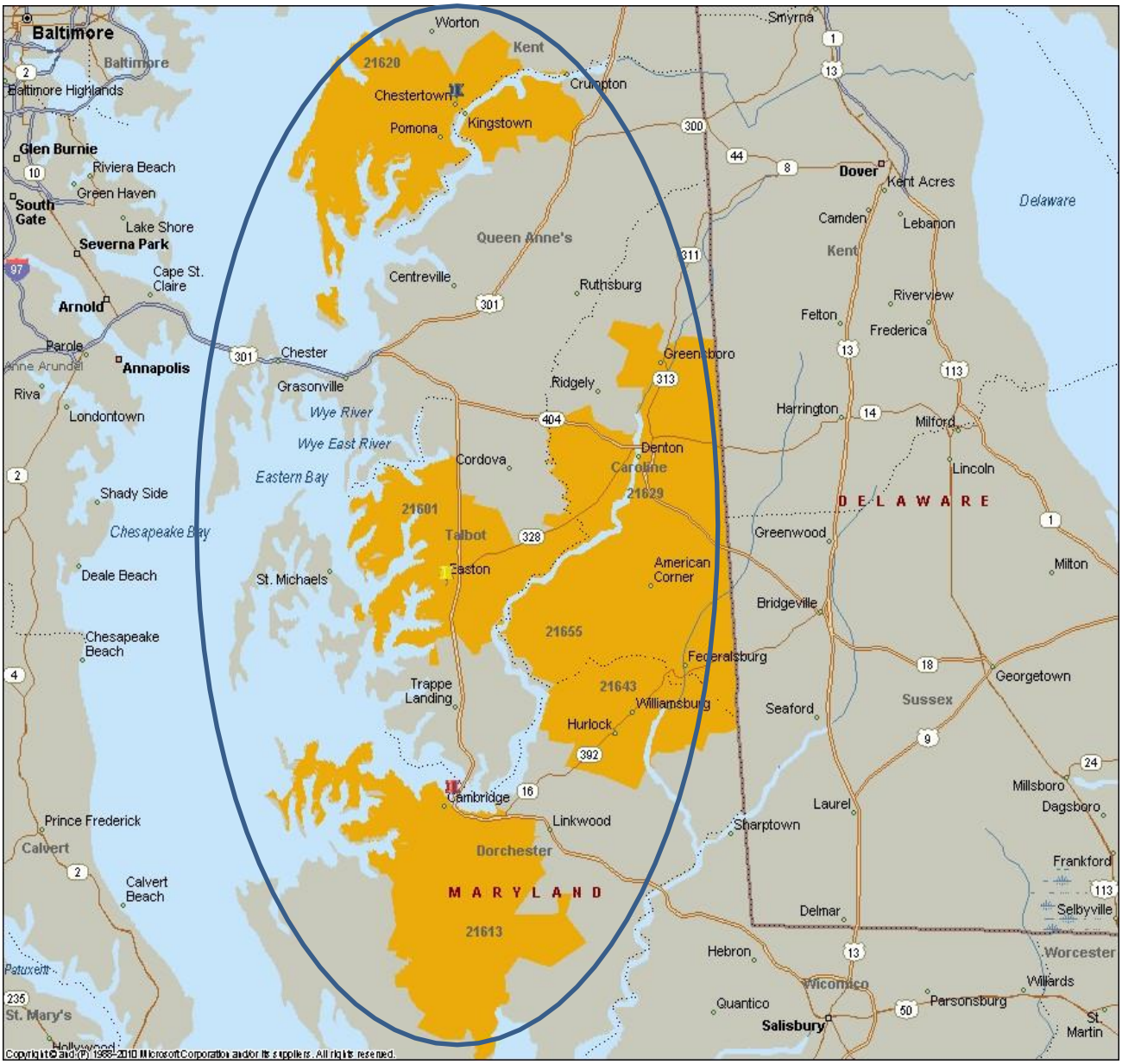
Primary Community Benefit Service Area

For purposes of community benefits programming and this report, Shore Regional Health's Community Benefit Service Area is defined as the Mid-Shore, the Maryland counties of Caroline, Dorchester, Kent, Queen Anne's and Talbot. (See Figure 3).

Figure 3 – 5 County UM SRH Community Benefit Service Area (CBSA)

- Caroline, Dorchester, Kent, Queen Anne's, Talbot Counties

The primary (CBSA) for UM SRH is the geographic area of the Mid-Shore and includes the zip codes that comprise 80% of all admissions



Orange Highlighted ZIP Codes – Top 65% of Market Discharges; Top 80% Circled in Blue

Zip Codes included in CBSA

Hospital	ZIP Code
SMC at Chestertown	21620 - Chestertown
	21661 - Rock Hall
	21678 - Worton
	21651 - Millington
	21617 - Centreville
SMC at Dorchester	21613 - Cambridge
	21643 - Hurlock
	21631 - East New
	21601 - Easton
	21664 - Secretary
	21835 - Linkwood
	21632 - Federalsburg
	21673 - Trappe
SMC at Easton	21601 - Easton
	21613 - Cambridge
	21629 - Denton
	21632 - Federalsburg
	21655 - Preston
	21643 - Hurlock
	21639 - Greensboro
	21663 - Saint Michaels
	21617 - Centreville
	21660 - Ridgely
	21673 - Trappe
	21625 - Cordova
	21620 - Chestertown

III. Collecting and Analyzing Data

UM SRH used primary and secondary sources of data as well as quantitative and qualitative data and consulted with numerous individuals and organizations during the CHNA, including community leaders, community partners, the University of Maryland Medical System Community Health Improvement Committee, the general public (5 focus groups and community survey), local health experts, and the Health Officers representing the five counties of the Mid-Shore. Using the above framework (Figures 1 & 2), the data collected was integrated into a comprehensive document which was utilized at a special planning session with the Mid Shore Health Improvement Coalition partners held on April 19, 2022. During that strategic planning session, priorities were identified using the collected data and an adapted version of a widely used and referenced quantitative tool (The Hanlon method) to rank the health-related needs based on four selected and weighted criteria:

- Importance to our community- 45% weight
- Capacity to address the need - 30% weight
- Strength of existing intervention/collaborations- 25% weight

The identified priorities were then validated by SRH Community Health Planning Leadership meeting held on April 26, 2022.

The following describes the individual data collection strategies with the accompanying results for each requisite stakeholder component of the CHNA:

A) Community Perspective

The community's perspective was obtained through a widely-distributed survey offered to the public via several methods throughout the Mid-Shore. The survey queried residents to identify their top health concerns and barriers in accessing health care.
(See Appendix 1 for the survey tool and resident comments)

Methods

The survey was distributed in FY2022 using the following methods:

- The link for the online survey was circulated to over 78,000 households within the CBSA via community advertising and social media
- Online survey posted to UM SRH website
- Mid Shore Health Improvement Coalition website
- Health fairs and events in neighborhoods within UM SRH's CBSA

The data from the five focus groups was also examined and considered:

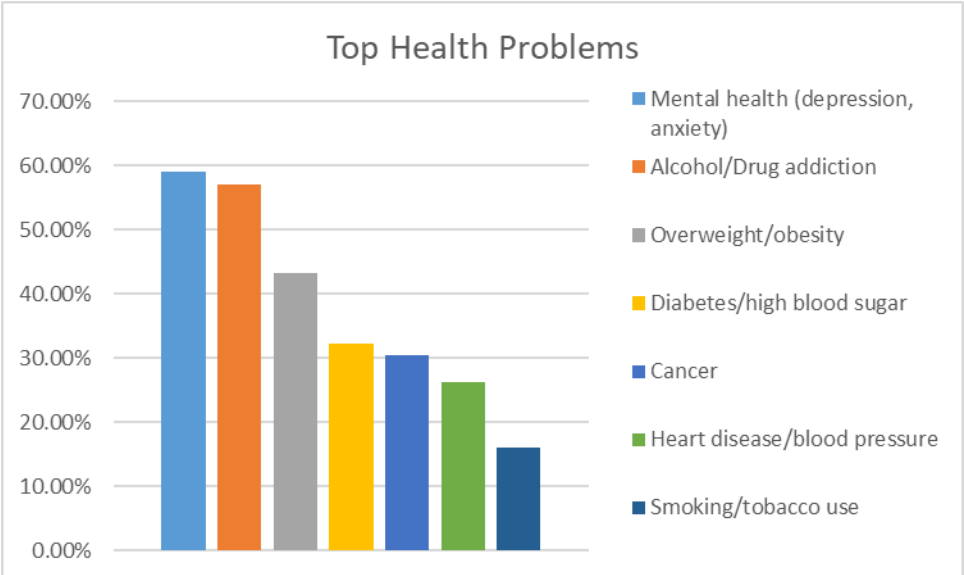
Results

- Top 5 Health Concerns from survey (See Chart 1 below)
    1. Mental health (depression, anxiety)
    2. Alcohol/Drug addiction
    3. Overweight/obesity
    4. Diabetes/high blood sugar
    5. Cancer

Analysis by CBSA targeted zip codes, revealed the same top health concerns and top health barriers bore little deviation from the overall DHMH State Health Improvement Process (SHIP) data which reports state and county level data on critical health measures.

Chart 1 - Community's Top Health Concerns

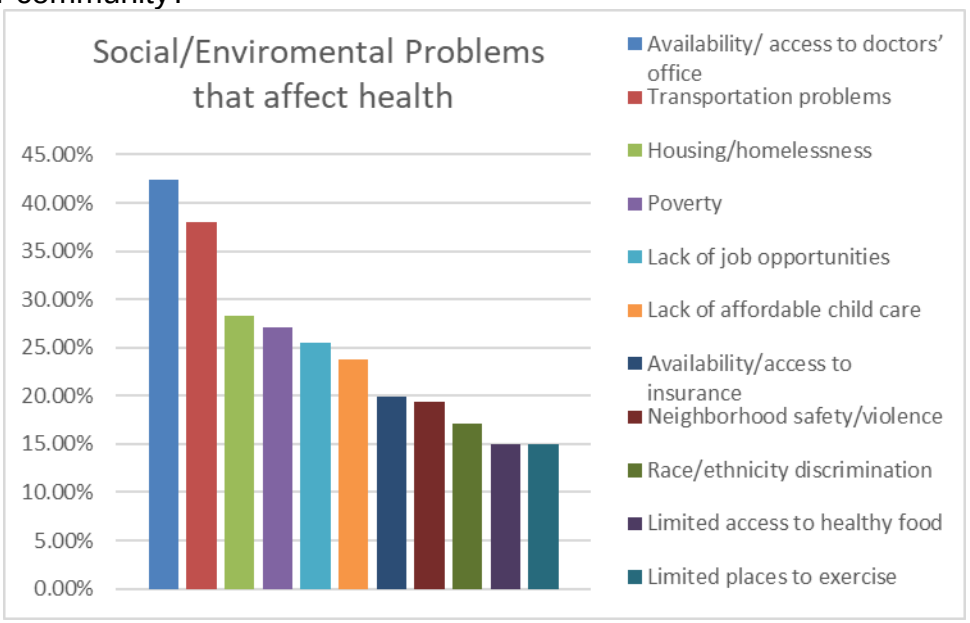
Question: What are the three most important health problems that affect the health of your community?



THE SAMPLE SIZE WAS 365 MID-SHORE RESIDENTS FROM THE IDENTIFIED CBSA.

Chart 2 - Community's Top Social/Environmental Concerns

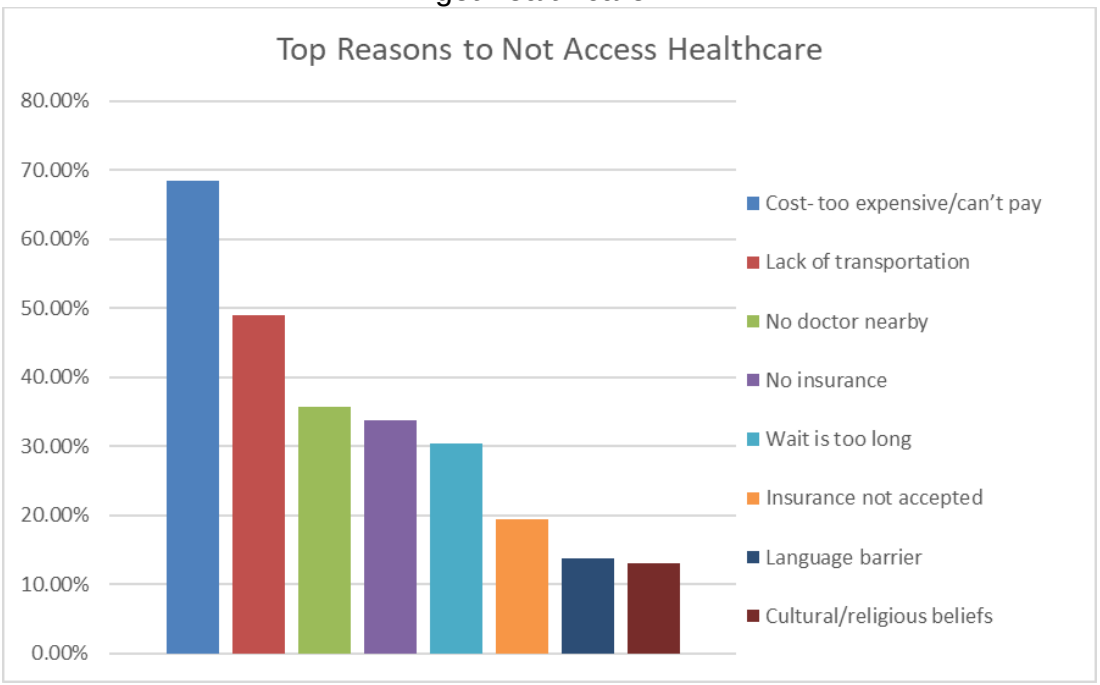
Question: What are the three most important social/environmental problems that affect the health of your community?



THE SAMPLE SIZE WAS 365 MID-SHORE RESIDENTS FROM THE IDENTIFIED CBSA

Chart 3 – Community's Top Barriers to Healthcare

Question: What are the three most important reasons why people in your community do not get health care?



THE SAMPLE SIZE WAS 365 MID-SHORE RESIDENTS FROM THE IDENTIFIED CBSA

■ **Focus group findings from community residents:**

A series of structured interviews/focus groups were conducted to obtain input from those with knowledge of specific communities/county, focus areas or disease states. Generally speaking, residents in the Mid-Shore region recognize that healthcare systems need to accommodate culturally diverse populations and the growing number of vulnerable residents, including elders with chronic health conditions. Recurring comments in these conversations included the need to ensure quality of care, build trust with community residents and partners, leverage existing programs, and support innovation.

The residents also feel that in order to improve the healthcare delivery system, recommendations must address social determinants of health. Residents support an integrated care delivery system across a continuum of care with services as close to home as possible. (Appendix 4)

- Support Local Health Coalition efforts – Social/Clinical Integration of services
- Support health professions education of local residents ("growing our own")
- Continue work of the Opioid Taskforce
- Continue to expand use of telemedicine

Major themes expressed-

Access to care:

- Health workforce shortage that includes primary care, behavioral health, dental, and **specialty care**
- Lack of public **transportation** system with difficulty accessing health services
- The lack of **care coordination** and connectivity to integrate patient care and services
- Limited number of wellness and **health education** programs
- Limited youth based programs

Sustainable funding:

- Grant based programming limitation- specifically in how funding is allocated, used, and tracked—to support greater effectiveness in population health improvement.

The five counties differ significantly in their capacity to:

- Provide accessible public health interventions
- Involve and sustain interest from their local Commissioners that set policy
- Serve subpopulations with higher uninsured, unemployed, and low income residents

B) Health Experts

Methods

- Reviewed State Community Health Priorities (Statewide Integrated Health Improvement Strategy Goals, SHIP Measures), findings from the Maryland Mid-Shore Rural Health Study and Maryland Rural Health Plan, Robert Wood Johnson County Rankings and Roadmaps, and Hospital Inpatient Readmissions and High Utilizer data.

Findings

- While progress has been made since 2019 - each county's progress varies widely on meeting the identified targets at the state level. Wide disparities exist within the CBSA territory.

Goals not met for the following areas for at least 4 of the 5 counties of the Mid-shore:

- Life expectancy
- Cancer mortality rate
- Adults who currently smoke
- Obesity -Adolescents who have obesity/Adults who are overweight or obese
- Emergency Department visit rates due to:
  - *Diabetes*
  - *Hypertension*
  - *Mental Health Conditions*
  - *Asthma*
  - *Addictions Related Conditions*

C) Community Leaders

Methods

- In partnership with the Mid Shore Local Health Improvement Coalition, meetings were conducted to obtain input from those with knowledge of specific communities, focus areas or disease states (Appendix 5)

Results

■ Top Health Priorities and Concerns:

Access to care:

- Health workforce shortage that includes **primary care**, behavioral health, specialty care and dentist who accept Medicaid patients.
- Lack of public transportation system with difficulty accessing health services
- The lack of care coordination and connectivity to integrate patient care and services
- Limited number of non-profits and private organizations as stakeholders to help share in filling gaps for vulnerable populations

Community leaders reported challenges/concerns about:

- Hospital care availability
- Lack of **primary care** providers, dental providers accepting Medicaid patients, and availability of specialists
- Limited public and medical transportation
- Needs of vulnerable populations.

The community leaders voiced the need for innovation and flexibility in promoting rural health.

D) Social Determinants of Health (SDoH)

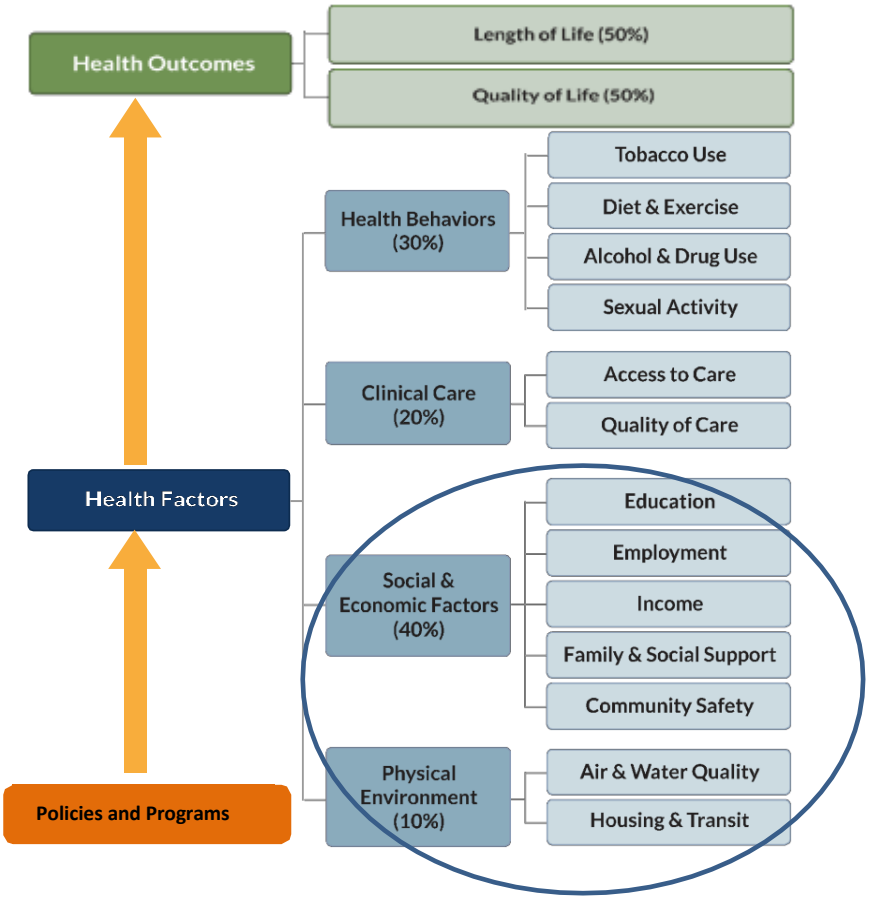
Methods

■ Reviewed Robert Wood Johnson County Health Rankings data (Appendix 2)

■ Reviewed data from Robert Wood Johnson Foundation, Social Determinants of Health (See Appendix 3)

Results

The *County Health Rankings & Roadmaps* report explores the wide gaps in health outcomes throughout Maryland and what is driving those differences. The report finds health status is influenced by every aspect of how and where we live. Access to affordable housing, safe neighborhoods, job training programs and quality early childhood education are examples of important changes that can put people on a path to a healthier life even more than access to medical care. But access to these opportunities varies county to county. This limits choices and makes it hard to be healthy.



- Top SDoHs impacting health on the Mid-Shore as reported in the Robert Wood Johnson County Health Rankings & Roadmaps 2021 report are:
  - Low Education Attainment (Dorchester and Caroline)
  - High Poverty Rate (Dorchester 15.81%, Caroline 13.88%, Kent (11.52%)
  - Children in Poverty (Dorchester 24%, Caroline 20%, Kent, 18%)
  - High Unemployment Rate (Dorchester 5.5%)
  - Severe Housing Problems (Caroline 18%, Dorchester 18%)

Local Health Context

- The five counties differ significantly in their capacity to:
  - Provide accessible public health interventions in the public schools
  - Establish relationships and involvement within their respective minority communities
  - Involve and sustain interest from their local Commissioners that set policy and funding priorities for the county

- Additional factors to be considered include those factors that uniquely challenge rural communities:
  - **Severe** health workforce shortage that includes primary care, behavioral health and specialty care.
  - Subpopulations within counties have higher uninsured, unemployed, and low income residents
  - Lack of public transportation system with difficulty accessing health services
  - Limited number of non-profits and private organizations as stakeholders to help share in filling gaps

E) Health Statistics/Indicators

Methods

Review annually and for this triennial survey the following:

- **Local data sources:**
  - MDH SHIP data
  - Statewide Integrated Health Improvement Data

- **National trends and data:**
  - Healthy People 2030
  - Robert Wood Johnson County Health Rankings
  - Centers for Disease Control reports/updates

Results

- Robert Wood Johnson County Health Data 2021

County Rankings: position out of 23 counties plus Baltimore City

	Length of Life	Quality of Life	Health Behaviors	Clinical Care	Economic Factors	Physical Environment
County	Rank	Rank	Rank	Rank	Rank	Rank
Caroline	17	19	21	23	19	19
Dorchester	23	22	22	14	22	22
Kent	11	17	12	5	16	2
Queen Anne's	4	7	10	7	6	9
Talbot	12	6	11	2	11	5

Poor health indicators exist in the following areas for at least 4 of the 5 counties of the mid-shore:

Health Behaviors

- Adult smoking
- Adult Obesity

Clinical Care

- Preventable hospital stays
- Uninsured
- Provider shortages
  - Primary care physicians
  - Dentists
  - Mental health providers

■ Outcomes Summary for CBSA territory

Top 3 Causes of Death on the Mid-Shore in rank order:

1. Heart Disease
2. Cancer
3. Stroke

IV. Selecting Priorities

Analysis of all quantitative and qualitative data described in the above section identified these top five areas of need within the Mid-Shore Counties. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths and mission. These priorities were identified and approved by SRH Community Health Planning Leadership (See Appendix 6) and validated with the UM SRH Strategic Planning Committee.

Results: Prioritization- with one being the greatest need:

The top five priorities:

1. Mental health/substance abuse (#4 in FY2020-FY2022 CHNA)
2. Access to care (#1 in FY2020-FY2022 CHNA)
3. Chronic Disease management (#3 in FY2020-FY2022 CHNA)
4. Preventive/wellness programs (#8 in FY2020-FY2022 CHNA)
5. Cancer (#5 in FY2020-FY2022 CHNA)

V. Documenting and Communicating Results

The completion of this community health needs assessment marks a milestone in community involvement and participation with input from the community stakeholders, the general public, UM SRH, and health experts. This report will be posted on the UM SRH website under the Community Health Needs section, https://www.umms.org/shore/community/assessment-implementation-plan
Highlights of this report will also be documented in both the Community Benefits Annual Report filed with the Health Services Cost Review Commission and the UMMS Community Health Improvement Report. Reports and data to be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

VI. Planning for Action and Monitoring Progress

A) Priorities & Implementation Planning

Based on the above assessment, findings, and priorities, the Community Health Planning Council developed the Community Health Implementation Plan (CHIP), to be publicly available June 2022. This plan is a living document that provides concrete actionable strategies for addressing the health needs of the Mid-Shore. UM SRH will track and evaluate progress towards achieving long-term outcome objectives measured through Statewide Integrated Health Improvement Strategy Goals and (MDH) SHIP metrics. Short-term programmatic objectives, including process and outcome metrics will be measured annually by UM SRH for each priority area through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

Because UM SRH serves the Mid-Shore region, priorities may need to be adjusted rapidly to address an urgent or emergent need in the community, (i.e. disaster response or infectious disease issue). The CHNA prioritized needs for the Sustained and Strategic Response Categories and the Rapid and Urgent Response Categories' needs will be determined on an as-needed basis.

UM SRH will provide leadership and support within the communities served at a variety of response levels. Rapid and Urgent response levels will receive priority over sustained and strategic initiatives as warranted.

- **Rapid Response -** Emergency response to local, national, and international disasters, i.e. civil unrest, terrorist attack, weather disasters – earthquake, blizzards
- **Urgent Response -** Urgent response to episodic community needs, i.e. Pandemic/COVID, H1N1/Flu response
- **Sustained Response -** Ongoing response to long-term community needs, i.e. obesity and tobacco prevention education, health screenings, workforce development
- **Strategic Response -** Long-term strategic leadership at legislative and corporate levels to leverage relationships to promote health-related policy or reform and build key networks

Future Community Health Needs Assessments will be conducted every three years and strategic priorities will be re-evaluated then. All community benefits reporting will occur annually to meet state and federal reporting requirements.

B) Unmet Community Needs

Several additional topic areas were identified during the CHNA process including: housing, transportation and workforce development. While UM SRH will focus the majority of our efforts on the identified priorities, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while significantly important to the health of the community, will be met through other health care organizations with our assistance as available.

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Community Health Implementation Plan, FY2023-FY2025

The Community Health Implementation Plan (CHIP) is a list of specific goals and strategies that demonstrate how UM SRH plans to address the most significant needs identified in the CHNA while also being aligned with UMMS community health improvement initiatives and national, state and local public health priorities.

Our Annual Operating Plan, which is derived from our strategic plan, includes community benefit and population health improvement activities.

Based on qualitative and quantitative data collected and analyzed during the CHNA process, UM SRH's Implementation Plan remains committed to the goals and strategies identified in the FY2020-FY2022 CNHA. Although some of the focus areas have changed in their order of priority per community feedback, the overall needs remain the same as reported in the previous CHNA.

Health Priorities FY2023-2025

The top five priorities:

1. Mental health/substance abuse
2. Access to care
3. Chronic Disease management
4. Preventive/wellness programs
5. Cancer

Overarching theme for addressing health priorities:

1. Reduce barriers to care
2. Improve care coordination
3. Focus on health outreach and education

UM SRH is engaged in numerous programs addressing the identified needs of the Mid-Shore. The UM SRH hospitals work to strategically allocate scarce resources to best serve the communities, increase trust and build stronger community partnerships.

The CHIP items which follow provide action plan strategies and examples of ongoing initiatives that address the identified needs. Strategies emphasize clinical and community partnership development and improved coordination of care. All identified key community needs are addressed either directly through designation as a prioritized key community need or incorporated as a component of a prioritized key community need.

HEALTH NEED 1: BEHAVIORAL HEALTH			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Improve access and integration/ coordination of intensive mental health and substance abuse services	**Strategy 1**: Provide access to acute inpatient and Intensive Outpatient services for mental health and substance use disorders including prevention and support services	• Number of referrals to the Intensive Outpatient programs. Both the mental health and Substance abuse programs • Number of adults admitted to inpatient services	• All Mid-Shore Mental Health Agencies • Local Health Departments • Local Emergency and Primary Care practices
	Strategy 2: Expand program(s) to support Primary Care patients waiting for outpatient mental health and/or substance use disorder treatment	• Number of referrals from primary care providers • Length of time to first mental health or substance abuse appointment • Number of Primary Care sites with co-located mental health services • Develop Urgent Care Services	• Community Behavioral Health • Local Mid-Shore Community Mental Health partners
	Strategy 3: Improve care coordination for mental health and substance abuse co-occurring conditions through facilitation of "direct hand-offs" in Emergency Departments and Primary Care Offices to the next level of care	• Number of patients referred between systems • Number of Inpatient readmissions • Number of Emergency room visits	• Local Emergency Departments • Primary Care Practices • Local Health Departments • Corsica River Behavioral Health • Community Behavioral Health • ACT Team

Opioids- Improve overdose mortality Statewide Integrated Health Improvement Strategy (SIHIS) goal	**Strategy 4:** • Expand screening, brief intervention, and referral to treatment (SBIRT) and buprenorphine induction in the Emergency Department and Substance Abuse IOP. • Distribute Naloxone to patients who receive treatment in the emergency department (ED) for a non-fatal overdose. • Connect with Regional Partnership on plans to expand behavioral health crisis infrastructure in the community	• Number of patients screened who presented to ED • Number/% of overdose patients presenting to the ED with intensive community peer support • Number of medication initiated encounter for opioid-using patients presenting to the ED • Number of patients linked to treatment after community peer engagement • Number of patients linked to MOUD induction in the ED to MOUD treatment same or next day after discharge	• Regional Opioid Taskforce • All Mid-Shore Local Addiction Authorities

EXAMPLE INITIATIVES:
Maryland Department of Health -Reverse the Cycle (RTC) program
Comprehensive hospital substance use response program RTC includes:

- Universal screening and peer intervention
- Overdose survivors outreach
- Medication initiation

Co-Location of Mental Health Services in Primary Care Clinics

"Warm handoff" to community resources from the inpatient unit

- Care Connections
- Community Behavioral Health
- Lower Shore ASCT team

Regional Opioid Task Force: The task force — which includes representatives of county health departments and emergency services, and emergency and behavioral health physicians and nurses, and hospital officials — is led by Dr. Walter Atha, regional director of emergency medicine for UM Shore Regional Health, and Dorchester County Health Officer Roger Harrell. The task force is working to coordinate and standardize the medical community's response among Mid-Shore counties tackling the heroin and opioid epidemic

HEALTH NEED 2: ACCESS TO CARE			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Improve access to care for medically underserved and vulnerable groups of all ages	**Strategy 1**: Increase capacity by addressing the recruitment, retention, accessibility, competency of providers	• Medical Staff assessment- identify shortages • Provide/fund physician subsidies to meet identified community needs • Establish physician/resident training programs	• University of Maryland School of Medicine and UMMC • AHEC • Choptank FQHC
	Strategy 2: Enhance and Expand Telemedicine Opportunities	• Increase total consults • Identify and implement new consult services: Neurology subspecialties	• Within SRH and its physicians • University of Maryland Medical Center and UM SOM/FPI
	Strategy 3: Reduce transportation barriers and enhance awareness of available services	• Number of transportation vouchers • Resource information distribution	• DCT and Queen Anne's County Ride cover Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties
	Strategy 4: Connect uninsured to private insurance, Medicaid, or other available coverage	• Number of insured residents	• County Medicaid offices through SRH Case Management

EXAMPLE INITIATIVES:

Recruit additional health care providers and specialists to the region to address access barriers identified by the community. Provide subsidies as a means to increase the availability of health care providers in order to best meet identified patient and community needs related to the availability of health care services.

Telehealth services Expand existing programs to outlying facilities as much as possible, increase both the number of specialties providing telehealth consultations and the number of telehealth consultations.

Transportation- Work to mitigate transportation barrier by assisting/arranging transportation for patients to travel to medical appointments

Uninsured/underinsured care -Inform patients and family members of UM SRH Financial Assistance Policy, assist with application for financial assistance, and provide financial assistance to eligible patients. Work with patients to determine eligibility for medical assistance, e.g. Medicaid, and other social services.

HEALTH NEED 3: Chronic Disease			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Prevent, detect, and manage chronic diseases	**Strategy 1**: Work with community organizations, congregational networks, and individuals to improve care, management and prevention of chronic diseases	• Number of health education/outreach encounters provided to community-based organizations and churches • Number of participants in health events and number of screenings performed • Number of outreach programs	• Health Departments • Faith based organizations • Homeports • Department(s) of Aging • YMCA • Area Schools
	Strategy 2: Screen for barriers/social needs of patients with chronic conditions during transitions to improve ability of patient to manage condition	• Increased transition support available to patients with chronic disease • Number of patients connected to services addressing social needs	• Home care providers • Faith based organizations • Department(s) of Social Services • Pharmacies • Meals on Wheels • Mobile Integrated Community Health
	Strategy 3: Provide specialized health information, "physician to physician" education regarding diabetes treatment and management.	• Number of provider outreach education sessions for primary care offices and medical staff	• Community providers

INITIATIVES:
Outreach: Education, screenings and support groups offered on the following topics/conditions: high blood pressure and heart disease; diabetes; cancer, stroke; hospice services and palliative care; obesity, exercise and nutrition; depression and anxiety

Chronic Disease: To address chronic disease-related emergency department visits, The Transitional Nurse Navigator (TNN) Program provides continued care coordination for high-risk patients from the beginning of their hospital stay through up to 30-days after discharge. The scope of the discharge planning process has been expanded to include the broader, holistic needs of patients. Caseworkers and transitional nurse navigators help patients anticipate what their care needs will be in their home environment, connect with the patient's primary

care provider to ensure proper follow-up, and provide links to needed community resources offering services such as transportation, home care, meals, home technologies and social support.

Food Distribution: Through grant funding, support Maryland Food Bank, Eastern Shore Mobile Pantry

Physician Outreach: Provide education to community physicians who manage patients with complex chronic conditions

HEALTH NEED 4: Preventive/wellness programs			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Health Promotion and Wellness Services strives to support inclusive, accessible, and diverse health and wellness opportunities.	**Strategy 1**: • Provide classes, program, speakers, events to improve health & wellness • Expand diabetes/pre-diabetes educational classes- State Diabetes Action Plan • Develop an annual calendar of events, screening and support groups sponsored by UM SRH, and community partners • Support Upper Shore Aging education programs for seniors and caregivers • Provide education specialist(s) needed to support wellness programing	• Number of classes offered • Number of attendees who participate	• Health Departments • Upper Shore Aging • YMCA • U of Md Extension
	Strategy 2: Health Literacy • Promote monthly "Community Conversation" - discussion with UMMS experts to learn more about a health topic and how to avoid/manage a medical condition. • Promote existing public library programs that enhance learning	• Number of events offered • Number of attendees	• University of Maryland Medical System • Local Libraries

	Strategy 3: Improve care coordination, info sharing protocols to achieve safer, more effective care	• Protocols developed • Educational materials standardized across setting. • % of educational materials available in Spanish	Health Departments

EXAMPLE INITIATIVES:

Education/Awareness: Cosponsor the series "Not All Wounds Are Visible": *A Community Conversation* and "Let's Talk About Health". The community events are facilitated by University of Maryland Medical System and the University of Maryland, Baltimore– to help community members engage with experts and gain valuable tools on how to lead a healthy life - mentally and physically.

Educational topics include:

Diabetes, Stroke, Heart Education Programs

- Education Series
- Support Groups
- Radio Broadcasts
- Heart Wellness Newsletter and Presentations
- Stroke Education/Presentations

- How to understand Medicare, Medicaid and commercial health insurance plan benefits (e.g. copays, coinsurance, in and out of network providers)
- How to choose where to see health care services (e.g. primary care, urgent care, Emergency Department)
- How to access community resources that can help prevent and manage chronic conditions

HEALTH NEED 5: Cancer			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Reduce cancer mortality rate	**Strategy 1**: Provide increased and improved screening and prevention services for breast, skin, prostate and colorectal cancer and evaluate adding cervical screening.	• Number of health education/outreach encounters provided to community • Number of participants in health events and number of screenings performed • Number of outreach programs	• University of Maryland Medical Center • County Health Departments • Specialty practices
	Strategy 2: Continue to educate the community about Lung Cancer Screening Program and support programming to reduce use of tobacco products	• Earlier detection of lung cancer • Improve survival rates • Work with Talbot County HD to develop a formal pathway for smoking cessation.	• County Health Departments • Community Providers

ACTIVITIES/INITIATIVES:

WELLNESS FOR WOMEN ACCESS TO CARE PROGRAM

The program serves as a point of access into care for age and risk specific mammography screening, clinical breast exam, and genetic testing for breast cancer.

Offers **no cost mammograms** to eligible women: those under the age of 40 and over 65 who have no insurance. Those women needing further diagnostic tests or who need treatment for breast cancer are enrolled in the State of Maryland Diagnosis and Treatment Program through the case manager.

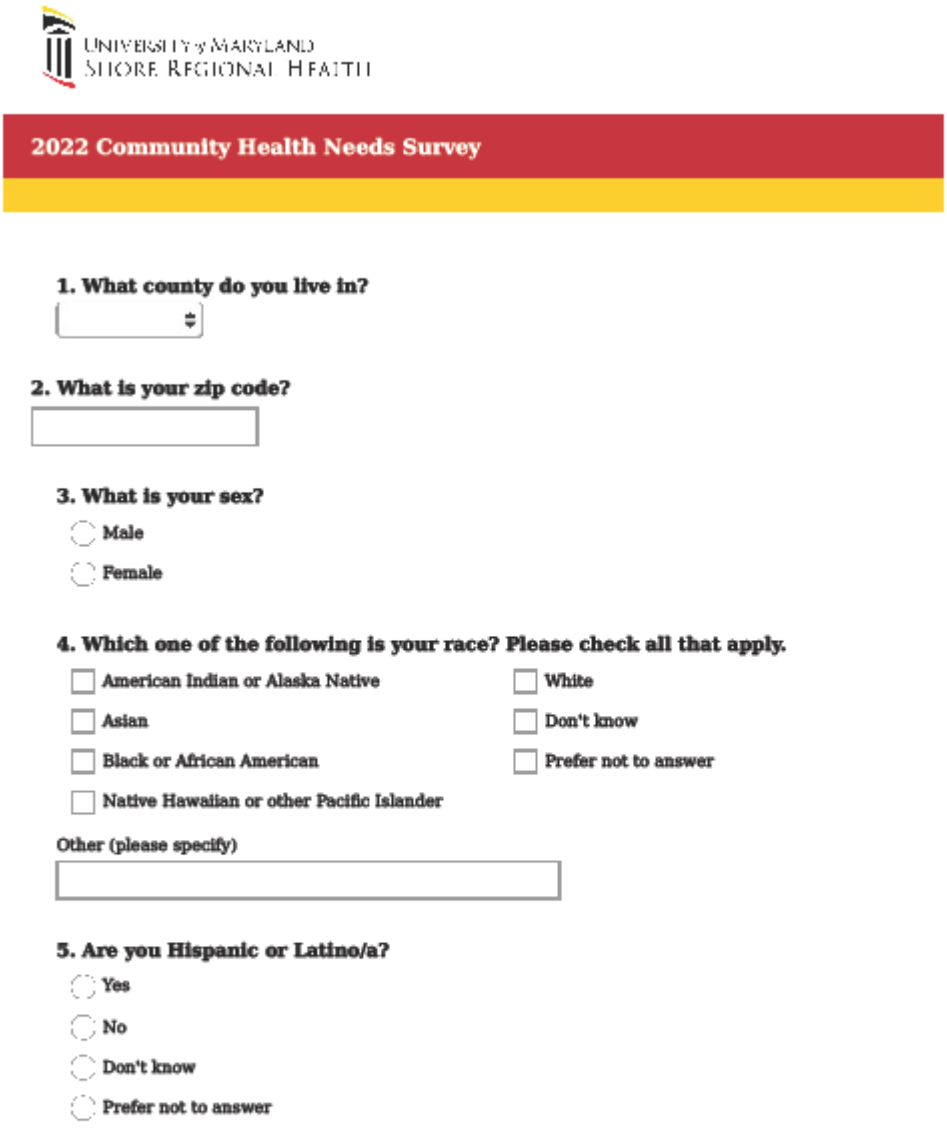
LUNG CANCER EARLY SCREENING PROGRAM

The low dose computed tomography (LDCT) screening program promotes earlier detection of lung cancer. Eligible patients are the high-risk groups which include those who have smoked a pack of cigarettes daily for two or three decades, who are currently smokers, or those who quit smoking less than 15 years ago to have them screening for lung cancer. Earlier detection promotes better treatment and survival rates.

ANNUAL PROSTATE SCREENING

Public screening for males who are $\geq$ 40 years of age for a baseline screening, African American men, men with a family history of disease, and males > 55-74 for yearly screening.

Appendix 1 – Community Survey



UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

2022 Community Health Needs Survey

1. What county do you live in?

2. What is your zip code?

3. What is your sex?

- Male
- Female

4. Which one of the following is your race? Please check all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Don't know
- Prefer not to answer

Other (please specify)

5. Are you Hispanic or Latino/a?

- Yes
- No
- Don't know
- Prefer not to answer

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

2019 Community Health Needs Survey

1. What county do you live in?

2. What is your zip code?

3. What is your sex?

- ○ Male
- ○ Female

4. Which one of the following is your race? Please check all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Don't know
- ☐ Prefer not to answer

Other (please specify)

5. Are you Hispanic or Latino/a?

- ○ Yes
- ○ No
- ○ Don't know
- ○ Prefer not to answer

1

6. On how many days during the past 30 days was your mental health not good?Mental health includes stress, depression and problems with emotions. Please write number of days.

- ◯ Zero days
- ◯ Prefer not to answer
- ◯ Don't know

Days

_____

7. What are the three most important health problems that affect the health of your community? *Please check only three*

- ☐ Alcohol/Drug addiction
- ☐ Alzheimer's/dementia
- ☐ Cancer
- ☐ Diabetes/high blood sugar
- ☐ Heart disease/blood pressure
- ☐ HIV/AIDS
- ☐ Infant death
- ☐ Lung disease/asthma/COPD
- ☐ Mental health (depression, anxiety)
- ☐ Overweight/obesity
- ☐ Smoking/tobacco use
- ☐ Stroke
- ☐ Don't know
- ☐ Prefer not to answer

8. What are the three most important social/environmental problems that affect the health of your community? *Please check only three*

- ☐ Availability/ access to doctors' office
- ☐ Availability/access to insurance
- ☐ Child abuse/neglect
- ☐ Domestic violence
- ☐ Housing/homelessness
- ☐ Lack of affordable child care
- ☐ Lack of job opportunities
- ☐ Limited access to healthy food
- ☐ Limited places to exercise
- ☐ Neighborhood safety/violence
- ☐ Poverty
- ☐ Race/ethnicity discrimination
- ☐ School dropout/poor schools
- ☐ Transportation problems
- ☐ Don't know
- ☐ Prefer not to answer

9. What are the three most important reasons why people in your community do not get health care? *Please check only three*

- ☐ Cost- too expensive/can't pay
- ☐ Cultural/religious beliefs
- ☐ No doctor nearby
- ☐ No insurance
- ☐ Insurance not accepted
- ☐ Lack of transportation
- ☐ Language barrier
- ☐ Wait is too long
- ☐ Don't know
- ☐ Prefer not to answer

10. What ideas or suggestions do you have to improve health in your community?

11. To be entered into the $100 Amazon Gift Card Raffle, please leave your contact information below (Optional)

Name

Email Address

Phone Number

3

Survey Question 10: What ideas or suggestions do you have to improve health in your community?

Caroline County Comments

- Putting in a hospital or have urgent care open 24/7! People in Denton should have access to urgent care all the time!
- Free healthcare for all.
- More programs geared towards the older people, meals, transportation, local activities, checking on the isolated, and loneliness - dental care, neighbor watch, and neighbors helping neighbors.
- More accessible, quality providers. Everything should not be centered in Easton.
- Most people in the county have to drive 20 minutes or more to get to a physician's office, which translates to several hours of work. If anything is truly wrong at the doctor's office, the closest facility is in the next county. The closest ER is in the next county as well. There should be a place to get diagnostic imaging and consultations with specialists in the county that won't require a full day of missed work and travel to plan
- Educate - let resident know what is available Offer resources, how to care for self
- Wellness day at a local facility
- I do not know
- Healthy low cost meal awareness, low cost exercise places.
- Go the gym three times a week
- Healthcare needs to be more affordable.
- I don’t know
- We need more outreach help. Also a need for Public transportation
- Increase on-demand transportation options for medical appointments. Increase availability of behavioral health treatment and continue to improve integration of behavioral health into primary care practices. Work to address systemic poverty. Increase interventions for children with high ACEs scores.
- Public transportation, mobile addiction treatment, better public outreach...go to where the problems are, more trauma based therapy for youth.
- Better mental health care Access- someone to tell you how to find services out there
- Education
- No clue. Until people are able to get better jobs with health care or more affordable health care I don't see any way to improve health.
- It would be nice to have other doctors come to county for office hours. It would be nice to offer wellness and educational programs in Caroline County instead of always driving to Easton.
- Lower taxes to attract more businesses and residents! poor county / highest taxes ?!?!? go hand in hand!!
- More bus routes that are easier to use and less restrictive as far as "who" can ride, and with less wait times.

- Need transportation for the elderly who do not have Medicaid; our Veterans do not have transportation to Cambridge or across the bridge; better mental health programs for Veterans that are accessible in County. Transportation is desperately needed for non-Medicaid people over 55 to go to the store (grocery) pharmacy and local physicians. More cost-effective medical programs for this population. Our County has a very high level of Medical Assistance residents and the "gray-area" people do without the programs they need.
- - keep and expand community health service like family planning, preventive health screenings, cancer screenings - Promote community education on health promotion, disease prevention (topics like diabetes, pre diabetes, obesity, tobacco/nicotine/Juling, nutrition, physical activity) - We need an indoor pool -- place for kids to learn to swim and for families and individuals to exercise - transportation barriers need addressed - encourage and offer incentives for doctors, especially specialists to practice on the shore and stay
- More dr's are needed for this area
- Free Healthcare to the elderly (65 years and older)
- TRANSPORTATION, EXERCISE AWARENESS SUCH AS PUBLIC ACTIVITIES
- Weekend dr hours outside of urgent care. Traveling dr would be amazing that does house calls
- Increase the amount of specialists available: OB/GYN, Pediatricians, Primary Care, ENT, GI
- access to mental health providers
- We need to develop a true system of transit. We have services in some of the town centers but getting to them is challenging.
- School based health care centers with mental and behavioral intervention support; more access to drug and alcohol treatment.
- Free health care, without financial limits
- enhanced transportation, local specialists, in county ob/gyn
- Transportation is a real issue. Use of MA Transportation is riddled with rules that impede actual use for our most vulnerable residents-- if someone has a car in their name, they can't use it (think about when the person has a setback in health and they are unable to drive for a period of time-- they would either have to sell their car, which doesn't make sense, or they just can't access MA Transportation at all-- even if they have proof that they are unable to drive and they have straight MA). Many clients simply stop going to the doctors because they don't have a reliable way to get to appts-- this leads to premature institutionalization when health declines and diseases are exacerbated due to lack of medical monitoring and treatment.
- To motivate people to take it upon themselves to have good health. "You can lead a horse to water but you can't make him drink"
- Don't know
- More outreach needs to be done for the community. I work for the Medicaid Department at the
- County Health Department and a lot of the community do not know that we are available to help them sign up for health insurance.
- Mobile health unit, outpt clinics, with scheduled transportation
- TRANSPORTATION TO HEALTH CARE FROM A PATIENT S HOME. SECONDARY INSURANCE FOR MEDICARE WITH PRE EXISTING HEALTH PROBLEMS.

- More Primary Care practices. Let's look in to Holistic & Naturopathic. So many issues that could be corrected by holistic health means- improved mental health, obesity etc.
- CLINICS AT THE HEALTH DEPT
- More availability of providers & not being put on a waiting list. More flexible transportation Understanding of conditions/diagnosis
- Need Behavioral Health services

Dorchester County Comments

- Increase transportation options, more physicians
- More resources for Diabetes/ High Blood Pressure patients. Increased accessibility to informational and exercise programs.
- I would talk with Church leaders to have an exercise or activity program. Go walking with your neighbor. Be aware of the health content of products "Read everything"
- The suggestion I have is better transportation, have several different times throughout the day that a medical bus can be taken to doctor offices with different pick up and drop off areas where patient can get bus from and bus should make stops to all medical doctors in Cambridge.
- More accessible health care and more providers. New construction for medical offices.
- More options to eat healthy at reasonable cost
- More job opportunities. Increased community services.
- Promote more of what we have to offer now.
- To move forward with the Shore Health new building and access to doctors in one area
- More availability to teledoctors or satellite clinics. Health Dept. to expand services to assist the public in guiding people to needed services and offer classes/education (cpr, nutrition, stds, family planning, etc.). Additional staff & area to expand clinic so more people can be seen.
- Our community needs more specialist in the area. To go to a specialist, we need to travel to other counties and transportation is an issue for many residents.
- Not Sure
- Make insurance affordable, especially for seniors.
- Improve transportation to include weekend transportation
- At this time, I think it would be important to have more access to a physicians in the local community.
- 1) I don't know if this is still a problem, but 3.5 years ago, there was no availability of in-home speech and occupational therapy services that accepted United Healthcare insurance; my husband could only get in-home physical therapy and skilled nursing services even though he had a great need for continuation of OT and speech therapy services that he had been receiving while in-patient. 2) Shore Rehab only offers 40 minute therapy sessions while other PT providers in the area offer 1 hour sessions. Since our insurance covers the 1 hour sessions,

but is limited to number of days of therapy, it is more beneficial for a patient to seek PT services elsewhere, even though the staff is great at Shore Rehab.

- A community pool in northern co
- No idea- awareness campaigns for eating healthy, no smoking, it's just a very poor place in general with many homeless who probably prefer not to be seen or participate in any programs. Education and employment opportunities and/or a willingness to work at jobs migrant workers previously held, who are now prohibited from entering the US to fill. It's a generational thing around here, sadly.
- More and better jobs. More and better education. More and better access to health care.
- Stop all the drug use
- Affordable health insurance, medical provider in Hurlock, safe place for senior citizens to walk.
- Do not get rid of facilities Many citizens live 45-60 minutes away from Cambridge and adding a 20 minutes' drive to Easton or 40 minutes' drive to Salisbury would jeopardize their health care
- There is a group of ladies that go with people to the doctors and help them learn about their health and they use to be ABC but I am not sur if the name now because it changed to Eastern Shore something, but their program is really helpful because me and my mom were able to work with them and now my mom is off of her High Blood Pressure Meds and I have lost 34 pounds through their program.
- Establish high performance heath call center for system to include all physician medical groups - including independent groups.
- Collaborate with EMS services to include screening & preventive services and establish referral process to outpatient services such as CP Rehab & Diabetes Center.
- Increase access to community education and health screening & preventative services.
- Creative solutions like mobile healthcare
- Need physicians in local doctor offices, vs. Nurse practitioners.
- We desperately need more facilities to help those with mental illness and addiction.
- Higher wages for techs to get a better pool of people to apply
- Effective ways of fighting disparities in people of color, which is another way of saying color discrimination in health care
- Affordable public transportation other than MA, due to the fact that it's an all-day process and becomes difficult with parents that have other children and lack of support.
- Transportation available to & from doctor's office to be made more convenient & available at very low cost or free.
- Stricter alcohol & tobacco sales (check ID on everyone).
- People need to start helping themselves also
- Educate the people here to care about their health and increase nutritional classes
- I think that healthcare should be free for all.
- More specialists having hours in Dorchester County; more flexible public transportation

- More farmer's markets and more availability to them in season. Obesity from poor eating choices is a huge issue but I honestly don't know how to address it; it is now a generational issue.
- Safer places to walk without having to run from dogs. Having access to the Cambridge Bridge. More sidewalks on side streets to give neighborhoods access to walking.
- I think if we make patients medication more affordable and physicians are able to spend more time with their patients we would have less readmissions and less patients going to the Emergency Room instead going to PCP.
- Partner with pharmacies more
- Education
- Have more minority and culturally competent professionals and staff. Individuals with compassion and empathy and are willing to learn and understand the culture of those in this community.
- Not sure at the moment
- More support groups and seminars to the general public with information on fighting poverty
- I find that a lot of people that live in Hurlock do not have transportation... So having monthly farmer markets or resource health fairs would be nice. Also the teenage population middle and high school do not have anything recreational to do that would improve their health and keep them out of trouble.
- Awareness of ACES - Adverse Childhood Experiences and their impact on health; tougher child welfare laws so children are truly protected; more mental health services available in schools; trauma informed schools
- Access to Free or Reduced cost Mental Health
- More Prevention for Children (mentors, character counts)
- Anonymous Mental Health
- Free or Reduce Health Care Clinic
- Better programs to address obesity.
- More access to mental health programs.
- Develop a health food store that has lower costs (Similar to Superfresh or Whole Foods), allow individuals who have Medicare and Medicaid to use their health insurance benefits towards the cost of healthy foods to improve their health, increase door to door transportation for individuals who have disabilities or limited mobility; give health-related business incentives and tax deductions for moving to Dorchester County, improve the communication with County and the City of Cambridge to help senior citizens and individuals who have disabilities navigate necessary services within the community; and give employers incentives for becoming disability friendly.
- Mobile screening trailers, education in schools and health fairs
- MORE DRUG ADDICTION RESOURCES AND EDUCATION
- Medical uber
- More diabetes education during the day. Some people can't drive at night
- Make hours more convenient. People that work cannot take off 8-4:30. Need later hours 2-3 days a week. This goes for doctors and physical therapy. Maybe until 6-6:30.

- Provide additional services to small business owners, provide programs and services to those middle income bracket families not just those in poverty, better school system discipline to not tolerate disruptions to other students.
- Educate /motivate people to get jobs as opposed to trying to work the system to stay at home and live off the government and hand-outs. Understand there are people in need, but many who just prefer not to work.
- Education, Healthy Lifestyles that are affordable.
- Need more primary care options
- It is estimated that in the next 20-30 years the number of people with Alzheimer's disease and related Dementias will triple. Our community will be significantly impacted by this because of a vast percentage of our population being 65+. More work needs to be done to educate the community about cognitive impairments and how to care for those suffering from them.
- Help people with no insurance and help to get healthy food cost down
- Universal healthcare

Kent County Comments

- Keep our regional hospital
- That Chestertown have a hospital serving the needs of the community and county. Provide more health care to Kent County!!!
- Keep the hospital open!
- More comprehensive services at the local hospital like 25/7 emergency cardiac care. Closer access to trauma services, transportation, better access to GOOD specialists.
- Keep the hospital open as full care facility.
- Give more educational programs at a time and location that people can attend
- If going to make current hospital an emergency room only then need better trained and professional doctors.
- Free day care.
- This is a fairly affluent community, obesity a problem in some areas. Information is not readily accessible
- more doctors
- Keep the hospital open and viable. Make access to specialists possible to people who do not have transportation to urban areas and teaching hospitals.
- Better education and communication
- More health expos, and doctors' seminars on public health issues.
- Mental health awareness, pediatric specialist for mental health
- Adult fitness facility.

- Stop the downgrading of the hospital in Chestertown. Only a glorified emergency room and not much else (too few inpatient beds and backup services for them and the ER). For the first time in my 65+ years I have no primary-care provider as there are only waiting lists for the creditable ones (internists esp.). Traveling 35 miles or so for one is not realistic.
- Retain inpatient and outpatient care at the hospital and open an urgent care clinic
- We need more doctors in and nearer to Kent County.
- Keep our hospital. Many seniors move here because of availability of community hospital. They bring $s and intellect via volunteering and participation.
- A viable hospital that plays an integral role in the community's health.
- Keep hospital in Chestertown.
- Keep our Hospital providing quality inpatient care. Encourage new Primary Care Physicians to come to town.
- Prioritize prevention through the Health Departments.
- Maryland state support of the hospital in Chestertown to ensure it will always provide inpatient care, including ICU; increased telemedicine (nephrology, behavioral, neurology, gerontology); 24/7 on-call cardiology, general surgery, orthopedic surgery; 911 responders to evaluate medical, mental, dietary, housing, transportation & other needs of frequent Emergency Dept. patients & hospital inpatients; increased availability inpatient addiction services.
- Reinstate pediatrics at the hospital in Chestertown. More PCPs in/near County. More mental health providers, including prescribers in/near County.
- more doctors
- Provide financial incentives for medical professionals to locate to rural areas to county. There is currently a lack of general practitioners as well as specialists. Wait times are often very long. The local hospital is a must. We need a place to get prolia for our aging population. The UMMCG offices in Chestertown and Denton and Centreville should be able to provide this service in their office.
- We need more primary care doctors that are accepting new patients. So many of the established practices aren't available to new residents or those who've changed insurance, etc.
- We need an urgent care facility
- Urgent care center, open to those with or without insurance with same care quality to both.
- Consider a partnership of care with the Elkton Hospital. In addition, satellite offices for routine care and surgical follow ups, at minimum 2 times a week. A few young mothers would like to see a certified mid-wife clinic for pre-natal care. Note: there is no pediatric emergency care in Chestertown.
- More accessible mental health nearby and need for walk in clinic to handle non-emergent health situations
- More job opportunities as well as safe things for kids to do when not in school
- Encourage healthier eating and weight management. Obesity a huge issue.
- There needs to be an urgent care nearby. I have to drive an hour with sick kids when they wake up sick or get sick on the weekend.
- Chestertown needs to retain in-patient beds and bring more doctors to the area

- Keep our hospital open, and run it as a full hospital not like an ER! ! !
- Keep access to specialists/hospital/ER in Chestertown Increase availability of primary care in Chestertown
- Urgent Care in Chestertown
- Revitalize Chester River Hospital. Clean it up and paint it. Recruit more specialists.
- Please keep our hospital open. We desperately need a hospital here.
- Walk in Clinics
- Unsure, only have been here less than two years. However, my health declined after we moved and I was fortunate to have the hospital here where I received a timely diagnosis of acute PE and DVT that likely saved my life.
- Please have more specialists come to Chestertown from Easton! Indoor walking area and/or place to exercise as not everyone can afford Aquafit.
- Identify people who are not getting health promotion and illness care and the reasons. Public education through the school system, community center, health fairs, other public gatherings. Blood pressure screenings. Home monitoring of patients with chronic disease, free transportation to doctors, clinics, etc.
- Keep the Chestertown hospital open for inpatient care.
- Get people to move, more than just to the next meal
- Education 2.) Gov't assisted healthcare or discounted healthcare services to those who qualify 3.) Health Club Membership supplied by business, education circulated to employees, incentives to practice good health, nutrition & exercise
- More and better employment affording better access to health care.
- Recruit more doctors to the area.
- More doctors or nurse practitioners throughout the counties.
- Keep Chestertown inpatient hospital open permanently
- Need more primary care providers.
- need more PCP's accepting new patients, need reliable public transportation, increase ways for people to get more exercise...better walkability
- SRH put more money into recruiting physicians
- Put the hospital back as a full service acute hospital with inpt beds and an icu
- Better access to mental health services
- Keep the hospital open and provide universal healthcare
- Keep the Chestertown hospital open as a real hospital. Attract general practice and specialty doctors to the community. I no longer have a doctor because mine opted recently for a VIP practice that costs a ridiculous amount annually on top of what I already pay for insurance. Other doctors aren't taking new patients.
- More public education, more preventive medicine, more specialists in town.

- Improve interaction with the black community. Bring businesses in that will increase job opportunities.
- There needs to be more health education during school for kids as after school for the parents. Health starts at home and if parents are not educated, that means their children are not and then unhealthy habits continue to form.
- Outdoor health awareness Fair in Rock Hall
- There is a problem with affordable healthcare and access to medical care.
- The local hospital in Chestertown has cut back on basic services and in house. People have to go to Easton, Annapolis or Baltimore for hospital care. Transportation is a problem. We need our hospital to restore the level of services that it once had. We have a college in town and a high percentage of seniors and working people.
- Keep the local hospital - in Chestertown - open
- Keep our hospital open, with full service so we don't have to leave area for another provider.
- Improve public education to help break the cycle of poverty.
- Recruit more doctors for the county. Keep the hospital in Chestertown open for inpatients since we are an aging county, including all the residents of Heron Point Assisted Living.
- Keep local hospital open for emergency, outpatient and acute care services. 2. Provide more outreach programs and education. 3. Utilize part or hospital as inpt rehab. 4. Utilize hospital as inpatient drug/ behavioral health rehab. 5. Recruit more family practice physicians. 6. Use hospital as teaching hospital for med school residents.
- Through the community organizations determine the greater need, then focus that need for ways to improve, then take the next need.
- Better mental health services and addiction services on the eastern shore.
- Keep Chestertown Hospital open and fully functional, i.e., maintain inpatient hospital beds, hire more physicians to replace those who have retired or moved from the area.
- We need gerontologist!! We have a very large retiree population. We need dialysis, midwife (at least), labor/delivery, ER, inpatient, in addition to what is already offered....all at a minimum.
- More general practice doctors. Advertise hours and availability of specialist.
- Transportation schedules posted in more areas.
- For the State of Maryland to support financially keeping the Chester River Medical Center a hospital with inpatient beds, an ICU, surgery services.
- Should be general practitioners and medical specialists in the community and a viable hospital.
- Keep inpatient beds in Chestertown
- Improve medical availability of County Hospital.
- More services/Doctors in Chestertown so people do not have to DRIVE to Easton! The community transportation is a joke!!
- Education from birth until death.
- Keep Chestertown hospital inpatient care.

- More robust hospital services and access to specialists
- Lower cost healthcare, more specialty physicians here in County,
- expand and improve the hospital the rest will follow
- More jobs with health insurance; many jobs are with small businesses and their health care supplements are very expensive for their employees
- Keep the Hospital.
- We need a real hospital and access to specialist
- Make sure the hospital in Chestertown remains open.
- Get/keep doctors at the Chestertown hospital. Require UMMS Residents to rotate to C'town. Some may actually enjoy living here. Set up medical school loan forgiveness program and allow docs to live in the houses the hospital bought for free for a period of time.

Talbot County Comments

- Have professional doctors address problems just as well as they do in the big cities.
- Need a paramedic on the ambulance crew in Oxford, MD
- none
- Have affordable healthcare options available for everyone. Healthcare is very expensive for most people.
- one of the problems in addition to those checked off above has to do with attitude and compliance on the part of the community members - see so much of noncompliance
- Transportation and awareness of how to access it.
- Improved access to affordable housing and healthy food. Equitable health practices would be a good start to address racial inequities and discrepancies.
- Improved transportation
- Need more GP's
- Aggressive programs focused on people under the age of 30 in terms of healthy lifestyle, diets, and habits.
- With the exception of the poor and impoverished, I believe most people in County manage to receive health care though there seem to be very few doctors accepting patients, particularly those with Medicare.
- -coordinated behavioral health services / improved SUD screenings at ER -community health interventions focused on achieving health equity - increased health education programs on chronic disease prevention (stress importance of cancer screenings) Increase rates of adults insured -STI prevention -improve food environment - More culturally competent care
- Educating the poorer public

- Thankfully a community health care facility was opened in the elementary school on the island -- a huge help for the aging population and others without transportation. That was a big factor, in my opinion.
- More urgent care offices and available transportation to them. The availability of seeing a doctor over the internet instead of going into an office.
- Make it easier to obtain treatment for drug addiction. Have clinics for those with no health insurance.
- Have enough culturally sensitive primary care providers accepting new patients and accepting all insurances. Have the UM system run a bus daily to transport people to and from appointments (or send an Uber)
- Don't know
- Have affordable health care facilities available 24 hours a day other than the Emergency Room. Have area transportation options.
- Affordable public transportation for every neighborhood locally
- Education and incentives to improve diet and quit smoking.
- Free health clinics
- More Family physicians
- Health prevention education, nutrition education, community fitness challenge

Queen Anne's County Comments

- more LOCAL doctors in 21620 Not an hour away
- Make Chestertown Hospital a true center for treatment of all medical problems of the community from prenatal to geriatrics.
- Offer more clinics at the Health Dept. (i.e. Diabetes management/ education, weight management/ access to weight loss programs at low to no cost). Also, increase funding for senior services.
- Access to maternity care. Access to specialists. Inpatient hospital beds. With a college, a senior community, and minority population, serious consideration for all aspects of health care.
- rural health clinics that could do routine healthcare, education of public on value of midwife/douma as
- alternative to hospital delivery
- An independent urgent care center would be life changing
- Need to recruit more primary care physicians to the area & promote health care programs. More Health fairs should be scheduled
- need urgent care
- Keep Chestertown Hospital
- Open the Chestertown hospital
- More health fairs. More Doctors with practices here on Kent Island

- Seeking better health and wellness planning.
- Community scheduling
- Walk, socialize
- Lower cost of in-hospital care (i.e. $2,000 for "OR “expense alone for routine colonoscopy is far too high.
- Better water drainage
- More free health assessments given through schools or churches in area.
- Keep the Chester River Hospital open as a functioning hospital. ....more specialists, neurologists, cardiologists, surgeons.
- Safer sidewalks for outdoor walking, a health food store, and organized walking groups. Place to walk indoors would be wonderful.
- Don't have any right now
- Keep the hospital in Chestertown
- Public transportation
- More quality physicians.
- More affordable public health insurance. More access to mental health services on the Eastern Shore.
- Need a walk in after hour walk in clinic.
- Keep doctors… need geriatricians, cardiologists, primary care providers
- Please hire doctors for our hospital in Kent Co.
- Develop easier access to food pantries that have fresh foods and heart healthy options.
- Develop transportation specifically for health care related visits.
- Better transportation for those who need public transportation.
- Mental health events for stress and anxiety.
- Stress and anxiety free zones/socials
- Affordable health care
- Increase availability of PCP in QAC
- More doctors accepting Priority Partners and Maryland Smile.
- Make sure the local hospital is not closed.
- Lower Rx costs. Transparent and published fee schedules to allow comparative shopping.
- Better transportation for people to get to/from dr appts. 2. Expansion of the cardiopulmonary rehab program at hospital
- Add community health clinics in the local health department. There are few local physicians and even fewer specialty care providers in County.

- More mental health service providers that accept patients with and without insurance, using sliding scale where necessary More awareness raising (advertising, awareness days, open houses, community events) re mental health services Chesapeake College is good location, larger venues in designated zip codes. Awareness raising campaigns of the value of exercise wherever and however you can find it - walking, dog walking, parking further away, reduced screen time exchanged for movement, convey the idea that you don't have to join a club or pay a fee to get movement in your day, raise awareness of improving nutrition - more home cooked food, what is a good grocery list, how to keep costs down when grocery shopping,
- Continued efforts to meet people on their 'turf'. Bi lingual contact needs to be improved
- Clinics or options that are on a sliding fee scale for those with little income and poor or no insurance.
- I know that there is a focus on affordable housing, but the continued development of high density housing without any supporting infrastructure is a serious issue effecting all aspects of life.
- none
- Access to high quality healthcare. Drs, specialist, etc have no reason to move to this area.
- Invest in the local hospital so that people in outlying areas have reasonable access. Bring obstetrics back to Chestertown. Refer people who call looking for healthcare to doctors closest to their zip codes. Give signing bonuses to new doctors to practice in outlying areas to make care as easily available as AAMC does, so our patients stay within the system. Improve our ER situation and have care available care for pediatric patients,
- In general, I think we now have the technological ability to do doctor's visits for simple ailments through phone or Internet. This should be both cheaper in the long term, and result in more care, where I might ordinarily wait till offices open back up, or not go at all. For us, living on Kent Island, we are close enough to major hospitals to have our more serious medical needs cared for.
- There seems to be plenty of doctors' offices in the area. Insurance, or lack thereof, has been a limiting factor for myself and my family in the past.
- Bring back services that aren't currently available at the local hospital (Chestertown).
- More activities for children and families to engage in positive, quality time together!

Appendix -2

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

Robert Wood Johnson Foundation

The 2021 Rankings includes deaths through 2019. See our FAQs for information about when we anticipate the inclusion of deaths attributed to COVID-19.

Caroline (CR)
2021 Rankings

Download Maryland Rankings Data

County Demographics

	County	State
Population	33,406	6,045,680
% below 18 years of age	23.6%	22.1%
% 65 and older	16.7%	15.9%
% Non-Hispanic Black	13.6%	29.9%
% American Indian & Alaska Native	0.9%	0.6%
% Asian	1.2%	6.7%
% Native Hawaiian/Other Pacific Islander	0.3%	0.1%
% Hispanic	7.8%	10.6%
% Non-Hispanic White	75.1%	50.0%
% not proficient in English	2%	3%
% Females	51.1%	51.6%
% Rural	76.0%	12.8%

	County	Error Margin	Top U.S. Performers ^	Maryland
Health Outcomes				
Length of Life				
Premature death	8,300	7,200-9,500	5,400	7,200
Quality of Life				
Poor or fair health **	21%	18-23%	14%	15%
Poor physical health days **	4.7	4.3-5.1	3.4	3.4
Poor mental health days **	5.1	4.7-5.5	3.8	3.7
Low birthweight	7%	6-8%	6%	9%
Additional Health Outcomes (not included in overall ranking)				
Life expectancy	76.8	75.9-77.8	81.1	79.2
Premature age-adjusted mortality	400	360-440	280	340
Child mortality	40	20-70	40	50
Infant mortality	8	5-12	4	6
Frequent physical distress **	14%	13-16%	10%	10%
Frequent mental distress **	16%	14-17%	12%	11%
Diabetes prevalence	15%	13-17%	8%	11%
HIV prevalence	209		50	653
Health Factors				
Health Behaviors				
Adult smoking **	21%	18-24%	16%	13%
Adult obesity	41%	38-44%	26%	32%
Food environment index	8.1		8.7	8.7
Physical inactivity	31%	28-34%	19%	22%
Access to exercise opportunities	48%		91%	93%
Excessive drinking **	16%	16-17%	15%	15%

https://www.countyhealthrankings.org/app/maryland/2021/county/snapshots/011+019+029+035+041/print 1/10

Alcohol-impaired driving deaths	28%	20-37%	11%	29%
Sexually transmitted infections	250.1		161.2	586.3
Teen births	21	17-24	12	16
Additional Health Behaviors (not included in overall ranking)				
Food insecurity	13%		9%	11%
Limited access to healthy foods	2%		2%	3%
Drug overdose deaths	43	31-58	11	38
Motor vehicle crash deaths	25	19-32	9	9
Insufficient sleep **	40%	39-41%	32%	38%
Clinical Care				
Uninsured	8%	7-9%	6%	7%
Primary care physicians	3,030:1		1,030:1	1,130:1
Dentists	1,760:1		1,210:1	1,260:1
Mental health providers	2,230:1		270:1	360:1
Preventable hospital stays	3,964		2,565	4,134
Mammography screening	39%		51%	42%
Flu vaccinations	49%		55%	52%
Additional Clinical Care (not included in overall ranking)				
Uninsured adults	10%	8-11%	7%	8%
Uninsured children	4%	3-5%	3%	3%
Other primary care providers	1,150:1		620:1	870:1
Social & Economic Factors				
High school completion	84%	83-86%	94%	90%
Some college	45%	40-50%	73%	70%
Unemployment	3.6%		2.6%	3.6%
Children in poverty	20%	13-26%	10%	12%
Income inequality	4.4	4.0-4.8	3.7	4.5
Children in single-parent households	27%	22-31%	14%	26%
Social associations	10.2		18.2	9.0
Violent crime	259		63	459
Injury deaths	99	83-114	59	82
Additional Social & Economic Factors (not included in overall ranking)				
High school graduation	89%		95%	87%
Disconnected youth			4%	6%
Reading scores			3.3	
Math scores			3.4	
Median household income	$60,100	$53,200-67,100	$72,900	$86,600
Children eligible for free or reduced price lunch	55%		32%	46%
Residential segregation - Black/White	38		23	63
Residential segregation - non-white/white	32		14	55
Homicides			2	9
Suicides	16	11-23	11	10
Firearm fatalities	14	9-21	8	12
Juvenile arrests	54			26
Physical Environment				
Air pollution - particulate matter	8.0		5.2	8.0
Drinking water violations	No			
Severe housing problems	18%	15-21%	9%	16%
Driving alone to work	84%	82-86%	72%	74%
Long commute - driving alone	49%	45-53%	16%	50%
Additional Physical Environment (not included in overall ranking)				
Traffic volume	39			734
Homeownership	73%	71-75%	81%	67%
Severe housing cost burden	14%	11-16%	7%	14%
Broadband access	80%	78-82%	86%	86%

^ 10th/90th percentile, i.e., only 10% are better.
** Data should not be compared with prior years
Note: Blank values reflect unreliable or missing data

Dorchester (DO)
2021 Rankings

Download Maryland Rankings Data

County Demographics

	County	State
Population	31,929	6,045,680
% below 18 years of age	21.0%	22.1%
% 65 and older	22.1%	15.9%
% Non-Hispanic Black	27.9%	29.9%
% American Indian & Alaska Native	0.5%	0.6%
% Asian	1.2%	6.7%
% Native Hawaiian/Other Pacific Islander	0.1%	0.1%
% Hispanic	6.1%	10.6%
% Non-Hispanic White	62.3%	50.0%
% not proficient in English	2%	3%
% Females	52.5%	51.6%
% Rural	56.2%	12.8%

	County	Error Margin	Top U.S. Performers ^	Maryland
Health Outcomes				
Length of Life				
Premature death	10,400	9,000-11,800	5,400	7,200
Quality of Life				
Poor or fair health **	21%	19-23%	14%	15%
Poor physical health days **	4.3	3.9-4.6	3.4	3.4
Poor mental health days **	4.7	4.3-5.0	3.8	3.7
Low birthweight	10%	9-12%	6%	9%
Additional Health Outcomes (not included in overall ranking)				
Life expectancy	75.6	74.5-76.7	81.1	79.2
Premature age-adjusted mortality	470	430-510	280	340
Child mortality	70	50-110	40	50
Infant mortality	9	5-13	4	6
Frequent physical distress **	13%	12-14%	10%	10%
Frequent mental distress **	15%	13-16%	12%	11%
Diabetes prevalence	19%	17-21%	8%	11%
HIV prevalence	536		50	653
Health Factors				
Health Behaviors				
Adult smoking **	21%	18-23%	16%	13%
Adult obesity	40%	37-44%	26%	32%
Food environment index	7.4		8.7	8.7
Physical inactivity	32%	30-35%	19%	22%
Access to exercise opportunities	68%		91%	93%
Excessive drinking **	15%	14-15%	15%	15%
Alcohol-impaired driving deaths	20%	10-32%	11%	29%
Sexually transmitted infections	640.5		161.2	586.3
Teen births	34	29-38	12	16
Additional Health Behaviors (not included in overall ranking)				
Food insecurity	15%		9%	11%
Limited access to healthy foods	6%		2%	3%
Drug overdose deaths	39	27-53	11	38
Motor vehicle crash deaths	14	9-19	9	9
Insufficient sleep **	39%	37-40%	32%	38%
Clinical Care				
Uninsured	7%	6-9%	6%	7%
Primary care physicians	2,130:1		1,030:1	1,130:1

Dentists	1,450:1		1,210:1	1,260:1
Mental health providers	390:1		270:1	360:1
Preventable hospital stays	3,345		2,565	4,134
Mammography screening	46%		51%	42%
Flu vaccinations	51%		55%	52%
Additional Clinical Care (not included in overall ranking)				
Uninsured adults	9%	7-10%	7%	8%
Uninsured children	4%	3-5%	3%	3%
Other primary care providers	1,330:1		620:1	870:1
Social & Economic Factors				
High school completion	88%	86-90%	94%	90%
Some college	54%	49-60%	73%	70%
Unemployment	4.8%		2.6%	3.6%
Children in poverty	24%	15-33%	10%	12%
Income inequality	4.7	4.1-5.2	3.7	4.5
Children in single-parent households	41%	33-48%	14%	26%
Social associations	10.6		18.2	9.0
Violent crime	456		63	459
Injury deaths	85	71-100	59	82
Additional Social & Economic Factors (not included in overall ranking)				
High school graduation	82%		95%	87%
Disconnected youth			4%	6%
Reading scores			3.3	
Math scores			3.4	
Median household income	$48,700	$43,300-54,100	$72,900	$86,600
Children eligible for free or reduced price lunch	100%		32%	46%
Residential segregation - Black/White	44		23	63
Residential segregation - non-white/white	42		14	55
Homicides	7	4-11	2	9
Suicides	16	10-23	11	10
Firearm fatalities	15	10-22	8	12
Juvenile arrests	110			26
Physical Environment				
Air pollution - particulate matter	7.9		5.2	8.0
Drinking water violations	Yes			
Severe housing problems	18%	16-20%	9%	16%
Driving alone to work	78%	75-81%	72%	74%
Long commute - driving alone	42%	37-46%	16%	50%
Additional Physical Environment (not included in overall ranking)				
Traffic volume	88			734
Homeownership	68%	66-70%	81%	67%
Severe housing cost burden	15%	12-17%	7%	14%
Broadband access	77%	76-79%	86%	86%

^ 10th/90th percentile, i.e., only 10% are better.
** Data should not be compared with prior years
Note: Blank values reflect unreliable or missing data

Kent (KE)
2021 Rankings

Download Maryland Rankings Data

County Demographics

	County	State
Population	19,422	6,045,680
% below 18 years of age	15.4%	22.1%
% 65 and older	27.1%	15.9%
% Non-Hispanic Black	14.4%	29.9%
% American Indian & Alaska Native	0.4%	0.6%
% Asian	1.4%	6.7%
% Native Hawaiian/Other Pacific Islander	0.1%	0.1%
% Hispanic	4.5%	10.6%
% Non-Hispanic White	77.8%	50.0%
% not proficient in English	1%	3%
% Females	51.9%	51.6%
% Rural	72.6%	12.8%

	County	Error Margin	Top U.S. Performers ^	Maryland
Health Outcomes				
Length of Life				
Premature death	6,900	5,400-8,400	5,400	7,200
Quality of Life				
Poor or fair health **	16%	14-19%	14%	15%
Poor physical health days **	3.8	3.4-4.2	3.4	3.4
Poor mental health days **	4.2	3.8-4.6	3.8	3.7
Low birthweight	10%	8-12%	6%	9%
Additional Health Outcomes (not included in overall ranking)				
Life expectancy	79.0	77.8-80.2	81.1	79.2
Premature age-adjusted mortality	340	300-390	280	340
Child mortality			40	50
Infant mortality			4	6
Frequent physical distress **	12%	10-13%	10%	10%
Frequent mental distress **	13%	12-15%	12%	11%
Diabetes prevalence	13%	11-15%	8%	11%
HIV prevalence	157		50	653
Health Factors				
Health Behaviors				
Adult smoking **	17%	14-20%	16%	13%
Adult obesity	30%	27-34%	26%	32%
Food environment index	8.4		8.7	8.7
Physical inactivity	27%	24-30%	19%	22%
Access to exercise opportunities	57%		91%	93%
Excessive drinking **	19%	18-19%	15%	15%
Alcohol-impaired driving deaths	27%	11-45%	11%	29%
Sexually transmitted infections	376.6		161.2	586.3
Teen births	11	8-14	12	16
Additional Health Behaviors (not included in overall ranking)				
Food insecurity	12%		9%	11%
Limited access to healthy foods	0%		2%	3%
Drug overdose deaths	24	13-40	11	38
Motor vehicle crash deaths	17	11-25	9	9
Insufficient sleep **	33%	32-35%	32%	38%
Clinical Care				
Uninsured	8%	7-9%	6%	7%
Primary care physicians	1,140:1		1,030:1	1,130:1

Dentists	2,160:1		1,210:1	1,260:1
Mental health providers	540:1		270:1	360:1
Preventable hospital stays	2,085		2,565	4,134
Mammography screening	42%		51%	42%
Flu vaccinations	56%		55%	52%
Additional Clinical Care (not included in overall ranking)				
Uninsured adults	9%	7-11%	7%	8%
Uninsured children	5%	3-6%	3%	3%
Other primary care providers	1,490:1		620:1	870:1
Social & Economic Factors				
High school completion	89%	86-91%	94%	90%
Some college	62%	54-69%	73%	70%
Unemployment	4.0%		2.6%	3.6%
Children in poverty	18%	11-25%	10%	12%
Income inequality	4.8	4.1-5.4	3.7	4.5
Children in single-parent households	38%	29-47%	14%	26%
Social associations	13.9		18.2	9.0
Violent crime	220		63	459
Injury deaths	87	69-108	59	82
Additional Social & Economic Factors (not included in overall ranking)				
High school graduation	93%		95%	87%
Disconnected youth			4%	6%
Reading scores			3.3	
Math scores			3.4	
Median household income	$65,600	$57,400-73,800	$72,900	$86,600
Children eligible for free or reduced price lunch	52%		32%	46%
Residential segregation - Black/White	18		23	63
Residential segregation - non-white/white	19		14	55
Homicides			2	9
Suicides	13	6-23	11	10
Firearm fatalities			8	12
Juvenile arrests	52			26
Physical Environment				
Air pollution - particulate matter	6.1		5.2	8.0
Drinking water violations	No			
Severe housing problems	16%	13-19%	9%	16%
Driving alone to work	69%	65-72%	72%	74%
Long commute - driving alone	37%	31-44%	16%	50%
Additional Physical Environment (not included in overall ranking)				
Traffic volume	71			734
Homeownership	69%	67-72%	81%	67%
Severe housing cost burden	15%	12-18%	7%	14%
Broadband access	75%	72-77%	86%	86%

^ 10th/90th percentile, i.e., only 10% are better.
** Data should not be compared with prior years
Note: Blank values reflect unreliable or missing data

Queen Anne's (QA)
2021 Rankings

Download Maryland Rankings Data

County Demographics

	County	State
Population	50,381	6,045,680
% below 18 years of age	21.4%	22.1%
% 65 and older	19.2%	15.9%
% Non-Hispanic Black	6.1%	29.9%
% American Indian & Alaska Native	0.5%	0.6%
% Asian	1.2%	6.7%
% Native Hawaiian/Other Pacific Islander	0.1%	0.1%
% Hispanic	4.3%	10.6%
% Non-Hispanic White	86.3%	50.0%
% not proficient in English	1%	3%
% Females	50.4%	51.6%
% Rural	54.5%	12.8%

	County	Error Margin	Top U.S. Performers ^	Maryland
Health Outcomes				
Length of Life				
Premature death	6,600	5,700-7,500	5,400	7,200
Quality of Life				
Poor or fair health **	13%	11-15%	14%	15%
Poor physical health days **	3.4	3.0-3.8	3.4	3.4
Poor mental health days **	3.9	3.6-4.3	3.8	3.7
Low birthweight	7%	6-8%	6%	9%
Additional Health Outcomes (not included in overall ranking)				
Life expectancy	79.8	78.9-80.6	81.1	79.2
Premature age-adjusted mortality	300	280-330	280	340
Child mortality	40	20-60	40	50
Infant mortality			4	6
Frequent physical distress **	10%	9-11%	10%	10%
Frequent mental distress **	12%	11-13%	12%	11%
Diabetes prevalence	10%	9-11%	8%	11%
HIV prevalence	105		50	653
Health Factors				
Health Behaviors				
Adult smoking **	16%	13-19%	16%	13%
Adult obesity	28%	26-31%	26%	32%
Food environment index	9.0		8.7	8.7
Physical inactivity	21%	19-24%	19%	22%
Access to exercise opportunities	82%		91%	93%
Excessive drinking **	21%	20-22%	15%	15%
Alcohol-impaired driving deaths	37%	29-44%	11%	29%
Sexually transmitted infections	249.1		161.2	586.3
Teen births	11	9-13	12	16
Additional Health Behaviors (not included in overall ranking)				
Food insecurity	8%		9%	11%
Limited access to healthy foods	3%		2%	3%
Drug overdose deaths	35	26-45	11	38
Motor vehicle crash deaths	14	11-19	9	9
Insufficient sleep **	33%	32-35%	32%	38%
Clinical Care				
Uninsured	5%	5-6%	6%	7%
Primary care physicians	2,790:1		1,030:1	1,130:1

Dentists	2,800:1		1,210:1	1,260:1
Mental health providers	950:1		270:1	360:1
Preventable hospital stays	2,657		2,565	4,134
Mammography screening	40%		51%	42%
Flu vaccinations	55%		55%	52%
Additional Clinical Care (not included in overall ranking)				
Uninsured adults	6%	5-7%	7%	8%
Uninsured children	3%	2-4%	3%	3%
Other primary care providers	1,800:1		620:1	870:1
Social & Economic Factors				
High school completion	93%	92-94%	94%	90%
Some college	68%	63-73%	73%	70%
Unemployment	3.1%		2.6%	3.6%
Children in poverty	7%	4-10%	10%	12%
Income inequality	3.8	3.5-4.1	3.7	4.5
Children in single-parent households	17%	13-20%	14%	26%
Social associations	7.2		18.2	9.0
Violent crime	233		63	459
Injury deaths	80	69-91	59	82
Additional Social & Economic Factors (not included in overall ranking)				
High school graduation	96%		95%	87%
Disconnected youth			4%	6%
Reading scores			3.3	
Math scores			3.4	
Median household income	$101,400	$94,200-108,500	$72,900	$86,600
Children eligible for free or reduced price lunch	24%		32%	46%
Residential segregation - Black/White	23		23	63
Residential segregation - non-white/white	17		14	55
Homicides			2	9
Suicides	14	10-20	11	10
Firearm fatalities	10	7-15	8	12
Juvenile arrests	19			26
Physical Environment				
Air pollution - particulate matter	8.2		5.2	8.0
Drinking water violations	No			
Severe housing problems	12%	10-14%	9%	16%
Driving alone to work	79%	77-81%	72%	74%
Long commute - driving alone	56%	53-60%	16%	50%
Additional Physical Environment (not included in overall ranking)				
Traffic volume	133			734
Homeownership	81%	79-83%	81%	67%
Severe housing cost burden	11%	9-13%	7%	14%
Broadband access	87%	85-88%	86%	86%

^ 10th/90th percentile, i.e., only 10% are better.
** Data should not be compared with prior years
Note: Blank values reflect unreliable or missing data

Talbot (TA)
2021 Rankings

Download Maryland Rankings Data

County Demographics

	County	State
Population	37,181	6,045,680
% below 18 years of age	18.2%	22.1%
% 65 and older	29.7%	15.9%
% Non-Hispanic Black	12.3%	29.9%
% American Indian & Alaska Native	0.4%	0.6%
% Asian	1.4%	6.7%
% Native Hawaiian/Other Pacific Islander	0.2%	0.1%
% Hispanic	7.2%	10.6%
% Non-Hispanic White	77.4%	50.0%
% not proficient in English	1%	3%
% Females	52.7%	51.6%
% Rural	54.7%	12.8%

	County	Error Margin	Top U.S. Performers ^	Maryland
Health Outcomes				
Length of Life				
Premature death	7,300	6,100-8,500	5,400	7,200
Quality of Life				
Poor or fair health **	14%	12-16%	14%	15%
Poor physical health days **	3.4	3.0-3.7	3.4	3.4
Poor mental health days **	3.8	3.5-4.2	3.8	3.7
Low birthweight	7%	6-8%	6%	9%
Additional Health Outcomes (not included in overall ranking)				
Life expectancy	80.4	79.3-81.4	81.1	79.2
Premature age-adjusted mortality	310	270-340	280	340
Child mortality	60	40-100	40	50
Infant mortality	9	6-14	4	6
Frequent physical distress **	10%	9-11%	10%	10%
Frequent mental distress **	12%	11-13%	12%	11%
Diabetes prevalence	11%	10-13%	8%	11%
HIV prevalence	230		50	653
Health Factors				
Health Behaviors				
Adult smoking **	16%	13-18%	16%	13%
Adult obesity	29%	27-32%	26%	32%
Food environment index	8.4		8.7	8.7
Physical inactivity	21%	19-23%	19%	22%
Access to exercise opportunities	76%		91%	93%
Excessive drinking **	20%	20-21%	15%	15%
Alcohol-impaired driving deaths	38%	29-47%	11%	29%
Sexually transmitted infections	277.6		161.2	586.3
Teen births	15	12-19	12	16
Additional Health Behaviors (not included in overall ranking)				
Food insecurity	11%		9%	11%
Limited access to healthy foods	2%		2%	3%
Drug overdose deaths	30	20-42	11	38
Motor vehicle crash deaths	10	6-15	9	9
Insufficient sleep **	34%	32-35%	32%	38%
Clinical Care				
Uninsured	8%	7-9%	6%	7%
Primary care physicians	1,000:1		1,030:1	1,130:1

Dentists	1,240:1		1,210:1	1,260:1
Mental health providers	210:1		270:1	360:1
Preventable hospital stays	1,861		2,565	4,134
Mammography screening	49%		51%	42%
Flu vaccinations	55%		55%	52%
Additional Clinical Care (not included in overall ranking)				
Uninsured adults	9%	7-10%	7%	8%
Uninsured children	5%	4-7%	3%	3%
Other primary care providers	640:1		620:1	870:1
Social & Economic Factors				
High school completion	91%	90-92%	94%	90%
Some college	68%	62-75%	73%	70%
Unemployment	3.4%		2.6%	3.6%
Children in poverty	13%	8-19%	10%	12%
Income inequality	4.7	4.1-5.3	3.7	4.5
Children in single-parent households	23%	18-28%	14%	26%
Social associations	12.4		18.2	9.0
Violent crime	243		63	459
Injury deaths	79	66-92	59	82
Additional Social & Economic Factors (not included in overall ranking)				
High school graduation	94%		95%	87%
Disconnected youth			4%	6%
Reading scores			3.3	
Math scores			3.4	
Median household income	$75,700	$70,000-81,400	$72,900	$86,600
Children eligible for free or reduced price lunch	49%		32%	46%
Residential segregation - Black/White	25		23	63
Residential segregation - non-white/white	24		14	55
Homicides			2	9
Suicides	12	7-18	11	10
Firearm fatalities	7	4-12	8	12
Juvenile arrests	35			26
Physical Environment				
Air pollution - particulate matter	8.0		5.2	8.0
Drinking water violations	No			
Severe housing problems	16%	14-19%	9%	16%
Driving alone to work	77%	75-79%	72%	74%
Long commute - driving alone	30%	26-33%	16%	50%
Additional Physical Environment (not included in overall ranking)				
Traffic volume	188			734
Homeownership	70%	69-72%	81%	67%
Severe housing cost burden	13%	11-15%	7%	14%
Broadband access	86%	84-88%	86%	86%

^ 10th/90th percentile, i.e., only 10% are better.
** Data should not be compared with prior years
Note: Blank values reflect unreliable or missing data

Appendix 3- County Compare: Social Determinants of Health

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

Robert Wood Johnson Foundation

The 2021 Rankings includes deaths through 2019. See our FAQs for information about when we anticipate the inclusion of deaths attributed to COVID-19.

Compare Counties

2021 Rankings

	Maryland	Caroline (CR), MD X	Dorchester (DO), MD X	Kent (KE), MD X	Talbot (TA), MD X	Queen Anne's (QA), MD X
Health Outcomes						
Length of Life						
Premature death	7,200	8,300	10,400	6,900	7,300	6,600
Quality of Life						
Poor or fair health**	15%	21%	21%	16%	14%	13%
Poor physical health days**	3.4	4.7	4.3	3.8	3.4	3.4
Poor mental health days**	3.7	5.1	4.7	4.2	3.8	3.9
Low birthweight	9%	7%	10%	10%	7%	7%
Health Factors						
Health Behaviors						
Adult smoking**	13%	21%	21%	17%	16%	16%
Adult obesity**	32%	41%	40%	30%	29%	28%
Food environment index**	8.7	8.1	7.4	8.4	8.4	9.0
Physical inactivity**	22%	31%	32%	27%	21%	21%
Access to exercise opportunities	93%	48%	68%	57%	76%	82%
Excessive drinking**	15%	16%	15%	19%	20%	21%
Alcohol-impaired driving deaths	29%	28%	20%	27%	38%	37%
Sexually transmitted infections**	586.3	250.1	640.5	376.6	277.6	249.1
Teen births	16	21	34	11	15	11
Clinical Care						
Uninsured	7%	8%	7%	8%	8%	5%
Primary care physicians	1,130:1	3,030:1	2,130:1	1,140:1	1,000:1	2,790:1

Dentists	1,260:1	1,760:1	1,450:1	2,160:1	1,240:1	2,800:1
Mental health providers	360:1	2,230:1	390:1	540:1	210:1	950:1
Preventable hospital stays	4,134	3,964	3,345	2,085	1,861	2,657
Mammography screening	42%	39%	46%	42%	49%	40%
Flu vaccinations	52%	49%	51%	56%	55%	55%
Social & Economic Factors						
High school completion	90%	84%	88%	89%	91%	93%
Some college	70%	45%	54%	62%	68%	68%
Unemployment**	3.6%	3.6%	4.8%	4.0%	3.4%	3.1%
Children in poverty	12%	20%	24%	18%	13%	7%
Income inequality	4.5	4.4	4.7	4.8	4.7	3.8
Children in single-parent households	26%	27%	41%	38%	23%	17%
Social associations	9.0	10.2	10.6	13.9	12.4	7.2
Violent crime**	459	259	456	220	243	233
Injury deaths	82	99	85	87	79	80
Physical Environment						
Air pollution - particulate matter	8.0	8.0	7.9	6.1	8.0	8.2
Drinking water violations		No	Yes	No	No	No
Severe housing problems	16%	18%	18%	16%	16%	12%
Driving alone to work	74%	84%	78%	69%	77%	79%
Long commute - driving alone	50%	49%	42%	37%	30%	56%

** Compare across states with caution
^ This measure should not be compared across states
Note: Blank values reflect unreliable or missing data

2021 County Health Rankings for Maryland: Measures and National/State Results

Measure	Description	US	MD	MD Minimum	MD Maximum
HEALTH OUTCOMES					
Premature death*	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	6,900	7,200	4,100	13,800
Poor or fair health	Percentage of adults reporting fair or poor health (age-adjusted).	17%	15%	11%	24%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	3.7	3.4	2.6	4.7
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	4.1	3.7	3.4	5.1
Low birthweight*	Percentage of live births with low birthweight (< 2,500 grams).	8%	9%	6%	12%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	Percentage of adults who are current smokers (age-adjusted).	17%	13%	9%	22%
Adult obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m^2.	30%	32%	22%	42%
Food environment index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	7.8	8.7	6.5	9.2
Physical inactivity	Percentage of adults age 20 and over reporting no leisure-time physical activity.	23%	22%	16%	33%
Access to exercise opportunities	Percentage of population with adequate access to locations for physical activity.	84%	93%	48%	100%
Excessive drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	19%	15%	13%	21%
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement.	27%	29%	20%	47%
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population.	539.9	586.3	130.0	1,310.1
Teen births*	Number of births per 1,000 female population ages 15-19.	21	16	6	34
CLINICAL CARE					
Uninsured	Percentage of population under age 65 without health insurance.	10%	7%	4%	11%
Primary care physicians	Ratio of population to primary care physicians.	1,320:1	1,130:1	3,030:1	520:1
Dentists	Ratio of population to dentists.	1,400:1	1,260:1	2,800:1	470:1
Mental health providers	Ratio of population to mental health providers.	380:1	360:1	2,230:1	200:1
Preventable hospital stays*	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	4,236	4,134	1,861	6,147
Mammography screening*	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.	42%	42%	36%	49%
Flu vaccinations*	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.	48%	52%	41%	59%
SOCIAL & ECONOMIC FACTORS					
High school completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	88%	90%	81%	95%
Some college	Percentage of adults ages 25-44 with some post-secondary education.	66%	70%	41%	86%
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	3.7%	3.6%	2.7%	7.4%
Children in poverty*	Percentage of people under age 18 in poverty.	17%	12%	6%	33%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	4.9	4.5	3.4	6.3
Children in single-parent households	Percentage of children that live in a household headed by single parent.	26%	26%	14%	53%
Social associations	Number of membership associations per 10,000 population.	9.3	9.0	5.6	17.5
Violent crime	Number of reported violent crime offenses per 100,000 population.	386	459	150	1,566
Injury deaths*	Number of deaths due to injury per 100,000 population.	72	82	40	180
PHYSICAL ENVIRONMENT					
Air pollution - particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	7.2	8.0	5.7	9.7
Drinking water violations	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	N/A	N/A	No	Yes
Severe housing problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	18%	16%	11%	25%
Driving alone to work*	Percentage of the workforce that drives alone to work.	76%	74%	60%	85%
Long commute - driving alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	37%	50%	21%	66%

* Indicates subgroup data by race and ethnicity is available

2021 County Health Rankings: Disaggregated State-Level Racial/Ethnic Data

Measure	Overall	AIAN	Asian	Black	Hispanic	White
HEALTH OUTCOMES						
Premature death*	7,200	4,500	2,700	9,700	3,900	6,900
Life expectancy	79.2	94.6	89.7	76.6	90.3	79.3
Premature age-adjusted mortality	340	210	130	450	160	330
Child mortality	50	---	30	80	40	40
Infant mortality	6	---	5	10	4	4
Low birthweight*	9%	8%	9%	12%	7%	7%
HEALTH FACTORS						
HEALTH BEHAVIORS						
Drug overdose deaths	38	26	5	43	10	46
Motor vehicle crash deaths	9	---	4	10	7	9
Teen births*	16	13	2	22	39	9
CLINICAL CARE						
Preventable hospital stays*	4,134	4,146	1,952	5,696	3,136	3,726
Mammography screening*	42%	36%	32%	41%	35%	42%
Flu vaccinations*	52%	48%	55%	41%	44%	55%
SOCIAL & ECONOMIC FACTORS						
Reading scores^	---	N/A	---	---	---	---
Math scores^	---	N/A	---	---	---	---
Children in poverty*†	12%	18%	7%	19%	16%	6%
Median household income	$86,600	$71,800	$105,700	$67,600	$72,800	$95,200
Injury deaths*	82	52	23	93	34	93
Homicides	9	---	2	23	5	2
Suicides	10	---	6	5	4	13
Firearm fatalities	12	---	2	24	3	8
PHYSICAL ENVIRONMENT						
Driving alone to work*	74%	66%	72%	72%	66%	81%

* Ranked measure

^ Data not available for AK, AZ, LA, MD, NM, NY, VT

^ Data not available for AK, AZ, LA, MD, NY, VT, VA

† Overall county level values of children in poverty are obtained from one-year modeled estimates from the Small Area Income and Poverty Estimates (SAIPE) Program. Because SAIPE does not provide estimates by racial and ethnic groups, data from the 5-year American Community Survey (ACS) was used to quantify children living in poverty by racial and ethnic groups.

N/A indicates data not available for this race/ethnicity.

--- Data not reported due to NCHS suppression rules (A missing value is reported for counties with fewer than 20 deaths or 10 births.)

2021 County Health Rankings: Ranked Measure Sources and Years of Data

	Measure	Weight	Source	Years of Data
HEALTH OUTCOMES				
Length of Life	Premature death*	50%	National Center for Health Statistics - Mortality Files	2017-2019
Quality of Life	Poor or fair health	10%	Behavioral Risk Factor Surveillance System	2018
	Poor physical health days	10%	Behavioral Risk Factor Surveillance System	2018
	Poor mental health days	10%	Behavioral Risk Factor Surveillance System	2018
	Low birthweight*	20%	National Center for Health Statistics - Natality files	2013-2019
HEALTH FACTORS				
HEALTH BEHAVIORS				
Tobacco Use	Adult smoking	10%	Behavioral Risk Factor Surveillance System	2018
Diet and Exercise	Adult obesity	5%	United States Diabetes Surveillance System	2017
	Food environment index	2%	USDA Food Environment Atlas, Map the Meal Gap from Feeding America	2015 & 2018
	Physical inactivity	2%	United States Diabetes Surveillance System	2017
	Access to exercise opportunities	1%	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files	2010 & 2019
Alcohol and Drug Use	Excessive drinking	2.5%	Behavioral Risk Factor Surveillance System	2018
	Alcohol-impaired driving deaths	2.5%	Fatality Analysis Reporting System	2015-2019
Sexual Activity	Sexually transmitted infections	2.5%	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018
	Teen births*	2.5%	National Center for Health Statistics - Natality files	2013-2019
CLINICAL CARE				
Access to Care	Uninsured	5%	Small Area Health Insurance Estimates	2018
	Primary care physicians	3%	Area Health Resource File/American Medical Association	2018
	Dentists	1%	Area Health Resource File/National Provider Identification file	2019
	Mental health providers	1%	CMS, National Provider Identification	2020
Quality of Care	Preventable hospital stays*	5%	Mapping Medicare Disparities Tool	2018
	Mammography screening*	2.5%	Mapping Medicare Disparities Tool	2018
	Flu vaccinations*	2.5%	Mapping Medicare Disparities Tool	2018
SOCIAL & ECONOMIC FACTORS				
Education	High school completion	5%	American Community Survey, 5-year estimates	2015-2019
	Some college	5%	American Community Survey, 5-year estimates	2015-2019
Employment	Unemployment	10%	Bureau of Labor Statistics	2019
Income	Children in poverty*	7.5%	Small Area Income and Poverty Estimates	2019
	Income inequality	2.5%	American Community Survey, 5-year estimates	2015-2019
Family and Social Support	Children in single-parent households	2.5%	American Community Survey, 5-year estimates	2015-2019
	Social associations	2.5%	County Business Patterns	2018
Community Safety	Violent crime	2.5%	Uniform Crime Reporting - FBI	2014 & 2016
	Injury deaths*	2.5%	National Center for Health Statistics - Mortality Files	2015-2019
PHYSICAL ENVIRONMENT				
Air and Water Quality	Air pollution - particulate matter	2.5%	Environmental Public Health Tracking Network	2016
	Drinking water violations	2.5%	Safe Drinking Water Information System	2019
Housing and Transit	Severe housing problems	2%	Comprehensive Housing Affordability Strategy (CHAS) data	2013-2017
	Driving alone to work*	2%	American Community Survey, 5-year estimates	2015-2019
	Long commute - driving alone	1%	American Community Survey, 5-year estimates	2015-2019

*Indicates subgroup data by race and ethnicity is available

2021 County Health Rankings: Additional Measure Sources and Years of Data

	Measure	Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Life expectancy*	National Center for Health Statistics - Mortality Files	2017-2019
	Premature age-adjusted mortality*	National Center for Health Statistics - Mortality Files	2017-2019
	Child mortality*	National Center for Health Statistics - Mortality Files	2016-2019
	Infant mortality*	National Center for Health Statistics - Mortality Files	2013-2019
Quality of Life	Frequent physical distress	Behavioral Risk Factor Surveillance System	2018
	Frequent mental distress	Behavioral Risk Factor Surveillance System	2018
	Diabetes prevalence	United States Diabetes Surveillance System	2017
	HIV prevalence	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018
HEALTH FACTORS			
HEALTH BEHAVIORS			
Diet and Exercise	Food insecurity	Map the Meal Gap	2018
	Limited access to healthy foods	USDA Food Environment Atlas	2015
Alcohol and Drug Use	Drug overdose deaths*	National Center for Health Statistics - Mortality Files	2017-2019
	Motor vehicle crash deaths*	National Center for Health Statistics - Mortality Files	2013-2019
Other Health Behaviors	Insufficient sleep	Behavioral Risk Factor Surveillance System	2018
CLINICAL CARE			
Access to Care	Uninsured adults	Small Area Health Insurance Estimates	2018
	Uninsured children	Small Area Health Insurance Estimates	2018
	Other primary care providers	CMS, National Provider Identification	2020
SOCIAL & ECONOMIC FACTORS			
Education	High school graduation	EDFacts	2017-2018
	Disconnected youth	American Community Survey, 5-year estimates	2015-2019
	Reading scores*+	Stanford Education Data Archive	2018
	Math scores*+	Stanford Education Data Archive	2018
Income	Median household income*	Small Area Income and Poverty Estimates	2019
	Children eligible for free or reduced price lunch	National Center for Education Statistics	2018-2019
Family and Social Support	Residential segregation - Black/White	American Community Survey, 5-year estimates	2015-2019
	Residential segregation - non-White/White	American Community Survey, 5-year estimates	2015-2019
Community Safety	Homicides*	National Center for Health Statistics - Mortality Files	2013-2019
	Suicides*	National Center for Health Statistics - Mortality Files	2015-2019
	Firearm fatalities*	National Center for Health Statistics - Mortality Files	2015-2019
	Juvenile arrests+	Easy Access to State and County Juvenile Court Case Counts	2018
PHYSICAL ENVIRONMENT			
Housing and Transit	Traffic volume	EJSCREEN: Environmental Justice Screening and Mapping Tool	2019
	Homeownership	American Community Survey, 5-year estimates	2015-2019
	Severe housing cost burden	American Community Survey, 5-year estimates	2015-2019
	Broadband access	American Community Survey, 5-year estimates	2015-2019

*Indicates subgroup data by race and ethnicity is available

+ Not available in all states

See additional contextual demographic information and measures online at www.countyhealthrankings.org

Technical Notes

How are race and ethnicity categories defined?

Race and ethnicity are different forms of identity but are sometimes categorized in non-exclusive ways. Race is a form of identity constructed by our society to give meaning to different groupings of observable physical traits. An individual may identify with more than one race group. Ethnicity is used to group individuals according to shared cultural elements. Racial and ethnic categorizations relate to health because our society sorts groups of individuals based on perceived identities. These categorizations have meaning because of social and political factors, including systems of power such as racism. Examining the variation among racial and ethnic groupings in health factors and outcomes is key to understanding and addressing historical and current context that underlie these differences.

Data sources differ in methods for defining and grouping race and ethnicity categories. To incorporate as much information as possible in our summaries, County Health Rankings & Roadmaps (CHR&R) race/ethnicity categories vary by data source. With a few exceptions, CHR&R adheres to the following nomenclature originally defined by The Office of Management and Budget (OMB):

American Indian & Alaska Native (AIAN): includes people who identify as American Indian or Alaska Native and do not identify as Hispanic.
Asian: includes people who identify as Asian or Pacific Islander and do not identify as Hispanic.
Black: includes people who identify as Black or African American and do not identify as Hispanic.
Hispanic: includes people who identify as Mexican, Puerto Rican, Cuban, Central or South American, other Hispanic, or Hispanic of unknown origin.
White: includes people who identify as White and do not identify as Hispanic.

Note:

- Racial and ethnic categorization masks variation within groups.
- Individuals may identify with multiple races, indicating that none of the offered categories reflect their identity; these individuals are not included in our summaries.
- OMB categories have limitations and have changed over time, reflecting the importance of attending to contemporary racialization as a principle for examining approaches to measurement.
- For some data sources, race categories other than White also include people who identify as Hispanic.

Learn More:

The above definitions apply to all measures using data from the National Center for Health Statistics (see Ranked & Additional Measure Sources and Years of Data tables on pages 4 & 5). For this data source, all race/ethnicity categories are exclusive so that each individual fits into only one category.

Other data sources offer slight nuances of the race/ethnicity categories listed above. The American Community Survey (ACS) only provides an exclusive race and ethnicity category for people who identify as non-Hispanic White. An individual who identifies as Hispanic and as Black would be included in both the Hispanic *and* Black race/ethnicity categories. Another difference with ACS data is the separate race categories for people who identify as Asian and people who identify as Hawaiian & Other Pacific Islander. For measures of Children in Poverty and Driving Alone to Work, CHR&R reports a combined estimate for the Asian & Other Pacific Islander categories, while for Median Household Income we only report the Asian race category.

Measures using data from the Center for Medicare and Medicaid Services (Mammography, Preventable Hospital Stays, Flu Vaccinations) follows the ACS categories with the exception of having a combined Asian/Pacific Islander category. For this data source, race and ethnicity are not self-reported.

The Stanford Education Data Archive used for the Reading and Math Scores measures follow the National Center for Education Statistics (NCES) definitions of Asian or Pacific Islander, American Indian & Alaska Native, non-Hispanic Black, non-Hispanic White, and Hispanic.

How do we rank counties?

To calculate the ranks, we first standardize each of the measures using z-scores. Z-scores allow us to combine multiple measures because the measures are now on the same scale. The ranks are then calculated based on weighted sums of the measure z-scores within each state to create an aggregate z-score. The county with the best aggregate z-score (healthiest) gets a rank of #1 for that state. To see more detailed information on rank calculation please visit our methods in **Explore Health Rankings** on our website: www.countyhealthrankings.org.

Appendix 4: Focus Group Questions

UM SRH completed focus group interviews with community residents and partners throughout the region to gain a better understanding of health needs from the perspective of those who live and work in the community.

Focus Group Questions

Question 1: What is your vision for a healthy community?

Share your ideas of a healthy community. What is healthy about your community and what is unhealthy?

Question 2: What is your perception of the most serious health issues facing this community?

What are your specific concerns?

Question 3: What is your perception of the most beneficial health resources or services in this community?

Share specific examples:

Question 4: What is your perception of the hospital overall and of specific programs and services?

Identify opportunities for improving current programs and services, as well as highlight service and program gaps.

Question 5: What is your perception of the physician and medical services?

Identify opportunities for improving current medical services, as well as high- light service gaps.

Question 6: What can the hospital do to improve health and quality of life in the community?

Share ideas for how to improve services and relationships in the community and provide direction for new activities or strategies.

Adapted from: Rural Health Works, Retrieved from http://ruralhealthworks.org/wp-content/files/2a-MSTR-CHNA-Template-APPs-F-J-

DO YOU LIVE ON THE MID SHORE?

Take part in an online focus group to talk about the health of your community. What are the needs? What could be done to make things better? Your thoughts matter!

DORCHESTER March 1, 10-11:30 AM
TALBOT March 1, 1-2:30 PM
KENT March 2, 10-11:30 AM
QUEEN ANNE'S March 2, 1-2:30 PM
CAROLINE, March 3, 10-11:30 AM

$25 gift cards for participation. Space is limited.
Call Hayden Rhodes to reserve your spot.
410-778-2533

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

MID SHORE
HEALTH IMPROVEMENT COALITION

Facilitaors, Organizers

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Jeanette Jeffrey	Health Educator, Rural Health Care Transformation University of Maryland Shore Regional Health
Nicole Morris	Lead, Mid Shore LHIC Director, KCHD Chronic Disease Public Information Officer, KCHD
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Participants

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Appendix - 5

Prioritization Process

Analysis of the qualitative community data revealed a list of pressing health needs. The next step is to prioritize needs that will be the focus of our community health improvement initiatives. A widely used and referenced quantitative tool (The Hanlon method) was chosen to rank the health-related needs based on select weighted criteria. This method allows for comparison of community defined needs in a relative framework, as equally as possible, and in a somewhat objective manner.

Step 1
Stakeholders receive initial list of community defined needs

Step 2
Local Health Improvement Coalition engages in a group prioritization activity to select priorities-
**Community stakeholders rank community needs individually using set criteria*

Step 3
Results will be used to prioritize needs that will be the focus of our community health improvement plan

Prioritization Criteria

Organizational capacity – Community has the capacity to address the issue.
Existing collaboration – there are established relationships with community partners to address the issue and existing resources are committed to the issue.

Health Need* (A)	Importance to community* (B) weight 45%	Capacity to address (C) weight 30%	Existing collaboration/ interventions (D) weight 25%	Final Score (E) Max=100
Score each criterion 0 (very low agreement) to 10 (very strong agreement)				
Access to care	10			Leave blank-Will be calculated
Chronic disease conditions	9			Leave blank-Will be calculated
Transportation	9			Leave blank-Will be calculated
Mental health/ substance abuse	10			Leave blank-Will be calculated
Care coordination	9			Leave blank-Will be calculated
Overweight/obesity	9			Leave blank-Will be calculated
Preventive/wellness programs	10			Leave blank-Will be calculated
Smoking	9			Leave blank-Will be calculated
Cancer	9			Leave blank-Will be calculated

*These two columns (A and B) are populated in accordance with the qualitative analysis findings.

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LHIC Attendees for April 19, 2022

1. Jim Barey
2. Cheryl Bush
3. Robin Cahall
4. Melanie Chapple
5. Joseph Ciotola
6. Ashley Clark
7. Amy Crooks
8. Jessica Denny
9. Ashyrra Dotson
10. Lynne Duncan
11. Stacy Ewing
12. Rya Griffis
13. Angela Grove
14. Vandrick Hamlin
15. Roger Harrell
16. Ulric Hetsberger
17. Kirk Howie
18. Jeanette Jeffrey
19. Tina Jones
20. Sue Lachenmayr
21. Nicole Leonard
22. Patty Linder
23. Leigh Marquess
24. Carol Masden
25. Kathryn McGrath
26. Amethyst McNabb
27. Lisa Middleton
28. Michelle Morgan
29. Nicole Morris
30. Vicki Petro
31. Hayden Rhodes
32. Isabel Robinson
33. Wayne Sanctifier
34. Shelley Stone
35. Cande Vasquez
36. Tara Wampler
37. William Webb
38. Savannah Winston
39. Lynette Wongus
40. Sarah Worm
41. Brittany Young

Appendix 6: Community Health Planning Leadership

- Arvin Singh –Vice President, Strategic Planning & Communications
- Kathleen McGrath – Director of Community Health & Outreach
- William Huffner, MD – Chief Medical Officer
- L. J. Pezor, MD – Medical Director Shore Behavioral Health
- Walter Atha, MD – Regional Director of Emergency Medicine
- Pamela Addy – Vice President of Clinical and Ambulatory Services
- Timothy Shanahan, DO – Medical Director University of Maryland Shore Medical Group
- Jeanie Scott, – Director of Oncology Services
- Lakshmi Vaidyanathan, MD, MBA, –Medical Director Shore Regional Palliative Care Program Population Health
- Nannette Bedell, RN – Director, Population Health
- Erica Jordan, RN, – Population Health Operations Manager
- Patricia Thompson, RN – Director of Behavioral Health Services
- Dennis Welsh – Vice President Rural Healthcare Transformation, Executive Director UM SMC
- Lara D. Wilson, Director, Rural Health Care Transformation
- Anna D'Acunzi – Director, Financial Decision Support
- Trena Williamson– Regional Director, Communications and Marketing

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UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Community Health Implementation Plan, FY2023-FY2025

The Community Health Implementation Plan (CHIP) is a list of specific goals and strategies that demonstrate how UM SRH plans to address the most significant needs identified in the CHNA while also being aligned with UMMS community health improvement initiatives and national, state and local public health priorities.

Our Annual Operating Plan, which is derived from our strategic plan, includes community benefit and population health improvement activities.

Based on qualitative and quantitative data collected and analyzed during the CHNA process, UM SRH's Implementation Plan remains committed to the goals and strategies identified in the FY2020-FY2022 CNHA. Although some of the focus areas have changed in their order of priority per community feedback, the overall needs remain the same as reported in the previous CHNA.

Health Priorities FY2023-2025

The top five priorities:

1. Mental health/substance abuse
2. Access to care
3. Chronic Disease management
4. Preventive/wellness programs
5. Cancer

Overarching theme for addressing health priorities:

1. Reduce barriers to care
2. Improve care coordination
3. Focus on health outreach and education

UM SRH is engaged in numerous programs addressing the identified needs of the Mid-Shore. The UM SRH hospitals work to strategically allocate scarce resources to best serve the communities, increase trust and build stronger community partnerships.

The CHIP items which follow provide action plan strategies and examples of ongoing initiatives that address the identified needs. Strategies emphasize clinical and community partnership development and improved coordination of care. All identified key community needs are addressed either directly through designation as a prioritized key community need or incorporated as a component of a prioritized key community need.

HEALTH NEED 1: BEHAVIORAL HEALTH			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Improve access and integration/ coordination of intensive mental health and substance abuse services	**Strategy 1**: Provide access to acute inpatient and Intensive Outpatient services for mental health and substance use disorders including prevention and support services	• Number of referrals to the Intensive Outpatient programs. Both the mental health and Substance abuse programs • Number of adults admitted to inpatient services	• All Mid-Shore Mental Health Agencies • Local Health Departments • Local Emergency and Primary Care practices
	Strategy 2: Expand program(s) to support Primary Care patients waiting for outpatient mental health and/or substance use disorder treatment	• Number of referrals from primary care providers • Length of time to first mental health or substance abuse appointment • Number of Primary Care sites with co-located mental health services • Develop Urgent Care Services	• Community Behavioral Health • Local Mid-Shore Community Mental Health partners
	Strategy 3: Improve care coordination for mental health and substance abuse co-occurring conditions through facilitation of "direct hand-offs" in Emergency Departments and Primary Care Offices to the next level of care	• Number of patients referred between systems • Number of Inpatient readmissions • Number of Emergency room visits	• Local Emergency Departments • Primary Care Practices • Local Health Departments • Corsica River Behavioral Health • Community Behavioral Health • ACT Team
Opioids- Improve overdose mortality Statewide Integrated Health Improvement Strategy (SIHIS) goal	**Strategy 4:** • Expand screening, brief intervention, and referral to treatment (SBIRT) and buprenorphine induction in the Emergency Department and Substance Abuse IOP. • Distribute Naloxone to patients who receive treatment in the emergency department (ED) for a non-fatal overdose. • Connect with Regional Partnership on plans to expand behavioral health crisis infrastructure in the community	• Number of patients screened who presented to ED • Number/% of overdose patients presenting to the ED with intensive community peer support • Number of medication initiated encounter for opioid-using patients presenting to the ED • Number of patients linked to treatment after community peer engagement • Number of patients linked to MOUD induction in the ED to MOUD treatment same or next day after discharge	• Regional Opioid Taskforce • All Mid-Shore Local Addiction Authorities

EXAMPLE INITIATIVES:

Maryland Department of Health -Reverse the Cycle (RTC) program

Comprehensive hospital substance use response program RTC includes:

- Universal screening and peer intervention
- Overdose survivors outreach
- Medication initiation

Co-Location of Mental Health Services in Primary Care Clinics

"Warm handoff" to community resources from the inpatient unit

- Care Connections
- Community Behavioral Health
- Lower Shore ASCT team

Regional Opioid Task Force: The task force — which includes representatives of county health departments and emergency services, and emergency and behavioral health physicians and nurses, and hospital officials — is led by Dr. Walter Atha, regional director of emergency medicine for UM Shore Regional Health, and Dorchester County Health Officer Roger Harrell. The task force is working to coordinate and standardize the medical community's response among Mid-Shore counties tackling the heroin and opioid epidemic

HEALTH NEED 2: ACCESS TO CARE			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Improve access to care for medically underserved and vulnerable groups of all ages	**Strategy 1**: Increase capacity by addressing the recruitment, retention, accessibility, competency of providers	• Medical Staff assessment-identify shortages • Provide/fund physician subsidies to meet identified community needs • Establish physician/resident training programs	• University of Maryland School of Medicine and UMMC • AHEC • Choptank FQHC
	Strategy 2: Enhance and Expand Telemedicine Opportunities	• Increase total consults • Identify and implement new consult services: Neurology subspecialties	• Within SRH and its physicians • University of Maryland Medical Center and UM SOM/FPI
	Strategy 3: Reduce transportation barriers and enhance awareness of available services	• Number of transportation vouchers • Resource information distribution	• DCT and Queen Anne's County Ride cover Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties
	Strategy 4: Connect uninsured to private insurance, Medicaid, or other available coverage	• Number of insured residents	• County Medicaid offices through SRH Case Management

EXAMPLE INITIATIVES:

Recruit additional health care providers and specialists to the region to address access barriers identified by the community. Provide subsidies as a means to increase the availability of health care providers in order to best meet identified patient and community needs related to the availability of health care services.

Telehealth services Expand existing programs to outlying facilities as much as possible, increase both the number of specialties providing telehealth consultations and the number of telehealth consultations.

Transportation- Work to mitigate transportation barrier by assisting/arranging transportation for patients to travel to medical appointments

Uninsured/underinsured care -Inform patients and family members of UM SRH Financial Assistance Policy, assist with application for financial assistance, and provide financial assistance to eligible patients. Work with patients to determine eligibility for medical assistance, e.g. Medicaid, and other social services.

HEALTH NEED 3: Chronic Disease			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Prevent, detect, and manage chronic diseases	**Strategy 1**: Work with community organizations, congregational networks, and individuals to improve care, management and prevention of chronic diseases	• Number of health education/outreach encounters provided to community-based organizations and churches • Number of participants in health events and number of screenings performed • Number of outreach programs	• Health Departments • Faith based organizations • Homeports • Department(s) of Aging • YMCA • Area Schools
	Strategy 2: Screen for barriers/social needs of patients with chronic conditions during transitions to improve ability of patient to manage condition	• Increased transition support available to patients with chronic disease • Number of patients connected to services addressing social needs	• Home care providers • Faith based organizations • Department(s) of Social Services • Pharmacies • Meals on Wheels • Mobile Integrated Community Health
	Strategy 3: Provide specialized health information, "physician to physician" education regarding diabetes treatment and management.	• Number of provider outreach education sessions for primary care offices and medical staff	• Community providers

INITIATIVES:

Outreach: Education, screenings and support groups offered on the following topics/conditions: high blood pressure and heart disease; diabetes; cancer, stroke; hospice services and palliative care; obesity, exercise and nutrition; depression and anxiety

Chronic Disease: To address chronic disease-related emergency department visits, The Transitional Nurse Navigator (TNN) Program provides continued care coordination for high-risk patients from the beginning of their hospital stay through up to 30-days after discharge. The scope of the discharge planning process has been expanded to include the broader, holistic needs of patients. Caseworkers and transitional nurse navigators help patients anticipate what their care needs will be in their home environment, connect with the patient's primary care provider to ensure proper follow-up, and provide links to needed community resources offering services such as transportation, home care, meals, home technologies and social support.

Food Distribution: Through grant funding, support Maryland Food Bank, Eastern Shore Mobile Pantry

Physician Outreach: Provide education to community physicians who manage patients with complex chronic conditions

HEALTH NEED 4: Preventive/wellness programs			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Health Promotion and Wellness Services strives to support inclusive, accessible, and diverse health and wellness opportunities.	**Strategy 1**: • Provide classes, program, speakers, events to improve health & wellness • Expand diabetes/pre-diabetes educational classes- State Diabetes Action Plan • Develop an annual calendar of events, screening and support groups sponsored by UM SRH, and community partners • Support Upper Shore Aging education programs for seniors and caregivers • Provide education specialist(s) needed to support wellness programing	• Number of classes offered • Number of attendees who participate	• Health Departments • Upper Shore Aging • YMCA • U of Md Extension
	Strategy 2: Health Literacy • Promote monthly "Community Conversation" - discussion with UMMS experts to learn more about a health topic and how to avoid/manage a medical condition. • Promote existing public library programs that enhance learning	• Number of events offered • Number of attendees	• University of Maryland Medical System • Local Libraries

	Strategy 3: Improve care coordination, info sharing protocols to achieve safer, more effective care	• Protocols developed • Educational materials standardized across setting. • % of educational materials available in Spanish	Health Departments

EXAMPLE INITIATIVES:

Education/Awareness: Cosponsor the series "Not All Wounds Are Visible": *A Community Conversation* and "Let's Talk About Health". The community events are facilitated by University of Maryland Medical System and the University of Maryland, Baltimore– to help community members engage with experts and gain valuable tools on how to lead a healthy life - mentally and physically.

Educational topics include:

Diabetes, Stroke, Heart Education Programs

- Education Series
- Support Groups
- Radio Broadcasts
- Heart Wellness Newsletter and Presentations
- Stroke Education/Presentations

- How to understand Medicare, Medicaid and commercial health insurance plan benefits (e.g. copays, coinsurance, in and out of network providers)
- How to choose where to see health care services (e.g. primary care, urgent care, Emergency Department)
- How to access community resources that can help prevent and manage chronic conditions

HEALTH NEED 5: Cancer			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Reduce cancer mortality rate	**Strategy 1**: Provide increased and improved screening and prevention services for breast, skin, prostate and colorectal cancer and evaluate adding cervical screening.	• Number of health education/outreach encounters provided to community • Number of participants in health events and number of screenings performed • Number of outreach programs	• University of Maryland Medical Center • County Health Departments • Specialty practices
	Strategy 2: Continue to educate the community about Lung Cancer Screening Program and support programming to reduce use of tobacco products	• Earlier detection of lung cancer • Improve survival rates • Work with Talbot County HD to develop a formal pathway for smoking cessation.	• County Health Departments • Community Providers

ACTIVITIES/INITIATIVES:

WELLNESS FOR WOMEN ACCESS TO CARE PROGRAM

The program serves as a point of access into care for age and risk specific mammography screening, clinical breast exam, and genetic testing for breast cancer.

Offers **no cost mammograms** to eligible women: those under the age of 40 and over 65 who have no insurance. Those women needing further diagnostic tests or who need treatment for breast cancer are enrolled in the State of Maryland Diagnosis and Treatment Program through the case manager.

LUNG CANCER EARLY SCREENING PROGRAM

The low dose computed tomography (LDCT) screening program promotes earlier detection of lung cancer. Eligible patients are the high-risk groups which include those who have smoked a pack of cigarettes daily for two or three decades, who are currently smokers, or those who quit smoking less than 15 years ago to have them screening for lung cancer. Earlier detection promotes better treatment and survival rates.

ANNUAL PROSTATE SCREENING

Public screening for males who are $\geq$ 40 years of age for a baseline screening, African American men, men with a family history of disease, and males > 55-74 for yearly screening.

UNIVERSITY of MARYLAND MEDICAL SYSTEM **Central Business Office**	**PAGE:** **1 OF 14**	**POLICY NO:** **CBO - 01**
	EFFECTIVE DATE: 09/18/19	**REVISION DATE(S):** 10/19/2020
SUBJECT: Financial Assistance		

KEY WORDS: Financial Assistance

OBJECTIVE/BACKGROUND:

The University of Maryland Medical System ("UMMS") is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

APPLICABILITY:

PROGRAM ELIGIBILITY

Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Specific exclusions to coverage under the Financial Assistance Program:

The Financial Assistance Program generally applies to all emergency and other medically necessary care provided by each UMMS hospital; however, the Financial Assistance Program does not apply to any of the following:

1. Services provided by healthcare providers not affiliated with UMMS hospitals (e.g., durable medical equipment, home health services).
2. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, or Workers Compensation), are not eligible for the Financial Assistance Program.
   a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.

3. Cosmetic or other non-medically necessary services.
4. Patient convenience items.
5. Patient meals and lodging.
6. Physician charges related to the date of service are excluded from this UMMS financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.
   a. A list of providers, other than the UMMS hospital itself, delivering medically necessary care in each UMMS hospital that specifies which such as providers are not covered by this policy (as well as certain such providers that are covered) may be obtained on the website of each UMMS Entity.

Patients may be ineligible for Financial Assistance for the following reasons:

1. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Medical Center due to insurance plan restrictions/limits.
2. Refusal to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.
3. Refusal to divulge information pertaining to a pending legal liability claim.
4. Foreign-nationals traveling to the United States seeking elective, non-emergent medical care.

Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

Unless they meet Presumptive Financial Assistance Eligibility criteria, patients shall be required to submit a complete Financial Assistance Application (with all required information and documentation) and determined to be eligible for financial assistance in order to obtain financial assistance. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application before receiving non-emergency medical care unless they meet Presumptive Financial Assistance Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

Those with income up to 200% of Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care ("MD DHMH") are eligible for free care. Those between 200% to 300% of MD DHMH are eligible for discounts on a sliding scale, as set forth in Attachment A.

Presumptive Financial Assistance

Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage
b. Specified Low Income Medicare (SLMB) coverage
c. Primary Adult Care (PAC) coverage
d. Homelessness
e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
f. Medical Assistance spend down amounts
g. Eligibility for other state or local assistance programs
h. Patient is deceased with no known estate
i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
j. Non-US Citizens deemed non-compliant
k. Non-Eligible Medical Assistance services for Medical Assistance eligible patients
l. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)

m. Bankruptcy, by law, as mandated by the federal courts
n. St. Clare Outreach Program eligible patients
o. UMSJMC Maternity Program eligible patients
p. UMSJMC Hernia Program eligible patients

Specific services or criteria that are ineligible for Presumptive Financial Assistance include:

a. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

POLICY:

This policy was approved by the UMMS Executive Compliance Committee (ECC) Board on October 19, 2020. This policy applies to the following hospital facilities of the University of Maryland Medical System ("UMMS hospitals"):

- University of Maryland Medical Center (UMMC)
- University of Maryland Medical Center Midtown Campus (MTC)
- University of Maryland Rehabilitation & Orthopaedic Institute (UMROI)
- University of Maryland St. Joseph Medical Center (UMSJMC)
- University of Maryland Baltimore Washington Medical Center (UMBWMC)
- University of Maryland Shore Medical Center at Chestertown (UMSMCC)
- University of Maryland Shore Medical Center at Dorchester (UMSMCD)
- University of Maryland Shore Medical Center at Easton (UMSME)
- University of Maryland Charles Regional Medical Center (UMCRMC)
- University of Maryland Upper Chesapeake Health (UCHS)
- University of Maryland Capital Region Health (UM Capital)

It is the policy of the UMMS hospitals to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications.

UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any) and admissions areas, as well as the Billing Office. Notice of availability will also be sent to the patient with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge, and it (along with this policy and the Financial Assistance Application) will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas. This policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency.

UMMS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, applications to the Financial Clearance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

This policy was adopted for University of Maryland St. Joseph Medical Center (UMSJMC) effective June 1, 2013.

This policy was adopted for University of Maryland Medical Center Midtown Campus (MTC) effective September 22, 2014.

This policy was adopted for University of Maryland Baltimore Washington Medical Center (UMBWMC) effective July 1, 2016.

This policy was adopted for University of Maryland Shore Medical Center at Chestertown (UMSMCC) effective September 1, 2017.

This policy was adopted for University of Maryland Shore Medical Center at Dorchester (UMSMCD) effective September 1, 2017.

This policy was adopted for University of Maryland Shore Medical Center at Easton (UMSMCE) effective September 1, 2017.

This policy was adopted for University of Maryland Charles Regional Medical Center (UMCRMC) effective December 2, 2018.

This policy was adopted for University of Maryland Upper Chesapeake Health (UCHS) effective July 1, 2019

This policy was adopted for University of Maryland Capital Region Health (UM Capital) effective September 18, 2019

PROCEDURE:

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.

2. When possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial

assistance. Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both.

d. If a patient submits a Financial Assistance Application without the information or documentation required for a final determination of eligibility, a written request for the missing information or documentation will be sent to the patient. This written request will also contain the contact information (including telephone number and physical location) of the office or department that can provide information about the Financial Assistance Program and assistance with the application process.
e. The patient will have thirty (30) days from the date this written request is provided to submit the required information or documentation to be considered for eligibility. If no data is received within the 30 days, a letter will be sent notifying the patient that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case by submitting the missing information or documentation 30 days after the date of the written request for missing information/documentation.
f. For any episode of care, the Financial Assistance Application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.
g. Individual notice regarding the hospital's Financial Assistance Policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

3. There will be one application process for UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital. The patient is required to provide a completed Financial Assistance Application orally or in writing. In addition, the following may be required:
   a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...
   b. A copy of their most recent pay stubs (if employed) or other evidence of income.
   c. A Medical Assistance Notice of Determination (if applicable).
   d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.

If a patient submits both a copy of their most recent Federal Income Tax Return and a copy of their most recent pay stubs (or other evidence of income), and only one of the two documents indicates eligibility for financial assistance, the most recent document will dictate eligibility. Oral submission of needed information will be accepted, where appropriate.

4. In addition to qualifying for Financial Assistance based on income, a patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses based on the Financial Hardship criteria discussed below. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.
    a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.
        i. If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
        ii. If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
            1. A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.

5. Once a patient is approved for Financial Assistance, Financial Assistance coverage is effective for the month of determination and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Assistance eligibility period further into the past or the future on a case-by-case basis. If additional healthcare services are provided beyond the eligibility period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

6. Account balances that have not been paid may be transferred to Bad Debt (deemed uncompensated care) and referred to an outside collection agency or to the UMMS hospital's attorney for legal and/or collection activity. Collection activities taken on behalf of the hospital by a collection agency or the hospital's attorney may include the following Extraordinary Collection Actions (ECAs):
    a. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.
    b. Commencing a civil action against the individual.

c. Placing a lien on an individual's property. A lien will be placed by the Court on primary residences within Baltimore City. The hospital will not pursue foreclosure of a primary residence but my maintain its position as a secured creditor if a property is otherwise foreclosed upon.
d. Attaching or seizing an individual's bank account or any other personal property.
e. Garnishing an individual's wage.

7. ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 120 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 30 days prior to commencement of the ECA. This written notice will indicate that financial assistance is available for eligible individuals, identify the ECAs that the hospital (or its collection agency, attorney, or other authorized party) intends to obtain payment for the care, and state a deadline after which such ECAs may be initiated. It will also include a Patient Billing and Financial Assistance Information Sheet. In addition, the hospital will make reasonable efforts to orally communicate the availability of financial assistance to the patient and tell the patient how he or she may obtain assistance with the application process. A presumptive eligibility review will occur prior to any ECA being taken. Finally, no ECA will be initiated until approval has been obtained from the CBO Revenue Cycle. UMMS will not engage in the following ECAs:
    a. Selling debt to another party.

    b. Charge interest on bills incurred by patients before a court judgement is obtained

8. If prior to receiving a service, a patient is determined to be ineligible for financial assistance for that service, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

9. A letter of final determination will be submitted to each patient who has formally submitted an application. The letter will notify the patient in writing of the eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for the determination. If the patient is determined to be eligible for assistance other than free care, the patient will also be provided with a billing statement that indicates the amount the patient owes for the care after financial assistance is applied.

10. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds will be issued back to the patient for credit balances, due to patient payments, resulting from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.

11. If a patient is determined to be eligible for financial assistance, the hospital (and/or its collection agency or attorney) will take all reasonably available measures to reverse any ECAs taken against the patient to obtain payment for care rendered during the financial assistance eligibility window. Such reasonably available measures will include measures to vacate any judgment against the patient, lift levies or liens on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

12. Patients who have access to other medical coverage (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.

13. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.

14. The Financial Assistance Program will accept all other UMMS hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.

15. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.

16. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.

a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

Financial Hardship

The amount of uninsured medical costs incurred at either, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital will be considered in determining a patient's eligibility for the Financial Assistance Program. The following guidelines are outlined as a separate, supplemental determination of Financial Assistance, known as Financial Hardship. Financial Hardship will be offered to all patients who apply for Financial Assistance and are determined to be eligible.

Medical Financial Hardship Assistance is available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy, but for whom:

1. Their medical debt incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship.

For the patients who are eligible for both, the Reduced Cost Care under the primary Financial Assistance criteria and also under the Financial Hardship Assistance criteria, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital will grant the reduction in charges, which is balance owed that is greater than 25% of the total annual household income.

Financial Hardship is defined as facility charges incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.

Medical Debt is defined as out of pocket expenses for the facility charges incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and/or UM Capital for medically necessary treatment.

Once a patient is approved for Financial Hardship Assistance, coverage will be effective for the month of the first qualifying date of service and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Hardship eligibility period further into the past or the future on a case-by-case basis according to their spell of illness/episode of care. It will cover the patient and the eligible family members living in the household for the approved reduced cost and eligibility period for medically necessary care.

All other eligibility, ineligibility, and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance criteria, unless otherwise stated above.

Appeals

- Patients whose financial assistance applications are denied have the option to appeal the decision.
- Appeals can be initiated verbally or written.
- Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
- Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.
- If the first level of appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
- The escalation can progress up to the Chief Financial Officer who will render a final decision.
- A letter of final determination will be submitted to each patient who has formally submitted an appeal.

ATTACHMENTS:

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

2021 Federal Poverty Limits (FPL) and Maryland Dept of Health & Mental Hygiene (DHMH) Annual Income Eligibility Limit Guidelines			UMMS 100% Charity	UMMS 90% Charity	UMMS 80% Charity	UMMS 70% Charity	UMMS 60% Charity	UMMS 50% Charity	UMMS 40% Charity	UMMS 30% Charity	UMMS 20% Charity	UMMS 10% Charity
			Equals Up to 200% of MD DHMH Annual Income limits	Equals Up to 210% of MD DHMH Annual Income limits	Equals Up to 220% of MD DHMH Annual Income limits	Equals Up to 230% of MD DHMH Annual Income limits	Equals Up to 240% of MD DHMH Annual Income limits	Equals Up to 250% of MD DHMH Annual Income limits	Equals Up to 260% of MD DHMH Annual Income limits	Equals Up to 270% of MD DHMH Annual Income limits	Equals Up to 280% of MD DHMH Annual Income limits	Equals Up to 290% of MD DHMH Annual Income limits
House-hold (HH) Size	2021 FPL Annual Income Elig Limits	2021 MD DHMH Annual Income Elig Limits	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:
Size	Up to	Up to	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max
1	12,760	**$17,785**	$35,570	$37,349	$39,127	$40,906	$42,684	$44,463	$46,241	$48,020	$49,798	$53,354
2	17,240	**$24,045**	$48,090	$50,495	$52,899	$55,304	$57,708	$60,113	$62,517	$64,922	$67,326	$72,134
3	21,720	**$30,305**	$60,610	$63,641	$66,671	$69,702	$72,732	$75,763	$78,793	$81,824	$84,854	$90,914
4	26,200	**$36,581**	$73,162	$76,820	$80,478	$84,136	$87,794	$91,453	$95,111	$98,769	$102,427	$109,742
5	31,800	**$42,841**	$85,682	$89,966	$94,250	$98,534	$102,818	$107,103	$111,387	$115,671	$119,955	$128,522
6	37,400	**$49,100**	$98,200	$103,110	$108,020	$112,930	$117,840	$122,750	$127,660	$132,570	$137,480	$147,299

*All discounts stated above shall be applied to the amount the patient is personally responsible for paying after insurance reimbursements.

*Amounts billed to patients who qualify for Reduced-Cost of Care on a sliding scale (or for Financial Hardship Assistance) will be less than the amounts generally billed to those with insurance (AGB), which in Maryland is the charge established by the Health Services Cost Review Commission (HSCRC). UMMS determines AGB by using the amount Medicare would allow for the care (including the amount the beneficiary would be personally responsible for paying, which is the HSCRC amount; this is known as the "prospective Medicare method".

Effective 7/1/21

POLICY OWNER:

UMMS CBO

APPROVED:

Executive Compliance Committee Approved Initial Policy: 09/18/19
Executive Compliance Committee Approved Revisions: 10/19/2020

From: Hilltop HCB Help Account
To: Mcgrath, Kathleen; Hilltop HCB Help Account
Subject: RE: Clarification Required - FY 22 UM Shore Regional Health Narrative
Date: Tuesday, March 14, 2023 3:06:19 PM

Thank you for writing. We cannot reopen your existing report, unfortunately. Instead we have prepared a supplemental survey containing only the questions regarding physician subsidies. Please use this link to provide your clarifying response:
https://umbc.co1.qualtrics.com/jfe/form/SV_2oan2McxDZ3HXYW?Q_CHL=gl&Q_DL=EMD_3hwBLODPYv40qqQ_2oan2McxDZ3HXYW_CGC_YdyYBV7aLB1sJeP&_g_=g

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From: Mcgrath, Kathleen <kfmcgrath@umm.edu>
Sent: Tuesday, March 14, 2023 2:22 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: RE: Clarification Required - FY 22 UM Shore Regional Health Narrative

Good afternoon,

I have revisions to make to the narrative in response to the questions below. Can you send me a link to the survey to enter revisions/clarifications that will align the narrative to financial sheets.

Thanks,

Kathleen McGrath
Director of Outreach and Community Health at UM Shore Regional Health
University of Maryland Medical System
410-822-1000 ext.5885
kfmcgrath@umm.edu

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From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Monday, March 6, 2023 4:19 PM
To: Mcgrath, Kathleen <kfmcgrath@umm.edu>; optimaloutcomesmd@gmail.com
Cc: adacunzi@umm.edu; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: Clarification Required - FY 22 UM Shore Regional Health Narrative

Thank you for submitting the FY 2022 Hospital Community Benefit Narrative report for UM Shore

Regional Health. In reviewing the narrative, we encountered several discrepancies between the physician subsidies in the financial and narrative reports (the two reports should align). Please clarify the following:

- The following entries were only present on the financial sheets, or it was unclear which subsidy indicated on the narrative survey corresponds to the program/specialty in question:
    - Nephrology
    - Hospitalist
    - Physicians on call
- The specialty "Neurology" was only present on the narrative survey (Question 79, pp 16-17), or it was unclear which subsidy indicated on the financial sheet corresponds to it.
- On the narrative survey, "Physician Recruitment to Meet Community Need" was selected under the "Why type of subsidy?" column for nearly all the subsidies indicated. However, the entries on the financial sheets identify the subsidy type for most entries as "Non-Resident House Staff and Hospitalists.

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

Q77. Section IV - Physician Gaps & Subsidies

Q78. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ○ No
- ◉ Yes

Q79. 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	◉	○	Non-resident house staff and hospitalists
Cardiology	◉	○	Non-resident house staff and hospitalists
Dermatology	○	◉	
Emergency Medicine	◉	○	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	◉	○	Non-resident house staff and hospitalists
Family Practice/General Practice	◉	○	Non-resident house staff and hospitalists
Geriatrics	○	◉	
Internal Medicine	○	◉	
Medical Genetics	○	◉	
Neurological Surgery	○	◉	
Neurology	○	◉	
Obstetrics & Gynecology	◉	○	Non-resident house staff and hospitalists
Oncology-Cancer	◉	○	Non-resident house staff and hospitalists
Ophthalmology	○	◉	
Orthopedics	○	◉	
Otolaryngology	◉	○	Non-resident house staff and hospitalists
Pathology	○	◉	
Pediatrics	◉	○	Non-resident house staff and hospitalists
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	○	◉	
Psychiatry	◉	○	Non-resident house staff and hospitalists
Radiology	○	◉	
Surgery	◉	○	Non-resident house staff and hospitalists

Urology	◉	○	Non-resident house staff and hospitalists
Other. (Describe) Digestive Health, Pulmonary Care, Acute Rehab, Wound Care, PalliativeNephrology, Physicians on call, Hospitalist	◉	○	Non-resident house staff and hospitalists

Q80. 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.

For residents of the five counties of the mid-shore, Access to Care has consistently been a top priority identified in the Community Health Needs Assessment (CHNA). The challenges to access care due to availability of primary care and specialty physicians is well documented in the white paper, UNDERSTANDING AND ADDRESSING THE NEEDS OF MARYLAND'S VULNERABLE RURAL HOSPITALS AND THEIR COMMUNITIES. The number and availability of physicians and Advanced Practice Providers (APPs, including nurse practitioners, physician assistants, midwives) whose practices are open to new patients and/or who have reasonable wait times to schedule such care have a profound impact on the health of the population served by UM SRH. To address Access to Care and as part of our ongoing strategic planning process and Community Health Implementation Plan (CHIP), UM SRH regularly evaluates the supply/demand and need for additional physicians and succession planning. UM SRH is the primary provider of specialty and emergency services within the midshore. In 2020, a consultant group was engaged to create a Medical Staff Development Plan; identifying gaps in physicians and physician specialties for our service area. The plan is based on service area profiles, access, medical market profiles, physician interviews, and community needs assessment. UM SRH developed a detailed recruitment/retention and succession action plan. The plan has identified the following needs and is actively engaged in recruitment and retention efforts for the following specialties; Neurology, Otolaryngology, Primary Care, Psychiatry, Rheumatology, General Surgery, Endocrinology, Medical oncology, Urology, Gastroenterology, Cardiology, Pulmonology & OBGYN. As a consequence of the challenges outlined above, within UM SRH, investments in hiring and retaining physicians and APPs are on the rise and occurring at a significant cost to the health system.

Q81. Please attach any files containing further information and data justifying physician subsidies at your hospital.

Q91. Summary & Report Submission

Q92.

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.