

COMMUNITY BENEFIT NARRATIVE ATLANTIC GENERAL

FY2017 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

On January 10, 2014, the Center for Medicare and Medicaid Innovation (CMMI) announced its approval of Maryland's historic and groundbreaking proposal to modernize Maryland's all-payer hospital payment system. The model shifts from traditional fee-for-service (FFS) payment towards global budgets and ties growth in per capita hospital spending to growth in the state's overall economy. In addition to meeting aggressive quality targets, the model requires the State to save at least \$330 million in Medicare spending over the next five years. The HSCRC will monitor progress overtime by measuring quality, patient experience, and cost. In addition, measures of overall population health from the State Health Improvement Process (SHIP) measures will also be monitored (see Attachment A).

To succeed in this new environment, hospital organizations will need to work in collaboration with other hospital and community based organizations to increase the impact of their efforts in the communities they serve. It is essential that hospital organizations work with community partners to identify and agree upon the top priority areas, and establish common outcome measures to evaluate the impact of these collaborative initiatives. Alignment of the community benefit operations, activities, and investments with these larger delivery reform efforts such as the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system.

As provided by federal regulation (26 CFR §1.501(r)—3(b)(6)) and for purposes of this report, a **COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)** report is a written document that has been adopted for the hospital facility by the organization's governing body (or an authorized body of the governing body), and includes:

- (A) A definition of the community served by the hospital facility and a description of how the community was determined;
- (B) A description of the process and methods used to conduct the CHNA;
- (C) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;
- (D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant; and prioritizing those significant health needs;
- (E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and
- (F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

Examples of sources of data available to develop a CHNA include, but are not limited to:

- (1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(<http://dhmh.maryland.gov/ship/>);
- (2) the Maryland Chartbook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
- (3) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
- (4) Local Health Departments;
- (5) County Health Rankings & Roadmaps (<http://www.countyhealthrankings.org>);
- (6) Healthy Communities Network (<http://www.healthycommunitiesinstitute.com/index.html>);
- (7) Health Plan ratings from MHCC (<http://mhcc.maryland.gov/hmo>);
- (8) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
- (9) CDC Behavioral Risk Factor Surveillance System (<http://www.cdc.gov/BRFSS>);
- (10) CDC Community Health Status Indicators (<http://www.cdc.gov/communityhealth>);
- (11) Youth Risk Behavior Survey (<http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx>);
- (12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
- (13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
- (14) Survey of community residents;
- (15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (<http://www.cdc.gov/chinav/>); and
- (16) CRISP Reporting Services.

In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the public and adopt an implementation strategy to address health needs identified by the CHNA.

Required by federal regulations, the **IMPLEMENTATION STRATEGY** is a written plan that is adopted by the hospital organization's governing body or by an authorized body thereof, and:

With respect to each significant health need identified through the CHNA, either—

- (i) Describes how the hospital facility plans to address the health need; or
- (ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address it.

HSCRC COMMUNITY BENEFIT REPORTING REQUIREMENTS

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. (For the purposes of this section, “primary services area” means the Maryland postal ZIP code areas from which the first 60 percent of a hospital’s patient discharges originate during the most recent 12-month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).
 - a. Bed Designation – The total number of licensed beds
 - b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
 - c. Primary Service Area (PSA) zip codes;
 - d. Listing of all other Maryland hospitals sharing your PSA;
 - e. The percentage of the hospital’s uninsured patients by county. (Please provide the source for this data, e.g., “review of hospital discharge data”);
 - f. The percentage of the hospital’s patients who are Medicaid recipients. (Please provide the source for this data (e.g., “review of hospital discharge data.”)
 - g. The percentage of the hospital’s patients who are Medicare beneficiaries. (Please provide the source for this data (e.g., “review of hospital discharge data.”)

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area zip codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of the Hospital’s Patients who are Uninsured:	f. Percentage of the Hospital’s Patients who are Medicaid Recipients:	g. Percentage of the Hospital’s Patients who are Medicare beneficiaries
62	3,281	Maryland only 60% patient discharge zip codes 21811 21842 21813 21863 21851 21804 21874 21850 21841 21843 Total top	McCready Memorial Hospital Peninsula Regional Medical Center	Total Self-pay 3,006 patient visits, 2.89% Worcester County Self Pay 1,294 patient visits, 43.08% (Data: Review of AGH patient vol visits) 8.7% Adults lack health insurance in	Medicaid MCO and Medicaid 16.89% (Data: Review of AGH patient vol visits by insurance company)	Medicare MCO and Medicare 48.16% (Data: Review of AGH patient vol visits by insurance company)

		60% patient discharge zip codes 21811 21842 19975 19945 21813 (AGH internal data source patient volumes)		Worcester County 7.7% Total persons lack health insurance in Worcester County (Data: Healthy Communities Institute 2015)		
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2. For purposes of reporting on your community benefit activities, please provide the following information:

- a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):
 - (i) A list of the zip codes included in the organization’s CBSA, and
 - (ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.
 - (iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., individuals with > 3 hospitalizations in the past year). This information may be copied directly from the community definition section of the organization’s federally-required CHNA Report ([26 CFR § 1.501\(r\)-3](#)).

Statistics may be accessed from:

The Maryland State Health Improvement Process (<http://dhmh.maryland.gov/ship/>);

The Maryland Vital Statistics Administration (<http://dhmh.maryland.gov/vsa/Pages/home.aspx>);

The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf);

The Maryland Chart Book of Minority Health and Minority Health Disparities, 2nd Edition (<http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf>);

The Maryland State Department of Education (The Maryland Report Card) (<http://www.mdreportcard.org>) Direct link to data– (<http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA>)

Community Health Status Indicators (<http://wwwn.cdc.gov/communityhealth>)

Table II

Demographic Characteristic	Description	Source
<p>Zip codes included in the organization’s CBSA, indicating which include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.</p>	<p>Zip codes in CBSA, including broader community who benefit from AGH services and programs: 21811 Berlin, MD – Worcester County 21842 Ocean City, MD- Worcester County 21843 Ocean City, MD- Worcester County 19975 Selbyville, DE- Sussex County 21813 Bishopville, MD- Worcester County 21863 Snow Hill, MD- Worcester County 19945 Frankford, DE- Sussex County 19939 Dagsboro, DE- Sussex County 21851 Pocomoke, MD- Worcester County 19970 Ocean View, DE- Sussex County 21850 Pittsville, MD-Wicomico County 21874 Willards, MD- Worcester County 21841Newark, MD- Worcester County 21872 Whaleyville, MD- Worcester County 21801 Salisbury, MD- Wicomico County 19966 Millsboro, DE- Sussex County 21804 Salisbury, MD- Wicomico County 19930 Bethany Beach, DE- Sussex County 21829 Girdletree, MD- Worcester County 19944 Fenwick Island, DE- Sussex County 21849 Parsonsburg, MD- Wicomico County 21862 Showell, MD- Worcester County 23356 Greenbackville, VA- Accomack County 21864 Stockton, MD- Worcester County 23336 Chincoteague Island, VA- Accomack County</p> <p>Atlantic General Hospital’s primary service area is defined as those zip codes that total 90% of patient admissions, emergency or outpatient visits from the residents and/or there is a contiguous geographic relationship. Worcester and Sussex County are rural and underserved area. There is a lack of public transportation making geographic location a factor in defining primary market.</p> <p>CBSA zip codes within Worcester and Sussex County geographical area in which there is an interdependence and belonging: 19939 Dagsboro, DE – Sussex County 19945 Frankford, DE– Sussex County 19975 Selbyville, DE– Sussex County 21811 Berlin, MD – Worcester County 21813 Bishopville, MD -Worcester County 21841Newark, MD– Worcester County 21842 Ocean City, MD– Worcester County 21843 Ocean City, MD– Worcester County 21862Showell, MD– Worcester County 21872Whaleyville, MD– Worcester County 21874 Willards, MD– Worcester County</p>	<p>AGH CBSA Primary/ Secondary market Areas</p> <p>AGH CHNA FY16-FY18 https://www.atlant icgeneral.org/docu ments/Community -Needs- Assessment- FY2016-BOD- apprvd-live- links.pdf AGH CHNA FY16-FY18 https://www.atlant icgeneral.org/docu ments/Community -Needs- Assessment- FY2016-BOD- apprvd-live- links.pdf</p>



Worcester County is the easternmost county located in the U.S. State of Maryland. The county contains the entire length on the state’s Atlantic coastline. It is the home to the popular vacation resort area of Ocean City. The county is approximately 60 miles long. According to the U.S. Census Bureau the county has a total area of 695 square miles which 468.28 square miles of it is land and 221 square miles is water.

Nearly one fourth of the Worcester County residents are over age 65. Our majority of health care claims are Medicare (more than 55%). The over 65 aged population of the county grew 27% between 2000 and 2010.

The largest concentration of the population is in the northern part of the county where the Ocean City resort area is located along with the Berlin/Ocean Pines area. This is a Mecca for retirees, many who divide their time between Maryland and Florida. The population of the resort of Ocean City increases by about 200,000 during the tourist season. Even though there is this area of higher population the entire county is considered rural and is determined to an “underserved” area for healthcare. The needs in the county vary greatly in the southern end from the northern end. Because the largest concentration of the population is in the north that is where the majority of the services are located and public transportation throughout the county is less than adequate.

The Community Health Needs Assessment FY16 is a primary tool used by the Hospital to determine its community benefit priorities, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of our service area. The process for determining the priorities of the Community Outreach programs involves many people inside and outside the organization. The hospital’s strategic initiatives are determined by the Hospital Board of Trustees, the Medical

AGH CHNA
FY16-FY18
<https://www.atlantcgeneral.org/documents/Community-Needs-Assessment-FY2016-BOD-apprvd-live-links.pdf>

US Census
Bureau
AGH CHNA
FY16-FY18
<https://www.atlantcgeneral.org/documents/Community-Needs-Assessment-FY2016-BOD-apprvd-live-links.pdf>

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	<p>Staff and the Leadership of the hospital. Each year those long term initiatives are evaluated and updated with environmental information, such as the most recent Community Needs Assessment. In addition to input from those groups there are two committees that have a part in setting our priorities; they are the Community Benefit Committee and the Healthy Happenings Advisory Board.</p> <p>Vulnerable Populations and Disparities: A closer look at health disparities in the area through the new Healthy Communities tool, which synthesizes data from several primary sources, provides a clear visual representation of many of the strengths and weakness evident in Worcester and Sussex Counties.</p> <p>In Sussex County:</p> <p>Prostate Cancer – Majority Black Male</p> <ul style="list-style-type: none"> Prostate Cancer Incidence by Race/Ethnicity: 214.4 Black male cases /100,000 males compared to 135.8 White male cases /100,000 males Age Adjusted Death Rate due to Prostate Cancer by Race/Ethnicity 48.0 Black male cases /100,000 males compared to 19.0 White male cases /100,000 males <p>Breast Cancer – Majority Black Female</p> <ul style="list-style-type: none"> Age Adjusted Death Rate due to Breast Cancer by Race/Ethnicity 28.0 Black female deaths/100,000 females compared to 19.6 White female deaths/100,000 females <p>Lung and Bronchus Cancer – Majority Males</p> <ul style="list-style-type: none"> Lung and Bronchus Cancer Incidence by Gender 68.0 female cases /100,000 population compared to 84.9 male cases/100,000 population <p>Teens who engage in Regular Physical Activity - Majority Males</p> <ul style="list-style-type: none"> 60.4% males compared to 39.8% females <p>In Worcester County:</p> <p>Adults Unable to Afford to See a Doctor - Majority Black</p> <ul style="list-style-type: none"> 23.3% Black compared to 15.5% White <p>Lung Cancer – Majority Black</p> <ul style="list-style-type: none"> Age-Adjusted Death Rate due to Lung Cancer by Race/Ethnicity 73.8 Black male deaths /100,000 population compared to 57.6 White deaths /100,000 population <p>Colorectal Cancer – Majority Black Male</p> <ul style="list-style-type: none"> Colorectal Cancer Incidence Rate by Gender 46.5 male cases/100,000 population compared to 27.4 female cases/100,000 population Colorectal Cancer Incidence Rate by Race/Ethnicity 40.5 Black cases/ 100,000 population 	<p>AGH CHNA FY16-FY18 https://www.atlantcgeneral.org/documents/Community-Needs-Assessment-FY2016-BOD-apprvd-live-links.pdf</p>
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	<p>compared to 33.2 White cases/100,000 population Lung and Bronchus Cancer –Majority Black Males</p> <ul style="list-style-type: none"> • Lung and Bronchus Cancer Incidence by Gender 59.5 female cases /100,000 population compared to 90.5 male cases/100,000 population • Lung and Bronchus Cancer Incidence Rate by Race/Ethnicity 88.7 Black cases/ 100,000 population compared to 68.5 White cases/100,000 population <p>Prostate Cancer – Majority Black Male</p> <ul style="list-style-type: none"> • Prostate Cancer Incidence by Race/Ethnicity 302.3 Black male cases /100,000 males compared to 139.6 White male cases /100,000 males 	
Median Household Income within the CBSA	<p>Worcester County, Maryland \$56,773 Sussex County, Delaware \$53,751</p>	<p>US Census Bureau www.census.gov</p>
Percentage of households in the CBSA with household income below the federal poverty guidelines	<p>Worcester County, Maryland 11.3% persons in poverty Sussex County, Delaware 12.3% persons in poverty</p> <p>2017 Families below the poverty level: Worcester County, Maryland 1,073 (7.35%) Sussex County, Maryland 5,518 (9.14%)</p> <p>2017 Families below the poverty level with children: Worcester County, Maryland 637 (4.37%) Sussex County, Delaware 3,951 (6.54%)</p>	<p>US Census Bureau www.census.gov</p> <p>Healthy Community Institute on www.atlanticgeneral.org</p>
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/af.html ; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	<p>Persons under 65 years of age without health insurance: Worcester County, Maryland 7.7% Sussex County, Maryland 9.4%</p>	<p>US Census Bureau www.census.gov</p>
Percentage of Medicaid recipients by	<p>Worcester County, MD 13.00% Sussex County, DE 22.60%</p>	<p>Healthy Community Institute on www.atlanticgene</p>

County within the CBSA.		ral.org																								
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/Pages/Home.aspx	<p>Life expectancy Worcester County, Maryland</p> <table> <tr><td>All Races</td><td>79.4 (2013-2015)</td></tr> <tr><td>Black</td><td>74.5 (2015)</td></tr> <tr><td>White</td><td>80.2</td></tr> </table> <p>All Races 79.4 (2013-2015) Black 74.5 (2015) White 80.2 (2015)</p> <p>Life expectancy Sussex County, Delaware</p> <table> <tr><td>All Races</td><td>77.0</td></tr> </table>	All Races	79.4 (2013-2015)	Black	74.5 (2015)	White	80.2	All Races	77.0	<p>MD SHIP http://dhmh.maryland.gov/ship/Pages/Home.aspx</p> <p>DE Vital Statistics</p>																
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Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx	<p>Worcester County, MD</p> <p>599 (actual) deaths in Worcester County</p> <table> <tr><td>White</td><td>– 510</td></tr> <tr><td>Black</td><td>– 86</td></tr> <tr><td>Hispanic</td><td>– 1</td></tr> <tr><td>Asian</td><td>- 1</td></tr> </table> <p>Sussex County, DE</p> <p>Sussex County – (adjusted rate of deaths per 100,000 population)</p> <table> <tr><td>687.6</td><td>- overall</td></tr> <tr><td>872.6</td><td>- White male</td></tr> <tr><td>639.7</td><td>– White females</td></tr> <tr><td>1057.8</td><td>– Black males</td></tr> <tr><td>682.6</td><td>– Black females</td></tr> </table>	White	– 510	Black	– 86	Hispanic	– 1	Asian	- 1	687.6	- overall	872.6	- White male	639.7	– White females	1057.8	– Black males	682.6	– Black females	<p>Worcester County Vital Stats (2014) http://dhmh.maryland.gov/vsa/Pages/reports.aspx</p> <p>Sources: vital stats, Worcester and Sussex County Sites</p>						
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Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials,	<p>Worcester County</p> <table> <tr><td>Air pollution - particulate matter</td><td>8.4</td></tr> <tr><td>Drinking water violations</td><td>No</td></tr> <tr><td>Severe housing problems</td><td>17%</td></tr> <tr><td>Driving alone to work</td><td>80%</td></tr> <tr><td>Long commute - driving alone</td><td>29%</td></tr> <tr><td>Food Environment Index</td><td>7.8</td></tr> </table> <p>Sussex County</p> <table> <tr><td>Air pollution - particulate matter</td><td>8.8</td></tr> <tr><td>Drinking water violations</td><td>Yes</td></tr> <tr><td>Severe housing problems</td><td>16%</td></tr> <tr><td>Driving alone to work</td><td>83%</td></tr> <tr><td>Long commute - driving alone</td><td>34%</td></tr> <tr><td>Food Environment Index</td><td>8.3</td></tr> </table>	Air pollution - particulate matter	8.4	Drinking water violations	No	Severe housing problems	17%	Driving alone to work	80%	Long commute - driving alone	29%	Food Environment Index	7.8	Air pollution - particulate matter	8.8	Drinking water violations	Yes	Severe housing problems	16%	Driving alone to work	83%	Long commute - driving alone	34%	Food Environment Index	8.3	<p>County Health Rankings http://www.countyhealthrankings.org/app/maryland/2017/rankings/worcester/county/outcomes/overall/snapshot</p> <p>County Health Rankings http://www.countyhealthrankings.org/app/delaware/2017/rankings/sussex/county/outcomes/overall/snapshot</p>
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<p>or other resources)</p> <p>See SHIP website for social and physical environmental data and county profiles for primary service area information:</p> <p>http://ship.md.net/workofcare.org/p/h/county-indicators.aspx</p>			
<p>Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions.</p> <p>http://ship.md.net/workofcare.org/p/h/county-indicators.aspx</p>	<p>Race</p> <p>2016 Population</p> <p>White</p> <p>Black/Af Amer</p> <p>Am Ind/AK Native</p> <p>Asian</p> <p>Native HI/PI</p> <p>Some Other Rac</p> <p>2+ Races</p> <p>Language</p> <p>Speak only English at Home</p> <p>Speak Spanish at Home</p> <p>Speak Asian/PI Lang at Home</p> <p>Speak Indo-European Lang at Home</p> <p>Speak Other Lang at Home</p> <p>Race</p> <p>2016 Population</p> <p>White</p> <p>Black/Af Amer</p> <p>Am Ind/AK Native</p> <p>Asian</p> <p>Native HI/PI</p> <p>Some Other Rac</p> <p>2+ Races</p> <p>Language</p> <p>Speak only English at Home</p> <p>Speak Spanish at Home</p> <p>Speak Asian/PI Lang at Home</p> <p>Speak Indo-European Lang at Home</p>	<p>Worcester County, MD</p> <p>51,769</p> <p>42,024</p> <p>7,159</p> <p>143</p> <p>729</p> <p>13</p> <p>699</p> <p>1,002</p> <p>Sussex County, DE</p> <p>216,486</p> <p>169,252</p> <p>26,855</p> <p>1,817</p> <p>2,582</p> <p>179</p> <p>10,183</p> <p>5,618</p> <p>93.31%</p> <p>2.74%</p> <p>0.38%</p> <p>3.28%</p>	<p>Data Source:</p> <p>Statistics available through Healthy Communities Institute on www.atlanticgeneral.org</p> <p>Claritas, updated January 2016</p>

	Speak Other Lang at Home	0.29%	
Other	Population per Physician in the CBSA: 3500:1 – Worcester County 2060:1 – Somerset County 1870:1 – Wicomico County 1165:1 – Sussex County		

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Within the past three fiscal years, has your hospital conducted a Community Health Needs Assessment that conforms to the IRS requirements detailed on pages 1-2 of these Instructions?

Yes Provide date approved by the hospital’s governing body or an authorized body thereof here: 05/05/16 (mm/dd/yy)
 No

If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

<http://www.atlanticgeneral.org/documents/Community-Needs-Assessment-FY2016-BOD-apprvd-live-links.pdf>

2. Has your hospital adopted an implementation strategy that conforms to the IRS requirements detailed on pages 3-4?

Yes Enter date approved by governing body/authorized body thereof here:
10/04/16 (mm/dd/yy)
 No

If you answered yes to this question, provide the link to the document here:

<http://www.atlanticgeneral.org/documents/Implementation-Plan-CHNA-2016-18.pdf>

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

- a. Are Community Benefits planning and investments part of your hospital’s internal strategic plan?

Yes
 No

If yes, please provide a specific description of how CB planning fits into the hospital’s strategic plan. If this is a publicly available document, please provide a link here and indicate which sections apply to CB planning.

Community Benefits is a large part of the planning of the hospital’s strategic plan. As we become more focused on population health management, we realize that the hospital’s job starts way before someone darkens the doors of our facilities. The key is to coordinate care for our patients by doing all the “Right” things. That is why our strategic plans involve the “Right Principles: Right Care, Right People, Right Place, Right Partners and Right Hospital”. Population Health: Community Education and Health Literacy are one of the key initiatives in the strategic plan. These two things make up a large portion of our Community Benefit contribution. This graphic helps to explain our strategic plan that began in FY15.



b. What stakeholders within the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

- 1. CEO ✓
- 2. CFO
- 3. Other (please specify)

Describe the role of Senior Leadership.

These positions make up our Senior Leadership Team.

- VP, Public Relations and Marketing
- VP, Medical Staff Services
- VP, Quality
- VP, Planning and Operations
- VP, Professional Services
- VP, Information Services
- VP, Patient Care Services ✓

Hospital Board of Trustees ✓

Describe the role of Senior Leadership.

The role of the Senior Leadership team is to guide the operations of the organization: to develop the strategic plan, to set the annual organizational goals, which ultimately guides the community benefit initiatives. In July FY2017, the Population Health Manager reported to the VP Patient Care Services. In June FY2017 the Population Health Manager's title changed to Director of Community Health. The Population Health Management Department's goals reflected of the organizational goals and Strategic Plan. The CEO oversees the Strategic Plan process.

ii. Clinical Leadership

- 1. Physician

2. Nurse
3. Social Worker
4. Other (please specify)

Describe the role of Clinical Leadership

Information Technology
 Nursing
 Patient Care Management
 Emergency Department
 Patient Centered Medical Home
 AGHS
 Behavioral Health Services
 Laboratory
 Endoscopy Center
 Women's Diagnostic Center
 Imaging
 Cancer Care Services
 Surgical Services
 Medical Staff Services
 Medical Information
 Supportive Care Services

Describe the role of clinical leadership:

Clinical leadership is involved in the Strategic Planning each year. It is through their input that goals and directions are set for the organization. It is through the support of these teams (and course set by the goals) that Community Benefits are accomplished. Each department plays an active role in the process and implementation of the Community benefit goals each year.

iii. Population Health Leadership and Staff

1. Population health VP or equivalent (please list)
2. Other population health staff (please list staff)

Population Health Manager title changed Director Community Health and Executive Care Coordination Team

Describe the role of population health leaders and staff in the community benefit process.

The Executive Care Coordination Team consists of the Director Community Health, CMO, VP Patient Care Services, VP Professional Services, Director PCMH/IP Clinical Integration, Director ED/Organizational Transformation. The population health team plays an active role in the care coordination process and implementation of the organizational goals, strategic plan, and community benefit goals. The team meets twice monthly.

iv. Community Benefit Operations

1. the Title of Individual(s) (please specify FTE)
2. Committee (please list members)

3. Department (please list staff)
4. Task Force (please list members)
5. Other (please describe)

Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

Director Community Health – CB Oversight/Department Head and Committee Chair

Population Health Clinical Assistant – performs CBISA data base reporting

Outreach Providers – teach workshops, provide first aid and perform many health screenings in the community

Community Benefit Committee – The reporters for each department- responsible for the data input for their department regarding Community Benefits. They meet quarterly and set annual goals for Community Benefits which stem from the organizational goals and the strategic plan. They meet quarterly to monitor the hospital's community benefits and to modify and plan accordingly to ensure goals are met

Community Benefits Committee

Donna Nordstrom

Lisa Iszard

Ashley Godwin

Leslie Clark

Vicki L. Brown

Toni Keiser

Alicia Warren

Kam LaBrunda

Dawn Denton

Jan Geiger

Eileen Haffner

Lynne Snyder

Bonnie Mannion

Bob Yocubik

Joyce Thomas

Gail Mansell

Linda Walter

Charles Gizara

Ingrid Cathell

Janice Novak

Michaelann Frate

Crystal Mumford

Jackie Todd j

Michelle Clifton

Allan Taylor

Michele S. Clauser

Connie Collins

Candy Gebhart

Kristina Messick

Sarah Yonker

Teresa Berger

Elizabeth Mueller

Jill Todd

Louis Brecht

Laura Foskey

Lekeshia Whaley
 Robin Rohlfing
 Sue Donaldson
 Sissy Mumford
 Scott Rose
 Christina L. Brown
 Althea Foreman
 Linda Corrigan
 Deborah Wolf
 Geri Rosol
 Patti Yocubik
 Darlene Jameson
 Denise Esham
 Tammy Simington
 Linda Dryden
 Stephanie Banks
 Kim Parce
 Amanda Buckley
 Michael Locke
 Laurie A. Gutberlet
 Lakita R. Hayward
 William Boothe
 M Bruce Todd

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?)

Spreadsheet yes no
 Narrative yes no

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)
 The audit is done quarterly by the Community Benefit Committee, Leadership Team, Senior Leadership and the Hospital Board of Trustees. The Community Benefit Committee and the Director Community Health sign off on the reporting.

d. Does the hospital’s Board review and approve the FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet yes no
 Narrative yes no

If no, please explain why.

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

Yes No

If yes, please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

Community Benefits is a large part of the planning of the hospital's strategic plan. As we become more focused on population health management, we realize that the hospital's job starts way before someone darkens the doors of our facilities. The key is to coordinate care for our patients by doing all the "Right" things. That is why our strategic plans involve the "Right Principles: Right Care, Right People, Right Place, Right Partners and Right Hospital". Population Health: Community Education and Health Literacy are one of the key initiatives in the strategic plan. These two things make up a large portion of our Community Benefit contribution.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners?

Other hospital organizations

Local Health Department

Local health improvement coalitions (LHICs)

Schools

Behavioral health organizations

Faith based community organizations

Social service organizations

Post-acute care facilities

- b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct a CHNA. Provide a brief description of collaborative activities indicating the roles and responsibilities of each partner and indicating the approximate time period during which collaborative activities occurred (please add as many rows to the table as necessary to be complete).

Organization	Name of Key Collaborator	Title	Collaboration Description
AGH Foundation Board of Directors	Todd Ferrante	Board Member	Promotes the philanthropic support for the enhancement of the health of our community. We will achieve this mission through supporting the objectives of Atlantic General Hospital and Health System to continually improve the health of our residents and visitors to Maryland's lower Eastern Shore.
AGH Junior Auxiliary Group	Jill Ferrante	Auxiliary Member	Promotes the welfare of the hospital by fostering good public relations, providing service to the hospital, organizing health related projects and spearheading fund raising activities
American Cancer Society Tri-County Leadership Committee	Arlene Schneider	Regional Representative, Committee Leader	Nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem. The Tri

			County Leadership Committee is the overseeing body for all of the ACS initiatives in Worcester, Wicomico and Somerset County.
Bethany/Fenwick Chamber of Commerce Board of Directors	Richard <u>Mais</u>	Board Member	Provides oversight and guidance to the Executive Director in carrying out Chamber business.
Big Brothers Big Sisters	Kristie <u>Maravalli</u>	Area Coordinator	National organization which matches boys and girls with mentors.
Blood Bank of Delmarva	Roy Roper Suzanne Murray	President/CEO Chapter Leader	Promote blood donation and lifesaving activities.
Cricket Center Board	Wendy Meyer Beau Oglesby Andi West-McCabe Althea Foreman	Advocacy Board Member State's Attorney ED Director ED Manager	Advocate for the care of children that have been physically or sexually abused. Look at processes, use of our forensic nurses and the team, partnering for their care and seeking prosecution for the acts.
CRT Advisory Board	Monica Martin	Supervisor Mobile Crisis Response Team	Address the care of our behavioral health patients and getting them to

			another level of care. Ex inpatient psych, alcohol rehab, etc...
Worcester County Local Emergency Planning Committee	Fred Webster	Emergency Services Director	
Ocean City Local Emergency Planning Committee	Bob Rhode	OC Emergency Services	
Delmarva Regional Health Mutual Aid Group (DRHMAG)	<u>Kristen McMenamin</u>	Worcester County Emergency Services	
DMV Youth Council Several	Several		Provide expertise in youth policy and assist the local board in developing and recommending local youth employment and training policy and practice. The Youth Council also endeavors to broaden the youth employment and training focus in a community and to incorporate a youth development perspective.
Domestic Violence Fatality Review Board	Several		Explores reasons/cause for domestic violence and tries to see if there are resources that are available to stop future

			crimes against victims of domestic violence.
EMS Advisory Board	Andi West-McCabe, Dr. Jeff Greenwood, Alana Long (ED), Colleen Wareing Chuck Barton Dr. Jeff Greenwood	EMS Advisory Board	Meets with all the EMS companies from DE, MD, and VA to ensure ambulance patients are appropriate to be cared for here and address any concerns.
ENCARE	<u>Kathy Cioccio</u>	Staff nurse at AGH and ENCARE rep	<u>Emergency health care professionals</u> that provide education to communities about injury prevention.
Faith Based Coalition	Gail Mansell	Chair	A group of community members from various places of worship in our area who meet to plan programming to meet health needs.
Greater Salisbury Committee	Mike Dunn	Executive Director	A non-profit association of business leaders on the Delmarva peninsula, who work together to improve the communities in which we live.
Greater Ocean City Chamber of Commerce Board of Directors,	Several		Provide community leadership in the

Legislative, Scholarship and Special Events Committees			promotion and support of economic development and the continued growth of tourism in Ocean City. The Chamber serves as the hub for the development, education and communication within the business community of Ocean City to preserve the viability, quality of life and aesthetic values of our town.
Habitat for Humanity		Volunteer	Local volunteer group which builds houses for those in need
Healthcare Provider Council in DE	Anna Short	Clinic Coordinator Sussex County Health Department	Regional group of healthcare providers who work in collaboration with one another to provide needed services throughout the area
Healthy Weight Coalition	Several		A sub-committee of the Maryland SHIP (state health improvement plan) which is working on the promoting programs which challenge healthy

			weight for everyone in our area.
Komen MD Coalition for Eastern Shore	Lori Yates	Regional Representative	Group of community members and health agencies which looks at breast cancer services and gaps in the area and works to fill gaps and promote programming
Lower Shore Red Cross			Provides disaster relief. The board plans events in collaboration with other agencies to meet the needs in our area.
March of Dimes	Jessica Hales	Area Executive Director	Supports local initiatives by education and financial contributions to prenatal and premature births
Maryland <u>eCare</u>	Michael Franklin	Chair	The Limited Liability Corporation (LLC) comprised of 7 hospitals/health systems in Maryland for the purposes of contracting for and managing telemedicine ICU physician services

			for Maryland hospitals. I serve on the Board of Directors, and AGH is a member of the LLC.
Maryland Hospital Association Community Connections Advisory Board	Toni Keiser	Board Member	The mission of this committee is to Help small, rural and independent hospitals and health systems to better communicate and serve their communities by providing them leadership, advocacy, education, and innovative programs and services.
Maryland Society for Healthcare Strategy and Market Development	Shannon Martin	President	The mission of the Maryland Chapter of the Society for Healthcare Strategy and Market Development is to provide healthcare planning, marketing, and communications professionals with the most highly valued resources for professional development.
Ocean City Drug and Alcohol Abuse and	Toni Keiser	Committee Member	In 1989, then Governor William

Prevention Committee		<p>Donald Schaefer asked the Mayor of Ocean City, Roland Powell, to set up a committee to fight the abuse of alcohol and other drugs in our community. Thus, was born the Ocean City Drug Alcohol Abuse Prevention Committee Inc. that works in a partnership with state and local government agencies, as well as many businesses and concerned citizens. Currently the committee is comprised of members from the Town of Ocean City including elected officials and town employees from the Town of Ocean City Police Department and Ocean City Recreation & Parks Department, Worcester County Health Department and Department of Juvenile Services personnel, local school administrators, and</p>
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			teachers, volunteers from community service organizations, and many caring and concerned citizens
Ocean Pines Chamber of Commerce Board of Directors	Ginger Fleming Amy Unger	Director President	Provides oversight and guidance to the Executive Director in carrying out Chamber business.
Opioid Task Force	Beau <u>Olgesby</u>	State's Attorney	– looking at use, trends and prevention in the community
Parkside Technical High School Board	Tracy Hunter	Teacher	<u>Oversees from the community healthcare perspective the CNA and GNA program at the technical high school.</u>
Play it Safe Committee	Toni Keiser	Committee Member	THE MISSION OF PLAY IT SAFE is to encourage high school graduates to make informed, healthy choices while having responsible fun without the use of alcohol and other drugs
Relay For Life	Debbie White	Area Coordinator	American Cancer Society group with raises money, awareness and

			educates the public on cancers
Retired Nurses of Ocean Pines	Joyce Brittan	Volunteer Coordinator	Help with volunteer projects and give feedback for programming in the healthcare field.
Resource Coordination Committee	Phyllis Burton, RN	Administrative Care Coordination, Care Coordination and Ombudsman Program.	
SAFE SART	Althea Foreman	Clinical Manager, ED, AGH	SAFE -Sexual Assault Forensic Examiners – Meetings of the certified RNs and standardizing care for domestic violence, elder abuse, play it safe, lethality assessment, etc. SART, Same as SAFE except it involves all the agencies from Worcester County including Social Services, Patient Advocates, Law Enforcement, States' Attorney, etc
Save a Leg, Save a Life	Geri Rosol, Director Atlantic General Wound Center	Local Representative	A grass roots organization founded in Jacksonville, Florida. There are <u>approximately 45</u> SALSAL chapters

			in the U.S., Latin America, and overseas. The immediate goal is a 25% reduction in lower extremity amputations in communities where SALSAL Chapters are established. Currently the Eastern Shore Chapter spans from Dover, DE – Easton, MD – Salisbury, MD – Berlin, MD
State Advisory Council on Quality Care at the End of Life	Gail Mansell, Chaplain, AGH	Local Representative	Discuss quality initiatives for quality palliative medicine and end of life services that may result in legislative actions for the state of Maryland.
Suicide Awareness Board	Brittany Hines	Worcester County Health Department	Community members working together to raise awareness and prevention of suicides
Tobacco and Cancer Coalition – Worcester County	Mimi Dean	Director Worcester County Health Department Prevention Office	Sharing group of partners from different agencies and community members looking at measures, <u>outcomes</u> and prevention of

			cancers in the area.
Tri County Diabetes Alliance	Dawn Wells	Co-chair	Collaborative group from Worcester, Wicomico and Somerset County who plan collaborative programming to educate, treat and prevent diabetes.
Tri County Health Planning Council	Kim Justice Donna Nordstrom	Member – representative from AGH	To improve the health of residents of Somerset, Wicomico and Worcester counties; increase accessibility, continuity, availability of quality of health services; optimize cost-effectiveness of providing health services and prevent unnecessary duplication of health resources.
The Tri-County Board	Colleen Wareing	Member – representative from AGH	Provides input into the development of statewide health planning documents and uses the State Health Improvement Plan (SHIP) and individual county community health assessments and health

			improvement plans to identify the Tri-County Health Improvement Plan (T-CHIP).
Tri county SHIP	Kim Justice	Member – representative from AGH	Serve to lend support, guidance, planning, collaboration on the State Health Improvement programs
United Way	Kathleen <u>Momme</u>	Local Director	An organization that provides funding for non-profit groups in the local community. Through this board many community needs are identified and partnerships are formed to meet the needs.
Visions (Health Happening) Board, Hospital and Community members	Donna Nordstrom	Chair	<u>who</u> plan and implement health education in the community.
Worcester County Board of Education	Robert Rosenthal	Board President	Oversees the public education in Worcester County.
Worcester County Drug and Alcohol Board Community	Colleen Wareing	Member – representative from AGH	partners working together to oversee the safe use of alcohol and tobacco in the community by

			planning awareness/ educational events and compliance checks for the merchants
Worcester County School Health Council.	Dr. Aaron Dale	Supervisor of Student Services	The purpose of this Council will be to act as an advisory body to the Worcester County Board of Education in the development and maintenance of effective and comprehensive health programs which afford maximum health benefits to students enrolled in Worcester County Public Schools. Recognizing that citizen participation is inherent in the development and maintenance of an effective comprehensive health program, the Council will broadly represent the views of Worcester County citizens

Worcester County Health Department Regional Planning Board	Debbie Goeller	Worcester County Health Department, Health Officer	Community entities work with the Worcester County Health Department to plan and implement needed initiatives in the area. Some are prevention, education, health promotion and healthy living activities
Worcester County Health and Medical Emergency Preparedness Committee			to prepare for emergency situation responses and to protect the health of the community.
Worcester County Crisis Response Team	Monica Martin	Supervisor Mobile Crisis Response Team	The Crisis response team is a crisis intervention team composed of psychiatric social workers and other team members that respond to mental health crisis/issues of patients within the Worcester County area. Their goal is diversion of patients from the Emergency Department and act as a link to community mental health resources
Worcester GOLD: Giving Other Lives Dignity	Claire Otterbein	Director	A non -profit organization that provides

			assistance to community members of all ages such as school supplies, utilities assistance, summer camp sponsor for children, Christmas support to families, replacement of a roof, rainbow room; children's clothing & food supplies. All families or person (s) are screened by Social Services Department of Worcester County
Child Fatality Review Team	Dr. Andrea Mathias	Medical Director, Worcester Co HD	A team that reviews cases in Worcester County.
Drug Overdose Fatality Review Team	Dr Andrea Mathias Doug Dodd	Medical Director, Worcester Co HD	A team that reviews cases in Worcester County.
National Alliance for Mental Illness (NAMI) Lower Shore	Carole Spurrier	Local Representative	A grassroots organization dedicated to advocacy, education and support for persons with mental illness, their families, and the wider community.

Lower Shore Critical Incident Crisis Management	Gail Mansell	Committee Member	CISM is a method of helping first responders and others who have been involved with events that leave them emotionally and/or physically affected by those incidents. CISM is a process that enables peers to help their peers understand problems that might occur after an event. This process also helps people prepare to continue to perform their services or in some cases return to a normal lifestyle.
Hudson Health Services	Leslie Brown, BS	President & Chief Executive Officer	offers inpatient treatment for Substance Use Disorders in Salisbury, Maryland, as well as Halfway and Recovery Housing in Maryland
Worcester County Warriors Against Opioid Use	Heidi McNeely	Director of committee	To provide support and education about opioid use to the community

Focus groups through our Chronic Disease Workshops (contributed to CHNA FY16-FY18)

Living Well –

Jan. 2014 – Indian River Senior Center, Millsboro, DE

Jan 2015, North Worcester Senior Center, Berlin, MD

April 2015, Ocean Pines Community Center, Berlin, MD

June 2015, Captains Cove, Greenbackville, VA

Stepping On Falls Workshop –

July 2014, Atlantic Health Center, Berlin, MD

September 2014, Indian River Senior Center, Millsboro, DE

March 2015, Worcester County Parks and Rec, Snow Hill, MD

June 2015, Pocomoke Senior Center, Pocomoke, MD

Diabetes Workshop –

July 2014, The Park, Berlin, MD

October 2014, Worcester Youth and Family Counseling Center, Berlin, MD

March 2015, Indian River Senior Center, Millsboro, DE

July 2015, North Worcester Senior Center, Berlin, MD

October 2015, Snow Hill Senior Center, Snow Hill, MD

October 2015, Ocean City Senior Center, Ocean City, MD

November 2015, Pocomoke Senior Center, Pocomoke, MD

- c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in one or more of the jurisdictions where the hospital organization is targeting community benefit dollars?

yes no

If the response to the question above is yes, please list the counties for which a member of the hospital organization co-chairs the LHIC.

- d. Is there a member of the hospital organization that attends or is a member of the LHIC in one or more of the jurisdictions where the hospital organization is targeting community benefit dollars?

yes no

If the response to the question above is yes, please list the counties in which a member of the hospital organization attends meetings or is a member of the LHIC.

Worcester County

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Please use Table III to provide a clear and concise description of the primary need identified for inclusion in this report, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10-point type). Please be sure these initiatives occurred in the FY in which you are reporting.

For example: for each principal initiative, provide the following:

- a. 1. Identified need: This may have been identified through a CHNA, a documented request from a public health agency or community group, or other generally accepted practice for developing community benefit programs. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include a description of the collaborative process used to identify common priority areas and alignment with other public and private organizations.
2. Please indicate how the community's need for the initiative was identified.
- b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based community health improvement initiatives may be found on the CDC's website using the following links: <http://www.thecommunityguide.org/> or <http://www.cdc.gov/chinav/>), or from the County Health Rankings and Roadmaps website, here: <http://tinyurl.com/mmea7nw>. (Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)
- c. Total number of people within the target population (how many people in the target area are affected by the particular disease or other negative health factor being addressed by the initiative)?
- d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?
- e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need,
- f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)
- g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.
- h. Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.

Describe here the measure(s)/health indicator(s) that the hospital will use to evaluate the initiative's impact. The hospital shall evaluate the initiative's impact by reporting (in item "i. Evaluation of Outcome"):

- (i) Statistical evidence of measurable improvement in health status of the target population. If the hospital is unable to provide statistical evidence of measurable improvement in health status of the target population, then it may substitute:
- (ii) Statistical evidence of measureable improvement in the health status of individuals served by the initiative. If the hospital is unable to provide statistical evidence of measureable improvement in the health status of individuals served by the initiative, then it may substitute:
- (iii) The number of people served by the initiative.

Please include short-term, mid-term, and long-term population health targets for each measure/health indicator. These should be monitored and tracked by the hospital organization, preferably in collaboration with appropriate community partners.

- i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)
 - j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? If not, why? What is the mechanism to scale up successful initiatives for a greater impact in the community?
 - k. Expense:
 - A. what were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, and grants associated with the fiscal year being reported.
 - B. Of the total costs associated with the initiative, what amount, if any, was provided through a restricted grant or donation?
2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples: the fact that another nearby hospital is focusing on that identified community need, or that the hospital does not have adequate resources to address it.) This information may be copied directly from the section of the CHNA that refers to community health needs identified but unmet.

Identified Needs Not Met:

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

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

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) <http://dhmh.maryland.gov/ship/SitePages/Home.aspx>
 COMMUNITY HEALTH RESOURCES COMMISSION <http://dhmh.maryland.gov/mchrc/sitepages/home.aspx>

The Community Benefits operation/activities at Atlantic General Hospital are in line with the State's initiative in all that we do. We keep those initiatives in the forefront when formulating our strategic plan. Of the 10 top priority diseases listed in the Maryland State Healthcare Innovation Plan we address directly 8 of those diseases and the other two indirectly.

We have programs in place to manage chronic disease, infectious disease and prevention of disease. Because we are in an area of high senior aged population we are less likely to prevent chronic illness but we can help manage their disease.

Through our Integrated Health Literacy program we are imparting the health message to the younger ages to prevent bad behaviors which lead to chronic conditions. This program and many others that we have are about preventing disease. We work with our local businesses to help make the workforce healthier and better managed.

It is our goal, along with the state's, that the majority of our population will fall into the "Healthy" or "Chronically Ill but Under Control" categories. Through sharing data across organization, sharing resources and not duplicating programs we will be able to have healthier communities and lower healthcare costs.

PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

Because of the rural area we serve and because of the demographics of our population we are considered an underserved area and there are physician gaps in all specialty areas. We are always in the recruitment mode for specialties; some which are more of a priority than others because of demonstrated need.

The number one determined specialty gap in services in our county is mental health providers. There is one full time psychiatrist for the nearly 50,000 residents. Because many of those, in need of mental health services, end up in the emergency department at the hospital it is a drain on the system. We continue to develop out Mental Health team and continue to utilize telemedicine collaboration with Shepard Pratt Hospital and other providers in the Baltimore area.

Another gap in specialty physicians is endocrinology. The diabetes rate in Worcester County is higher than the national rate. In this area, there are two endocrinology practices and neither is located in this county. This puts a large burden on the primary care doctors, and diabetes programs to educate and manage diabetic patients. Because of lack of services many residents must go outside of the eastern shore area for diabetic care and many go untreated or minimally managed. There is a Tri County Diabetes Alliance that we are part of that through their web site and community activities provides screenings and education for diabetes. There are several Diabetes Education programs in the area, including the program at AGH. We also have a Diabetes community education program using the Stanford Chronic Disease Diabetes curriculum. We continue to recruit for this specialty to add to our AGHS staff of physicians.

AGHS hired a Dermatologist and Gynecologist in FY16. AGH/AGHS hired two General Surgeons, one Gynecologist, one Family Medicine Physician, and one Neurologist FY17.

Population per Physician in the CBSA:

- 3500:1 – Worcester County
- 2060:1 – Somerset County
- 1870:1 – Wicomico County
- 1165:1 – Sussex County

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

Table IV – Physician Subsidies

Category of Subsidy	Explanation of Need for Service
Hospital-Based physicians	

Non-Resident House Staff and Hospitalists	
Coverage of Emergency Department Call	
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other Physician Provider Based Practices	In rural area without the support of the hospital we could not meet the needs of the community

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):

- a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's FAP. (label appendix I)

For example, state whether the hospital:

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
 - in a culturally sensitive manner,
 - at a reading comprehension level appropriate to the CBSA's population, and
 - in non-English languages that are prevalent in the CBSA.
 - Posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
 - Provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
 - Provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
 - Includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills;
 - Besides English, in what language(s) is the Patient Information sheet available;
 - Discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.
- b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).
 - c. Include a copy of your hospital's FAP (label appendix III).
 - d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with

Health-General §19-214.1(e). Link to instructions:

http://www.hsrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospitalPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

Appendix I

The FAP information is an information sheet which can be found in all public waiting areas of the hospital and health system sites. We also run articles in our newsletters that are distributed in the homes of all residents in the county and service areas. Our Case Management and Patient Financial Services Departments also assist in identifying those in need and guide them through the process as described above. Our Patient Financial team attends many community events to raise awareness of the services; some of these include health fairs and homeless days, soup kitchens and food distribution sites. The information is also found on our website. The financial team screens patients for financial assistance who do not have other means to pay their bills. They are also trained and work closely with the local Maryland Healthcare Exchange workers. All AGH associates are trained in their responsibility regarding FAP as part of our annual mandatory learning. The Patient Financial Assistants review, with the patients, the entire policy to revise the interpretation for patients who are approved for assistance and can discuss Medicaid and state programs that will assist the patient.

The information and services are available to everyone, not culturally exclusive and is written at a 5th grade level for comprehension. Spanish is the most prevalent language other than English and all of the information/application is available in Spanish.

Appendix II

Our financial assistance policy did not change as a result of the ACA expansion. However, some of our processes changed. For example, when Hospital Support Services screened a patient for medical assistance, if they were over income for MA, but appeared eligible and were interested in a Health Plan through the ACA, she would send a referral to the Worcester County Health Department. The Health Department would then get in touch with the patient and help the patient get insurance. Also, all Atlantic General Hospital associates shared the basic information with all patients that appeared interested or eligible, by providing them with information, dates, times, and locations for signing up. We really did a big push to let the public know about it. As of today, our financial assistance policy does not require patients to get insurance through the ACA before they can be approved for financial assistance. However, it has been discussed thoroughly during each financial assistance policy review, but has not become a requirement.

As an added note, we had a huge influx of patients applying for financial assistance during this time. We discovered that they thought if they got financial assistance, they wouldn't be required to get insurance through ACA, and wouldn't be penalized on their taxes, if they didn't.

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM
POLICY AND PROCEDURE

TITLE: Financial Assistant Policy
DEPARTMENT: Patient Financial Services

Effective Date: 7/1/16 Number: _____
Revised: _____ Pages: Five (5)
Reviewed: _____
Signature: _____

Vice President, Finance

Director, Patient Financial Services

POLICY:

It is the policy of Atlantic General Hospital/Health System (AGH/HS) to provide medically necessary services without charge or at a reduced cost to all eligible patients who lack health care coverage or whose health care coverage does not pay the full cost of their hospital bill. Financial Assistance (FA) is granted after all other avenues have been exhausted, including, but not limited to Medical Assistance, private funding, grant programs, credit cards, and/or payment arrangements. FA applies only to bills related to services provided by the AGH/HS. Fees for healthcare and professional services that are not provided by AGH/HS are not included in this policy. Emergent and urgent services may be considered for FA; elective care services are excluded. A roster of providers that deliver emergent, urgent, and other medically necessary care is updated quarterly and available on the hospital website at www.atlanticgeneral.org, indicating which providers are covered and which are not under the FA policy. This information is also available by calling a Financial Counselor at (410) 629-6025. The patient must have a valid social security number, valid green card or valid visa. A patient's payment for reduced-cost care for AGH shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission (HSCRC).

Definitions:

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

Elective Care: Care that can be postponed without harm to the patient or that is not medically necessary. An appropriate nursing or physician representative will be contacted for consultation in determining the patient status.

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

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

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

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

Medical Hardship: Medical debt incurred by a family over the course of the previous twelve months that exceeds 25% of the family's income. Medical debt is defined as out of pocket expenses for medical costs billed by the health system. The hospital will provide reduced-cost, medically necessary care to patients with family income below 500% of the Federal Poverty Level.

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

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

Income: The amount of income as defined on the tax returns.

Procedures:

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

1. Available upon request by calling (410) 629-6025.
2. Picked up in the registration areas
3. Downloaded from the hospital website; www.atlanticgeneral.org/FAP
4. The Plain Language Summary is inserted in the Admission packet
5. FA language is included on all statements that include the telephone number to call and request a copy and the website address where copies may be obtained.
6. FA notification signs are posted in the main registration areas
7. An annual notification is posted in the local newspaper, and presented at area events
8. Patients who have difficulty in completing the application can orally provide the information

No ECA will be taken within 120 days of the first post-discharge billing statement. A message will be on the statement thirty days prior to initiating ECA notifying the patient. During the 120 day period, the patient will be reminded of the FA program during normal collection calls. If the application is ineligible, normal collection actions will resume, which includes notifying the agency if applicable to proceed with ECA efforts. If the application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all Extraordinary Collection Actions (ECA) until the application and all appeal rights have been processed. A list of approved ECA actions may be found in the Collection Policy. The patient may appeal a denied application by submitting a letter to the Director of Patient Financial Services indicating the reason for the request.

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

If the FA is approved, service 3 months before the date of the original approval date and twelve months after the approval day will be included in the adjustment. For patients that have been approved for 100%, any amount exceeding \$5.00 that has already been collected from the patient or guarantor for approved dates of service at 100% shall be refunded to the patient if the determination is made within 2 years of the date of the FA approval.

Eligibility determination will be provided in writing within 2 business days of receipt of a completed application by the FA Committee.

Automatic Eligibility:

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

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

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

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

Eligibility Consideration:

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

1. The amount requested is greater than \$20,000
2. The tax return shows a significant amount of interest income
3. The patient has a savings or checking account greater than \$10,000
4. If the patient/guarantor is self-employed, a profit and loss statement may be required

The following assets are excluded:

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

FA approval is based on the following income level:

- 0% to 200% of the Federal Poverty Guideline – 100% reduction for Medically Necessary care

- Between 201% and 225% of the Federal Poverty Guidelines – Reduced cost Medically Necessary care at 75%
- Between 226% and 250% of the Federal Poverty Guidelines - Reduces cost Medically Necessary care at 50%
- Between 251% and 300% of the Federal Poverty Guidelines – Reduces cost care Medically Necessary care at 25%

Medical Hardship is based on the following income level:

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

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

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

Appendix IV



Financial Assistance Information

This hospital provides emergency or urgent care to all patients regardless of ability to pay.

Hospital Financial Assistance Policy:

You are receiving this information sheet because, under Maryland law, this hospital must have a financial assistance policy and must inform you that you may be entitled to receive financial assistance with the cost of medically necessary hospital services if: you do not have insurance meet the qualifications, or your insurance does not cover you medically – necessary hospital care and you meet the qualifications. Financial Assistance will be available to all qualifying patients without discrimination on the grounds of race, color, national origin, age, gender, religion and creed.

Patients' Rights and Obligations

Patients' Rights: If you meet our financial assistance criteria described above and you don't qualify for State Medical Assistance, you may receive assistance from the hospital in paying your bill. If you believe you were wrongly referred to a collection agency, you have the right to contact the hospital to request assistance at 410-641-9096.

Patients' Obligations: If you have the ability to pay your bill, it is your obligation to pay the hospital in a timely manner. Atlantic General Hospital makes every effort to see that patient accounts are properly billed, and you may expect to receive a uniform summary statement within 7 days of discharge. It is your responsibility to provide correct insurance information. If you do not have health coverage, we expect you to pay your bill in a timely manner. If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. In determining whether you are eligible for free care or a payment plan, it is your obligation to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office to provide updated/corrected information.

Contacts:

For Hospital Billing Questions: 410-641-9606 Hospital Billing Fax Number: 410-641-1581

For Maryland Medical Assistance: You may contact your local Health Department or Department of Social Services or the Maryland Department of Human Services by phone at: 1-800-332-6347;
TTY: 1-800-925-4434; or the Internet at: www.dhr.state.md.us

For Hospital Financial Assistance Questions: 410-629-6027 or 410-629-6025. The uniform financial assistance application is also available online at the following link: http://www.hsrc.state.md.us/consumers_uniform.cfm
This form can also be obtained at Atlantic General Hospital Registration or the Patient Accounting Office.

For Physician Services: Physician services provided during your stay will be billed separately and are not included on your hospital billing statement. These offices may be contacted at the numbers below:

Atlantic General Physicians Billing: 410-641-9450	Peninsula Cardiology: 410-641-3794
Emergency Service Associates: 866-964-6774	Delmarva Radiology: 410-219-5199
Delmarva Heart: 410-629-0888	



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

MISSION
To create a coordinated care delivery system that will provide access to quality care, personalized service and education to improve individual and community health.

VALUES
(Keeping "PATIENTS" at the Center of our Values)

- P** Patient safety first
- A** Accountability for financial resources
- T** Trust, respect & kindness
- I** Integrity, honesty & dignity
- E** Education – continued learning & improvement
- N** Needs of our community – Participation & community commitment
- T** Teamwork, partnership & communication
- S** Service & personalized attention

These values are honored in all we do for our patients, visitors, medical staff, associates, partners and volunteers.

ETHICAL COMMITMENT
To conduct ourselves in an ethical manner that emphasizes community service and justifies the public trust.

QUALITY STATEMENT
We deliver care that is accessible, safe, appropriate, coordinated, effective, and centered on the needs of individuals within a system that demonstrates continual improvement.

Attachment A

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) SELECT POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy
- Reduce infant mortality
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers
- Reduce the % of youth using any kind of tobacco product
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- Increase the % vaccinated annually for seasonal influenza
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce hospital ED visits from asthma
- Reduce hospital ED visits related to mental health conditions
- Reduce hospital ED visits related to addictions
- Reduce Fall-related death rate

Table III – FY 2017 Community Benefits Narrative Report – Initiative 9 Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions in the community

<p>A. 1. Identified Need: A. 2. How was the need identified:</p>	<p><u>Arthritis, Osteoporosis & Chronic Back Pain</u> During the FY16 CHNA process, PRC and Community Surveys identified Arthritis, Osteoporosis & Chronic Back Pain as a significant community concern. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.</p> <p>According to Healthy People 2020, arthritis, osteoporosis and chronic back pain impact quality of life, activities of daily living and ability to work. Arthritis affects one in five adults. Osteoporosis affects approximately 5.3 million adults aged 50 years and older in the United States. Also, approximately 80 percent of people in the United States experience chronic back conditions. Successful and underused interventions include weight management, physical activity and self-management. (Healthy People 2020)</p> <p>According to PRC Survey summary of findings, areas of significant need include prevalence of sciatica and chronic back pain in the community.</p>
<p>B: Name of hospital initiative</p>	<p><u>Initiative:</u> Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions in the community. (Healthy People 2020 Goal: Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions.) Clinical Screenings CPSMP Workshops Pain Management Clinic Referrals Provider Recruitment</p>
<p>C: Total number of people within target population</p>	<p>According to WCHD CHNA FY14, 25.7% populations combined Worcester/Wicomico Counties suffer from back and neck problems and 14.4% diagnosed with arthritis and rheumatism.</p>
<p>D: Total number of people reached by the initiative</p>	<p>1,115 persons served by initiative through clinical screenings, CPSMP workshops and pain management referrals in the community 36 persons were treated for RA disorders by AGH ED and IP FY17</p>
<p>E: Primary objective of initiative:</p>	<p>1) <u>Reduce unnecessary healthcare costs</u> a) Description: AGH will focus on reducing unnecessary healthcare costs related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions through community education initiatives, increasing provider services and appropriate use of hospital services through patient referral to clinic settings. b) Metrics: AGH hospital admission and re-admission rates each fiscal year.</p> <p>2) <u>Increase provider services to community to provide for arthritis and other rheumatic conditions, osteoporosis, and chronic back condition related treatments</u> a) Description: AGH will focus on increasing provider services to the community as evidenced by the following strategies 1) Recruit Rheumatologist to community 2) Implement Osteopenia Program 3) Increase accurate and up-to-date information and referral service. b) Metrics: Strategy #1 – Human Resources reporting of Rheumatologist recruitment to CBSA. Strategy #2 – Track referrals to Osteopenia Program each fiscal year. Strategy #3 – Track referrals to Atlantic Health Center Pain Management Clinic each fiscal year.</p> <p>3) <u>Increase health literacy and self-management for chronic health conditions/healthy living.</u> a) Description: AGH will focus on two strategies to increase community education opportunities. 1) Utilizing Faith Based Partnerships to provide access to</p>

Table III – FY 2017 Community Benefits Narrative Report – Initiative 9 Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions in the community

	<p>high risk populations for education about healthy lifestyles and chronic pain workshops. AGH Population Health collaborates with MAC, Inc. to provide Stanford Peer Leader Training and CPSMP workshops to target population.</p> <p>2) Utilize Women’s Diagnostic Health Services, to provide access to high risk populations about healthy lifestyles, raise community awareness about osteopenia/osteoporosis, and provide bone density screenings</p> <p>b) Metrics: Strategy #1- Population Health Department will track CPSMP workshop attendance offered to target population each fiscal year. Strategy #2 – Population Health Department will track number of bone density screenings offered to target population each fiscal year.</p>
<p>F: Single or multi-year plan:</p>	<p>Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY16-FY18. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
<p>G: Key collaborators in delivery:</p>	<p>Hospital Resources: •Population Health Department •Human Resources •Atlantic Health Center/Pain Management •Women’s Diagnostic Health Services</p> <p>Community Resources: •MAC, Inc. •Faith-based Partnership</p>
<p>H: Impact of hospital initiative:</p>	<p>1)Objective: <u>Reduce unnecessary healthcare costs</u></p> <p>a) Metrics: AGH hospital admission and re-admission rates each fiscal year.</p> <p>Outcomes: According to AGH ED and IP data FY17, 36 persons were treated for RA disorders by AGH ED and inpatient services; compared to 42 FY16</p> <p>2) Objective: <u>Increase provider services to community to provide for arthritis and other rheumatic conditions, osteoporosis, and chronic back condition related treatments</u></p> <p>a) Metrics: Strategy #1 – Human Resources reporting of Rheumatologist recruitment to CBSA. Strategy #2 – Track referrals to Osteopenia Program each fiscal year. Strategy #3 – Track referrals to Atlantic Health Center Pain Management Clinic each fiscal year.</p> <p>Outcome: Strategy #1 – AGH/AGHS continues efforts to increase specialty providers to the community. However, no Rheumatologist was hired in FY16 or FY17. Will continue efforts FY18. Strategy #2 - Through health fairs and clinical screening opportunities, 34 bone density screening events were offered to the community serving 736 persons and 35% osteopenia/osteoporosis were referred for further evaluation. Strategy #3 – FY16 ED Referral to Pain Clinic Algorithm implemented. According to Pain Management Clinic, 252 persons served via referral tracking. FY17 ED Referral to Pain Clinic, 342 persons served.</p> <p>2) Objective: Increase health literacy and self-management for chronic</p>

Table III – FY 2017 Community Benefits Narrative Report – Initiative 9 Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions in the community

	<p>health conditions/healthy living.</p> <p>a) Metrics: Strategy #1- Population Health Department will track CPSMP workshop attendance offered to target population each fiscal year. Strategy #2 – Population Health Department will track number of bone density screenings offered to target population each fiscal year.</p> <p>Outcome: Strategy #1 – Population Health served 37 persons through CPSMP workshop opportunities FY17. Strategy #2 – Through health fairs and clinical screening opportunities, 34 bone density screening events were offered to the community serving 736 persons and 35% osteopenia/osteoporosis were referred for further evaluation.</p>	
I: Evaluation of outcome	<p>The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above. Long term outcome metrics include Community Survey and Health People 2020 measures.</p>	
J: Continuation of initiative:	<p>We will continue to monitor connections made to community programming for Arthritis, Osteoporosis & Chronic Back Pain during FY18.</p>	
<p>K: Expense:</p> <p>A. Total Cost of Initiative for Current Fiscal Year</p> <p>B. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>a. Total Cost of Initiative for Current Fiscal Year</p> <p>\$7,421 clinical screenings, health fairs and CPSMP</p>	<p>b. Restricted Grants/Direct offsetting revenue</p> <p>None</p>

Table III – FY 2017 Community Benefits Narrative Report – Initiative 8 Reduce opioid substance abuse to protect community health, safety, and quality of life for all

<p>A. 1. Identified Need: A. 2. How was the need identified:</p>	<p><u>Opioid Abuse</u> During the FY16 CHNA process, the Community Survey identified drug abuse as a significant community health concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via survey and met with community partners to determine that opioid abuse and drug death overdose are growing community health problems. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.</p> <p>According to Healthy People 2020, approximately 22 million Americans struggle with addiction to alcohol and/or drugs and approximately 95 percent are unaware they have a substance use issue. An emerging area of substance use issues includes opiate use. Teen rates of prescription drug abuse have increased over the last 5 years, including nonmedical use of drugs such as Vicodin and OxyContin. (Healthy People 2020)</p> <table border="1" data-bbox="451 657 1318 846"> <thead> <tr> <th></th> <th>Worcester County</th> <th>Maryland</th> <th>Sussex County</th> <th>Delaware</th> </tr> </thead> <tbody> <tr> <td>Drug Death Overdose</td> <td>15</td> <td>16</td> <td>16</td> <td>18</td> </tr> <tr> <td>Drug Death Overdose - modeled</td> <td>18.1-20.0</td> <td>17.4</td> <td>16.1-18.0</td> <td>20.9</td> </tr> </tbody> </table> <p>(County Health Rankings, 2016)</p> <p><i>Worcester County SMART data show rising rates of entry to treatment for opioid addiction, which likely reflects increased risk of opioid related overdose, or death:</i></p> <ul style="list-style-type: none"> • The number of admissions to treatment for Heroin doubled in Worcester during a period in which statewide the number remained constant (2009-2011) • The number of admissions to treatment for Oxycodone increased 8x in Worcester, while the number increased 3X (tripled) statewide • The total number of Opioid-related admissions to treatment tripled in Worcester while the number increased by less than 2% statewide <p><i>Anecdotally, in communication with law enforcement, and Addictions treatment program counselors, Worcester has begun to see locally the trend of increasing incidence of heroin abuse and overdose, while the incidence of prescription opioid related overdose may be decreasing. This reflects an emerging trend statewide</i> (http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/Documents/WorcesterCountyO_PP_FinalPlan.pdf)</p>		Worcester County	Maryland	Sussex County	Delaware	Drug Death Overdose	15	16	16	18	Drug Death Overdose - modeled	18.1-20.0	17.4	16.1-18.0	20.9
	Worcester County	Maryland	Sussex County	Delaware												
Drug Death Overdose	15	16	16	18												
Drug Death Overdose - modeled	18.1-20.0	17.4	16.1-18.0	20.9												
<p>B: Name of hospital initiative</p>	<p><u>Initiative:</u> Reduce opioid substance abuse to protect community health, safety, and quality of life for all. (Healthy People 2020 Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children) IHLP Community Education CPSMP (evidence based) Opioid Task Force Narcan Training Pain Management PDMP Care Coordination/Community Collaboration</p>															
<p>C: Total number of people within target population</p>	<p>Opioid-related incidents have risen in the AGH ED by over 155% since 2013 from 144 to 347 in 2017. (AGH Internal Data) Drug death overdose modeled: Worcester County 18.1-20.0 and Sussex County 16.1 – 18.0. (County Health Rankings, 2016) FY17 ED visits related to opioid overdose/poisoning 109 persons and 71 persons opioid dependency ED visits. CY2016 all AGH IP, ED and Obs visits totaled 304 persons. (AGH Internal Data)</p>															

Table III – FY 2017 Community Benefits Narrative Report – Initiative 8 Reduce opioid substance abuse to protect community health, safety, and quality of life for all

D: Total number of people reached by the initiative	859 persons served
E: Primary objective of initiative:	<p>Primary Objectives</p> <p>1) <u>Improve health literacy in middle schools related to opioid abuse.</u></p> <p>a) Description: FY17 IHLP, Pocomoke Middle and Snow Hill Middle 6th grades, focused on a substance abuse component as part of DARE Program. In order to promote awareness via IHLP the Health Literacy Liaison is involved in multiple councils/committees such as Worcester County Opioid Awareness Task Force, Worcester County Health Council and Worcester County Warrior’s Education Subcommittee. Due to community need FY17 IHLP incorporated opioid education in eighth grade during the “Heroin and Substance Abuse” unit. These lessons include the effects of heroin in the body, consequences related to heroin use as well as a component that discusses the criminal justice system’s role in the heroin epidemic.</p> <p>b) Metrics: Track number of middle school students participating in the Health Literacy (IHLP) Program related to substance/opioid use by the end of the FY17.</p> <p>2) <u>Increase accurate and up-to-date information and referral service.</u></p> <p>a) Description: In FY17 AGH continued focusing on three strategies 1)Increasing the proportion of persons who are referred for follow-up care for opioid problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED) 2) Evaluate and educate organization and community on appropriate prescribing practices 3) Implement Prescription Drug Maintenance Program (PDMP) via CRISP. Implementing the Prescription Drug Monitoring Program (PDMP) to give healthcare providers and public health and safety authorities a new tool to reduce prescription drug abuse</p> <p>b) Metrics: Strategy #1 -Track ED referrals for follow-up care at Atlantic Health Center Pain Management Clinic Strategy #2 – Track education opportunities to educate community and organization on prescribing practices Strategy #3 – Reported implementation of PDMP via Crisp</p> <p>3) <u>Decrease opioid abuse and over dose rates</u></p> <p>a) Description: AGH focused on 1)Providing educational opportunities to raise community awareness about opioid use and 2)Participate in Worcester County Health Department naloxone training sessions sponsored by Opiate Overdose Prevention Program and offer opportunities for Narcan training at community events.</p> <p>b) Metrics: Strategy #1 – Track number of community educational opportunities Strategy #2 – Track number of classes and participants receive Narcan training</p> <p>4) <u>Increase and strengthen capacity for shared responsibility to address unmet health needs.</u></p> <p>a) Description: The ability to increase and strengthen capacity for shared responsibility to address unmet health needs involves community wide collaborations. In FY17, AGH increased participation on committees and councils to promote community involvement and shared responsibility. Two key programs include WOW Committee (Worcester Warriors) and the Opioid Task Force. These councils and committees include community members, local health department, health agencies, law enforcement, etc</p> <p>b) Metrics: Participation on WOW Committee and Opioid Task Force by the end of the fiscal year.</p>

Table III – FY 2017 Community Benefits Narrative Report – Initiative 8 Reduce opioid substance abuse to protect community health, safety, and quality of life for all

<p>F: Single or multi-year plan:</p>	<p>Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY16-FY18. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
<p>G: Key collaborators in delivery:</p>	<p>Hospital Resources: <ul style="list-style-type: none"> •Population Health Department •Emergency Department •Atlantic Health Center/Pain Management •Pharmacy <p>Community Resources: <ul style="list-style-type: none"> •Worcester County Health Department •Worcester County Public Schools •WOW Committee •Opioid Task Force •CRISP </p> </p>
<p>H: Impact of hospital initiative: Outcomes (Include process and impact measures)</p>	<p>Objective 1: <u>Improve health literacy in middle schools related to opioid abuse.</u></p> <p>a) Metrics: Track number of students participating in the Health Literacy (IHLP) Program by the end of the FY17</p> <ul style="list-style-type: none"> • Outcome: There were a total of 3400 students who participated in IHLP (all lesson topics). For sixth grade students participate in the substance abuse component in DARE Program there were approximately 60 students served. In FY17, 8th grade students participated in pilot lessons at Stephen Decatur Middle School. The 8th grade lesson topic focused on heroin and substance abuse. Will track outcomes FY18 post 7th and 8th grade roll out. FY 18 IHLP will be county-wide grades 1 – 8. <p>Objective 2: <u>Increase accurate and up-to-date information and referral service.</u></p> <p>a) Metrics: Strategy #1 -Track ED referrals for follow-up care at Atlantic Health Center Pain Management Clinic Strategy #2 – Track education opportunities to educate community and organization on prescribing practices</p> <ul style="list-style-type: none"> • Outcome: Strategy #1 - ED Referral process to Pain Management Clinic Algorithm implemented. During FY16, Pain Management Clinic served 252 patients referred to clinic compared to 342 patients referred in FY17. Will continue to track in FY18. Strategy #2 - Reported implementation of PDMP via Crisp continued during FY17. AGH has trained over 150 providers in the use of the Prescription Drug Monitoring Program and promotes the use of this tool throughout the system. Chesapeake Regional Information System for our Patients (CRISP) is utilized to track ED recidivism and total cost of care opportunity. Prescribing practice community education events offered during FY17. Addiction Hurts Event Jan 2017 provided the community with Opioid education with speakers Marie Allen, author Dope Help, and the local sheriff’s office. AGH ED and pharmacy were on hand as vendors educating the community on prescribing practices. Will track success of program FY18. <p>Objective 3: <u>Decrease opioid abuse and over dose rates</u></p> <p>a) Metrics: Strategy #1 – Track number of community educational opportunities Strategy #2 – Track number of classes and participants receive Narcan training</p> <ul style="list-style-type: none"> • Outcomes:

Table III – FY 2017 Community Benefits Narrative Report – Initiative 8 Reduce opioid substance abuse to protect community health, safety, and quality of life for all

	<p>Strategy #1 – Due to the ongoing awareness of opioid initiatives, community education opportunities will still continue to be tracked into FY18. In FY17, events with an indirect effect on the opioid epidemic:</p> <ul style="list-style-type: none"> •National Night Out (Pocomoke and Berlin) – August 2016 •Chronic Pain Workshops - Oct/Nov 2016 <p>Addiction Hurts Event – January 2017</p> <ul style="list-style-type: none"> •Support of Play It Safe Program in OC – June 2017 <p>Strategy #2 – AGH Employee Education Department partnered with the Worcester County Health Department during FY16 offering 2 Narcan training sessions with 20 participants. During FY17, Narcan training was offered by the local health department at the following events sponsored by AGH (no certification data available):</p> <p>Ocean City Health Fair Addiction Hurts Event</p> <p>Objective 4: <u>Increase and strengthen capacity for shared responsibility to address unmet health needs.</u></p> <p>a) Metrics: Participation on WOW Committee and Opioid Task Force by the end of the fiscal year.</p> <ul style="list-style-type: none"> • Outcomes : Active participation on WOW Committee FY16 – FY17 by VP Patient Care Services, Health Literacy Liaison, and Opioid Nurse. Active participation on Opioid Task Force Committee FY16 –FY17 by VP Patient Care Services, Pharmacy, Population Health Manager/Director Community Health, Pharmacy, ED and Opioid Nurse. 	
I: Evaluation of outcome	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above. Long term measures include Healthy People 2020 and Community Survey.	
J: Continuation of initiative:	We will continue to monitor connections made to community programming for opioid abuse initiatives in FY18.	
K: Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	a. Total Cost of Initiative for Current Fiscal Year \$19,223	b. Restricted Grants/Direct offsetting revenue None

Table III – FY 2017 Community Benefits Narrative Report - Initiative 7 Promote and ensure local resources are in place to address mental health.

<p>A. 1. Identified Need: A. 2. How was the need identified:</p>	<p><u>Mental Health Disorders</u> During the FY16 CHNA process, PRC and Community Surveys identified mental health disorders a significant community concern. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.</p> <p>According to the CDC Mental Health Surveillance (2013), mental illness affects approximately 25 percent of the U.S. population and is associated with a variety of chronic illnesses.</p> <table border="1" data-bbox="493 506 1390 621"> <thead> <tr> <th></th> <th>Worcester County</th> <th>Maryland</th> <th>Sussex County</th> <th>Delaware</th> </tr> </thead> <tbody> <tr> <td>Mental Health Providers</td> <td>520:1</td> <td>470:1</td> <td>610:1</td> <td>440:1</td> </tr> <tr> <td>Poor Mental Health Days</td> <td>3.5</td> <td>3.4</td> <td>3.5</td> <td>3.7</td> </tr> </tbody> </table> <p>(County Health Rankings, 2016)</p>		Worcester County	Maryland	Sussex County	Delaware	Mental Health Providers	520:1	470:1	610:1	440:1	Poor Mental Health Days	3.5	3.4	3.5	3.7
	Worcester County	Maryland	Sussex County	Delaware												
Mental Health Providers	520:1	470:1	610:1	440:1												
Poor Mental Health Days	3.5	3.4	3.5	3.7												
<p>B: Name of hospital initiative</p>	<p><u>Hospital Initiative:</u> Promote and ensure local resources are in place to address mental health. (Healthy People 2020 Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.)</p>															
<p>C: Total number of people within target population</p>	<p>2,469 persons served IP and ED for mental health disorders during FY17; compared to 2,914 persons served FY16. Poor mental health days: Worcester County 3.5 and Sussex County 3.5 (County Health Rankings, 2016) Care Coordination Community Partnerships Support Groups Community Education Faith Based Partnerships Telemedicine IHLP</p>															
<p>D: Total number of people reached by the initiative</p>	<p>1,447 persons served by initiative FY17</p>															
<p>E: Primary objective of initiative:</p>	<p>1) <u>Increase accurate and up-to-date information and referral service</u> a)Description: Engage Critical Response Team, when a mental health crisis is discovered b)Metric: Track CRT service and referrals during FY17</p> <p>2) <u>Improve Health Literacy in elementary and middle schools related to mental health</u> a)Description: Improve health literacy in schools related to mental health and emotional health. IN FY17, AGH's Integrated Health Literacy Program (IHLP) partnered with Worcester County Public School (WCPS) to provide lessons on mental health topics. b)Metric: Track number of students in IHLP participating in mental health lesson topics in WCPS during FY17.</p> <p>3) <u>Increase awareness of community resources, programs and services</u> a)Description: Participate in community events that spotlight mental health services. During FY17, AGH collaborated on a variety of community events. Partnerships included the local health departments, local scholarship foundation, and a motivational speaker event. b)Metric: Track number of events that highlight mental health services and education during FY17.</p> <p>4) <u>Increase and strengthen capacity and collaboration for shared responsibility to</u></p>															

Table III – FY 2017 Community Benefits Narrative Report - Initiative 7 Promote and ensure local resources are in place to address mental health.

	<p><u>address unmet health needs</u> a)Description: Increase access and continue to collaborate with Sheppard Pratt telemedicine services to provide additional psychiatry professional b)Metric: Track service collaboration with Sheppard Pratt during FY17</p> <p>5) <u>Increase provider services in community to provide for mental health related treatment</u> a)Description: Recruit Psychiatrist to the community b)Metric: AGH recruitment of Psychiatrist to community by end of FY17.</p>
<p>F: Single or multi-year plan:</p>	<p>Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY16 – FY18. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
<p>G: Key collaborators in delivery:</p>	<p>Hospital Resources: Population Health Department Atlantic Health Center Human Resources Pastoral Care Services Bereavement Support Group</p> <p>Community Resources: Sheppard Pratt Worcester County Health Department Worcester Youth and Family Services Hudson Health Services NAMI Lower Shore Support Group Jesse’s Paddle Organization Surfer’s Healing Camps Autism Speaks Chapter</p>
<p>H: Impact of hospital initiative:</p>	<p>Objective 1) <u>Increase accurate and up-to-date information and referral service</u> <u>Metric: Track CRT service and referrals during FY17.</u> • Outcome: AGH continues to partner with local community resources, such as the local health departments for timely and accurate referral of service. No data to report at this time for CRT tracking due to HIPAA guidelines for mental health patients’ data is unavailable.</p> <p>Objective 2) <u>Improve Health Literacy in elementary and middle schools related to mental health</u> Metric: Track number of students in IHLP participating in mental health lesson topics in WCPS during FY17. • Outcome: In FY17, the only grades that discussed mental health were grade 5 county-wide and a 7th and 8th grade pilot. Fifth grade’s topic was anxiety. The 7th and 8th grade topic was stress management and coping skills. In FY 16, 435 fifth graders were impacted. No FY17 data is available at this time to track number of students. Will continue to track program in FY18 with the curriculum roll out county-wide for grades 7th and 8th.</p> <p>Objective 3) <u>Increase awareness of community resources, programs and services</u> <u>Metric: Track number of events that highlight mental health services and education during FY17.</u> • Outcome: -Out of Darkness Walk Sept 2017 and sit on planning community throughout year -50 persons served -Suicide prevention vendor, Jesse Klump Foundation, attendance at several health fairs - 660 persons served -Surfer’s Healing event August 2017 – 150 persons served -Monthly AGH based NAMI Support Group - 81 persons served</p>

Table III – FY 2017 Community Benefits Narrative Report - Initiative 7 Promote and ensure local resources are in place to address mental health.

	<p>-Monthly Bereavement Support Group – 36 persons served</p> <p>Objective 4) <u>Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs</u> Metric: Track service collaboration with Sheppard Pratt during FY17</p> <ul style="list-style-type: none"> • Outcome: During FY16, AGH noted increase in services by one additional provider and 2 extra hours per week/8 per month. The additional hours provided to children with Autism Spectrum Disorders. No increase in services FY17. Will continue to track in FY18. At the start of FY18, provider availability decreased to one provider. <p>Objective 5) <u>Increase provider services in community to provide for mental health related treatment</u> Metric: AGH recruitment of Psychiatrist to community by end of FY17</p> <ul style="list-style-type: none"> • Outcome: AGH will continue recruitment efforts FY18. Will continue to track in Sheppard Pratt telemental health services in FY18. At the start of FY18, provider availability decreased to one provider. Will continue to collaborate with local health department for mental health services. 	
I: Evaluation of outcome	<p>The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above. Long term measurements: Healthy People 2020 Behavioral Risk Factor Surveillance System County Health Rankings</p>	
J: Continuation of initiative:	<p>We will continue to monitor connections made to community programming for mental health disorders and access to care during FY17.</p>	
<p>K: Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>a. Total Cost of Initiative for Current Fiscal Year</p> <p>\$13,153 community events</p>	<p>b. Restricted Grants/Direct offsetting revenue</p> <p>Berger Restricted funds for IHLP MOI \$120</p>

Table III – FY 2017 Community Benefits Narrative Report - Initiative 6 Improve cardiovascular health of community

<p>A. 1. Identified Need: A. 2. How was the need identified:</p>	<p><u>Heart Disease & Stroke</u> During the FY16 CHNA process, PRC and Community Surveys identified heart disease and stroke as significant community area of concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to heart disease and stroke. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.</p> <p>According to the CDC Heart Disease Statistics and Maps (2015), approximately 610,000 people die of heart disease in the United States yearly. Heart disease is the leading cause death among most ethnic groups. Hypertension, high cholesterol and smoking are key risk factors and 47 percent of Americans have at least one risk factor Heart Disease Statistics and Maps (CDC, 2015).</p> <table border="1" data-bbox="506 682 1382 884"> <thead> <tr> <th>(per 100,000)</th> <th>Worcester County</th> <th>Sussex County</th> <th>U.S. Median</th> <th>Healthy People 2020 Target</th> </tr> </thead> <tbody> <tr> <td>Coronary Heart Disease Deaths</td> <td>141.7</td> <td>143.2</td> <td>126.7</td> <td>103.4</td> </tr> <tr> <td>Stroke Deaths</td> <td>34.3</td> <td>34.1</td> <td>46</td> <td>34.8</td> </tr> </tbody> </table> <p>(CHSI, 2015)</p>	(per 100,000)	Worcester County	Sussex County	U.S. Median	Healthy People 2020 Target	Coronary Heart Disease Deaths	141.7	143.2	126.7	103.4	Stroke Deaths	34.3	34.1	46	34.8
(per 100,000)	Worcester County	Sussex County	U.S. Median	Healthy People 2020 Target												
Coronary Heart Disease Deaths	141.7	143.2	126.7	103.4												
Stroke Deaths	34.3	34.1	46	34.8												
<p>B: Name of hospital initiative</p>	<p><u>Initiative:</u> Goal: Improve cardiovascular health of community. (Healthy People 2020 Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events) AGH Tobacco Free Campus Community Screenings CDSMP (evidence based) Living Well with Hypertension Workshops (evidence based) Speaker’s Bureau Faith Based Partnership Integrated Health Literacy Program with Worcester County Board of Education Support Groups</p>															
<p>C: Total number of people within target population</p>	<p>Coronary Artery Disease Worcester County 141.7/100,000 and Sussex County 143.2/100,000</p>															
<p>D: Total number of people reached by the initiative</p>	<p>2,712 persons served through screenings, workshops, speaker’s bureau and community education 500 students identified through the Integrated Health Literacy Program 885 employees served and identified through AGH tobacco free campus Heart Disease ED 4,374 persons and IP 1,298 persons (AGH internal Data)</p>															
<p>E: Primary objective of initiative:</p>	<p>1) <u>Increase awareness around importance of prevention and early detection of heart disease and hypertension</u> a) Description: Provide community education opportunities b) Metrics: Track number of community education events FY17</p> <p>2) <u>Increase health literacy for health conditions/healthy living</u> a) Description: Improve Health Literacy in elementary and middle schools related to heart health. Heart health lessons are taught in the second grade. b) Metrics: Track number of students served by program FY17</p>															

Table III – FY 2017 Community Benefits Narrative Report - Initiative 6 Improve cardiovascular health of community

	<p>3) <u>Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations</u> a) Description: Increase community health screenings for high blood pressure, carotid artery and cholesterol b) Metrics: Track number of persons screened FY17</p> <p>4) <u>Increase provider services in community to provide for cardiovascular related treatment</u> a) Description: Ensure proper professionals in community to provide vascular care b) Metrics: Track provider recruitment efforts FY17</p> <p>5) <u>Increase community capacity and collaboration for shared responsibility to address unmet health needs</u> a) Description: Develop partnerships and participate on committees b) Metrics: Track active participation FY17</p> <p>6) <u>Increase patient engagement in self-management of chronic conditions</u> a) Description: Utilize Faith Based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management b) Metrics: Track number of wellness workshops FY17</p> <p>7) <u>Increase care for individuals suffering from chronic conditions and decrease hospital admissions and readmissions</u> a) Description: Decrease readmissions to hospital for chronic disease management and reduce unnecessary healthcare costs b) Metrics: Track readmission rate FY17</p> <p>8) <u>Decrease tobacco use in Worcester County</u> a) Description: Maintain AGH/HS campus and locations as tobacco free b) Metric: Track measures to decrease tobacco use in Worcester FY17</p>
F: Single or multi-year plan:	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY16-FY18. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
G: Key collaborators in delivery:	<p>Hospital Resources: Population Health Department AGH/HS Lab Services Human Resources Cardiology – Peninsula Cardiology and Delmarva Heart PCMH Stroke Center</p> <p>Community Resources: Faith-based Partnership MAC, Inc. Worcester County Health Department Sussex County Employees Worcester County Employees Healthiest Business Initiative Local Pharmacies MSEA MD Barr Assoc</p>
H: Impact of hospital	Objective #1 - <u>Increase awareness around importance of prevention and early</u>

Table III – FY 2017 Community Benefits Narrative Report - Initiative 6 Improve cardiovascular health of community

<p>initiative:</p>	<p><u>detection of heart disease and hypertension</u></p> <p>Metrics: Track number of community education events FY17</p> <ul style="list-style-type: none"> • Outcome: Speakers Bureau 1 events in FY17 the topic was cholesterol Tri-County Go Red Event Feb 2017 Stroke Support Groups monthly meetings FY17 <p>Objective #2 - <u>Increase health literacy and self-management for health conditions/healthy living</u></p> <p>Metrics: Track number of students served by health literacy program FY17</p> <ul style="list-style-type: none"> • Outcome: The health literacy program provided heart health lessons to 500 second grade students during FY17. <p>Objective #3 - Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations</p> <p>Metrics: Track number of persons screened FY17</p> <ul style="list-style-type: none"> • Outcome: BP Screenings during FY17 – 1839 persons served, 19% referred for follow-up Carotid Screening during FY17 – 366 persons screened, 39% referred for follow-up Cholesterol Screenings during FY17 – 314 persons served compared to 223 persons served in FY16; FY17 61% were abnormal <p>Objective #4 - <u>Increase provider services in community to provide for cardiovascular related treatment</u></p> <p>Metrics: Track provider recruitment efforts FY17</p> <ul style="list-style-type: none"> • Outcome: AGH/HS continues efforts to recruit providers to meet the needs of the community. Will continue to track efforts in FY18. No data to report at this time. <p>Objective #5 - <u>Increase community capacity and collaboration for shared responsibility to address unmet health needs</u></p> <p>Metrics: Track active participation FY17</p> <ul style="list-style-type: none"> • Outcome: AGH continues collaboration and shared responsibility to meet health needs through partnership with the local health departments: Tri-County Go Red Event – Feb 2017 WCHD referrals to patients needing assistance with smoking cessation Local businesses: Sussex County and Worcester County Employees, MSEA, Maryland Barr Association to promote heart health and wellness opportunities <p>Objective #6 - <u>Increase patient engagement in self-management of chronic conditions</u></p>
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Table III – FY 2017 Community Benefits Narrative Report - Initiative 6 Improve cardiovascular health of community

	<p>Metrics: Track number of wellness workshops FY17</p> <ul style="list-style-type: none"> Outcome: CDSMP – 1 events, total 14 persons served Pocomoke Senior Center Ocean City Senior Center April 2016 Living Well With HTN- 1 events, total 15 persons served North Worcester Senior Center <p>Objective #7 - <u>Increase care for individuals suffering from chronic conditions and decrease hospital admissions and readmissions related to cardiovascular health.</u></p> <p>Metrics: Track readmission rate FY17</p> <ul style="list-style-type: none"> Outcome: AGH inpatients with heart disease 1321 persons (AGH internal data) FY16 compared to Heart Disease ED 4,374 persons and IP 1,298 persons (AGH internal data) 1.0% readmission rate FY17 <p>Objective #8 - <u>Decrease tobacco use in Worcester County</u></p> <p>Metric: Track measures to decrease tobacco use in Worcester FY17</p> <ul style="list-style-type: none"> Outcome: AGH remains a tobacco free campus during FY17 and will continue initiative. AGH provided a tobacco free campus 885 employees FY17. 	
I: Evaluation of outcome	<p>The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above. Long term measurements include: Measurement: Healthy People 2020 Readmission rate</p>	
J: Continuation of initiative:	<p>We will continue to monitor connections made to community programming for heart disease and stroke in to FY18.</p>	
K: Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	<p>a. Total Cost of Initiative for Current Fiscal Year</p> <p>\$34,366</p>	<p>b. Restricted Grants/Direct offsetting revenue</p> <p>None</p>

Table III – FY 2017 Community Benefits Narrative Report - Initiative 5 Decrease incidence of diabetes in the community

<p>A. 1. Identified Need: A. 2. How was the need identified:</p>	<p><u>Diabetes</u> During the FY16 CHNA process, PRC and Community Surveys identified diabetes as significant community area of concern. Diabetes management and numbers were associated concerns. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to diabetes. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.</p> <p>According to the CDC National Center for Health Stats (2015), national data trends for people with Diabetes show a significant rise in diagnoses. In the U.S., Diabetes is becoming more common. Diagnoses from 1980 – 2014 increased from 5.5 million to 22 million.</p> <table border="1" data-bbox="500 625 1230 800"> <thead> <tr> <th></th> <th>Worcester County</th> <th>Maryland</th> <th>Sussex County</th> <th>Delaware</th> </tr> </thead> <tbody> <tr> <td>Diabetic Monitoring (Medicare)</td> <td>88%</td> <td>85%</td> <td>89%</td> <td>86%</td> </tr> <tr> <td>Diabetes Prevalence</td> <td>13%</td> <td>10%</td> <td>13%</td> <td>11%</td> </tr> </tbody> </table> <p>(County Health Rankings, 2016)</p>		Worcester County	Maryland	Sussex County	Delaware	Diabetic Monitoring (Medicare)	88%	85%	89%	86%	Diabetes Prevalence	13%	10%	13%	11%
	Worcester County	Maryland	Sussex County	Delaware												
Diabetic Monitoring (Medicare)	88%	85%	89%	86%												
Diabetes Prevalence	13%	10%	13%	11%												
<p>B: Name of hospital initiative</p>	<p><u>Initiative:</u> Decrease incidence of diabetes in the community. (Healthy People 2020 Goal: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.) Clinical Screening Support Group Diabetes Education Chronic Disease Self-Management Program (evidence based) Patient Centered Medical Home Faith-based Partnerships Care Coordination Team Speaker’s Bureau Community Education</p>															
<p>C: Total number of people within target population</p>	<p>Worcester County 13% Diabetes Prevalence Sussex County 13% Diabetes Prevalence (Data: County Health Rankings 2016)</p>															
<p>D: Total number of people reached by the initiative</p>	<p>2,799 persons served through community education, screenings and support groups</p>															
<p>E: Primary objective of initiative:</p>	<p>1) <u>Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions</u> a) Description: Through AGH’s initiative to improve access to care reduction in unnecessary healthcare costs would be an impact of objectives improving access to care, educating the community on ED appropriate use, Diabetes chronic illness self-management, Diabetes prevention, and collaboration efforts with community organizations with a shared vision. b) Metric: Track hospital admission rate and ED rate FY17 2) <u>Increase awareness around importance of prevention of diabetes and early detection</u> a) Description: Strategy #1 -Provide diabetes screenings in community via health fairs and clinical</p>															

Table III – FY 2017 Community Benefits Narrative Report - Initiative 5 Decrease incidence of diabetes in the community

	<p>screening events Strategy #2 - Increase prevention behaviors in persons at high risk for diabetes with prediabetes through community education opportunities</p> <p>b) Metric: Strategy #1 - Track Diabetic community screening opportunities. Strategy #2 - Track community education opportunities that highlight Diabetes and pre-Diabetes.</p> <p>3) <u>Increase patient engagement in self-management of chronic conditions</u> a) Description: AGH partners with MAC, local senior centers and faith-based partnerships to bring Stanford self-management workshops to the community to increase patient engagement and self-management of chronic disease b) Metric: Track DSMP wellness workshops</p> <p>4) <u>Increase provider services in community to provide for diabetes related treatment</u> a) Description: Strategy #1 - Continue to provide Diabetes Education and chronic disease care via Patient Centered Medical Home Strategy #2 - Recruit Endocrinologist to community b) Metric: Strategy #1 -Track Diabetes Education via PCMH progress. Strategy #2 -Track Endocrinologist recruitment efforts.</p> <p>5) <u>Increase participation in community glucose screenings – especially at-risk and vulnerable populations</u> a) Description: AGH partners with local community organizations, including faith-based partnerships to bring glucose screening services to at-risk individuals such as minority populations and vulnerable populations such as homeless persons or those without adequate insurance coverage. b) Metric: Compare FY17 and FY16 glucose screening events</p> <p>6) <u>Increase community capacity and collaboration for shared responsibility to address unmet health needs</u> a) Description: -Partner with local health agencies to facilitate grant applications to fund diabetes programs b) Metric: -Track partnerships with local health agencies</p>
<p>F: Single or multi-year plan:</p>	<p>Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY16 – FY18. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
<p>G: Key collaborators in delivery:</p>	<p>Hospital Resources: •Diabetes Outpatient Education Program/PCMH •Diabetes Support Group •Population Health Department •Emergency Department •Foundation •Human Resources •Endocrinology •Lab Services</p> <p>Community Resources:</p>

Table III – FY 2017 Community Benefits Narrative Report - Initiative 5 Decrease incidence of diabetes in the community

	<ul style="list-style-type: none"> •Worcester County Health Department •MAC, Inc. •Tri-County Diabetes Alliance
<p>H: Impact of hospital initiative:</p>	<p>Objective #1 <u>-Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions</u></p> <p style="padding-left: 40px;">Metric: Track hospital admission rate and ED rate FY17</p> <ul style="list-style-type: none"> • Outcome: According to AGH ED and IP data during FY17, AGH served 1,239 persons with Diabetes compared to FY16 1,436 persons served. Readmission rate FY17 0.15% (AGH internal data) <p>Objective #2 <u>-Increase awareness around importance of prevention of diabetes and early detection</u></p> <p style="padding-left: 40px;">Metric:</p> <p>Strategy #1 - Track Diabetic community screening opportunities FY17 Strategy #2 - Track community education opportunities that highlight Diabetes and pre-Diabetes during FY17</p> <ul style="list-style-type: none"> • Outcome: Strategy #1 and Strategy #2 combined– WCPS and WCBOE MSEA Convention Bayside Development Institute – Speaker’s Bureau Ocean City Health Fair Ocean Pines Health Fair Wallops Island Health Fair Multiple Faith-based Partnership Church Health Fairs Worcester Prep School MSEA Diabetes Support Group x 15 <p>Objective #3 <u>- Increase patient engagement in self-management of chronic conditions</u></p> <p style="padding-left: 40px;">Metric: Track DSMP wellness workshops during FY17</p> <ul style="list-style-type: none"> • Outcome: DSMP 4 workshops offered to the community FY16 compared to zero DSMP offered in FY17. Will continue to monitor FY18 with MAC facilitation of workshops. <p>Objective #4 <u>-Increase provider services in community to provide for diabetes related treatment</u></p> <p style="padding-left: 40px;">Metric:</p> <p>Strategy #1 -Track Diabetes Education via PCMH progress FY16 Strategy #2 -Track Endocrinologist recruitment efforts FY16</p> <ul style="list-style-type: none"> • Outcome: Strategy #1- FY16 the Diabetes Education Program via PCMH served a total of 42 persons obtaining new referrals to program every 1 ½ to 2 months. The program provided education and community resource navigation for supplies to those needing assistance. No FY17 data available. Will continue to track FY18 in which the program transitioned from PCMH to Endocrinology Office. Strategy #2- AGH recruited an Endocrinologist to begin services in FY18. Will

Table III – FY 2017 Community Benefits Narrative Report - Initiative 5 Decrease incidence of diabetes in the community

	<p>continue to track FY18. continues to recruit specialty providers. Will continue to track recruitment progress as most efforts will not come to fruition until FY17.</p> <p><u>Objective #5 - Increase participation in community glucose screenings – especially at-risk and vulnerable populations</u></p> <p>Metric: Compare FY17 and FY16 glucose screening events</p> <ul style="list-style-type: none"> • Outcome: In FY17 AGH provided glucose screenings (lab draw) to 314 persons. In FY16, AGH provided screenings to 394 persons. Glucose checks by Diabetes Educator 57 persons FY17. Will continue to track FY18. <p>Objective #6 - Increase community capacity and collaboration for shared responsibility to address unmet health needs</p> <p>Metric: Track partnerships with local health agencies FY17</p> <ul style="list-style-type: none"> • Outcome: AGH continues to partner with the following: -Referral process in place with local health departments -Area Agencies on Aging -Faith-based partnerships -AGH continues to partner with local health agencies to facilitate grant applications to fund Diabetes Programs. Will continue to track FY18. -Tri-County Diabetes Alliance 	
<p>I: Evaluation of outcome</p>	<p>The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.</p> <p>Primary Objectives Long Term Measurements:</p> <ul style="list-style-type: none"> -Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes/objectives -Incidence of adult diabetes -Decrease ED visits due to acute episodes related to diabetes condition -County Health Rankings 	
<p>J: Continuation of initiative:</p>	<p>We will continue to monitor connections made to community programming for diabetes in to FY18.</p>	
<p>K: Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>a. Total Cost of Initiative for Current Fiscal Year</p> <p>\$23,122 community education, screenings and support groups</p>	<p>b. Restricted Grants/Direct offsetting revenue</p> <p>None</p>

Table III – FY 2017 Community Benefits Narrative Report - Initiative 4 Support community members in achieving a healthy weight

<p>A. 1. Identified Need: A. 2. How was the need identified:</p>	<p><u>Nutrition, Physical Activity & Weight</u> During the FY16 CHNA process, PRC and Community Surveys identified nutrition, physical activity and weight as significant community areas of great concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to poor nutrition, poor physical activity and obesity. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.</p> <p>Obesity is defined as having a Body Mass Index (BMI) that is greater than or equal to 30, while being overweight is defined as having a BMI of 25 – 29.9. Obesity has been linked to a variety of cancers and chronic illnesses including diabetes, colorectal cancer, kidney cancer, breast cancer, hypertension and cardiovascular disease (NCI, 2015).</p> <p>According to the CDC National Center for Health Statistics (2015), the prevalence of obesity was slightly more than 36 percent in adults and 17 percent in youth.</p> <ul style="list-style-type: none"> •The prevalence of obesity was higher in women 38.3% than in men 34.3%. No significant difference was noted by gender among youth. •The prevalence of obesity was higher among middle-aged and older adults than younger adults. (2013 – 2014) <table border="1" data-bbox="423 831 1427 1052"> <thead> <tr> <th></th> <th>Worcester County</th> <th>Maryland</th> <th>Sussex County</th> <th>Delaware</th> </tr> </thead> <tbody> <tr> <td>Adult Obesity</td> <td>30%</td> <td>28%</td> <td>31%</td> <td>29%</td> </tr> <tr> <td>Physical Inactivity</td> <td>27%</td> <td>23%</td> <td>27%</td> <td>25%</td> </tr> <tr> <td>Limited Access to Health Foods</td> <td>4%</td> <td>3%</td> <td>5%</td> <td>6%</td> </tr> </tbody> </table> <p>(County Health Rankings, 2016)</p>		Worcester County	Maryland	Sussex County	Delaware	Adult Obesity	30%	28%	31%	29%	Physical Inactivity	27%	23%	27%	25%	Limited Access to Health Foods	4%	3%	5%	6%
	Worcester County	Maryland	Sussex County	Delaware																	
Adult Obesity	30%	28%	31%	29%																	
Physical Inactivity	27%	23%	27%	25%																	
Limited Access to Health Foods	4%	3%	5%	6%																	
<p>B: Name of hospital initiative</p>	<p><u>Initiative:</u> Support community members in achieving a healthy weight. (Healthy People 2020: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights) BMI Screenings Hypertension Screenings Nutrition Counseling Nutrition Speakers through Speaker’s Bureau Education through Faith based Partnerships Integrated Health Literacy Program Support Groups TOPS and Overeaters Anonymous CDSMP (evidence based)</p>																				
<p>C: Total number of people within target population</p>	<p>Adult obesity Worcester County 30% and Sussex County 31% Adolescent obesity 2010 data 12.4% Healthy People 2020 in Worcester County Target according to MD SHIP is 11.3% of adolescents.</p>																				
<p>D: Total number of people reached by the initiative</p>	<p>6,157 persons served by initiative</p>																				
<p>E: Primary objective of initiative:</p>	<p>1) <u>Increase health literacy and self-management for health conditions/healthy living by increasing awareness around importance of nutrition, exercise and healthy weight</u></p> <p>Description: Strategy #1 - Improve Health Literacy in elementary and middle schools related to nutrition and exercise through the integrated health literacy program. Students in grades one through six county-wide participated in curriculum that included nutrition and/or physical exercise lessons. The 7th and 8th grade pilot at Stephen Decatur Middle School also included a lesson on</p>																				

Table III – FY 2017 Community Benefits Narrative Report - Initiative 4 Support community members in achieving a healthy weight

	<p>nutrition.</p> <p>Strategy #2 – Provide AGH based support groups/wellness classes to the community that promote healthy eating habits and exercise</p> <p>Metric: Strategy #1 -Track student participation in nutrition and physical activity lessons FY17. Strategy #2 - Track Support Groups TOPS and Overeaters Anonymous FY17.</p> <p>2) <u>Increase patient engagement in self-management of chronic conditions</u></p> <p>Description: Continue to provide education on health living topics to Faith-based Partnership and community senior centers</p> <p>Metric: Track CDSMP workshops FY17</p> <p>3) <u>Increase awareness of community resources, programs and services</u></p> <p>Description: Strategy #1 - Distribution brochure to public about Farmer’s Market & fresh produce preparation Strategy #2 - Participate in community events to spotlight surgical and non-surgical weight loss services</p> <p>Metric: Strategy #1 -Track brochure distribution FY17 Strategy #2 – Track persons served by events to spotlight surgical and non-surgical weight loss services FY17</p> <p>4) <u>Increase participation in community BMI screenings and Hypertension screenings – especially at-risk and vulnerable populations</u></p> <p>Description: Provide Hypertension and BMI screenings in the community</p> <p>Metric: Track persons screened FY17</p> <p>5) <u>Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs</u></p> <p>Description: Strategy #1 -Integrate Healthy People 2020 objectives into AGHS offices Strategy #2 - Participate in the “Just Walk” program of Worcester County</p> <p>Metric: Strategy #1 - Track integration of Healthy People 2020 objectives into AGHS offices FY17 Strategy #2 - Track participation in the “Just Walk” program of Worcester County FY17</p> <p>6) <u>Increase access to healthy foods and nutritional information</u></p> <p>Description: Provide speakers to community groups on nutrition</p> <p>Metric: Track community education/ speakers bureau events and persons served FY17</p>
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Table III – FY 2017 Community Benefits Narrative Report - Initiative 4 Support community members in achieving a healthy weight

<p>F: Single or multi-year plan:</p>	<p>Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY16 – FY18. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
<p>G: Key collaborators in delivery:</p>	<p>Hospital Resources: Population Health Department AGHS Offices Overeaters Anonymous Support Group Nutrition Services Atlantic General Bariatric Center AGH New Direction Medical Weight Loss Program</p> <p>Community Resources: Faith-based Partnership Worcester County Public Schools Worcester County Health Department MAC, Inc. Community Senior Centers Yoga/Tai Chi Programs TOPS of Berlin</p>
<p>H: Impact of hospital initiative:</p>	<p><u>Objective #1: Increase health literacy and self-management for health conditions/healthy living by increasing awareness around importance of nutrition, exercise and healthy weight</u></p> <p>Metric: Strategy #1 -Track student participation in nutrition and physical activity lessons FY17. Strategy #2 - Track Support Groups TOPS and Overeaters Anonymous FY17</p> <ul style="list-style-type: none"> • Outcome: <p>Strategy#1 - Based on the enrollment totals, there are 2400 students in grades two through six that participated in IHLP lessons on nutrition and physical activity during FY17. There were approximately 67 students who took part in this lessons in the sixth grade pilot during FY16. 100% of students recognize MyPlate. Increase in number of students who recognize the term “heart healthy” from FY15 63%. In FY17, a 7th and 8th grade curriculum was piloted at Stephen Decatur Middle School. 7th grade and 8th grades participated in nutrition lessons, specifically nutrition and diabetes for 8th grade students. No data available on number of students participating in 7th and 8th grade pilot. Will continue to track during FY18 county-wide grades 1 through 8.</p> <p>Strategy #2 – Persons served unavailable for Support Group TOPS FY17. FY16 42 persons served through presentations. Monthly groups offered to community. Will track FY18. Persons served unavailable for Support Group Overeaters Anonymous FY17. Monthly groups offered to community. Will track FY18. Yoga group FY17 persons served 266. Tai Chi group persons served FY17 persons served 6.</p> <p>2) <u>Increase patient engagement in self-management of chronic conditions</u></p> <p>Metric: Track CDSMP workshops FY17</p> <ul style="list-style-type: none"> • Outcome: <p>1CDSMP workshops were offered in FY17 serving 14 persons total Pocomoke Senior Center March/April 2017</p>

Table III – FY 2017 Community Benefits Narrative Report - Initiative 4 Support community members in achieving a healthy weight

	<p>3) <u>Increase awareness of community resources, programs and services</u></p> <p>Metric: Strategy #1 -Track brochure distribution FY17 Strategy #2 – Track persons served by events to spotlight surgical and non-surgical weight loss services FY17</p> <ul style="list-style-type: none"> Outcome: Strategy #1 – Brochure distribution numbers zero FY16 – FY17. 2000 distributed FY15. Will continue to monitor FY18. Strategy#2 – Bariatric nonsurgical support group implemented March 2016 and served 33 persons FY16. During FY 17, the support group served 217persons. <p>4) <u>Increase participation in community BMI screenings and Hypertension screenings – especially at-risk and vulnerable populations</u></p> <p>Metric: Track persons screened FY17</p> <ul style="list-style-type: none"> Outcomes: BMI Screenings FY17 338 persons served. Hypertension Screenings FY17 1839 persons served. <p>5) <u>Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs</u></p> <p>Metric: Strategy #1 - Track integration of Healthy People 2020 objectives into AGHS offices FY17 Strategy #2 - Track participation in the “Just Walk” program of Worcester County FY17</p> <ul style="list-style-type: none"> Outcome: Strategy #1 – No data available for tracking purposes. Healthy People Objectives integrated into AGHS offices FY16. Strategy #2 – 11 persons served at “Just Walk” program in Worcester County FY16. No data is available for FY17. <p>6) <u>Increase access to healthy foods and nutritional information</u></p> <p>Metric: Track community education/speakers bureau events and persons served FY17</p> <ul style="list-style-type: none"> Outcome: 1,083 were served by nutritional information and information on access to healthy foods during FY17 	
<p>I: Evaluation of outcome</p>	<p>The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above. Long term measurements: Healthy People 2020 Objectives CDC National Center for Health Statistics County Health Rankings</p>	
<p>J: Continuation of initiative:</p>	<p>We will continue to monitor connections made to community programming for nutrition, physical activity and weight in FY18.</p>	
<p>K: Expense: A. Total Cost of Initiative for Current Fiscal</p>	<p>a. Total Cost of Initiative for Current Fiscal Year \$60,207</p>	<p>b. Restricted Grants/Direct offsetting revenue IHLP Berger Restricted Fund MOI</p>

Table III – FY 2017 Community Benefits Narrative Report - Initiative 4 Support community members in achieving a healthy weight

Year B. What amount is Restricted Grants/Direct offsetting revenue		\$1,046
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Table III – FY 2017 Community Benefits Narrative Report – Initiative 3 Promote community respiratory health through better prevention, detection, treatment, and education efforts

<p>A. 1. Identified Need: A. 2. How was the need identified:</p>	<p><u>Respiratory Disease & Smoking</u> During the FY16 CHNA process, PRC and Community Surveys identified respiratory disease and smoking cancer as significant community area of great concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to respiratory disease and smoking. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.</p> <p>According to Healthy People 2020, approximately 23 million Americans have asthma and approximately 13.6 million adults have COPD. Healthy People 2020 estimates there are an equal number of undiagnosed Americans. (Healthy People 2020)</p> <table border="1" data-bbox="516 634 1380 850"> <thead> <tr> <th></th> <th>Worcester County</th> <th>Sussex County</th> <th>U.S. Median</th> <th>Healthy People 2020</th> </tr> </thead> <tbody> <tr> <td>Adults Smoking</td> <td>21.9%</td> <td>21.7%</td> <td>21.7%</td> <td>12%</td> </tr> <tr> <td>Older Adult Asthma</td> <td>3.8%</td> <td>3.6%</td> <td>3.6%</td> <td>-</td> </tr> <tr> <td>Chronic Lower Respiratory Deaths</td> <td>34.1/100,000</td> <td>41.6/100,000</td> <td>49.6/100,000</td> <td>-</td> </tr> </tbody> </table> <p>(CHSI, 2015)</p>		Worcester County	Sussex County	U.S. Median	Healthy People 2020	Adults Smoking	21.9%	21.7%	21.7%	12%	Older Adult Asthma	3.8%	3.6%	3.6%	-	Chronic Lower Respiratory Deaths	34.1/100,000	41.6/100,000	49.6/100,000	-
	Worcester County	Sussex County	U.S. Median	Healthy People 2020																	
Adults Smoking	21.9%	21.7%	21.7%	12%																	
Older Adult Asthma	3.8%	3.6%	3.6%	-																	
Chronic Lower Respiratory Deaths	34.1/100,000	41.6/100,000	49.6/100,000	-																	
<p>B: Name of hospital initiative</p>	<p><u>Initiative:</u> Promote community respiratory health through better prevention, detection, treatment, and education efforts. (Healthy People 2020 Goal: Promote respiratory health through better prevention, detection, treatment, and education efforts.) Community Screenings Care Coordination/Community Partnerships CDSMP (evidence based) Speaker’s Bureau Integrated Health Literacy Program (IHLP)</p>																				
<p>C: Total number of people within target population</p>	<p>Adults smoking Worcester County 21.9% and Sussex County 21.7% (CHSI, 2015) Older adult asthma Worcester County 3.8% and Sussex County 3.6% (CHSI, 2015) Asthma in younger adults admission rate not available via MD SHIP 2,013 adults have COPD in Worcester County (MD SHIP, 2013)</p>																				
<p>D: Total number of people reached by the initiative</p>	<p>4,688 persons served by initiative FY17; a 33% increase from FY16</p>																				
<p>E: Primary objective of initiative:</p>	<p>1) Decrease tobacco use in Worcester County a) Description: Strategy #1 -Provide speakers to community groups on smoking cessation Strategy #2 - Collaborate with Worcester County Health Department Prevention Department to promote smoking cessation and tobacco use reduction in community b) Metric: Strategy #1 -Track smoking cessation education opportunities during FY17 Strategy #2 - Track collaboration opportunities with Worcester County Health Department FY17</p> <p>2) Increase participation in community lung/respiratory screenings – especially at-risk and vulnerable populations a) Description: Improve proportion of minorities receiving LDCT screenings b) Metric: Track persons served by lung/respiratory screening events FY17</p> <p>3) Increase awareness around importance of prevention and early detection</p>																				

Table III – FY 2017 Community Benefits Narrative Report – Initiative 3 Promote community respiratory health through better prevention, detection, treatment, and education efforts

	<p>a) Description: Participate in community events to spotlight pulmonary clinic services Provide community education events to the community to increase awareness around the importance of prevention and early detection.</p> <p>b) Metric: Track community events which spotlight pulmonary clinic services FY 17 Track community education opportunities FY17</p> <p>4) Increase health literacy for health conditions/healthy living</p> <p>a) Description: Improve Health Literacy in middle schools related to tobacco use</p> <p>b) Metric: Track students participating in tobacco use lessons provided by the Integrated Health Literacy Program FY17</p> <p>5) Increase provider services in community to provide for respiratory related treatment</p> <p>a) Description: Recruit Pulmonologist to community</p> <p>b) Metric: Track recruitment efforts of Pulmonologist to the community FY17</p> <p>6) Decrease hospital admissions and readmissions</p> <p>a) Description: Reduce emergency department (ED) visits for chronic obstructive pulmonary disease (COPD) and asthma</p> <p>b) Metric: Track ED visits related to COPD and asthma FY 17</p>
<p>F: Single or multi-year plan:</p>	<p>Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY16 – FY18. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
<p>G: Key collaborators in delivery:</p>	<p>Hospital Resources:</p> <ul style="list-style-type: none"> •Pulmonary Clinic •Imaging •Emergency Department •Population Health Department •Human Resources •Pulmonology <p>Community Resources:</p> <ul style="list-style-type: none"> •Worcester County Health Department •Worcester County Public Schools
<p>H: Impact of hospital initiative:</p>	<p>Objective #1: Decrease tobacco use in Worcester County</p> <p>Metric:</p> <p>Strategy #1 -Track smoking cessation education opportunities during FY17</p> <p>Strategy #2 - Track collaboration opportunities with Worcester County Health Department FY17</p> <ul style="list-style-type: none"> • Outcome: <p>Strategy #1 – Smoking cessation education opportunities available to report FY17 stem from health fair educational opportunities which include 8 events. Persons served are referred to the local health department’s program.</p> <p>Strategy #2 – AGH continues to collaborate with WCHD by providing referrals to patients needing assistance with smoking cessation. Will continue to monitor FY18. AGH collaborated with the WCHD as part of a Tobacco Prevention Education Mini Grant to promote education to Worcester County residents, specifically targeting middle school students, including tobacco, vaping, and e cigarettes. 501 Worcester County residents and 1,453 Worcester County middle school students were served by this program. Brochures and posters were created and distributed in partnership</p>

Table III – FY 2017 Community Benefits Narrative Report – Initiative 3 Promote community respiratory health through better prevention, detection, treatment, and education efforts

	<p>with the local health department during FY17.</p> <p>Objective #2: Increase participation in community lung/respiratory screenings – especially at-risk and vulnerable populations</p> <p>Metric: Track persons served by lung/respiratory screening events FY17</p> <ul style="list-style-type: none"> • Outcome: 78 persons were served through pulmonary function screenings FY17 149 persons were served by LDCT community education FY17 <p>Objective #3: Increase awareness around importance of prevention and early detection</p> <p>Metric: Strategy #1 -Track community events which spotlight pulmonary clinic services FY 17 Strategy #2 - Track community education opportunities FY17</p> <ul style="list-style-type: none"> • Outcome: Strategies 1 and 2 combined – total person served 1,320 persons served from the following events: Captains Cove Health Fair August 2016 Worcester Prep Health Fair August 2016 Wallops Island Health Fair October 2016 Ocean Pines Health Fair October 2016 Worcester Board of Education March 2017 UMES Health Fair March 2017 Wor Wic College Health Fair May 2017 Ocean City Health Fair May 2017 <p>Strategy 2 – CDSMP Pocomoke Senior Center, March/April 2017, 14 persons served Will track during FY18 through new partnership with MAC, Inc.</p> <p>Objective #4: Increase health literacy for health conditions/healthy living</p> <p>Metric: Track students participating in tobacco use lessons provided by the Integrated Health Literacy Program FY17</p> <ul style="list-style-type: none"> • Outcome: 75 students participated in lessons on substance abuse, tobacco and e-cigarettes during FY17. <p>Objective #5: Increase provider services in community to provide for respiratory related treatment</p> <p>Metric: Track recruitment efforts of Pulmonologist to the community FY17.</p> <ul style="list-style-type: none"> • Outcome: AGH continues recruitment efforts to increase healthcare providers in the community service area. No Pulmonologist was hired in FY17. Recruitment efforts will continue FY18. <p>Objective #6: Decrease hospital admissions and readmissions</p> <p>Metric: Track ED visits related to COPD and asthma FY 17</p>
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Table III – FY 2017 Community Benefits Narrative Report – Initiative 3 Promote community respiratory health through better prevention, detection, treatment, and education efforts

	<ul style="list-style-type: none"> Outcome: According to AGH ED data FY17: 685 persons presented in the ED with Asthma compared to 934 persons FY16 413 persons presented in the ED with COPD compared to 960 persons FY16 	
I: Evaluation of outcome	<p>The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.</p> <p>Long term measurements:</p> <ul style="list-style-type: none"> -Healthy People 2020 -Decrease ED visits due to acute episodes related to respiratory condition -CHSI 	
J: Continuation of initiative:	We will continue to monitor connections made to community programming for respiratory disease and smoking prevention/cessation during FY18.	
K: Expense:	a. Total Cost of Initiative for Current Fiscal Year	b. Restricted Grants/Direct offsetting revenue
A. Total Cost of Initiative for Current Fiscal Year	\$12,417	
B. What amount is Restricted Grants/Direct offsetting revenue		Tobacco Mini-Grant \$1,500

Table III – FY 2017 Community Benefits Narrative Report - Initiative 2 Decrease the incidence of advanced breast, lung, colon and skin cancer in the community

<p>A. 1. Identified Need: A. 2. How was the need identified:</p>	<p><u>Cancer</u> During the FY16 CHNA process, PRC and Community Surveys identified cancer as significant community area of great concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to cancer diagnoses. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.</p> <p>According to Healthy People 2020, continued advances in cancer detection, research and cancer treatment have decreased cancer incidences and death rates in the United States. Despite continued advances, cancer remains a leading cause of death second to heart disease in the United States. (Healthy People 2020)</p> <table border="1" data-bbox="483 625 1307 930"> <thead> <tr> <th>(rate per 100,000 persons)</th> <th>Worcester County</th> <th>Sussex County</th> <th>U.S. Median</th> <th>Healthy People 2020</th> </tr> </thead> <tbody> <tr> <td>Cancer Deaths</td> <td>188.0</td> <td>184.1</td> <td>185</td> <td>161.4</td> </tr> <tr> <td>Cancer</td> <td>506.1</td> <td>505.8</td> <td>457.6</td> <td>-</td> </tr> <tr> <td>Colon Rectum Cancer</td> <td>43.2</td> <td>46.3</td> <td>-</td> <td>-</td> </tr> <tr> <td>Female Breast Cancer</td> <td>138.5</td> <td>125.7</td> <td>-</td> <td>-</td> </tr> <tr> <td>Lung Bronchus Cancer</td> <td>71</td> <td>77.7</td> <td>-</td> <td>-</td> </tr> <tr> <td>Male Prostate Cancer</td> <td>190.1</td> <td>156.6</td> <td>-</td> <td>-</td> </tr> </tbody> </table> <p>(CHSI, 2015)</p> <table border="1" data-bbox="483 961 1323 1108"> <thead> <tr> <th></th> <th>Worcester County</th> <th>Sussex County</th> <th>U.S. Median</th> <th>Healthy People 2020</th> </tr> </thead> <tbody> <tr> <td>Melanoma Deaths (age adjusted per 100,000)</td> <td>4.6</td> <td>2.6</td> <td>2.7</td> <td>2.4</td> </tr> </tbody> </table> <p>(State Cancer Profiles, 2009-2013)</p>	(rate per 100,000 persons)	Worcester County	Sussex County	U.S. Median	Healthy People 2020	Cancer Deaths	188.0	184.1	185	161.4	Cancer	506.1	505.8	457.6	-	Colon Rectum Cancer	43.2	46.3	-	-	Female Breast Cancer	138.5	125.7	-	-	Lung Bronchus Cancer	71	77.7	-	-	Male Prostate Cancer	190.1	156.6	-	-		Worcester County	Sussex County	U.S. Median	Healthy People 2020	Melanoma Deaths (age adjusted per 100,000)	4.6	2.6	2.7	2.4
(rate per 100,000 persons)	Worcester County	Sussex County	U.S. Median	Healthy People 2020																																										
Cancer Deaths	188.0	184.1	185	161.4																																										
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	Worcester County	Sussex County	U.S. Median	Healthy People 2020																																										
Melanoma Deaths (age adjusted per 100,000)	4.6	2.6	2.7	2.4																																										
<p>B: Name of hospital initiative</p>	<p>Initiative: Decrease the incidence of advanced breast, lung, colon, and skin cancer in community. (Healthy People 2020 Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.) Community Education Clinical Screenings Grant Writing Speakers Bureau Support Groups</p>																																													
<p>C: Total number of people within target population</p>	<p>Worcester County 506.1/100,000 persons with Cancer Sussex County 505.8/100,000 persons with Cancer (Data: CHSI, 2015)</p>																																													
<p>D: Total number of people reached by the initiative</p>	<p>3,714 persons were served at community education, speaker’s bureau, support group, and community clinical screening events. Due to size of initiative, these events are the only accurate tracking record for number of persons served</p>																																													
<p>E: Primary objective of initiative:</p>	<p>1) Increase awareness around importance of prevention and early detection and reduce health disparities a) Description: -Improve proportion of minorities receiving women’s preventative health services -Improve proportion of minorities participating in community health screenings b) Metrics: Healthy People 2020 AGH databases on ethnicity CHSI</p>																																													

Table III – FY 2017 Community Benefits Narrative Report - Initiative 2 Decrease the incidence of advanced breast, lung, colon and skin cancer in the community

	<p>2) Increase provider services in community to provide for cancer related treatment</p> <p>a) Description: Recruit proper professionals in community to provide for cancer related treatment</p> <p>b) Metrics: Track provider recruitment FY16</p> <p>3) Improve access and referrals to community resources resulting in better outcomes</p> <p>a) Description: Partner with local health agencies to facilitate grant application to fund cancer programs</p> <p>b) Metrics: Track grant opportunities and formal partnerships FY16</p> <p>4) Increase support to patients and caregivers</p> <p>a) Description: Patients and caregivers need support throughout the cancer treatment process. Patients experience the physical and emotional stressors undergoing treatment while caregivers fulfill a prominent and unique role supporting cancer patients and multitude of services such as home support, medical tasks support, communication with healthcare providers and patient advocate. AGH community education opportunities provide support and promote an informed patient and caregiver.</p> <p>b) Metrics: Track cancer prevention and educational opportunities FY16</p> <p>5) Increase participation in community cancer screenings – especially at-risk and vulnerable populations</p> <p>a) Description: -Provide community health screenings: -Improve proportion of minorities receiving colonoscopy screenings -Improve proportion of minorities receiving LDCT screenings -Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn through melanoma education and skin cancer screenings</p> <p>b) Metrics: Track community screening events and persons screened FY16</p>
<p>F: Single or multi-year plan:</p>	<p>Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY16 – FY18. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
<p>G: Key collaborators in delivery:</p>	<p>Hospital Resources:</p> <ul style="list-style-type: none"> •Population Health Department •Human Resources •Foundation •Women’s Diagnostic Center •Endoscopy •Imaging •Pulmonary Clinic •Dermatology •Medical Oncology •Regional Cancer Care Center •Radiation Oncology •AGH Cancer Committee <p>Community Resources: Worcester County Health Department Komen Consortium Relay for Life</p>

Table III – FY 2017 Community Benefits Narrative Report - Initiative 2 Decrease the incidence of advanced breast, lung, colon and skin cancer in the community

	<p>Women Supporting Women Red Devils</p>
<p>H: Impact of hospital initiative:</p>	<p>Objective 1: Increase awareness around importance of prevention and early detection and reduce health disparities</p> <p>Metrics: Track Community Health Needs Assessment data FY16-18 AGH internal data</p> <ul style="list-style-type: none"> • Outcome: CY2016 AGH data top cancers seen: Melanoma 30.73% Breast Cancer 14.06% Prostate Cancer 8.07% Lung Cancer 8.07% Bladder Cancer 7.03% Colon Cancer 5.47% (AGH Internal Data from Cancer Care Center) <p>According to CHNA FY16-FY18 Worcester County data:</p> <ul style="list-style-type: none"> • Lung Cancer – Majority Black • Age-Adjusted Death Rate due to Lung Cancer by Race/Ethnicity 73.8 Black male deaths /100,000 population compared to 57.6 White deaths /100,000 population • Colorectal Cancer – Majority Black Male • Colorectal Cancer Incidence Rate by Gender 46.5 male cases/100,000 population compared to 27.4 female cases/100,000 population • Colorectal Cancer Incidence Rate by Race/Ethnicity 40.5 Black cases/ 100,000 population compared to 33.2 White cases/100,000 population • Lung and Bronchus Cancer –Majority Black Males • Lung and Bronchus Cancer Incidence by Gender 59.5 female cases /100,000 population compared to 90.5 male cases/100,000 population • Lung and Bronchus Cancer Incidence Rate by Race/Ethnicity 88.7 Black cases/ 100,000 population compared to 68.5 White cases/100,000 population • Prostate Cancer – Majority Black Male • Prostate Cancer Incidence by Race/Ethnicity 302.3 Black male cases /100,000 males compared to 139.6 White male cases /100,000 males <p>According to CHNA FY16 Sussex County data:</p> <ul style="list-style-type: none"> • Prostate Cancer – Majority Black Male • Prostate Cancer Incidence by Race/Ethnicity: 214.4 Black male cases /100,000 males compared to 135.8 White male cases /100,000 males • Age Adjusted Death Rate due to Prostate Cancer by Race/Ethnicity 48.0 Black male cases /100,000 males compared to 19.0 White male cases /100,000 males • Breast Cancer – Majority Black Female • Age Adjusted Death Rate due to Breast Cancer by Race/Ethnicity 28.0 Black female deaths/100,000 females compared to 19.6 White female deaths/100,000 females • Lung and Bronchus Cancer – Majority Males • Lung and Bronchus Cancer Incidence by Gender

Table III – FY 2017 Community Benefits Narrative Report - Initiative 2 Decrease the incidence of advanced breast, lung, colon and skin cancer in the community

	<p>68.0 female cases /100,000 population compared to 84.9 male cases/100,000 population</p> <p>Objective 2: Increase provider services in community to provide for cancer related treatment</p> <p>Metrics: Track provider recruitmentFY17</p> <ul style="list-style-type: none"> • Outcome: <ul style="list-style-type: none"> -Zero providers recruited for cancer initiative FY17 -Capital Campaign for Regional Cancer Care Center FY16 and construction of RCCC in progress FY17. Will track progress FY18. <p>Objective 3: Improve access and referrals to community resources resulting in better outcomes</p> <p>Metrics: Track grant opportunities and formal partnerships FY17</p> <ul style="list-style-type: none"> • Outcome: <ul style="list-style-type: none"> Grant submissions/awards FY17 <ul style="list-style-type: none"> • 2/17/17 - SUBMITTED-AWARDED - Worcester County Commissioners - \$100,000 Campaign for the Future - Regional Cancer Care Center (received in FY18 from the county’s FY18 budget appropriation) • 2/01/17 - SUBMITTED-AWARDED - Community Foundation of the Eastern Shore’s Community Needs Grant Program - \$5,000 for Integrative Therapies at the Regional Cancer Care Center • 11/15/16 - SUBMITTED-AWARDED - Community Foundation of the Eastern Shore Mini-Grant - \$1,000 for Patient Assistance Fund for RCCC patients Formal partnerships during FY17 include: <ul style="list-style-type: none"> Komen 21st Century Oncology Local Health Departments Women Supporting Women Support Group American Cancer Society Red Devils Relay for Life <p>Objective 4: Increase support to patients and caregivers</p> <p>Metrics: Track cancer prevention and educational opportunities FY17</p> <ul style="list-style-type: none"> • Outcome: <ul style="list-style-type: none"> The following community education activities were tracked in FY17: <ul style="list-style-type: none"> Increase awareness around importance of prevention and early detection and reduce health disparities – 49 events Improve proportion of minorities receiving women’s preventative health services – 13 events <p>Objective 5: Increase participation in community cancer screenings – especially at-risk and vulnerable populations</p> <p>Metrics: Track community screening events and persons screened FY17</p> <ul style="list-style-type: none"> • Outcome: <ul style="list-style-type: none"> Screenings provided at health fairs and clinical screening events FY17:
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Table III – FY 2017 Community Benefits Narrative Report - Initiative 2 Decrease the incidence of advanced breast, lung, colon and skin cancer in the community

	<p>Respiratory Screenings, 78 persons screened, 19% referred for follow-up Skin Cancer Screenings, 108 persons screened, 47% referred for follow-up AGH provided 4 screening events which were aimed to improve proportion of minorities participating in community health screenings. AGH provided free 3D Mammogram services West OC. No data available at this time to report on the proportion of minorities receiving colonoscopy screenings. Will continue to track FY18.</p>	
<p>I: Evaluation of outcome</p>	<p>The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above. Long term measurements: Community Needs Survey Healthy People 2020 AGH databases on ethnicity CHSI</p>	
<p>J: Continuation of initiative:</p>	<p>We will continue to monitor connections made to community programming for access to cancer prevention and screenings FY18.</p>	
<p>K: Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>a. Total Cost of Initiative for Current Fiscal Year \$42,169 Community education, clinical screening events, Speaker’s Bureau, and Support Groups</p>	<p>b. Restricted Grants/Direct offsetting revenue Zero revenue for community education, speakers, groups and community clinical screening events</p>

Table III – FY 2017 Community Benefits Narrative Report – Access to Care

<p>A. 1. Identified Need:</p> <p>A. 2. How was the need identified:</p>	<p><u>Access to Care</u></p> <p>During the FY16 CHNA process, PRC and Community Surveys identified access to care as the greatest community concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to access to care. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.</p> <p>Atlantic General Hospital is the only hospital in Worcester County, a DHMH federally-designated medically-underserved area, a state-designated rural community, and a HRSA-designated Health Professional Shortage Area for primary care, mental health, and dental health. In AGH’s service area, the top reasons for patients not seeking health care in our communities are cost, transportation, and lack of providers. According to the Community Health Needs Assessment (CHNA) FY2016, the community rated the follow as the top barriers to access health care:</p> <ul style="list-style-type: none"> • Too expensive/can’t afford it 65.3% • No health insurance 53.5% • Couldn’t get an appointment with my doctor 19.6% • No transportation 18.1% • Local doctors are not on my insurance plan 13.7% • Service is not available in our community 9.2% • Doctor is too far away from my home 4.8% <table border="1" data-bbox="548 1016 1325 1474"> <thead> <tr> <th></th> <th>Worcester County</th> <th>Sussex County</th> <th>U.S. Median</th> <th>Healthy People 2020 Target</th> </tr> </thead> <tbody> <tr> <td>Cost Barrier to Care</td> <td>16.1%</td> <td>12.2%</td> <td>15.6%</td> <td>9%</td> </tr> <tr> <td>Older Adult Preventable Hospitalizations (Medicare Enrollees)</td> <td>51.9/1,000</td> <td>53/1,000</td> <td>71.3/1,000</td> <td>-</td> </tr> <tr> <td>Primary Care Provider Access</td> <td>58.2/100,000</td> <td>57.4/100,000</td> <td>48/100,000</td> <td>-</td> </tr> <tr> <td>Uninsured</td> <td>14.2%</td> <td>14.0%</td> <td>17.7%</td> <td>-</td> </tr> <tr> <td>Dentist Access</td> <td>50.5/100,000</td> <td>22.0/100,000</td> <td>-</td> <td>-</td> </tr> <tr> <td>Poverty</td> <td>11.1%</td> <td>15.7%</td> <td>16.3%</td> <td>-</td> </tr> <tr> <td>Overall Health Status</td> <td>13.3%</td> <td>14.6%</td> <td>16.5%</td> <td>-</td> </tr> </tbody> </table> <p>(CHSI. 2015)</p>		Worcester County	Sussex County	U.S. Median	Healthy People 2020 Target	Cost Barrier to Care	16.1%	12.2%	15.6%	9%	Older Adult Preventable Hospitalizations (Medicare Enrollees)	51.9/1,000	53/1,000	71.3/1,000	-	Primary Care Provider Access	58.2/100,000	57.4/100,000	48/100,000	-	Uninsured	14.2%	14.0%	17.7%	-	Dentist Access	50.5/100,000	22.0/100,000	-	-	Poverty	11.1%	15.7%	16.3%	-	Overall Health Status	13.3%	14.6%	16.5%	-
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<p>B: Name of hospital initiative</p>	<p><u>Initiative:</u> Increase community access to comprehensive, quality health care services. (Healthy People 2020 Goal: Improve access to comprehensive, quality health care services) CPSMP Clinical Screenings Community Meetings/Coalitions DSMP Flu Clinics Health Fairs Health Literacy</p>																																								

Table III – FY 2017 Community Benefits Narrative Report – Access to Care

	<p>HTN Clinics Living Well Workshops Provider Recruitment Speaker’s Bureau Wellness Van</p>
<p>C: Total number of people within target population</p>	<p>14.2% uninsured Worcester County 14.0% uninsured Sussex County (Data: CHSI) Population Worcester County: Total Population 51,769 White 42,024 Black/Af Amer 7,159 Am Ind/AK Native 143 Asian 729 Native HI/PI 13 Some Other Race 699 2+ Races 1,002 (Data: Healthy Communities Institute) Population Sussex County: Total Population 216,486 White 169,252 Black/Af Amer 26,855 Am Ind/AK Native 1,817 Asian 2,582 Native HI/PI 179 Some Other Race 10,183 2+ Races 5,618 (Data: Healthy Communities Institute) 3500:1 Worcester County 2060:1 Somerset County 1870:1 Wicomico County 1165:1 Sussex County</p>
<p>D: Total number of people reached by the initiative</p>	<p>21,050 encounters</p>
<p>E: Primary objective of initiative:</p>	<p>1) <u>Reduce unnecessary healthcare costs and reduction in hospital admissions and readmissions during FY17</u> a) Description: Through AGH’s initiative to improve access to care reduction in unnecessary healthcare costs would be an impact of objectives improving access to care, educating the community on ED appropriate use, chronic illness self-management, and collaboration efforts with community organizations with a shared vision. b) Metrics: Hospital readmission rate</p> <p>2) <u>Increase in awareness and self-management of chronic disease during FY17</u> a) Description: Utilize Faith-based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management b) Metrics: Community Survey Track Wellness Workshops</p> <p>3) <u>Reduce health disparities during FY17</u> a) Description: Strategy #1-Partner with poultry plants to promote wellness by community</p>

Table III – FY 2017 Community Benefits Narrative Report – Access to Care

	<p>education events and access to screenings. Strategy #2-Provide community health events to target minority populations by increasing relationships with faith-based partnerships, local businesses and cultural/ethnic community events. Strategy #3-Educate community on financial assistance options to improve affordability of care and reduce delay in care.</p> <p>b) Metrics: Community Survey CHSI AGH databases on ethnicity Maryland SHIP Healthy People 2020</p> <p>4) <u>Increase community capacity and collaboration for shared responsibility to address unmet health needs during FY17</u> a) Description: Partnering with community organizations and participation on committees that address access to care and health disparities: -Partner with homeless shelters and food pantries to promote wellness -Refer community to local agencies such as Shore Transit and Worcester County Health Department for transportation assistance -Participate on Tri County Health Planning Council -Participate on Lower Shore Dental Task Force -Participate on Worcester County Healthy Planning Advisory Council -Participate on Homelessness Committee</p> <p>b) Metrics: Track committee participation and partnerships</p> <p>5) <u>Increase number of practicing primary care providers and specialists to community during FY17</u> a) Description: Provider recruitment b) Metrics: Track provider recruitment Community Survey</p>
<p>F: Single or multi-year plan:</p>	<p>Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY16 – FY18. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
<p>G: Key collaborators in delivery:</p>	<p>Hospital Resources:</p> <ul style="list-style-type: none"> • Population Health Department • AGH/HS • Human Resources • Registration/Billing Services • Emergency Department • Executive Care Coordination Team <p>Community Resources:</p> <ul style="list-style-type: none"> • Faith-based Partnership • Lower Shore Dental Task Force • Homelessness Committee • Worcester County Healthy Planning Advisory Council • Worcester County Health Department • Local Food Pantries/Shelters • Wagner Wellness Van • Perdue and Mountaire Poultry Plants • Shore Transit • Tri County Health Planning Council
<p>H: Impact of hospital initiative:</p>	<p>Objective 1: <u>Reduce unnecessary healthcare costs and reduction in hospital admissions and readmissions during FY17</u></p>

Table III – FY 2017 Community Benefits Narrative Report – Access to Care

	<p>Metrics: Hospital readmission rate</p> <ul style="list-style-type: none"> • Outcome: As of June 30, 2016, AGH Hospital readmission rate 9.1% (MHA). IP readmission rate (risk adjusted rated-AGH performance based) 8.9% AGH/ 10.78% CY2016 Target. <p>Objective 2:<u>Increase in awareness and self-management of chronic disease during FY17</u></p> <p>Metrics: -Community Survey to be completed as part of CHNA FY18 -Track Wellness Workshops</p> <ul style="list-style-type: none"> • Outcome: Population Health offered the following wellness workshops in FY17: HTN – 1, CDSMP – 1, CPSMP – 3, Stepping On – 1, DSMP – 0 = total 6 workshops. Will continue to monitor as part of an expanded MAC partnership in FY18. <p>Objective 3: <u>Reduce health disparities during FY17</u></p> <p>Metrics: Community Survey to be completed as part of CHNA FY18 CHSI AGH databases on ethnicity Maryland SHIP Healthy People 2020</p> <ul style="list-style-type: none"> • Outcome: Strategy #1-Developed relationship with Perdue Salisbury and Mountaire poultry plants, to explore and assess need for opportunities to promote wellness via community education events and access to screenings. Will continue to build relationship efforts FY18 and provide events. -Community health education events during FY17 targeting minority population: 27 events Strategy #2 -Screenings during FY17: BMI, 338 persons screened, 63% overweight/obese Bone Density, 736 persons screened, 35% referred for follow-up Breast Exams, 0 persons screened BP Screenings, 1,839 persons screened, 39% referred for follow-up Respiratory Screenings, 78 persons screened, 19% referred for follow-up Skin Cancer Screenings, 108 persons screened, 47% referred for follow-up Carotid Artery Screenings, 366 screened, 39% referred for follow-up Strategy #3 -Community health education events that educated community on financial assistance options to improve affordability of care and reduce delay in care during FY17: 4 events <p>Objective 4:<u>Increase community capacity and collaboration for shared responsibility to address unmet health needs during FY17</u></p> <p>Metrics: Track committee participation and partnerships</p> <ul style="list-style-type: none"> * Outcome: --Continued relationship with local shelters and food pantries through Faith-Based Partnership to explore and assess need for opportunities to promote wellness via community education events and access to screenings. Will continue to promote relationship efforts FY18. Implementation of HSCRC Regional Grant partnership with PRMC Wellness Van outreach project FY2017. -Population Health Manager/Director Community Health active participation on the following committees FY17 to promote care coordination and
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Table III – FY 2017 Community Benefits Narrative Report – Access to Care

	<p>community collaboration: Tri County Health Planning Council, Lower Shore Dental Task Force, Worcester County Healthy Planning Advisory Council, and Homelessness Committee.</p> <p>Objective 5: <u>Increase number of practicing primary care providers and specialists to community during FY17</u> Metrics: Track provider recruitment Community Survey</p> <ul style="list-style-type: none"> • Outcome: <ul style="list-style-type: none"> - Community Survey to be completed as part of CHNA FY18 - During FY16, AGH/AGHS hired one GYN and one Dermatologist. During FY17, AGH/AGHS hired two general surgeons, one GYN, one neurologist, and one family med physician. Will continue to track FY18. 	
<p>I: Evaluation of outcome</p>	<p>-The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above. Long term measurements include: Community Survey to be completed as part of CHNA FY18 CHSI Maryland SHIP Healthy People 2020</p>	
<p>J: Continuation of initiative:</p>	<p>We will continue to monitor connections made to community programming for access to care programs in FY18.</p>	
<p>K: Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>a. Total Cost of Initiative for Current Fiscal Year \$316,614</p>	<p>b. Restricted Grants/Direct offsetting revenue HSCRC Regional Grant \$2,550 wellness van</p>