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 Hospital's Uninsured Patients,:	f. Percentage of Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare Beneficiaries:
Adults: 292 Newborn: 28	Adults: 17,023 Newborn: 1,992	21804 21801 21853 21811 21851 21875 21826 21817 21863 21842	Atlantic General Hospital McCready Memorial Hospital	Review of Hospital Discharge Data Wicomico: 1.63% Worcester: .99% Somerset: .74%	Review of Hospital Discharge Data Wicomico: 26.52% Worcester: 24.08% Somerset: 29.32%	Review of Hospital Discharge Data Wicomico: Medicare 28.5% Medicare HMO .13% Worcester: Medicare 34.29% Medicare HMO .27% Somerset: Medicare 29.46% Medicare HMO .07%

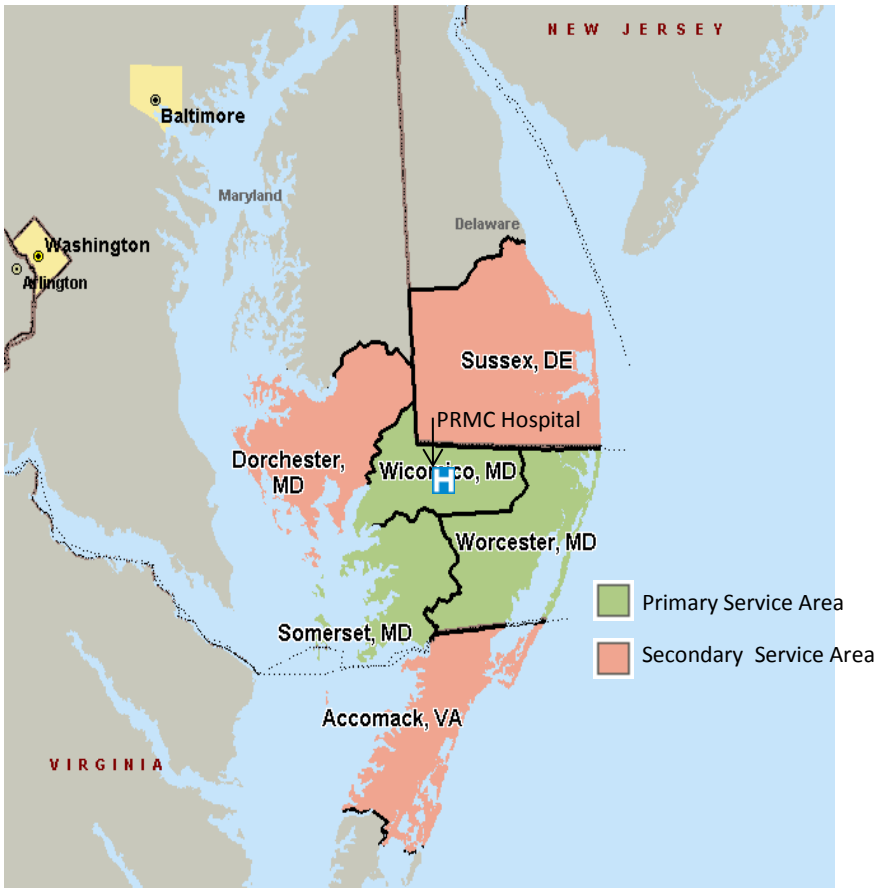
Table II

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

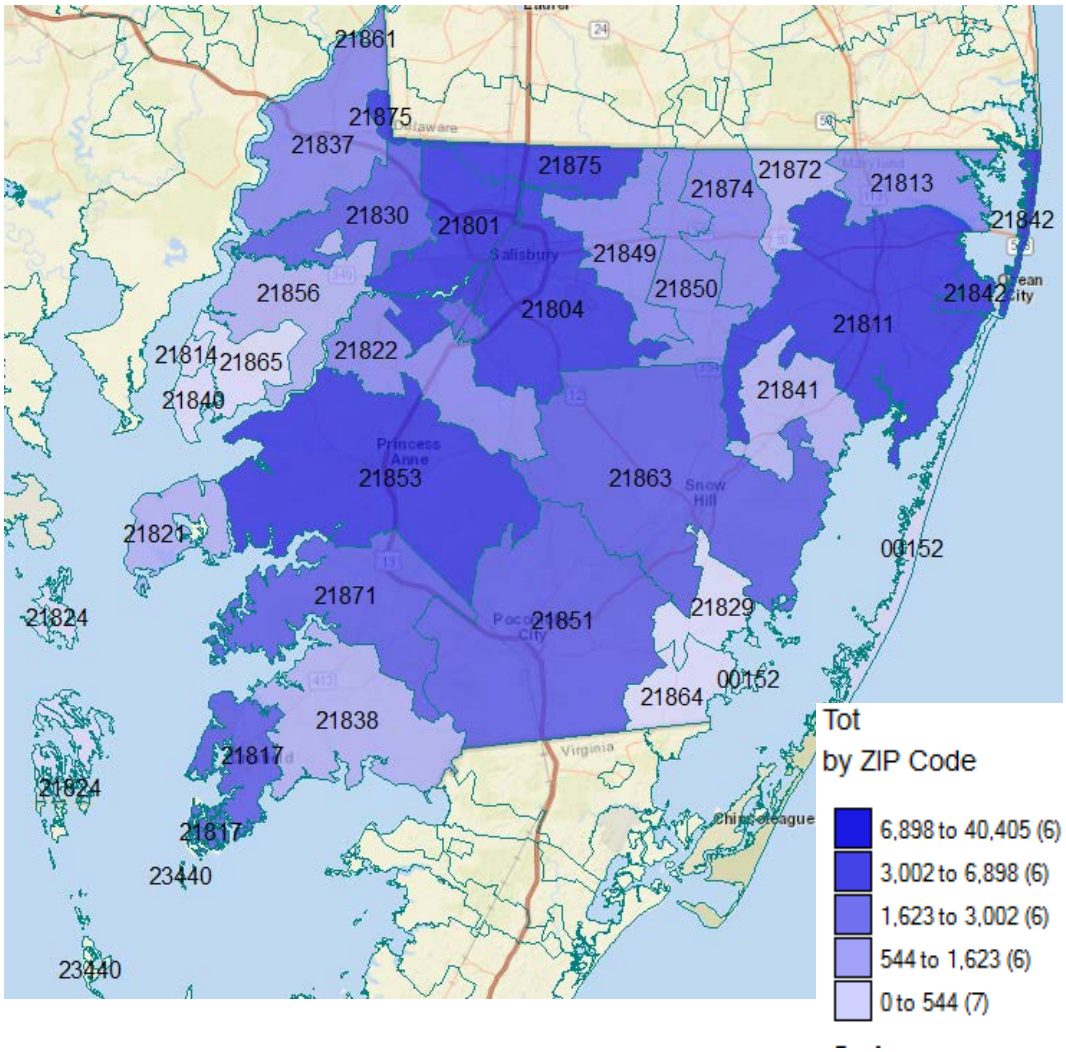
(i) A list of the zip codes included in the organization's CBSA, and

The Community We Serve

Peninsula Regional Medical Center functions as the primary hospital provider for the rural southernmost three counties of the Eastern Shore of Maryland, which includes Wicomico, Worcester and Somerset Counties (highlighted in green). In FY 2016, approximately 77% of the patients discharged from the Medical Center were residents of the primary service area, which has an estimated population of approximately 179,752 in 2016 and is expected to increase to 183,873 in 2021, or by 2.3%. The primary service area population has grown by an estimated 10% since 2000.



Peninsula Regional's CBSA consists of those zip codes within our primary service area. The majority of the population resides in Wicomico County (103,773) with Salisbury serving as the capital of the Eastern Shore. Salisbury is located on the headwaters of the Wicomico River and it is located at the crossroads of the Bay and the Ocean. The region is unique; the city of Salisbury has similar socio-economic and demographic characteristics of a large city, however, the area surrounding Salisbury is rural and has like-kind characteristics of small town America. Due to this dichotomy, serving both sometimes presents a challenge in delivering healthcare. The two other counties in Peninsula Regional's CBSA include Worcester County, with a population of 52,052 and Somerset County with a population of 23,639. The map below identifies Peninsula Regional's CBSA by zip codes by population density.



(ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations reside.

The greater ***"metropolitan"*** Salisbury area (zip codes 21801, 21804) has a higher population density than the surrounding rural areas. This area has a vulnerable population that includes the indigent and a higher Medicaid mix. Moving east towards the beach located in Worcester County several of the larger towns Berlin (21811) and Ocean City (21842) have a higher population density. South of Salisbury, located in Somerset County, the town of Princess Anne (21853) and Crisfield (21817) are two of the larger towns. Excluding the greater Salisbury area, the landscape and environment is considered rural, made up of small businesses and agriculture.

All three counties can be classified as rural with a historic economic foundation in agriculture, poultry and tourism. Watermen and farmers have always comprised a large percentage of the peninsula population; however, their numbers have been declining with growth in the population and expansion of other small businesses. Ocean City, located in Worcester County, is a major tourist destination; during the summer weekends, the city hosts between 320,000 and 345,000 vacationers, and up to 8 million visitors annually.

The three counties have a diversified economic base; however, it is predominately made up of small employers (companies with less than 50 employees). Major employers include local hospitals, the chicken industry, local colleges and teaching institutions. The median income in our Community Benefits Service Area is considerably less than $54,131, compared to Maryland's median income of $77,385. In addition, 2015 unemployment rates were higher for Maryland's most Eastern Shore counties. The unemployment rate in Maryland was 5.2%, the Nation 5.3% compared to Wicomico 6.0%; Worcester 8.6%; and Somerset 8.1%. Research indicates lower median incomes and higher unemployment rates contribute to a disparity in access to medical care and a prevalence of untreated chronic disease.

(iii) Describe how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

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

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

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

1,330 residents that meet the criteria of "Super Utilizers" stratified by socio-demographics and chronic disease.

Peninsula Regional is targeting CBSA zip codes based upon social and economic determinants of health to include the uninsured, indigent population, residents who lack transportation, lack of education and availability of healthy foods. Targeting this by cluster and block groups, we seek to impact the health by providing primary health services, education, access and more importantly by fostering relationships within the community we serve. For example, our Wagner Wellness Van travels locally to block groups where there was an identified need for basic health services, in addition to providing health services and education to local ethnic churches and civic organizations.

PRMC CBSA

Race/Ethnicity	CBSA Primary Service Area		USA % of Total
White Non-Hispanic	119,583	66.5%	61.3%
Black Non-Hispanic	42,794	23.8%	12.3%
Hispanic	8,710	4.8%	17.8%
Asian & Pacific Non-Hisp.	4,087	2.3%	5.4%
All Others	4,578	2.5%	3.1%
Total	**179,752**	**100%**	**100.0%**

Source: Truven Health Analytics 2016

Within our CBSA, Wicomico has the highest Hispanic/Latino population at 6%, though all three counties have smaller percentages compared to Maryland. Worcester has the highest percentage of Whites (81%), whereas Somerset has the lowest percentage (52%). Somerset has the largest proportion of Black/African Americans (43%), whereas Worcester has the lowest (14%). The other race groups comprise a tiny sliver of the tri-county population in comparison.

The three counties in the PRMC CBSA have varying age distributions when compared to each other and to the state of Maryland. The proportion of young adults in Somerset and Wicomico are higher compared to Maryland or Worcester. Over half of Maryland is comprised of adults aged 25 to 64, whereas this age group accounts for slightly below 50% of the population of each of the three counties. The baby boomer population (those aged 55+) represent a greater portion of the total population in Peninsula Regional's CBSA as compared to the Nation. The Eastern Shore of Maryland is fast becoming a popular retirement destination, and the trend is likely to continue. The chronic conditions of this particular stratus consume healthcare resources at much higher rates than some of the other younger age-cohorts.

CBSA Population Age-Cohorts

Age Group	2016 Population	% of Total	USA 2016 % of Total
0-14	29,571	16.5%	19.0%
15-17	6,606	3.7%	4.0%
18-24	23,217	12.9%	9.8%
25-34	21,588	12.4%	13.3%
35-54	41,596	23.1%	26.3%
55-64	24,287	13.5%	12.8%
65+	32,887	18.3%	15.1%
Total	**179,752**	**100.0%**	**100.0%**

CBSA Population Sex

Population	Primary Service Area
Female Population	88,106
Male Population	91,646
Child Bearing	34,835

Source: Truven Health Analytics 2016

CBSA Health Disparities *(Wicomico, Worcester, Somerset)*
The most recent key findings from The Office of Minority Health and Health Disparities (MHHD) at the Department of Health and Mental Hygiene include:

Wicomico County

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

Worcester County

- African-Americans in Worcester County had higher mortality rates than Whites for all-cause mortality and for five of the top six causes of death (heart, cancer stroke, diabetes, kidney disease).
- The greatest mortality ratio disparity for African-Americans compared to Whites was for kidney disease, where African-Americans have 3.3 times the rate of death compared to Whites.

Somerset County

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

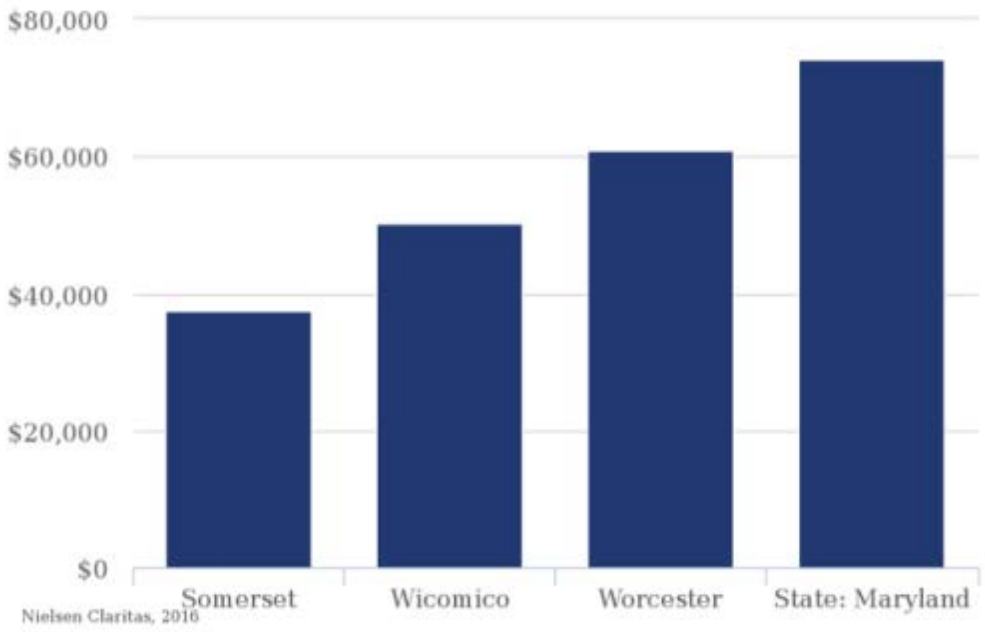
Chronic Disease Management

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

Source: Maryland Chartbook of Minority Health and Minority Health Disparities Data.

Median Household Income within the CBSA

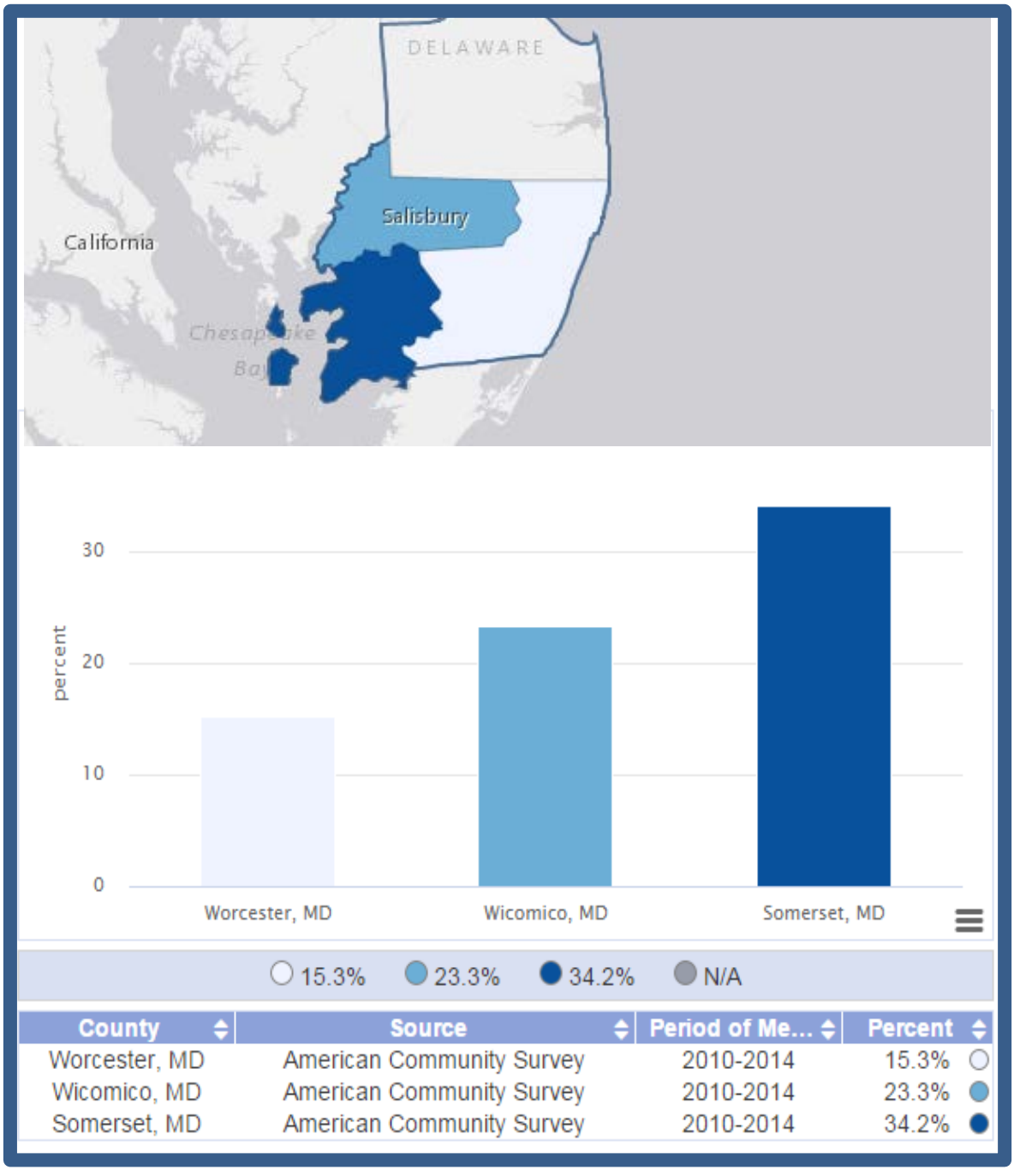
The median household income values in all three counties are lower than that of Maryland. Somerset has the lowest median household income in the tri-county service area with a value of $37,385. Worcester has the highest median household income in the service area at $60,834. Source: Nielsen Claritas 2016



Percentage of households with incomes below the federal poverty guidelines within the CBSA

In all identified areas of poverty, Somerset County has the highest percentage of families, children and those over the age of 65 living in poverty, closely followed by Wicomico and Worcester County respectively.

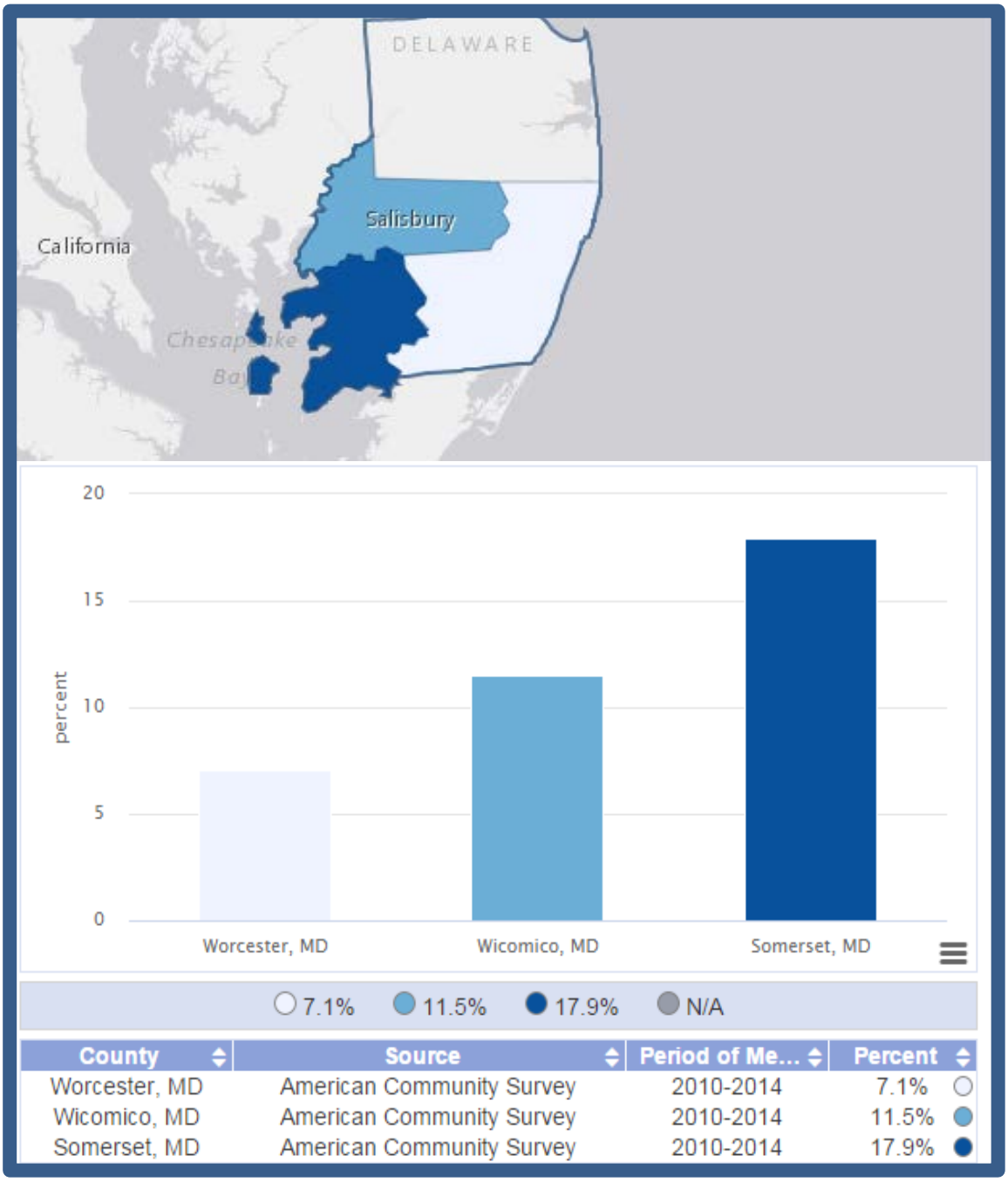
Children Living Below Poverty Level



County	Source	Period of Me...	Percent
Worcester, MD	American Community Survey	2010-2014	15.3%
Wicomico, MD	American Community Survey	2010-2014	23.3%
Somerset, MD	American Community Survey	2010-2014	34.2%

Source: Healthy Communities Inc. 2016

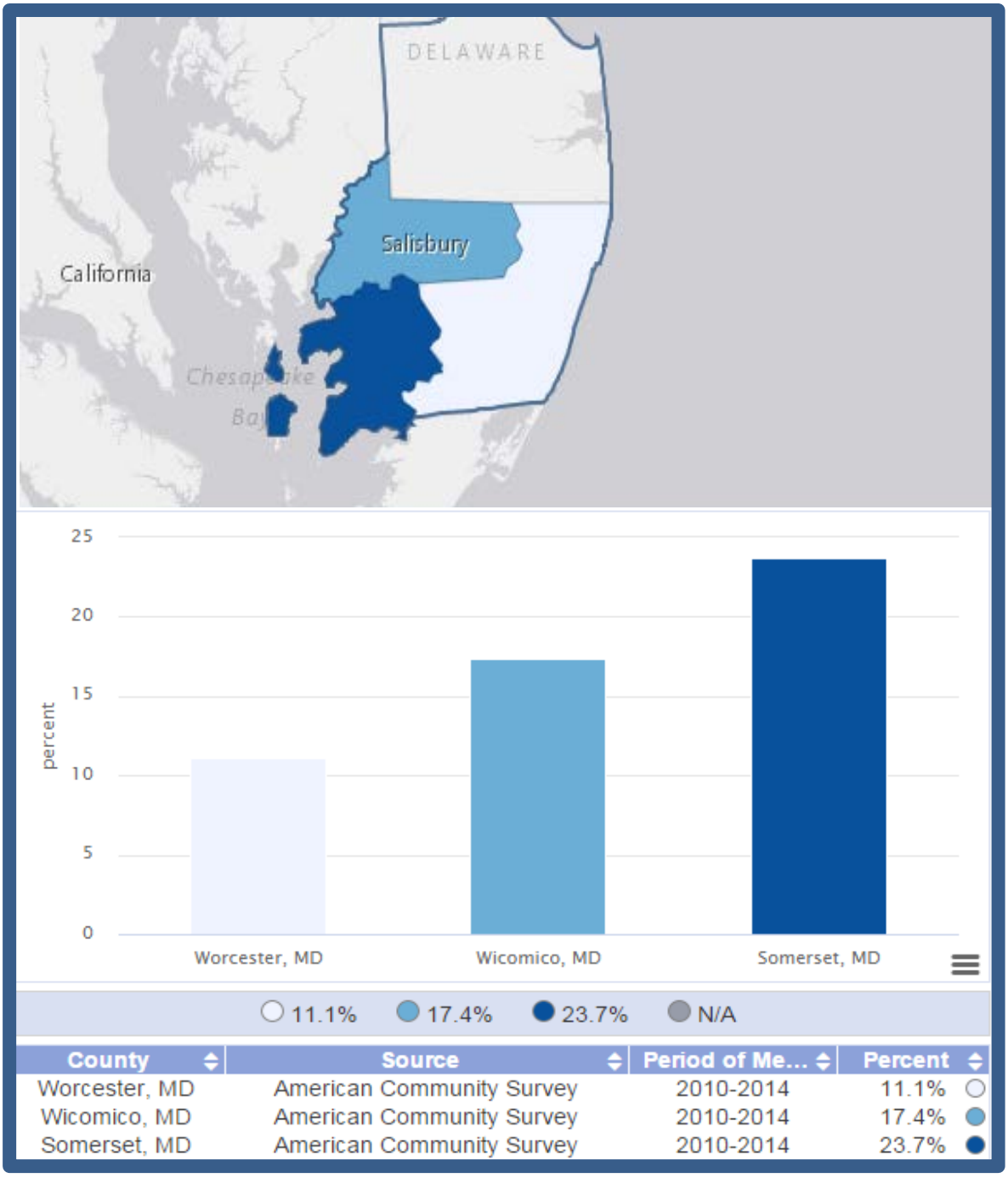
Families Living Below Poverty Level



County	Source	Period of Me...	Percent
Worcester, MD	American Community Survey	2010-2014	7.1%
Wicomico, MD	American Community Survey	2010-2014	11.5%
Somerset, MD	American Community Survey	2010-2014	17.9%

Source: Healthy Communities Inc. 2016

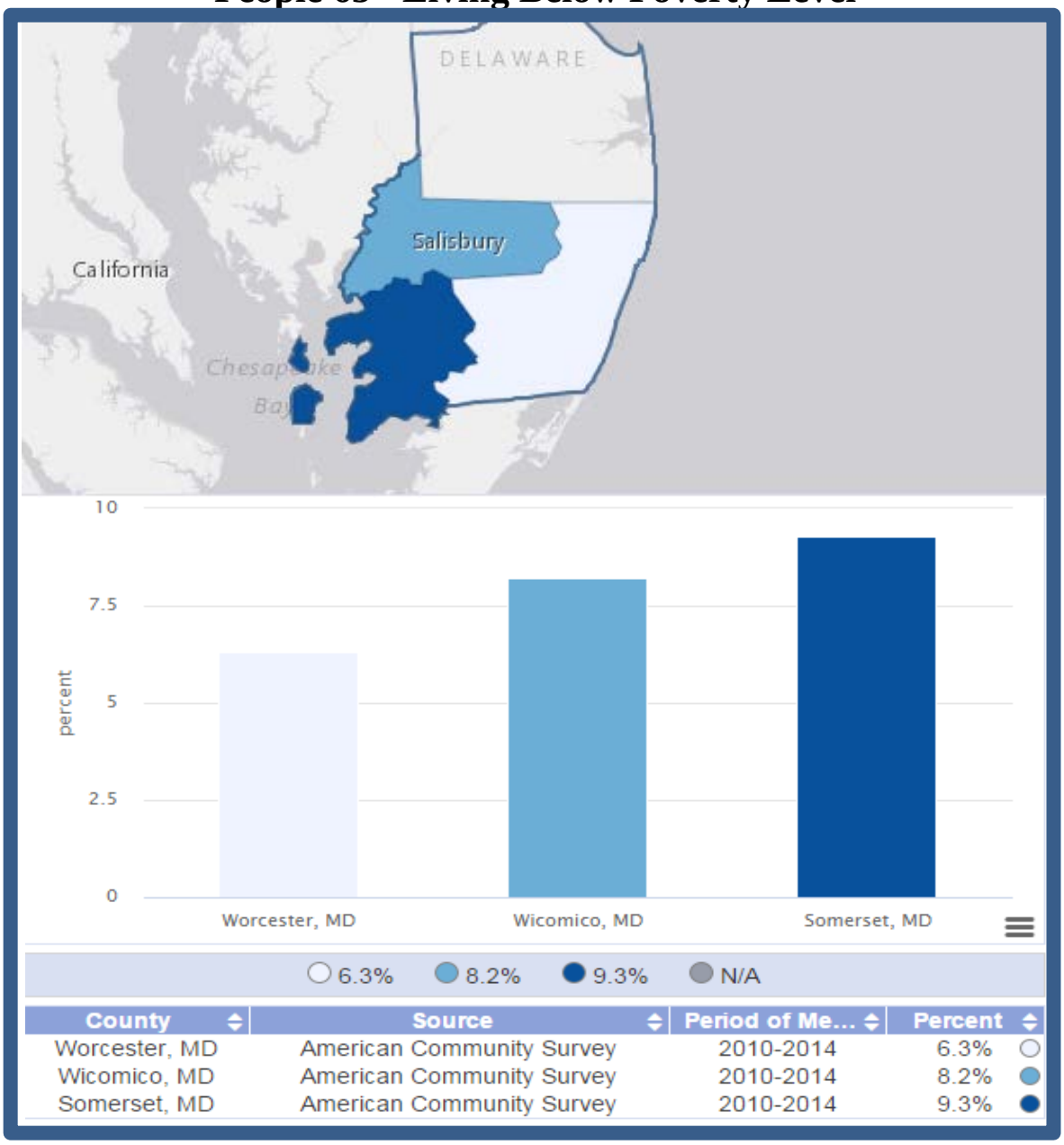
People Below Poverty Level



County	Source	Period of Me...	Percent
Worcester, MD	American Community Survey	2010-2014	11.1%
Wicomico, MD	American Community Survey	2010-2014	17.4%
Somerset, MD	American Community Survey	2010-2014	23.7%

Source: Healthy Communities Inc. 2016

People 65+ Living Below Poverty Level



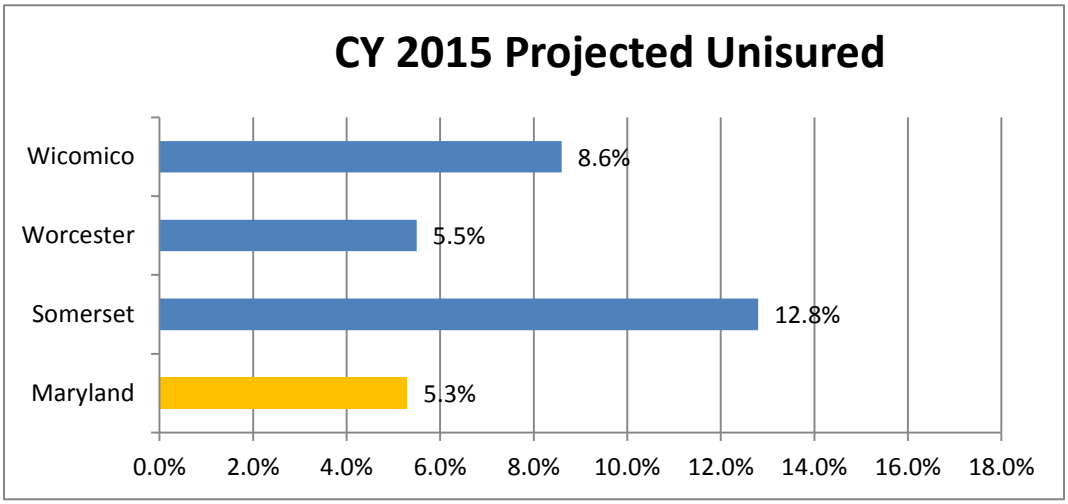
County	Source	Period of Me...	Percent
Worcester, MD	American Community Survey	2010-2014	6.3%
Wicomico, MD	American Community Survey	2010-2014	8.2%
Somerset, MD	American Community Survey	2010-2014	9.3%

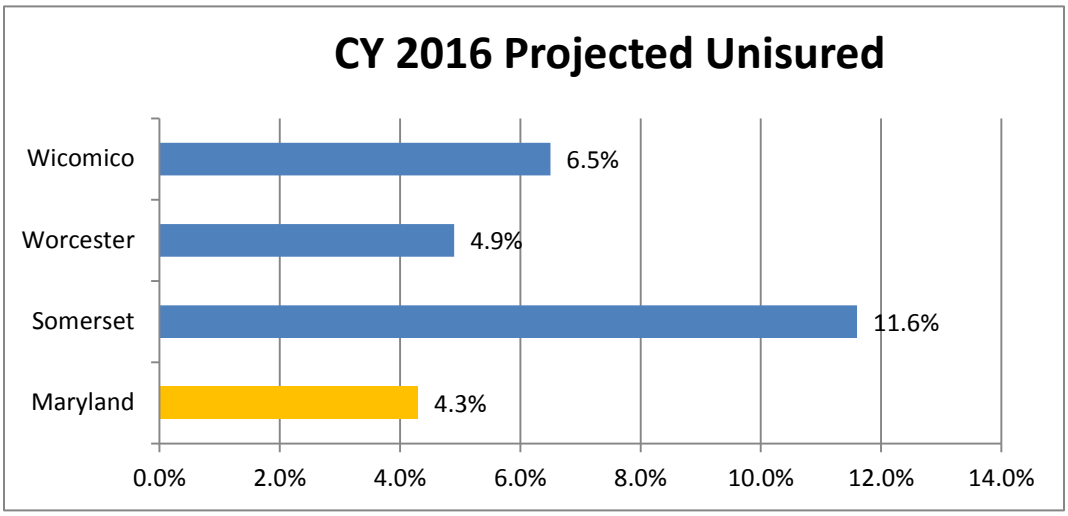
Source: Healthy Communities Inc. 2016

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

http://www.census.gov/hhes/www/hlthins/data/acs/aff.html;
http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml

The total number of projected uninsured continues to decrease from the last several years, primarily due to an increase in Medicaid enrollees and enrollment in various private and public health exchanges. However, compared to Maryland, Peninsula Regional's CBSA, specifically Wicomico and Worcester County, still has a greater percentage of its population uninsured.

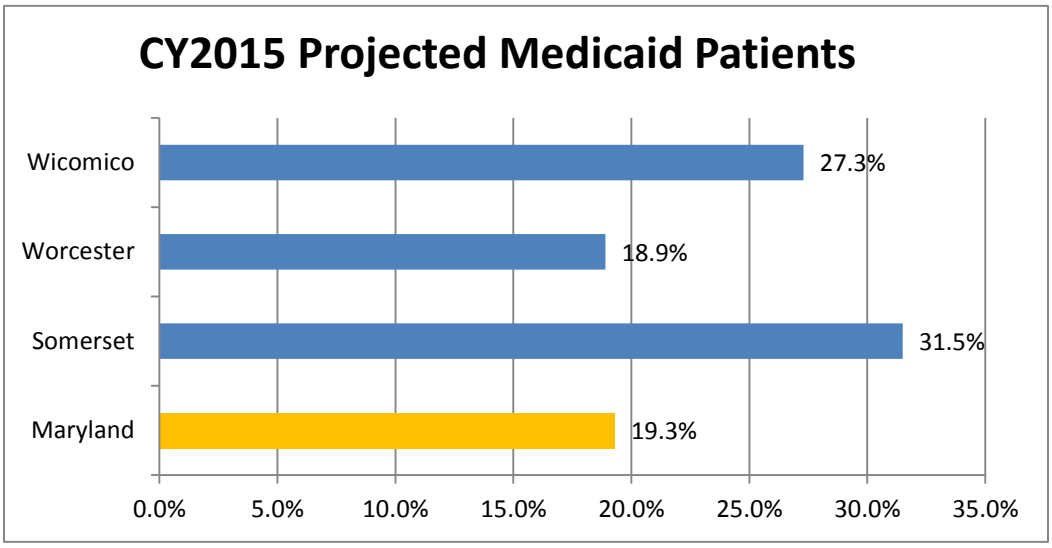


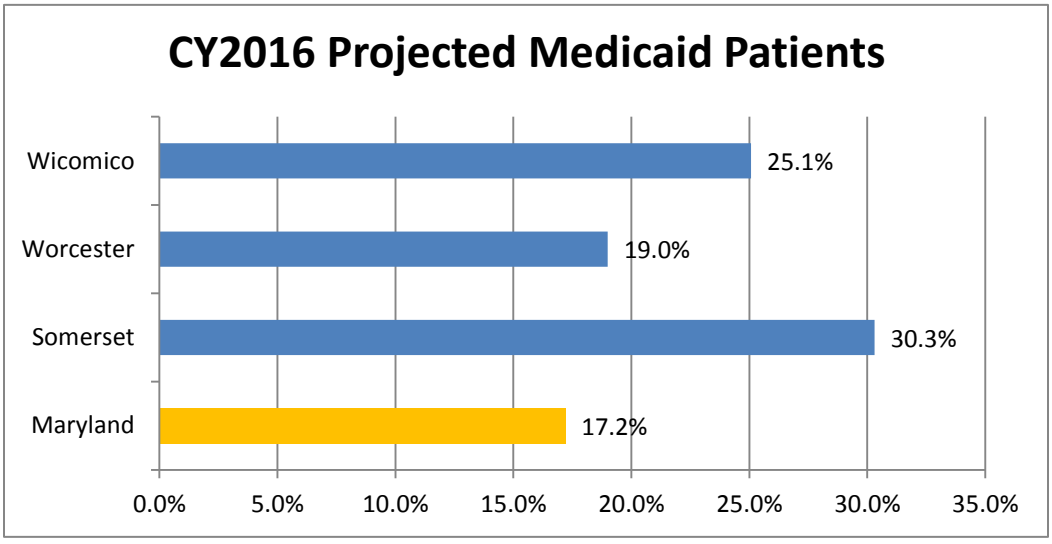


Source: Truven Health Analytics 2015, 2016

Percentage of Medicaid recipients by County within the CBSA.

In comparison to the state of Maryland, Peninsula Regional's CBSA has a greater proportion of Medicaid recipients. Several of the poorer counties in Maryland, Wicomico and Somerset have a substantially higher percentage of Medicaid participants than the State. The continued growth of Medicaid recipients within our CBSA has reduced the total number of uninsured patients. Most importantly, more patients have health insurance on the Eastern Shore, providing families better access to appropriateness of care. Social determinants such as lower median income, higher unemployment rates, rural economics, and lower educational attainment continue to challenge access to care and healthy lifestyle changes.





Source: Truven Health Analytics 2015, 2016

Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website:

http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx

The life expectancy in all three counties is 3-7% below the Maryland SHIP Target of 82.5 years. Worcester County is very close to meeting the SHIP target of 82.5 years; however, there is a gap of 5 years between Black/African Americans and White residents. Both Somerset and Worcester are 5 years behind in meeting the Maryland SHIP longevity target. The top leading causes of death in our CBSA area are heart-related and cancer-related diseases, which as a percentage are higher than other Maryland counties. Supporting social determinants indicate an underlying lack of healthy lifestyle adoption/education, poverty, and lack of chronic disease management/education.

County	Life Expectancy	Maryland SHIP Target
Wicomico All	77.3	82.5
Black	74.7	82.5
White	78.1	82.5
Worcester All	80.0	82.5
Black	75.8	82.5
White	80.5	82.5
Somerset All	77.2	82.5
Black	77.2	82.5
White	76.5	82.5

Source: Most current available Maryland Vital Statistic Report 2014

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).

Crude Death Rate

The crude death rate for Wicomico County is 938.6, Worcester County 1,159.2, and Somerset County 1032.5, all higher than Maryland at 764.5 deaths/100,000. The large crude death rates reflect multiple factors: specifically, a more aging 65+ population, in addition to healthcare access issues, cultural and lifestyle characteristics not conducive to healthy lifestyles, and lack of education regarding chronic disease management in rural areas.

Health Disparity Age-Adjusted Death Rates

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

Diseases of the Heart Age-Adjusted Death Rates (2012-2014)

For diseases of the heart, several counties' age-adjusted death rates are much higher than the Maryland average:
Wicomico: 49.9% higher heart age-adjusted death rate than MD.
Worcester: 7.8% higher heart age-adjusted death rate than MD.
Somerset: 73.3% higher heart age-adjusted death rate than MD.

Malignant Neoplasms Age-Adjusted Death Rates (2012-2014)

For malignant neoplasms, all counties' age-adjusted death rates are higher than Maryland.
Wicomico: 21.7% higher malignant neoplasm age-adjusted death rate than MD.
Worcester: 8.5% higher malignant neoplasm age-adjusted death rate than MD.
Somerset: 23.0% higher malignant neoplasm age-adjusted death rate than MD.

Chronic Lower Respiratory Diseases Age-Adjusted Death Rates (2012-2014)

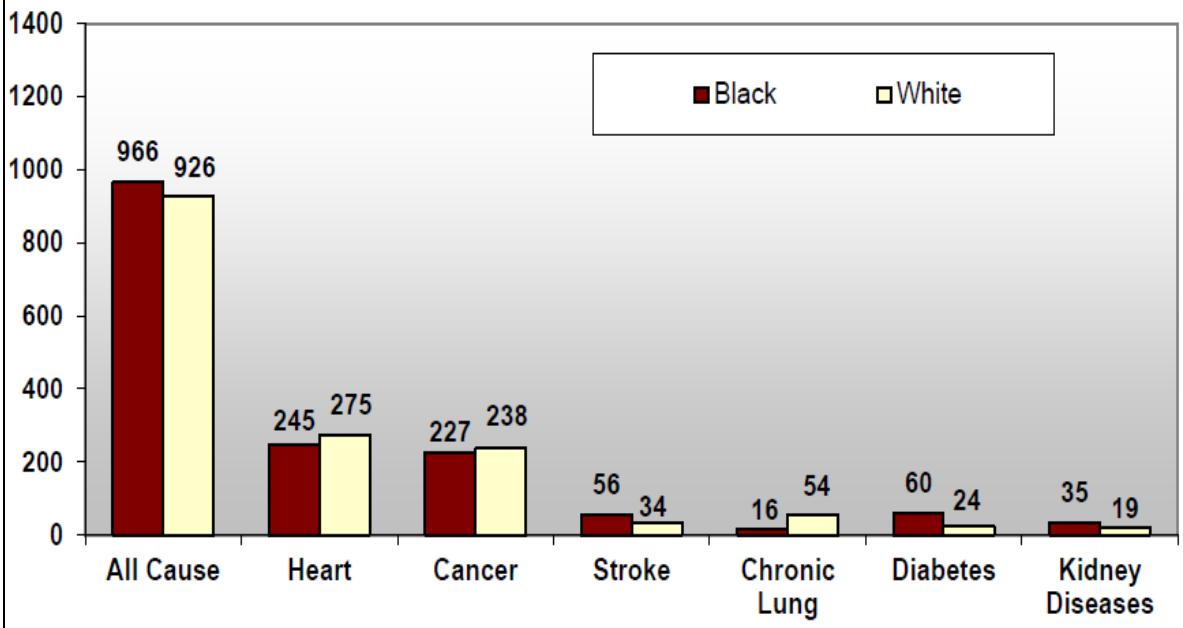
For chronic lower respiratory diseases, all counties' age-adjusted death rates are higher than Maryland:
Wicomico: 57.2% higher chronic lower respiratory diseases age-adjusted death rate than MD.
Worcester: 27.7% higher chronic lower respiratory age-adjusted death rate than MD.
Somerset: 50.8% higher chronic lower respiratory age-adjusted death rate than MD.

Source: Most current available Maryland Vital Statistics Report 2014

Wicomico County

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

Wicomico County Age-Adjusted Morality Rates, Maryland 2005-2009

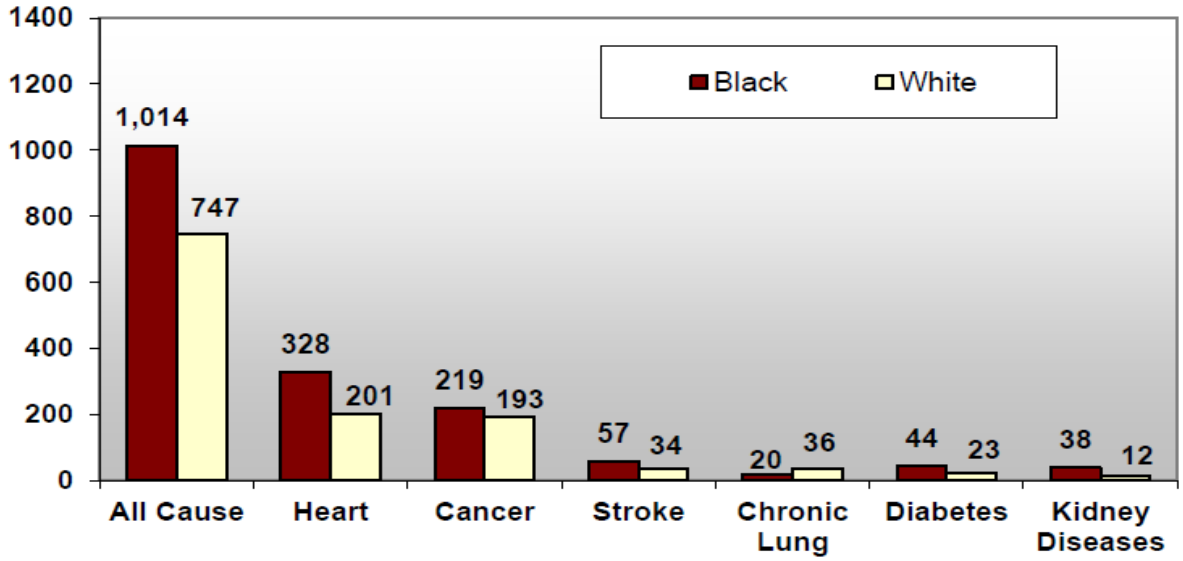


Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

Worcester County

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

Worcester County Age-Adjusted Morality Rates, Maryland 2005-2009



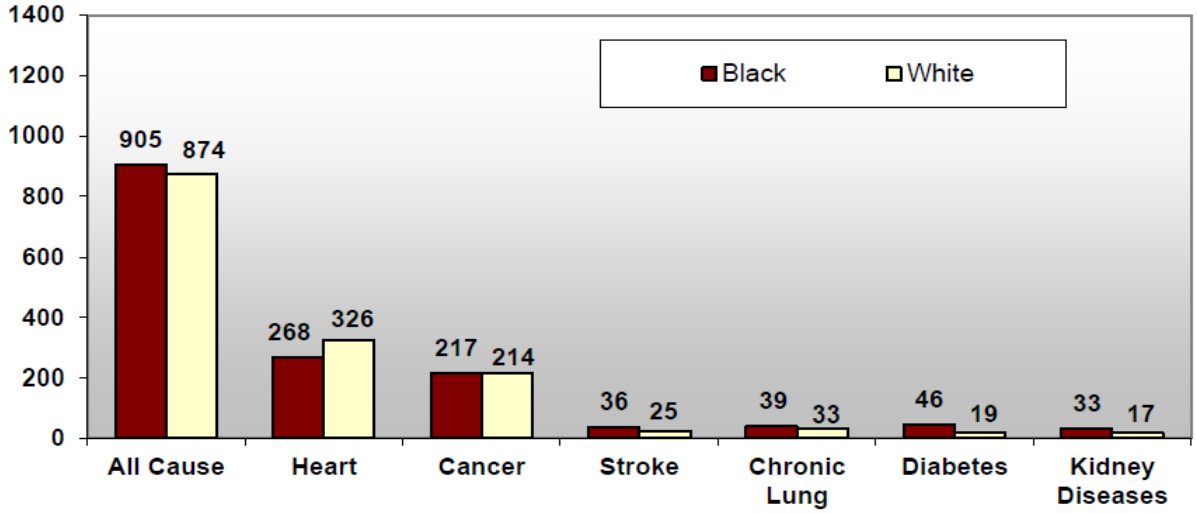
Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

Somerset County

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

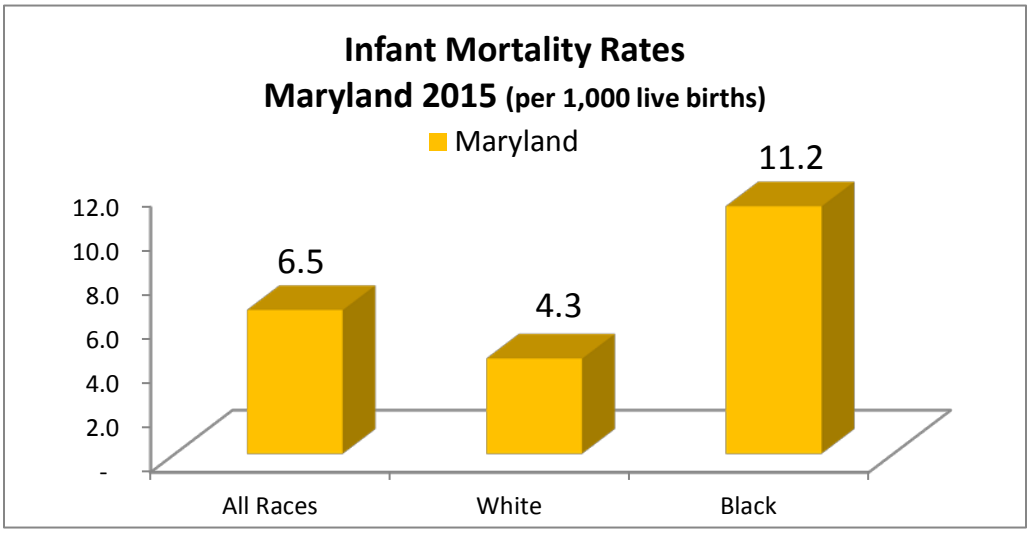
The diabetes mortality rate for Blacks or African Americans was 2.4 times higher than for Whites; and the kidney disease mortality rate was 1.9 times higher for Blacks or African Americans.

Somerset County Age-Adjusted Morality Rates, Maryland 2005-2009

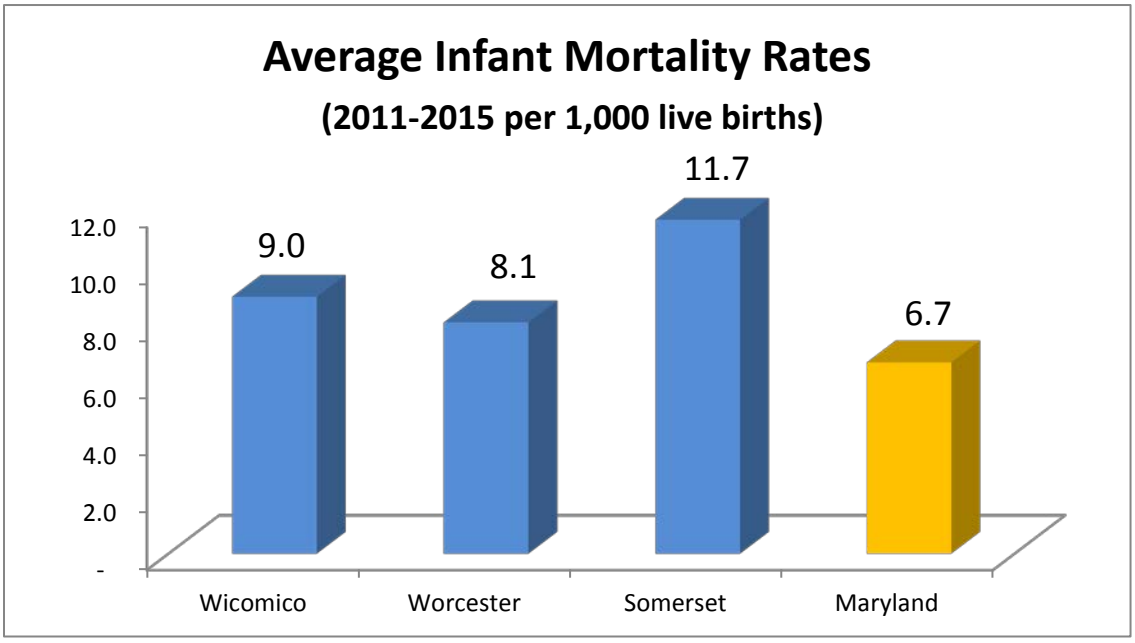


Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

According to the 2015 Maryland Vital Statistics, the average infant mortality rate has fallen by 14% in Maryland over the past decade, with an 11% decline in the average rate among white infants and a 17% decline among black infants,



Despite the statewide decline in infant mortality rate over the past decade, the Lower Eastern Shore's average infant mortality rate has increased by 23% between 2006-2010 and 2011-2015.

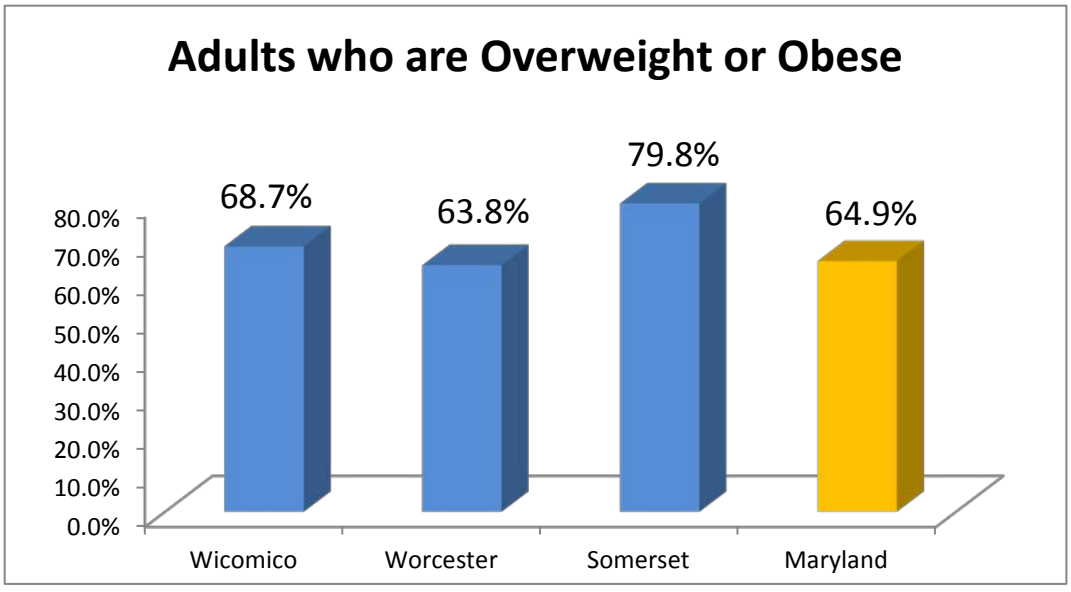


Source: Maryland Department of Health and Mental Hygiene, Infant Mortality in Maryland, 2015

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources).
See SHIP website for social and physical environmental data and county profiles for primary service area information:
http://dhmh.maryland.gov/ship/SitePages/measures.aspx

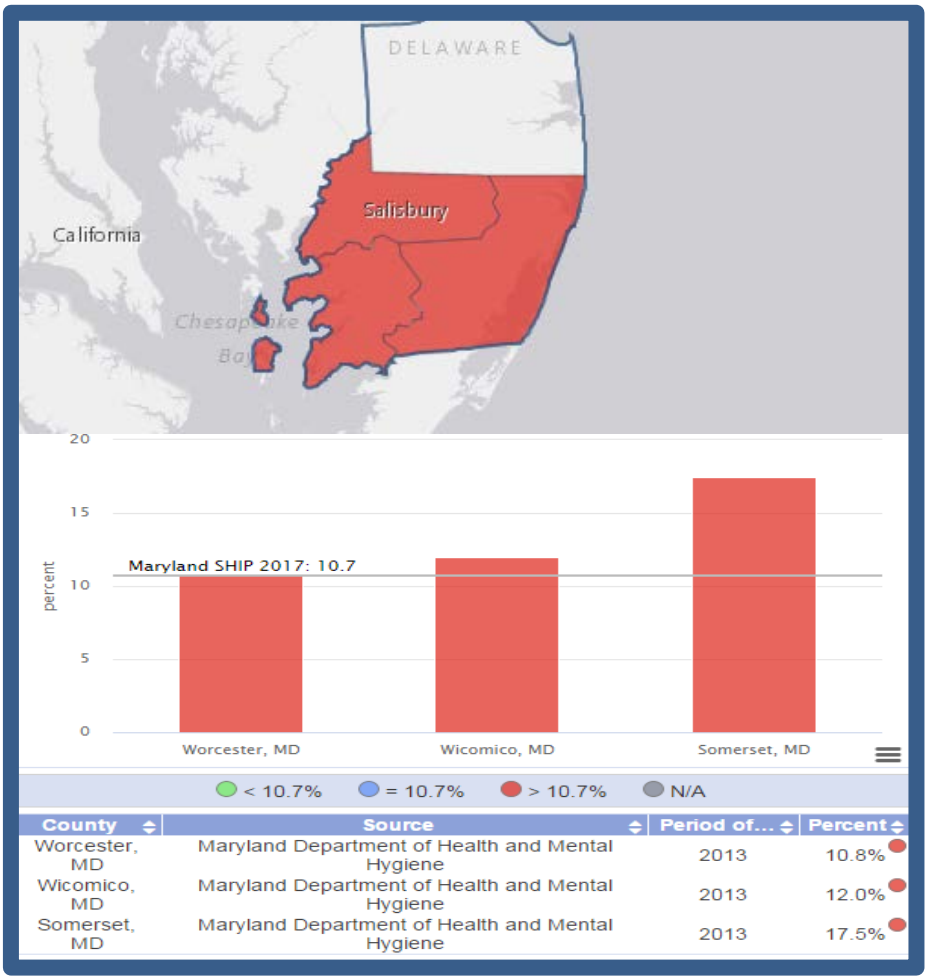
Access to Healthy Food
Healthy Food/Healthy Lifestyle Environmental Factors
Obesity continues to be a health issue in Wicomico, Worcester and Somerset Counties. Somerset County has a high percentage of adolescent obesity: 17.5% compared to the Maryland SHIP 2017 target of 10.7%. The tri-county area has a higher percentage of overweight or obese adults than Maryland, and is an indicator of general overall health. Additional weight and obesity increases the risk of many diseases and health conditions. These include type 2 diabetes, cancer, hypertension, stroke, liver, gallbladder and respiratory problems, all of which we are experiencing. Being obese also carries significant economic costs due to increased healthcare spending.

Fast food is often high in fat and calories and lacking in recommended nutrients. Frequent consumption of fast food increases the risk of our population being overweight and obese. Based upon the density of grocery stores per 1,000 population, residents of Wicomico and Somerset County indicates limited access to grocery stores that sell a variety of nutritious food choices. Since these are rural counties, there are a higher number of convenience stores that sell less nutrient-dense foods. Residents of these rural counties living outside of local cities typically use convenience stores for food purchases. However, the summer months increase the availability of fresh fruits and vegetables since these counties have a strong agricultural heritage, and the density of famers markets per 1,000 populations is comparatively high.



Source: HCI Healthy Communities Inc.

Adolescent Obesity



County	Source	Period of...	Percent
Worcester, MD	Maryland Department of Health and Mental Hygiene	2013	10.8%
Wicomico, MD	Maryland Department of Health and Mental Hygiene	2013	12.0%
Somerset, MD	Maryland Department of Health and Mental Hygiene	2013	17.5%

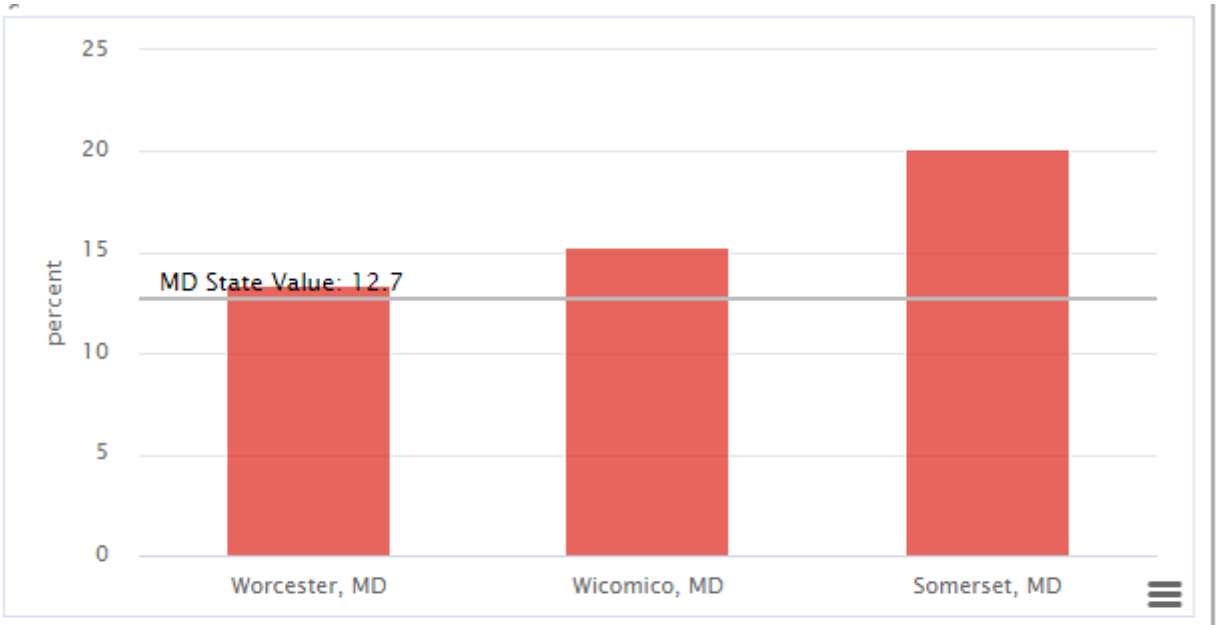
Source: HCI Healthy Communities Inc.

Food Insecurity

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

Somerset County has an exceptionally high food insecurity rate compared to national norms and Maryland; consequently the likelihood of childhood obesity is intensified as reflected in the preceding and following graph. The availability of grocery stores in this rural area, in addition to poverty and lack of nutritional education, results in lifelong habit patterns that contribute to obesity. Over a lifetime, poor habits lead to various comorbidities and chronic disease.

Food Insecurity Rate



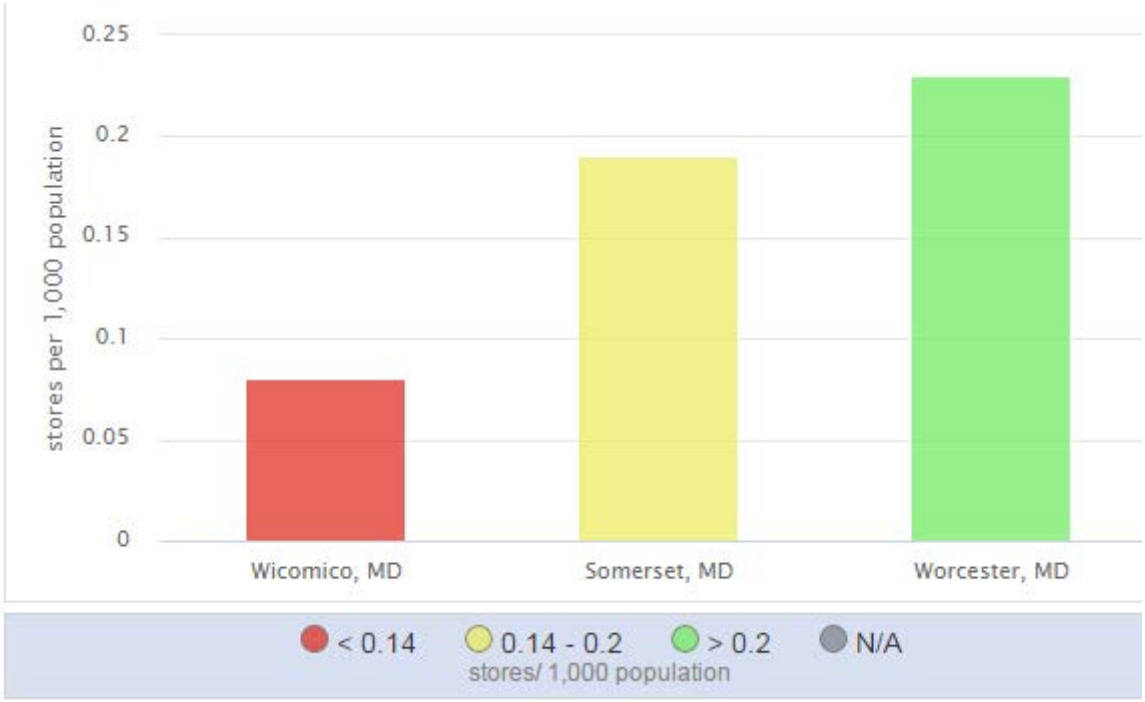
County	Source	Period of Measu...	Percent
Worcester, MD	Feeding America	2014	13.4%
Wicomico, MD	Feeding America	2014	15.3%
Somerset, MD	Feeding America	2014	20.1%

Source: HCI Healthy Communities Inc.

Grocery Store Density

There are strong correlations between the density of grocery stores in a neighborhood and the nutrition and diet of its residents. The availability and affordability of healthy and varied food options in the community increase the likelihood that residents will have a balanced and nutritious diet.

Wicomico and Somerset County have low grocery store density compared to other U.S. Counties, which can be a disadvantage to having a healthy food lifestyle. Combining this in a rural, poverty-stricken area, low access severely limits the availability of nutritious food.



Source: HCI Healthy Communities Inc.

Adult Fruit and Vegetable Consumption

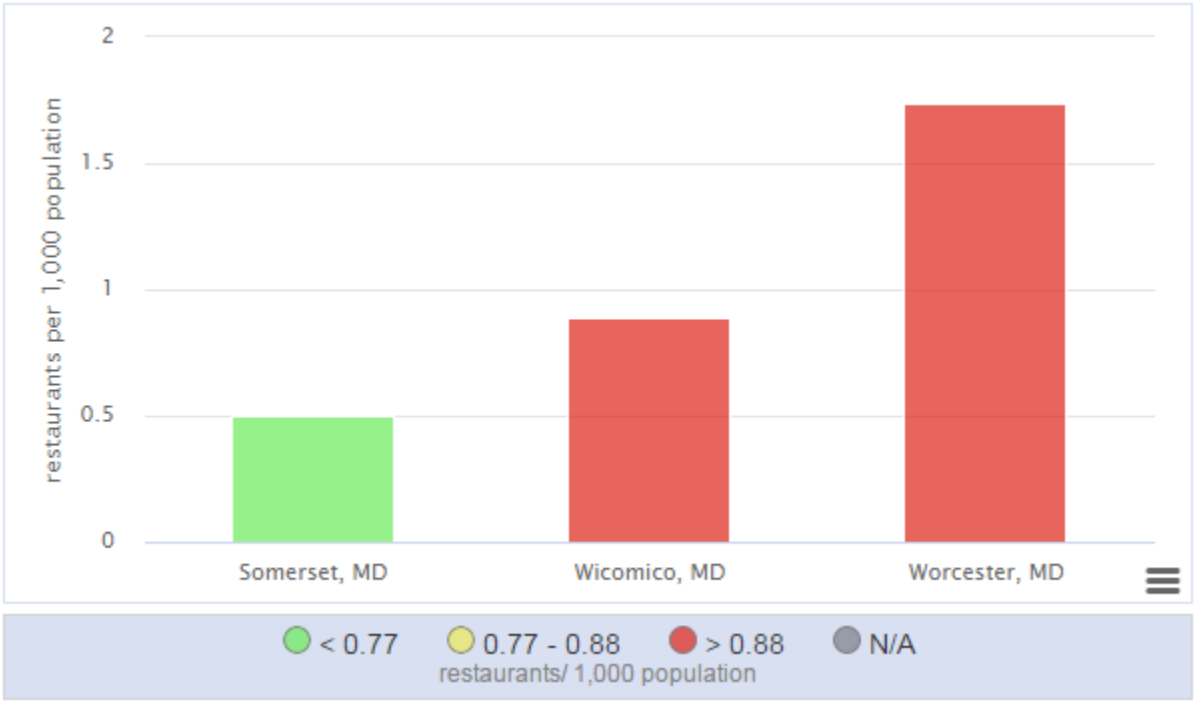
Based upon Maryland's most recent Behavioral Risk Factor Surveillance System, adults living in Wicomico and Somerset counties are not consuming adequate amounts of fruits and vegetables in their diet. This statistic indicates that an opportunity exists for education about healthy lifestyle choices. Worcester County is a more affluent county and has a very positive grocery store density to population ratio.

Adult Fruit and Vegetable Consumption

	VALUE	COMPARED TO:
County: Somerset, MD	17.2% (2010)	MD Counties
County: Wicomico, MD	23.1% (2010)	MD Counties
County: Worcester, MD	30.0% (2010)	MD Counties

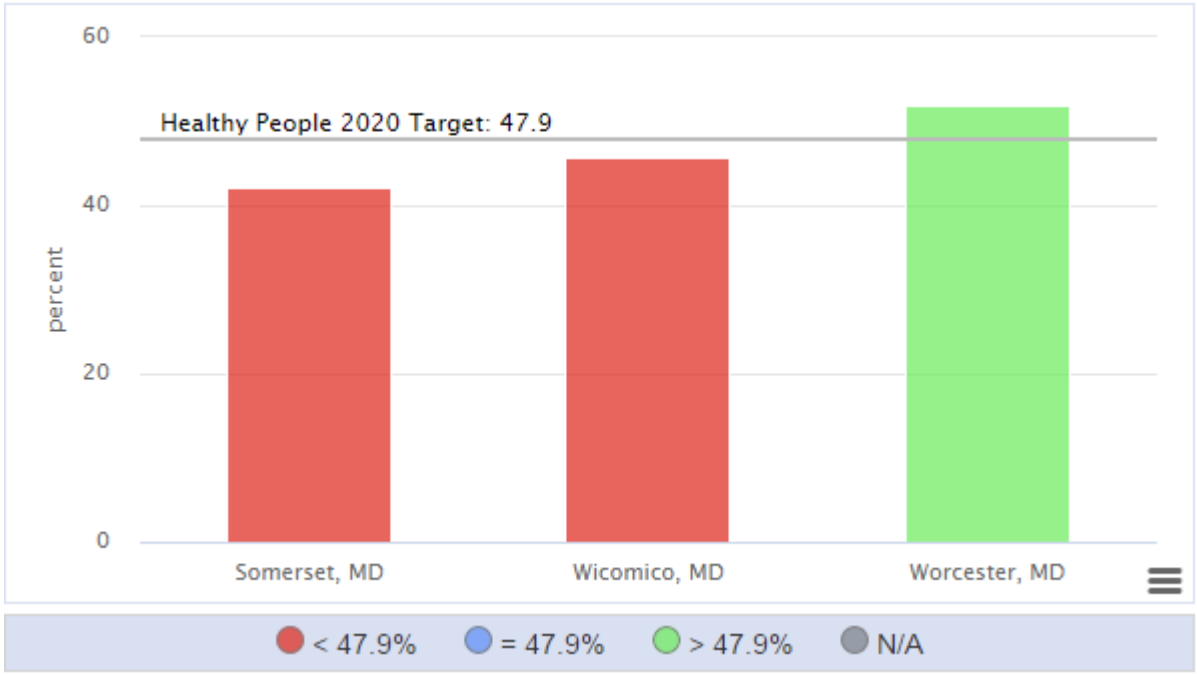
Source: HCI Healthy Communities Inc.

Fast Food Restaurant Density



Source: HCI Healthy Communities Inc.

Adults Engaging in Regular Physician Activity



Source: HCI Healthy Communities Inc.

The social determinants of health within our CBSA (as evidenced by the preceding charts) suggest that residents would benefit from a "Live Well" campaign. This campaign was designed to create awareness and provide a forum for becoming engaged and actively pursuing living a healthy lifestyle. Live Well Delmarva promotes healthy lifestyles and provides information and access to free screenings and healthy living tips.

Live Well Delmarva
https://www.facebook.com/livewellprmc/

CARE | COACH | CONNECT
PENINSULA REGIONAL
MEDICAL CENTER

Peninsula Regional Medical Center recently launched a new website that embodies the spirit of Care | Coach | Connect. Our providers CARE for you COACH you to wellness and CONNECT you with the right providers. The site not only provides information about hospital services, but also those provided outside of the Medical Center walls in our communities.

These offerings include:

- Free skin cancer screenings
- Live Well HealthFest, an annual event with 35+ health screenings, exercise demonstrations and kids' activities
- Free women's heart screenings (total cholesterol, HDL, risk ratio and glucose, ankle/brachial index, resting 12-lead EKG, pulse oximetry testing, strength and more)
- Drive-Thru Flu Clinic, a one-day event that results in the vaccination of more than 3,600 community members

In FY15, Peninsula Regional kicked off a Live Well community campaign that promoted healthy lifestyle choices with monthly themes including:

- Play Hard. Live Well.
- Eat Healthy. Live Well.
- Wash Your Hands. Live Well.
- Be Social. Live Well.
- Check Up. Live Well.
- Take Your Meds. Live Well.
- Know Your Numbers. Live Well.
- Go Green. Live Well.
- Get Screened. Live Well.
- Wear Sunscreen. Live Well.
- Chill Out. Live Well.

During the campaign, PRMC offered free promotional items that supported the Live Well theme. Items like jump ropes, hand sanitizers, sunscreen and lip balm were distributed throughout the community.

Transportation Services

Peninsula Regional does make available transportation services for those in extenuating circumstances. Every effort will be made to assist patients receiving care under a series account like radiation oncology or chemo by utilizing various community resources. When community resources are not available, the transportation coordinator will arrange transportation as available through Hart to Heart Ambulance Services van transportation.

Upon inpatient hospital discharge, the Institution also provides transportation for certain elderly patients who do not drive and/or those who may lack a caregiver. A bus tickets or a taxi fare is provided for those patients who are indigent or may lack a vehicle. Our Patient Care Management Department manages these cases on a patient by patient basis.

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

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

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

Households without a Vehicle

	VALUE	COMPARED TO:
County: Somerset, MD	10.3% (2010-2014)	MD Counties
County: Wicomico, MD	7.5% (2010-2014)	MD Counties
County: Worcester, MD	6.1% (2010-2014)	MD Counties

Source: HCI Healthy Communities Inc.

Affordable Housing

Peninsula Regional's CBSA has exceptionally high household rent compared to other Maryland counties. Spending a high percentage of household income on rent can create financial hardship, especially for lower-income renters. Limited income due to high rent makes it difficult to access health care resources.

Renters Spending 30% or More of Household Income on Rent

	VALUE	COMPARED TO:
County: Somerset, MD	62.9% (2010-2014)	MD Counties
County: Wicomico, MD	55.5% (2010-2014)	MD Counties
County: Worcester, MD	53.3% (2010-2014)	MD Counties

Source: HCI Healthy Communities Inc.

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

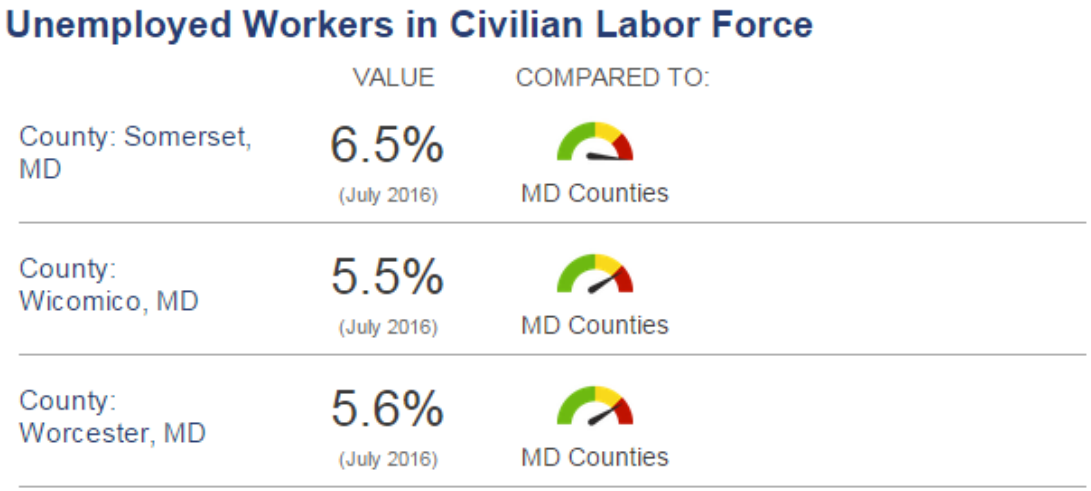
Severe Housing Problems

	VALUE	COMPARED TO:
County: Somerset, MD	21.3% (2008-2012)	MD Counties
County: Wicomico, MD	20.5% (2008-2012)	MD Counties
County: Worcester, MD	16.2% (2008-2012)	MD Counties

Source: HCI Healthy Communities Inc.

Unemployment

Compared to other counties, the unemployment rate is high in Wicomico, Worcester and Somerset counties. Unemployment is a key indicator of the health of the local economy; in addition, high unemployment rates can be related to reduced access to health resources.



Unemployed Workers in Civilian Labor Force

	VALUE	COMPARED TO:
County: Somerset, MD	6.5% (July 2016)	MD Counties
County: Wicomico, MD	5.5% (July 2016)	MD Counties
County: Worcester, MD	5.6% (July 2016)	MD Counties

Source: HCI Healthy Communities Inc.

Sources:
Healthy Communities (HCI)
www.ers.usda.gov/FoodAtlas/
www.shoretransit.org
Truven Health Analytics 2016

Available detail on race, ethnicity, and language within CBSA.

See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx

Within our CBSA, all three counties' average household incomes are considerably less than Maryland's average. In addition, a smaller percentage of the population has a bachelor's degree or above. Wicomico County (13.3%) and Somerset County (19.7%) have a much higher high school drop-out rate than the state of Maryland (11.1%). Research indicates that education level is a social determinant and predictor of a healthy lifestyle and health literacy.

Wicomico has the highest Hispanic/Latino population in the tri-county area although all have smaller percentages compared to Maryland. Worcester has the higher percentage of white population at 64%, whereas Somerset has the lowest at 49.8%. Somerset has the largest proportion of Black/African Americans at 42.2%, whereas Worcester has the lowest at 13.8%.

Of the three counties, Wicomico has the most Spanish-speaking households and households that speak an Asian language. Wicomico has the largest and most divergent population of the tri-county area due to the city of Salisbury. Ocean City along with Salisbury and the surrounding area have the highest percentage of households that speak any non-English language.

Demographics	Wicomico County	Worcester County	Somerset County	Benchmark Maryland
Race/Ethnicity				
White Non-Hispanic	64.0%	79.2%	49.8%	**51.8%**
Black Non-Hispanic	24.6%	13.8%	42.2%	**29.2%**
Hispanic	5.6%	3.5%	4.4%	**9.7%**
Asian & Pacific	3.0%	1.5%	.9%	**6.4%**
All Others	2.8%	2.0%	2.7%	**2.9%**
Average Household Income	$67,745	$82,169	$50,547	**$98,950**
Pop. 25+ Without H.S. Diploma	13.3%	10.9%	19.7%	**10.9%**
Pop. 25+ With Bachelor's Degree or Above+	26.8%	27.9%	14.0%	**37.3%**

Demographics	Wicomico County	Worcester County	Somerset County	Benchmark Maryland
English Spoken at Home	89.6%	94.2%	92.7%	**83.1%**
Spanish Spoken at Home	4.5%	2.4%	3.0%	**7.0%**
Other Spoken at Home	5.9%	3.4%	4.3%	**9.9%**

Source: United States Census Bureau, Advisory Board 2016

Other

SocioNeeds Index

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

HCI SocioNeeds Index

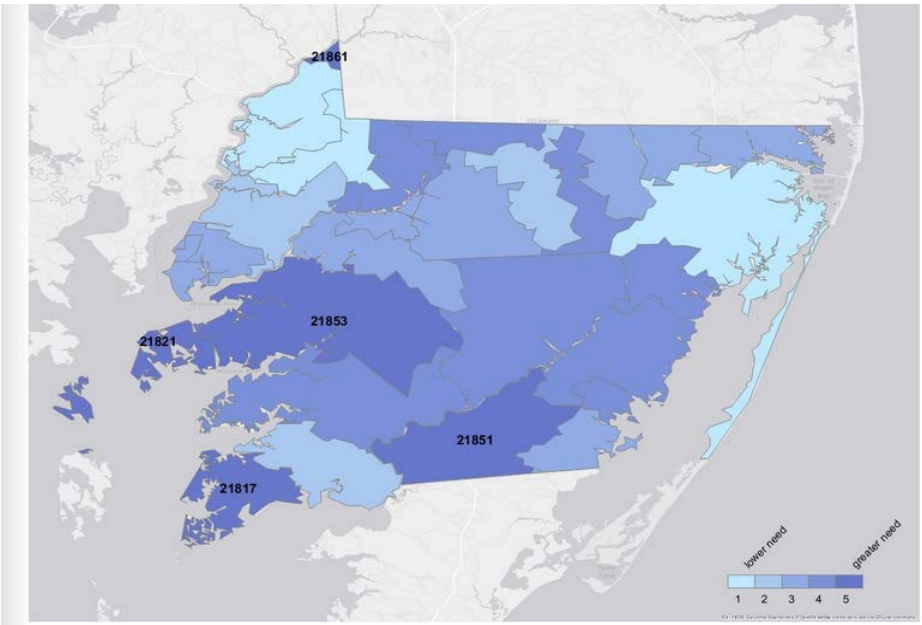


FIGURE 15: ZIP CODES WITH HIGHEST SOCIOECONOMIC NEED

Somerset	21817	21821	21853
Wicomico	21861		
Worcester	21851		

Other Needs were identified as part of Peninsula Regional's Community Health Needs Assessment; both primary and secondary data alluded to issues surrounding barriers to health services and quality of life indicators. These findings were consistent for the following topics: the social environment, the economy and education.

Social Environment

Secondary data showed there are indicators warning about Social Environment being a concern. Most of these indicators were household family structure topics with regards to children. Seven of ten key informants, however, spoke more to the issues around Social Environment as it relates to the following:

- Stigma/fear associated with drug addiction or mental disorders
- Lack of support services in community
- Lack of teen/adolescent counseling or support
- Cultural barriers

Additionally, respondents in the community survey ranked Social Environment third highest for conditions of daily life that most impact the community.

Economy

Economy was found significant in secondary data analysis with the following indicators: People Living Below Poverty Level, Homeownership, Households with Cash Public Assistance, and Unemployment Per Capita Income. Key informants spoke about Economy as being a significant barrier with regards to accessing care, low income populations being highly affected, immigrant populations, and in general the high cost to use the healthcare system. The following are themes that emerged from those discussions:

- Poor, rural community
- Lots of low income families
- Immigrant families
- Seasonal farmers/watermen
- Healthcare costs high
- Need more money put towards building community resources and support services
- No health insurance

Respondents in the community survey also ranked Economy as the second highest condition of daily life that most impacts the community.

Education

Education was found to be a concern due to the following warning indicators: People 25+ with a HS Degree or Higher, People 25+ with a Bachelor's or Higher, and School Readiness at Kindergarten Entry. These signal issues around level of Education attained in the tri-county service area. On a slightly different level, eight of twelve key informants spoke mostly about Education as it related to being a barrier where there is lack of knowledge or awareness around health issues in the community. The following are themes base on these informants' discussions:

- Community awareness around health issues
- Healthcare navigation
- Teen/adolescent education for drug awareness
- Educate Hispanic populations on health resources
- Educate youth and parents on healthy eating
- Education also ranked fourth by respondents on the community survey

Source: HCI Healthy Communities Inc.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?

   _X_ Yes
   ____No

   Provide date here: _06/28 /2016_ (mm/dd/yy)

   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).

   www.peninsula.org

   Go to quick links Community

   Go to Community Health Needs Assessment

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 3?

   _X_ Yes 11/02/2016 (mm/dd/yy) Enter date approved by governing body here:
   ___ No

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

   Go to quick links Community

   Go to Community Health Needs Assessment

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? **(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b.)**

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

_X Yes
___No

If yes, please provide a description of how the CB **planning** fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

Community Benefits is woven throughout Peninsula Regional's ***Vision 2020 Strategic Plan*** and is an integral part of each of our Strategic Tenets, which encompass the following themes: patient-centered care, population health management and expanding access through growth of an ambulatory presence.

Peninsula Regional Vision 2020- Strategy 2.0

To deliver population-based care through health and wellness; medical and chronic disease management; clinically integrated networks and alliances; primary care development; physician integration; and research development

Peninsula Regional Vision 2020- Strategy 3.0

To expand access to care through the continued growth of an ambulatory presence; continued development of affiliations and partnerships; and the evaluation of medical education and training.

The Strategic Plan is a living document that interfaces with Community Benefit Initiatives, the Strategic Transformation Plan, Local County Health Departments, and dovetails with the State Health Improvement Plan (SHIP) goals. In addition, collaboration and partnerships with local civic organizations, faith-based institutions and community providers like the YMCA and MAC, etc., are now the norm instead of the exception.

As part of the preceding Strategic Tenet, Peninsula Regional continues to build the future care infrastructure for ongoing community health benefits by investing in patient-centered care, provider/care team innovations, health information systems reinvestment and employee/ family, *"Live Well"* initiatives. The synergy created by these incremental health building blocks has provided access to those most in need of health resources and chronic disease management in our community.

Transformational Initiatives

Population Health & Community Based Care

- Development of a Weight Loss and Wellness Center, a multidisciplinary team that incorporates nutrition, weight loss, physical activity and support groups.
- Peninsula Regional's Wellness Van, the mobile clinic on wheels, travels to local targeted area community locations to provide clinic access, social work support and health resources and education to high-risk, underserved patients.
- Continuing to develop the behavioral health "Partial Hospitalization Program" in partnership with Adventist secondary to a community assessment for gaps in service for the region.
- A **"Renal Coach"** who meets with patients in stage 4 and 5 to help reduce the rate of transitions to dialysis.
- COPD (Chronic Obstructive Pulmonary Disease) program where the organization has implemented a mobile medical van where one of our providers goes to see patients in an area of need at no charge; no appointment or travel is necessary.
- Partnering with TLC (Three Lower Counties) a federally qualified health center to improve access to primary care appointments.
- Inpatient post-discharge chronic disease management through remote data collection and data management services.
- Provision of medication for indigent population to pay for meds to help prevent readmissions and develop a healthier community.

- Palliative care whose focus on patients with complex chronic disease states with specialized care revolves around symptom control, counseling, family support and education/assistance with end-of-life decision making.
- RN coordinators to improve access to primary care appointments within 72 hours of discharge.
- Grant to local Department of Aging to support chronic disease self-management classes (Stanford Model) within the community
- Additional social worker to connect ED high utilizers with community services, primary care physicians including helping to provide transportation and access to disease management education.
- Community-Based Care Coordination supported by our Home Health Provider focuses on patients at high risk of hospital readmissions. These complex, high-needs patients are supported by an RN and three community health workers.
- Health Coaches at Peninsula Home Care focus on heart failure and chronic kidney disease patients, providing assistance with improving compliance with dietary and medication management.
- Endocrinology: Implementation of telemedicine/diabetes clinic for pediatric patients with a focus on accurate diagnosis/ treatment using family support and school nurse. Patient education and chronic disease management for diabetes and the co-morbidities associated diabetes, which is so prevalent in our region.
- Continued recruitment of primary care physicians that develop care models targeting high-risk patients, assigning them to specific care plans and care plan coordinators.

Integrator

HealthPartners Delmarva - In 2014 Peninsula Regional and Bayhealth of Dover and Milford Delaware formed a partnership called HealthPartners Delmarva. This partnership seeks to improve the health of the patients within our regional population and create ways to provide services in the most affordable setting. Our goal is to identify new opportunities to improve outcomes and innovative ways to share best practices, reduce expenses and leverage the expertise and technology of both partners.

Clinical Partnerships - with Adventist Healthcare, Johns Hopkins and Children's National Health System.

Advanced Health Collaborative - a collaborative with four other leading Maryland health systems: Adventist HealthCare, LifeBridge Health, Mercy Health Services, and Trivergent Health Alliance. The key benefit of this membership will be shared learning and collaboration, allowing partners to manage changes in healthcare more efficiently and effectively with a unified focus on improving health for their patients and communities.

Health Information Systems

The conversion to **EPIC** EMR (Electronic Medical Record) establishes a foundation from which we are truly sharing information. The University of Maryland, Johns Hopkins, Anne Arundel Medical Center, Mercy, the new Riverside hospital coming to Virginia's Eastern Shore, and our HealthVisions Delmarva partner, Bayhealth in Dover and Milford, DE, are all Epic hospitals or soon will be. "Care Everywhere" is the name of the EPIC program that allows all of us to see the same record, to share the same information at admission or referral or in the Emergency Department when seconds count. And EPIC provides each of us Best Practice Advisories, so we can trade and then potentially implement ourselves what is working best for the patient at our peer hospitals or participating physician offices.

Peninsula Regional's Health Information System's software continues to evolve in support of predictive analytics modeling that helps identify high-risk patients, subsequently engaging physicians and caregivers in implementing patient's self-care regimen. Development of processes used to identify high-risk patients for care, identification of quality care issues and improvements to prevent complications and readmissions.

PRCIN (Peninsula Regional Clinically Integrated Network)

In FY2016, the Centers for Medicare & Medicaid Services approved Peninsula Regional Health System's clinically integrated network or ACO (Accountable Care Organization). This new Medicare network brings the Hospital, local physician, and providers together to provide higher-quality, coordinated care to patients. Ultimately, this is about delivering better care, spending dollars more wisely and having healthier people and communities. The PRCIN's mission is to drive health care progress by improving the coordination and integration of health care, and improving the health of patients, with a priority placed on prevention and wellness. There are four domains of ACO quality measures and multiple metrics within each domain:

- Patient/caregivers' experience
- Preventive care
- Care coordination/patient safety
- At-risk population

The **YMCA** of the Chesapeake and Peninsula Regional Medical Center entered into a strategic partnership to explore options to manage and prevent chronic diseases and to engage the Delmarva community to participate in activities and lifestyle changes to sustain lifelong wellness.

The partnership joins the YMCA, the largest human services organization in the region with over 27,000 active members at 7 locations across the Maryland's Eastern Shore and in Chincoteague, VA, with PRMC, the largest and most clinically advanced tertiary medical center on the Delmarva Peninsula.

"The YMCA has a number of successful programs underway now that assist people in managing chronic conditions," said Robbie Gill, Chief Executive Officer of the YMCA of the Chesapeake. "One of the great benefits we expect from this partnership is having PRMC clinicians and educators actively involved in our programs to create those very special one-to-one relationships that bond people emotionally, establish trust and understanding and lead to healthier and happier lives."

Some of the quick wins that the YMCA and PRMC plan to capture immediately from the partnership include: the establishment of monthly educational series on a number of health-related topics, participation by PRMC clinical teams in YMCA programs and services, health literacy programs for families, increased blood pressure and hypertension monitoring, enhanced diabetes education and a focused collaboration around the Y's successful Healthy Us initiative to combat childhood obesity.

"Childhood obesity only leads to adult obesity and with it a slew of chronic conditions including heart disease, diabetes and high blood pressure that strain families and drain healthcare services," said Karen Poisker, PRMC's Vice President for Population Health. "We are excited to partner with the YMCA to help entire families to think differently about taking care of themselves and their children now, when it matters most and when we can manage peer pressures and provide the peer support that will create some really sustainable lifestyle changes."

Care Wrap

Lower Shore Clinic (LSC) and Peninsula Regional Medical Center (PRMC) are collaborating on an initiative establishing an outreach team of health professionals, called CareWrap, whose goal is to enhance access to community-based primary and mental health care by targeting people at risk of 30-day readmission. Thirty-day readmission refers to a patient returning to the hospital within 30 days of discharge, which is an expensive and undesirable outcome for both patient and hospital.

"CareWrap is another of those absolutely essential pieces to the population health puzzle that we don't have to invent or reinvent. It's a proven approach to care that lets us touch some of our most at-risk patients, through one-on-one, face-to-face education and instruction," said Karen Poisker, PRMC's Vice President of Population Health. "We know that if we ingrain those good habits associated with properly managing chronic conditions, we can keep people healthier and out of our emergency department or hospital."

The CareWrap team, led by a registered nurse and consisting of two medical assistants and a part-time benefits coordinator, closely follows newly discharged inpatients who agree to participate. For up to three months, the team will: assist in filling prescriptions, see that discharge instructions are being followed, schedule appointments and ensure they are kept, provide instruction on maintaining a healthy lifestyle, and link to social supports, housing, and benefits as eligible. If clients do not have a primary health care provider, they will be offered care at a 'Bridge Clinic' for primary and preventive care.

CARE SAGE

Through a program called CareSage, PRMC's Philips Lifeline program identifies patients at risk for falls or who have chronic conditions such as COPD, CHF or diabetes, and offers them Lifeline monitoring service free for 60 days to help keep them safe and reduce readmissions. Peninsula Regional and Phillips have partnered to identify hospital-discharged patients at risk who could benefit. The monitoring service is available for free for 60 days, as well as for those who can't qualify for CareSage but would benefit from in-home monitoring.

Wagner Wellness Van

The Wagner Wellness Van makes routine visits to shelters and local churches and is a population heath platform visiting locals with the van equipped as a clinic. We have established a presence at many locations throughout the tri-county area; the van conducts blood pressure screenings, height/weight and acts as a conduit for education and access to other health care providers and facilities. On most Thursdays of every month the van visits Urban Ministries and it has impacted 156 health/wellness community programs.

Opening of Child and Adolescent Outpatient Behavioral Health Unit

This year Peninsula Regional celebrated the opening of the Rebecca and Leighton Moore Child and Adolescent Outpatient Behavioral Health Unit. The unit offers outpatient therapeutic behavioral health services, including individual therapy and medication management, for children and adolescents. Our clinical team provides a customized treatment plan that is designed to help patients successfully manage their illness and maintain optimal activity at home, work, or school. Behavioral Health Services at PRMC are provided in a joint partnership between PRMC and Adventist HealthCare Behavioral Health and Wellness Services (BH&WS).

Employee Family "Live Well" Campaign

Building on the externally focused "Live Well" marketing efforts, Peninsula Regional turned that inward to the new "Live Well" campaign that is directed at employees and their families. This campaign encourages/promotes healthy lifestyles through education, financial benefits, health care assessments, chronic disease management and other collective health activities.

A specific module associated with the "Live Well" campaign focuses on employees with diabetes as a diagnosis; the primary objective is to improve diabetes control and reduce A1C for individuals over time. Employees participating in the program receive a reduction in cost for their health care benefit and receive free testing and medications for their diabetes care. In addition, PRMC is currently developing a playbook to build ways to engage its employees and their families in a comprehensive "Live Well" lifestyle.

Population Health

Over the last few years, population health activities have been based upon community and regional needs. PRMC's overarching goals have been to provide care within the community to improve the overall quality of life, reduce health disparities, work with community organization and county health departments that impact the population on a daily basis, and to increase access to care outside of the acute care setting. The Community Health Benefits Report details efforts around Diabetes, Obesity and how PRMC has been working to further population health efforts.

Future Community Benefit Intent:

PRMC has determined that there is a great need to focus activities in the community with Care Managers located in primary care offices to assist primary care physicians in caring for patients with multiple admissions/emergency room visits and with multiple chronic conditions. Further, there is a need to access care for those patients who do not have a primary care physician by assisting patients within a bridge clinic. Action plans are being developed to assist patients by providing a mobile van to address rural disparities in accessing health. Initiatives include chronic disease management through Heartline, a data collection source, and health coaches who use the information to assist patients in better managing chronic disease. We are also developing care managers to assist primary care practitioners, patients and their families to make palliative care and hospital referrals for outpatient symptom control and counseling as well as in-home services. Finally, in collaboration with multiple partners such as Atlantic General, McCready Hospital, Crisfield Clinic and multiple SNF's/Rehab, PRMC seeks to prevent avoidable admissions by addressing behavioral/chronic health needs and chronic disease management.

Ambulatory Access

PRMC is committed to being an integrator of health services. As an integrator, we must provide appropriate access to service for the populations we seek to serve across the entire continuum. The range of services that populations require is broad and includes:

- Facility-based services such as hospitals, free-standing urgent care centers, clinics and other essential ambulatory networks.
- Non-facility-based services.
- New partnerships, relationships, affiliations and pathways to drive integration and innovation.
- Health professional services such as physicians, nurse practitioners and physician assistants.

The Peninsula Regional Health System officially dedicated its new, community-based **Peninsula Breast Center** in Salisbury this year. The Peninsula Breast Center provides women the most comprehensive breast health services on Delmarva with care plans individualized for each woman. The warm and caring staff believes in a team approach, and will offer 3D mammography, biopsies, physician consultations and surgical services all in a single location.

The Peninsula Weight Loss and Wellness Center opened at MAC, Inc. this year on Snow Hill Road in Salisbury. It provides clients with medically managed weight loss options and the support system they need to succeed. At the new center, clients are empowered to make decisions regarding their diet and overall health. The philosophy is not to swear off certain foods, but to learn about diet and nutrition to achieve a healthy balance. The Center give patients the tools they need to make healthy choices with resources that are easy to obtain. The ongoing delivery of information will lead to healthy lifelong habits and the maintenance of weight loss goals.

In the last several years Peninsula Regional has opened several Health Pavilions within the community; one in Millsboro, Delaware, and one in Ocean Pines, Maryland. Most recently PRMC has broken ground in Ocean Pines for a new comprehensive cancer services center, which will be located next to the newly built primary care center. The new center will bring both radiation and medical oncology services to Worcester County.

As part of our plan to expand health services outside the hospital walls and into communities, the strategy provides ease of access and promotes continuity of primary and population health services. These health pavilions provide primary care physicians, a pharmacy, rehab, medical imaging, and partnerships that provide specialty services such as cardiology and orthopedics. Each pavilion has an educational room that can be used by the public and other community health providers to hold health seminars and educational sessions. PRMC continues to develop its ambulatory care presence in addition to affiliations and partnerships as we review the external environment's socio-demographics, gaps in health services and access needs.

III. COMMUNITY BENEFIT ADMINISTRATION

b. What stakeholders in 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. _X_ CEO – Dr. Peggy Naleppa
2. _X_ CFO – Bruce Ritchie
3. _X_ Other-

COO- Cindy Lunsford

CMO- Dr. Charles B. Silvia

CNO- Shei Matter

VP Operations- Steve Leonard

VP Strategy CBO- Christopher Hall

VP Safety and Compliance Officer- Tim Feist

VP Population Health- Karen Poisker

VP People- Mitzi Scott

Describe the role of Senior Leadership.

The Community Benefits Team at PRMC encompasses many departments and facets of the organization. Senior Leadership is responsible for defining the organization's population health objective and creating the infrastructure that delivers health services to targeted populations. Other roles include creating business cases for population health management initiatives, providing leadership for future health information systems connectivity, targeting high-risk populations for chronic disease management/ interventions, identifying service line gaps, building partnerships and collaborations with other health care providers, and setting overall direction and goals.

ii. Clinical Leadership

1. _X_ Physician
2. _X_ Nurse
3. _X_ Social Worker
4. _X_ Other (please specify)
    a. Community Health Worker

Describe the role of Clinical Leadership

Clinical Leadership creates tactical action plans around population health initiatives that achieve the best health outcomes for residents. Their roles include designing care management processes, engaging targeted population with care and wellness plans, health education, follow-up, intervention, transportation, coordination of care along the continuum, health analytics/ metrics, and collaborating with other providers and local health departments.

iii. Population Health Leadership and Staff

1. _X_ Population health VP or equivalent (please list)
   VP Population Health- Karen Poisker

2. _X_ Other population health staff (please list staff)
   Executive Director Pop. Health- Kathryn Fiddler
   Director Community Health Services- Stephanie Elliot

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

The role of our population health leaders is to develop, direct, coordinate the organization-wide oversight of Peninsula Regional Health System's population health initiatives. The leadership is responsible for implementing delivery of new clinical/community outreach services, development of innovative strategies supportive of population health directives, collaboration among community partners, supportive establishment of performance analytics and stewardship that achieves the Triple-Aim priorities.

iv. Community Benefit Operations

1. _X_ Individual (please specify FTE)
   a. Rhonda Lasher- Administration and Coordination of Services
2. _X_ Committee (please list members)
   a. Exercise Physiologists and Nutritionist- Caroline Farrell
   b. Director Physician Relations and Coordinator of Community Benefits- Patti Serkes
   c. Communication and Messaging- Gwen Garland
   d. Strategic Guidance and Oversight- VP Chris Hall
   e. Planning and Data Analytics- Henry Nyce
   f. Behavioral Health Leadership- Kim Butler
   g. Weight Loss and Wellness Center- Christine Carpenter
   h. Diabetes Educator Coordinator- Susan Cottongim
   i. Care-Coach-Connect Campaign Administrator- Laren Carmean
   j. Community Health Initiatives- Stephanie Elliott
   k. Pediatric Weight Loss and Nutrition- Flora Glasgow
3. _X_ Department (please list staff)
   Transitions Coaches- Jennifer Rayne, Lois Morgan, Anna Kirchner, Tammy Kinhart, Barbara Haines, Shelley Flaig
4. ___Task Force (please list members)
5. _X_ Other (please describe)
   a. Pulmonary Diagnostics Services Supervisor- Tom Russ
   b. Employee Health and Wellness- VP Mitzi Scott

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

The preceding Community Benefit Health & Wellness Committee and the Transitions Services/Population Health Department work in tandem identifying, targeting, developing and implementing action plans for community health. These stakeholders collaborate with local county health departments, civic organizations, faith based groups and other local providers.

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

Spreadsheet	_X_ yes	_____no
Narrative	_X_ yes	_____no

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

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

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

Spreadsheet	_X_yes	_____no
Narrative	_X_yes	_____no

If no, please explain why.

Each year, the Board of Trustees receives a copy of the Community Benefit report and a presentation at their monthly education session. Following the education session, the board fully accepts the community benefit report through the passing of a resolution.

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:

__X__ Other hospital organizations
__X__ Local Health Department
__X__ Local health improvement coalitions (LHICs)
__X__ Schools
__X__ Behavioral health organizations
__X__ Faith based community organizations
__X__ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

The 2014 PRC (Professional Research Corporation) Community Health Needs Assessment Report was sponsored by Peninsula Regional Medical Center, Atlantic General Hospital, Wicomico Health Department and Worcester County Health Department. This report determined the health status, behaviors and needs of residents in our service area. The information has subsequently been used to make informed decisions and guide efforts to improve the community health and wellness.

Our core partners over the last decade have sponsored and supported CHNA reporting, which has led to development of health and wellness programs and collaborations throughout the Tri-County region:

- Peninsula Regional
- Atlantic General
- McCready Health/Hospital
- Wicomico Health Department
- Worcester Health Department
- Somerset Health Department

New IRS regulations required Peninsula Regional Medical Center to conduct a **2016 Community Health Needs Assessment (CHNA).** This CHNA report was developed to provide an overview of the health needs in the PRMC tri-county service area, including Somerset, Wicomico, and Worcester counties in Maryland, our

Community Benefit CBSA. PRMC partnered with Healthy Communities Institute (HCI), a Xerox Company, to conduct the CHNA. The goal of this report is to offer a meaningful understanding of the greatest health needs across the PRMC service area, as well as to guide planning efforts to address those needs. Special attention has been given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community. Members of the community are invited to provide feedback and comments on this report through multiple avenues. First, the report will be published on PRMC's website (www.Peninsula.org); when opening the report, a pop-up survey box will be there asking for feedback. In addition, community members are able to send emails to the community relations department via community.relations@peninsula.org.

Over the years the collective outcome of CHNA participation has led to collaborations and partnerships with some of the following key organizations:

Organization/ Key Partners	Name of Key Collaborator	Title	Collaboration Description
Tri-County Diabetes Alliance		Worcester County Chronic Disease Prevention	General Diabetes Awareness, Education & Management
Hospitals Atlantic General	Patti Yocubik	RN/CDE VP	
McCready	Joy Strand	CEO	
PRMC	Susan Cottongim Kathryn Fiddler	Manager Diabetes Education Exc. Dir. Pop. Hlth.	
Health Departments			
Somerset County	Craig Stofko Dawn Mills Sharon Lynch	Health Officer Exec Dir. Wellness	
Wicomico County	Lori Brewster Jennifer Johnson	Health Officer Chronic Disease	
Worcester County	Deborah Goeller Mimi Dean	Health Officer Dir of Plan & Pop	

	Maureen Sharkey		
TLC	Joan Robbins	TLC Executive Director	
UMES	Cathy Ferraro		
Salisbury Urban Ministries	Debbie Donaway	Executive Director	
PRMC Parents & Teens Children's National Medical Center	Susan Cottongim Parents & Teens Physicians	Manager Diabetes Education	Diabetes Support Group for Teens
PRMC CNMC- Children's National Medical Center YMCA Delmarva	Diane Hitchens & Flora Glasgow Chris Hall Robbie Gill Amy Sorg	Executive Director of Women's & Children's Services Nurse Practitioner VP PRMC YMCA Exec Dir. Wellness Director	Pediatric Weight Management Program
PRMC Parents & Children	PRMC Health Day Care Program- Linda Brannock	Director of Child Care	Pediatric Weight Management: PRMC Healthy Day Care Program
Health Fest PRMC James M. Bennett High School	PRMC Health and Wellness Committee Rick Briggs	See Section III. iii. Community Benefit Operations 2. Principal	Obesity-Reduce the Proportion of Children and Adolescents Who are Considered Obese- General Awareness Campaign
University of Maryland MAC- Maintaining Active Citizens	 Peggy Bradford/Pattie	 Executive Director Health & Wellness	Chronic Disease Management Partners

	Tingle Leigh Ann Eagle	 Project Director Branch Director	
Peninsula Regional Home Care	Nancy Bagwell	Director of Operations	
Local Churches New Dimensions Church	Jesse Abbott	Bishop	
Crisfield Church of God	Harvey Tyler Alana Tyler	Pastor Pastor	
Shelters HOPE inc.	Donna Clark	RN	
HALO Hope and Life Outreach	Celeste Savage	Executive Director	
PRMC Adventist Behavioral Health	 Kevin Young	 President of Adventist Behavioral Health	Partnered with Adventist Health to Provide Behavioral Health Services in the Emergency Department
Lower Shore Health Clinic Go-Getters	Richard Bearman	Clinic Director	Behavioral Health Services
Atlantic General McCready Health Emergency Service Associates	Colleen Wareing Joy Strand	CNO CEO	ED Care Management for High Utilizers
Salisbury Genesis Aurora Nursing Home Berlin Nursing Home White Oak SNF Harrison House Hartley Hall Deers Head Center	Rob Stofer Marsha Strauss	Administrator CNO	Partnering with 7 SNFs for Transitions of Care

EMT Services Crisfield Clinic	Dr. Kerry Palakanis	CFNP	Partnering with EMT Services and the Crisfield Clinic to provide Care Management and Telemedicine Services to High Utilizes of Smith Island
Independent and Employed Providers within Primary and Secondary Service Areas	PRMC & Peninsula Regional Medical Group Three Lower Counties Community Services Dr. Jonathan Patrowicz Dr. Alon Davis Dr. Chris Huddleston Dr. Vel Natesan	Physicians Physicians	PRMC Clinically Integrated Network: Develop Clinical Integration Including Physician Alignment And New Partnerships

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

_____yes __X__ no

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

___X_ yes _____no

TABLE III

a. 1. Identified Need 2. Was this identified through the CHNA process?	Reduce Diabetes complications as measured by SHIP 27. Reduce diabetes-related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management in the community. *Peninsula Regional engaged HCI (Healthy Communities Institute) to conduct a Community Health Needs Assessment Survey (2016). The CHNA findings were drawn from analysis of primary data interviewing community health leaders and organizations that serve the community at large.* ***The secondary data analysis for Diabetes resulted in a score that ranked in the top ten in the list of health concerns for the tri-county area.*** *There are specific diabetes-related indicators of concern across the three counties:* • *Adults with Diabetes (highest in Worcester County)* • *ER Rate due to Diabetes (highest in Wicomico County)* • *Diabetes Death Rate (highest in Somerset County)* • *Diabetes in the Medicare Population (highest in Somerset County)* ***In Wicomico County, which has the largest population of the tri-county area, three indicators had multiple extremely poor comparisons:*** • *Diabetes in the Medicare Population — the Wicomico County value of 31.3% in 2014 was higher than the U.S. value of 26.7% and fell in the bottom quartile of U.S. counties* • *Adults with Diabetes — the Wicomico County value of 12.9% in 2014 was much higher than the Maryland value of 10.2% and the U.S. value of 10%* • *ER Rate Due to Diabetes — the Wicomico County value of 372.7 ER visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties* ***In Worcester County, one indicator had multiple extremely poor comparisons:*** • *Adults with Diabetes — the Worcester County value of 18.2% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland Counties* ***In Somerset County, four indicators had multiple extremely poor comparisons:*** • *Diabetes in the Medicare Population — the Somerset County value of 34% in 2014 was higher than the U.S. value of 26.7%, the Maryland value of 29%, and fell in the bottom quartile of both U.S. counties and Maryland counties* • *Age-Adjusted Death Rate Due to Diabetes — the Somerset County value of 25.2 deaths/100,000 population in 2010-2012 was higher than the U.S. value of 21.2, the Maryland value of 19.9, and fell in the bottom quartile of Maryland counties* • *Adults with Diabetes — the Somerset County value of 13.3% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland counties* • *ER Rate Due to Diabetes — the Somerset County value of 253.8 ER visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties*

	Prevalence of Diabetes is high in this community, higher than average within Maryland and the country. Management of the disease among those with Diabetes is inadequate, as evidenced by the high ER and death rates. *When looking at sub-populations disproportionately impacted by diabetes, the Black community has a greater burden of the disease, almost double the prevalence of the White community. Of adults, in Wicomico County 16.9% of Black adults have diabetes, compared to 9.8% of White adults. In Somerset County, 28.8% of Black adults have diabetes, compared to 9.9% of White adults. There are also disparities for women in Somerset County with almost triple the diabetes prevalence of men — 20.6% of women have diabetes, compared to 7.5% of men. Asian and Other Race groups are also disproportionately affected in Wicomico County, with 17.9% of Asian adults and 33.1% of Other Race adults impacted by diabetes.* *The figure below indicates some direct quotes from key informants regarding Diabetes and related health issues in their community and the populations most impacted.* "There is a pre-diabetes population on the Eastern Shore. Often times, our population isn't aware." "Obesity and diabetes are main focuses in our community and our work." Yes, this was identified through the CHNA process.
b. Hospital Initiative	*Provide awareness, education & diabetes management to the community. The goals and initiatives include: reducing the number of diabetes related emergency room visits; tracking the number of tri-county diabetes risk assessment tests administered; and increasing community participation in diabetes management and education programs.*
c. Total Number of People Within the Target Population	Percent of Diabetes: Health / Diabetes **County: Somerset, MD** VALUE COMPARED TO: Adults with Diabetes 13.3% (2014) MD Counties **County: Wicomico, MD** VALUE COMPARED TO: Adults with Diabetes 12.9% (2014) MD Counties **County: Worcester, MD** VALUE COMPARED TO: Adults with Diabetes 18.2% (2014) MD Counties PRMC serves a rural population in Wicomico, Worcester and Somerset counties which have an extremely high prevalence of diabetes. This is Peninsula Regional's

	target population; Truven Health Analytics projects a local propensity of 20,000+ adults that have the chronic condition of diabetes within these counties. *Source: 2016 Healthy Communities Inc.*
d. Total Number of People Reached by the Initiative Within the Target Population	Total Community Benefit diabetes encounters or "touchpoints" in FY2016 was over 1,200.
e. Primary Objective of the Initiative	Continue to create general public awareness around the high prevalence of diabetes in this region. As part of this initiative PRMC has collaborated with our partners to educate the public via various venues: • Diabetes Prevention & Education • Participation in Health Fairs throughout region • Travel to Community Events and Present Healthy Lifestyles • Local Health Department- "Health Events" • Diabetes Screenings (paper) at civic events • Diabetes support group meetings
f. Single or Multi-Year Initiative –Time Period	These initiatives have been very well received by the community and as an Organization we will continue to provide these educational forums, however, there are several new strategies that will be pursued this year based upon the latest CHNA. **Expansion of Initiatives Based Upon New 2016 CHNA:** **Strategies** **1. The offering of chronic disease management classes (Diabetes) throughout the tri-county area.** **2. Expansion of the Wagner Wellness Van mobile clinic services to increase the frequency and outreach of services (i.e. Diabetes)**. **See Appendix A for Expansion of Initiatives**
g. Key Collaborators in Delivery of the Initiative	• Peninsula Regional's Center for Diabetes and Endocrinology • Tri-County Health Departments • Tri-County Diabetes Alliance • Tri-County Healthy Weight Coalitions • Wicomico County Diabetes Planning Committee
h. Impact/Outcome of Hospital Initiative?	Travel to community events where at-risk populations are present for diabetes screenings and education. **In FY 2016** Total Community Benefit Diabetes Encounters/Touch Points was over 1,200 Health Fairs Attended: 7 Diabetes Encounters/Screenings: 797 Annual Diabetes Support Group Meetings: 16

	• Diabetes Support • Diabetes Insulin Pump Support • Diabetes Support Group for Kids and Teens Collaboration & Partnership Meetings & Events: 4+	
i. Evaluation of Outcomes:	The outcomes are evaluated individually based upon response rate and participation and by the Community Benefits Task Force.	
j. Continuation of Initiative?	Yes, plan to continue all of these initiatives but build upon these initiatives with several new strategies: • The offering of chronic disease management classes throughout the tri-county area. • Expansion of the Wagner Wellness Van mobile clinic services to increase the frequency and outreach of services.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $1,669	B. Direct Offsetting Revenue from Restricted Grants $0

Initiative 2- Diabetes Support Group for Teens and Children

a. Identified Need 2. Was this identified through the CHNA process?	Reduce Diabetes complications as measured by SHIP 27. Reduce diabetes related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management within the community. *Peninsula Regional engaged HCI (Healthy Communities Institute) to conduct a Community Health Needs Assessment Survey (2016). The CHNA findings were drawn from analysis of primary data interviewing community health leaders and organizations that serve the community at large.* ***The secondary data analysis for Diabetes resulted in a score which ranked in the top ten in the list of health concerns for the tri-county area.*** *There are specific diabetes-related indicators of concern across the three counties:* • *Adults with Diabetes (highest in Worcester County)* • *ER Rate due to Diabetes (highest in Wicomico County)* • *Diabetes Death Rate (highest in Somerset County)* • *Diabetes in the Medicare Population (highest in Somerset County)* ***In Wicomico County, which has the largest population of the tri-county area, three indicators had multiple extremely poor comparisons:*** • *Diabetes in the Medicare Population — the Wicomico County value of 31.3% in 2014 was higher than the U.S. value of 26.7% and fell in the bottom quartile of U.S. counties* • *Adults with Diabetes — the Wicomico County value of 12.9% in 2014 was much higher than the Maryland value of 10.2% and the U.S. value of 10%* • *ER Rate Due to Diabetes — the Wicomico County value of 372.7 ER visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties* ***In Worcester County, one indicator had multiple extremely poor comparisons:*** • *Adults with Diabetes — the Worcester County value of 18.2% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland Counties* ***In Somerset County, four indicators had multiple extremely poor comparisons:*** • *Diabetes in the Medicare Population — the Somerset County value of 34% in 2014 was higher than the U.S. value of 26.7%, the Maryland value of 29%, and fell in the bottom quartile of both U.S. counties and Maryland counties* • *Age-Adjusted Death Rate Due to Diabetes — the Somerset County value of 25.2 deaths/100,000 population in 2010-2012 was higher than the U.S. value of 21.2, the Maryland value of 19.9, and fell in the bottom quartile of Maryland counties* • *Adults with Diabetes — the Somerset County value of 13.3% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland counties* • *ER Rate Due to Diabetes — the Somerset County value of 253.8 ER*

	visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties *Prevalence of Diabetes is high in this community, higher than average within Maryland and the country. Management of the disease among those with Diabetes is inadequate, as evidenced by the high ER and death rates.* *When looking at sub-populations disproportionately impacted by diabetes, the Black community has a greater burden of the disease, almost double the prevalence of the White community. Of adults, in Wicomico County 16.9% of Black adults have diabetes, compared to 9.8% of White adults. In Somerset County, 28.8% of Black adults have diabetes, compared to 9.9% of White adults. There are also disparities for women in Somerset County with almost triple the diabetes prevalence of men — 20.6% of women have diabetes, compared to 7.5% of men. Asian and Other Race groups are also disproportionately affected in Wicomico County, with 17.9% of Asian adults and 33.1% of Other Race adults impacted by diabetes.* *The figure below indicates some direct quotes from key informants regarding Diabetes and related health issues in their community and the populations most impacted.* "There is a pre-diabetes population on the Eastern Shore. Often times, our population isn't aware." "Obesity and diabetes are main focuses in our community and our work." Yes, this was identified through the CHNA process.
b. Hospital Initiative	Provide awareness, education & diabetes management to the community.
c. Total Number of People Within the Target Population	**Percent of Diabetes:** Health / Diabetes **County: Somerset, MD** VALUE: 13.3% (2014) — Adults with Diabetes — COMPARED TO: MD Counties **County: Wicomico, MD** VALUE: 12.9% (2014) — Adults with Diabetes — COMPARED TO: MD Counties **County: Worcester, MD** VALUE: 18.2% (2014) — Adults with Diabetes — COMPARED TO: MD Counties PRMC serves a rural population in Wicomico, Worcester and Somerset counties

	that have extremely high prevalence of diabetes. This is our target population with a projection of 20,000+ residents that have this chronic disease. *Source: 2016 Healthy Communities Inc.* *Truven Health Analytics*	
d. Total Number of People Reached by the Initiative Within the Target Population	Total Community Benefit childhood diabetes encounters or "touchpoints" in FY2016 was over 32 children and is even more as we have educated the parents and caretakers.	
e. Primary Objective of the Initiative	Creation and continuation of a "Diabetes Support Group for Teens and Kids" that meets the medical, educational and social needs of this group.	
f. Single or Multi-Year Initiative –Time Period	Multi-Year Initiative.	
g. Key Collaborators in Delivery of the Initiative	• Peninsula Regional Center for Diabetes and Endocrinology • Partnership with Parents • Tri-County Diabetes Alliance of whom PRMC is a partner; working with local county educators to provide referrals to students in need of diabetes support groups.	
h. Impact/Outcome of Hospital Initiative?	Group meetings: 4 *(Group meets every other month)* **Program Overview** • Exercise/Sports • Eating/Nutrition • Self-Awareness • Managing your Diabetes • Group Interaction Track # of attendees to the support group: 32 adolescents not including the parents. A core children's & teen diabetes group is now established, this group supports, shares and encourages members in controlling their diabetes. Referred children to Peninsula Regional Endocrinology Office as needed.	
i. Evaluation of Outcomes:	Outcomes are evaluated by the help and the education provided to these children in addition to physician referrals.	
j. Continuation of Initiative?	PRMC will continue to promote this initiative through disseminating promotional flyers as pediatric offices in addition to promoting this service to local pediatricians. PRMC will continue to promote this service to local school nurses in an effort to identify children and teens that would benefit from a diabetes support group.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $869	B. Direct Offsetting Revenue from Restricted Grants $0

Initiative 3- Partnership with Tri-County Diabetes Alliance

a. Identified Need 2. Was this identified through the CHNA process?	Reduce Diabetes complications as measured by SHIP 27. Reduce diabetes related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management within the community. *Peninsula Regional engaged HCI (Healthy Communities Institute) to conduct a Community Health Needs Assessment Survey (2016). The CHNA findings were drawn from analysis of primary data interviewing community health leaders and organizations that serve the community at large.* ***The secondary data analysis for Diabetes resulted in a score which ranked in the top ten in the list of health concerns for the tri-county area.*** *There are specific diabetes-related indicators of concern across the three counties:* • *Adults with Diabetes (highest in Worcester County)* • *ER Rate due to Diabetes (highest in Wicomico County)* • *Diabetes Death Rate (highest in Somerset County)* • *Diabetes in the Medicare Population (highest in Somerset County)* ***In Wicomico County, which has the largest population of the tri-county area, three indicators had multiple extremely poor comparisons:*** • *Diabetes in the Medicare Population — the Wicomico County value of 31.3% in 2014 was higher than the U.S. value of 26.7% and fell in the bottom quartile of U.S. counties* • *Adults with Diabetes — the Wicomico County value of 12.9% in 2014 was much higher than the Maryland value of 10.2% and the U.S. value of 10%* • *ER Rate Due to Diabetes — the Wicomico County value of 372.7 ER visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties* ***In Worcester County, one indicator had multiple extremely poor comparisons:*** • *Adults with Diabetes — the Worcester County value of 18.2% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland Counties* ***In Somerset County, four indicators had multiple extremely poor comparisons:*** • *Diabetes in the Medicare Population — the Somerset County value of 34% in 2014 was higher than the U.S. value of 26.7%, the Maryland value of 29%, and fell in the bottom quartile of both U.S. counties and Maryland counties* • *Age-Adjusted Death Rate Due to Diabetes — the Somerset County value of 25.2 deaths/100,000 population in 2010-2012 was higher than the U.S. value of 21.2, the Maryland value of 19.9, and fell in the bottom quartile of Maryland counties* • *Adults with Diabetes — the Somerset County value of 13.3% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland counties* • *ER Rate Due to Diabetes — the Somerset County value of 253.8 ER visits/100,000 population was much higher than the Maryland state value*

	of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties *Prevalence of Diabetes is high in this community, higher than average within Maryland and the country. Management of the disease among those with Diabetes is inadequate, as evidenced by the high ER and death rates.* *When looking at sub-populations disproportionately impacted by diabetes, the Black community has a greater burden of the disease, almost double the prevalence of the White community. Of adults, in Wicomico County 16.9% of Black adults have diabetes, compared to 9.8% of White adults. In Somerset County, 28.8% of Black adults have diabetes, compared to 9.9% of White adults. There are also disparities for women in Somerset County with almost triple the diabetes prevalence of men — 20.6% of women have diabetes, compared to 7.5% of men. Asian and Other Race groups are also disproportionately affected in Wicomico County, with 17.9% of Asian adults and 33.1% of Other Race adults impacted by diabetes.* *The figure below indicates some direct quotes from key informants regarding Diabetes and related health issues in their community and the populations most impacted.* "There is a pre-diabetes population on the Eastern Shore. Often times, our population isn't aware." "Obesity and diabetes are main focuses in our community and our work." Yes, this was identified through the CHNA process.
b. Hospital Initiative	Provide awareness, education & diabetes management to the community.
c. Total Number of People Within the Target Population	**Percent of Diabetes:** Health / Diabetes **County: Somerset, MD** VALUE: Adults with Diabetes 13.3% (2014) — COMPARED TO: MD Counties **County: Wicomico, MD** VALUE: Adults with Diabetes 12.9% (2014) — COMPARED TO: MD Counties **County: Worcester, MD** VALUE: Adults with Diabetes 18.2% (2014) — COMPARED TO: MD Counties PRMC serves a rural population in Wicomico, Worcester and Somerset counties that have extremely high prevalence of diabetes. The target population is

	projected at 20,000+ that have diabetes. *Source: 2016 Healthy Communities Inc.*
d. Total Number of People Reached by the Initiative Within the Target Population	To be determined by the Tri-County Diabetes Alliance Members for FY2016.
e. Primary Objective of the Initiative	Support and partner with the TCDA, (Tri-County Diabetes Alliance) to create awareness, education and management of the diabetes population in the lower three counties.
f. Single or Multi-Year Initiative –Time Period	Multi-Year Initiative
g. Key Collaborators in Delivery of the Initiative	• Peninsula Regional Medical Center • TCDA Tri-County Diabetes Alliance • Tri-County Health Departments (Wicomico, Worcester, Somerset) • UMES- University of Maryland Eastern Shore • McCready Hospital • Atlantic General Hospital • Three Lower Counties - Salisbury • Urban Ministries
h. Impact/Outcome of Hospital Initiative?	PRMC is a partner in the Tri-County Diabetes Alliance (TCDA) and for FY16 and FY17 the goal of TCDA is to focus on the following objectives: • Improve glycemic control among the population with diagnosed diabetes. • Improve lipid control among persons with diagnosed diabetes. • Increase the proportion of the population with diagnosed diabetes whose blood pressure is under control. • Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education. • Increase the proportion of adults with diabetes whose condition has been diagnosed. • Increase prevention behaviors in persons at high risk for diabetes and those with pre-diabetes. PRMC's Wagner Wellness Van is present at 7+ local community health fairs and festivals a year. At these venues, community members who are screened and identified at risk for diabetes are referred to TCDA when appropriate for follow-up and educational sessions. Track the number of participants in all collaborative meetings: (10-15) per meeting 10 times per year. TCDA continues to collaborate with the Tri County Health Planning Board to focus on reducing diabetes-related emergency room visits in Wicomico, Worcester, and Somerset. PRMC sends a list of "frequent flier" diabetes patients presenting to our ER (5-10 per quarter) to be case managed and referred for further diabetes education or support group participation.
i. Evaluation of Outcomes:	Outcomes are evaluated by the Tri-County Diabetes Alliance Members TCDA is following the Healthy People 2020 guidelines for diabetes and will increase the education and identification of those at risk for diabetes.
j. Continuation of Initiative?	Plan to Continue

k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $0	b. Direct Offsetting Revenue from Restricted Grants $0

New Initiative 4- Partnership with MAC Chronic Disease Management

a. Identified Need 2. Was this identified through the CHNA process?	Reduce Diabetes complications as measured by SHIP 27. Reduce diabetes-related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management within the community. *Peninsula Regional engaged HCI (Healthy Communities Institute) to conduct a Community Health Needs Assessment Survey (2016). The CHNA findings were drawn from analysis of primary data interviewing community health leaders and organizations that serve the community at large.* ***The secondary data analysis for Diabetes resulted in a score which ranked in the top ten in the list of health concerns for the tri-county area.*** *There are specific diabetes-related indicators of concern across the three counties:* • *Adults with Diabetes (highest in Worcester County)* • *ER Rate due to Diabetes (highest in Wicomico County)* • *Diabetes Death Rate (highest in Somerset County)* • *Diabetes in the Medicare Population (highest in Somerset County)* ***In Wicomico County, which has the largest population of the tri-county area, three indicators had multiple extremely poor comparisons:*** • *Diabetes in the Medicare Population — the Wicomico County value of 31.3% in 2014 was higher than the U.S. value of 26.7% and fell in the bottom quartile of U.S. counties* • *Adults with Diabetes — the Wicomico County value of 12.9% in 2014 was much higher than the Maryland value of 10.2% and the U.S. value of 10%* • *ER Rate Due to Diabetes — the Wicomico County value of 372.7 ER visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties* ***In Worcester County, one indicator had multiple extremely poor comparisons:*** • *Adults with Diabetes — the Worcester County value of 18.2% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland Counties*

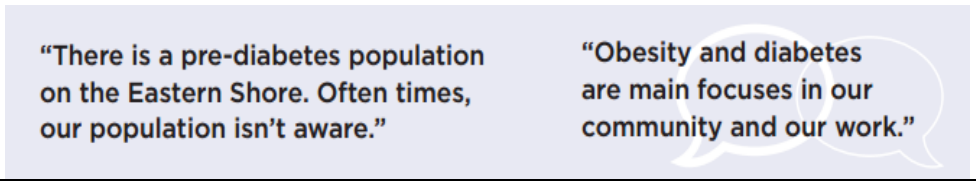
In Somerset County, four indicators had multiple extremely poor comparisons:

- *Diabetes in the Medicare Population — the Somerset County value of 34% in 2014 was higher than the U.S. value of 26.7%, the Maryland value of 29%, and fell in the bottom quartile of both U.S. counties and Maryland counties*
- *Age-Adjusted Death Rate Due to Diabetes — the Somerset County value of 25.2 deaths/100,000 population in 2010-2012 was higher than the U.S. value of 21.2, the Maryland value of 19.9, and fell in the bottom quartile of Maryland counties*
- *Adults with Diabetes — the Somerset County value of 13.3% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland counties*
- *ER Rate Due to Diabetes — the Somerset County value of 253.8 ER visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties*

Prevalence of Diabetes is high in this community, higher than average within Maryland and the country. Management of the disease among those with Diabetes is inadequate, as evidenced by the high ER and death rates.

When looking at sub-populations disproportionately impacted by diabetes, the Black community has a greater burden of the disease, almost double the prevalence of the White community. Of adults, in Wicomico County 16.9% of Black adults have diabetes, compared to 9.8% of White adults. In Somerset County, 28.8% of Black adults have diabetes, compared to 9.9% of White adults. There are also disparities for women in Somerset County with almost triple the diabetes prevalence of men — 20.6% of women have diabetes, compared to 7.5% of men. Asian and Other Race groups are also disproportionately affected in Wicomico County, with 17.9% of Asian adults and 33.1% of Other Race adults impacted by diabetes.

The figure below indicates some direct quotes from key informants regarding Diabetes and related health issues in their community and the populations most



	impacted. Yes, this was identified through the CHNA process.
b. Hospital Initiative	Local community partnership for Chronic Disease Management of Diabetes using the Stanford Model.
c. Total Number of People Within the Target Population	Percent of Diabetes: Health / Diabetes **County: Somerset, MD** VALUE COMPARED TO: Adults with Diabetes 13.3% (2014) MD Counties **County: Wicomico, MD** VALUE COMPARED TO: Adults with Diabetes 12.9% (2014) MD Counties **County: Worcester, MD** VALUE COMPARED TO: Adults with Diabetes 18.2% (2014) MD Counties PRMC serves a rural population in Wicomico, Worcester and Somerset counties that have extremely high prevalence of diabetes. This is our target population. *Source: 2016 Healthy Communities Inc.*
d. Total Number of People Reached by the Initiative Within the Target Population	In FY2016, 390 members of the community have participated in a chronic disease self-management class for diabetic education and self- management.
e. Primary Objective of the Initiative	The primary objective is to deliver chronic disease self-management services to community residents. The program will promote increased patient competence and coping through treatment plans that include education and referrals to necessary resources. Provide comprehensive assessments and assist the patient utilize the health system appropriately. **Healthy Living with Diabetes.** A diabetes self-management education program at MAC. Healthy Living with Diabetes is a 6-8 week workshop developed at Stanford University, based on self-management. CDSMP- Chronic Diabetes Self- Management Program
f. Single or Multi-Year Initiative –Time Period	Multi-Year Initiative Grant to local Department of Aging MAC (Maintaining Active Citizens) to support Chronic Disease Self-Management Classes - Stanford Model, within the community
g. Key Collaborators in Delivery of the Initiative	MAC's "Center of Excellence" hospital partners include: • Johns Hopkins • Meritus Health • Peninsula Regional

<table>
<tr><td></td><td colspan="2">o Physician Practices
o Home Health
o Long Term Care Facilities
o Retail Pharmacies</td></tr>
<tr><td>h. Impact/Outcome of Hospital Initiative?</td><td colspan="2">Referrals to MAC for Chronic Disease Self- Management Program (CDSMP):
• 80% of patients confident with their ability to manage their diabetes
• 98% of patients feel more motivated to take care of their health since they took the workshop

MAC disease self-management sessions
Number of workshops: 54

Average participants per workshop: 10.5
Number of participants: 390
Number who completed 4 or more sessions: 300 (77%)

<table>
<tr><th>County</th><th>Count</th><th>Percent</th></tr>
<tr><td>Wicomico</td><td>189</td><td>33%</td></tr>
<tr><td>Dorchester</td><td>112</td><td>20%</td></tr>
<tr><td>Somerset</td><td>43</td><td>8%</td></tr>
<tr><td>Worcester</td><td>40</td><td>7%</td></tr>
<tr><td>Sussex</td><td>6</td><td>1%</td></tr>
</table></td></tr>
<tr><td>i. Evaluation of Outcomes:</td><td colspan="2">MAC will oversee all the fidelity, data management, and will maintain a database of all chronic disease self-management education trainers and outcomes. To be further developed.</td></tr>
<tr><td>j. Continuation of Initiative?</td><td colspan="2">Plan to Continue</td></tr>
<tr><td>k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue</td><td>a. Total Cost of Initiative

$92,366</td><td>b. Direct Offsetting Revenue from Restricted Grants

$0</td></tr>
</table>

a. 1. Identified Need 2. Was this identified through the CHNA process?	**OBESITY- EXERCISE, NUTRITION, and WEIGHT** SHIP 31. Reduce the proportion of children and adolescents who are considered obese. *The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included:* • *Adults who are Obese* • *Child Food Insecurity Rate* ***In Wicomico County, which has the largest population of the tri-county area, several indicators had multiple, extremely poor comparisons:*** • *Adults who are Obese — the Wicomico County value of 34.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%* • *Adults with a Healthy Weight — the Wicomico County value of 31.3% in 2014 was lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%* • *Other environmental indicators related to Nutrition and Exercise with poor comparisons included:* o *Child Food Insecurity Rate* o *Food Environment Index* o *Food Insecurity Rate* o *Grocery Store Density* o *Low-Income and Low Access to a Grocery Store* o *Fast Food Restaurant Density* o *Workers who Walk to Work* ***In Worcester County, several indicators had multiple extremely poor comparisons, mostly related to environment:*** • *Child Food Insecurity Rate* • *65+ with Low Access to a Grocery Store* • *Fast Food Restaurant Density* ***Somerset County had the most indicators with very poor comparisons:*** • *Adults who are Obese — the Somerset County value of 49.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%. Also, Somerset County fell in the bottom quartile of Maryland counties.* • *Adults with a Healthy Weight — the Somerset County value of 21.2% in 2014 was much lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adults who are overweight or obese — the Somerset County value of 79.8% in 2014 was much higher than the U.S. value of 65% and Maryland value of 64.9%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties*

	Other environmental indicators related to Nutrition and Exercise with poor comparisons included: • *Child Food Insecurity Rate* • *Food Insecurity Rate* • *Food Environment Index* • *Access to Exercise Opportunities* • *Low-Income and Access to a Grocery Store* *When looking at sub-populations with disparities for Exercise, Nutrition, and Weight, we see racial and ethnic disparities as well as gender. In Worcester County adults, Blacks (47%) are more obese than Whites (27.1%). In Somerset County adults, Blacks (74%) and Latinos (60.3%) are more obese than Whites (40.8%); women (62.4%) are more obese than men (39.9%). COMMUNITY INPUT Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area.* ***COMMUNITY INPUT*** Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area. Yes, this was identified through the CHNA process.
b. Hospital Initiative	Reduce the # of child & adolescents in Wicomico, Worcester and Somerset who are considered overweight and present a healthy lifestyle of nutrition and exercise opportunities.
c. Total Number of People Within the Target Population	PRMC services a rural population where the percentage of adults who are obese is very high. Compared to other Maryland counties both Somerset and Wicomico have an exceptionally high number of adults who are overweight or obese. **Adults who are Overweight or Obese** VALUE — COMPARED TO: County: Somerset, MD — 79.8% (2014) — MD Counties County: Wicomico, MD — 68.7% (2014) — MD Counties County: Worcester, MD — 63.8% (2014) — MD Counties Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community wide health care initiative. **Adolescents who are Obese** — the Somerset County value of 17.5% in 2013 was higher than three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the

	bottom quartile of Maryland counties *Source: 2016 HCI Community Health Needs Assessment*
d. Total Number of People Reached by the Initiative Within the Target Population	Total Community Benefit Obesity encounters or "touchpoints" in FY2016 continues to exceed over 2,000 residents based upon all the programs and interactions provided.
e. Primary Objective of the Initiative	PRMC will develop educational modules and increase educational awareness around childhood & adolescent obesity to reduce the total number of children that are overweight.
f. Single or Multi-Year Initiative –Time Period	This is a multi-year initiative that will continue into the future. In addition there will be an expansion of this obesity initiative based upon the most current 2016 CHNA. The priority area will be broadened to include Exercise, Nutrition and Weight which will encompass several new strategies with the goal of increasing awareness and engagement in healthy lifestyle behaviors. **Expansion of Initiatives Based Upon New 2016 CHNA:** **Strategies** 1. Implement an after-school program for weight loss in collaboration with the YMCA (Healthy Us). 2. Develop and implement Improving Walkability in Wicomico County program. **See Appendix A for Expansion of Initiatives**
g. Key Collaborators in Delivery of the Initiative	PRMC Health and Wellness Committee working with local employers, community groups and attends community events. YMCA Schools Pediatric Referring Physicians Wicomico County Health Department Eastern Shore Regional GIS Cooperative
h. Impact/Outcome of Hospital Initiative?	Track number of venues information was distributed. We participated in a total of 9 local health festivals and fairs at which 1,166 encounters, "touch points" occurred where there were healthy lifestyles choices, education and screenings. Encounters included weight/healthy lifestyle screenings with subsequent suggested referrals for at-risk residents. Over 500 "Fitness Guides" distributed 250 "Healthy Lifestyle Coloring Books" sent home 100 "Fast Food Calorie Guides" passed out 50 "Portion Control Plates" for Adult and Children sizes 1000 Know your medicine pill boxes distributed

	Over 1,000 beach balls, jump ropes, frisbees and airplanes distributed to children to promote outdoor physical activity. 100 Tooth brushes/paste and dental books passed out to children 500 Bottles of sunscreen distributed	
i. Evaluation of Outcomes:	The outcomes are evaluated individually based upon response rate and participation and by the Community Benefits Task Force.	
j. Continuation of Initiative?	Yes, plan to continue all of these initiatives.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 7,412	B. Direct Offsetting Revenue from Restricted Grants: N/A

Initiative 2- Healthy Day Care Program

a. 1. Identified Need 2. Was this identified through the CHNA process?	**OBESITY- EXERCISE, NUTRITION, and WEIGHT** SHIP 31. Reduce the proportion of children and adolescents who are considered obese. *The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included:* • *Adults who are Obese* • *Child Food Insecurity Rate* ***In Wicomico County, which has the largest population of the tri-county area, several indicators had multiple, extremely poor comparisons:*** • *Adults who are Obese — the Wicomico County value of 34.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%* • *Adults with a Healthy Weight — the Wicomico County value of 31.3% in 2014 was lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%* • *Other environmental indicators related to Nutrition and Exercise with poor comparisons included:* o *Child Food Insecurity Rate* o *Food Environment Index* o *Food Insecurity Rate* o *Grocery Store Density* o *Low-Income and Low Access to a Grocery Store* o *Fast Food Restaurant Density* o *Workers who Walk to Work* ***In Worcester County, several indicators had multiple extremely poor comparisons, mostly related to environment:*** • *Child Food Insecurity Rate* • *65+ with Low Access to a Grocery Store* • *Fast Food Restaurant Density* ***Somerset County had the most indicators with very poor comparisons:*** • *Adults who are Obese — the Somerset County value of 49.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%. Also, Somerset County fell in the bottom quartile of Maryland counties.* • *Adults with a Healthy Weight — the Somerset County value of 21.2% in 2014 was much lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adults who are overweight or obese — the Somerset County value of 79.8% in 2014 was much higher than the U.S. value of 65% and Maryland value of*

	64.9%. Also, Somerset County fell in the bottom quartile of Maryland counties • *Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties* ***Other environmental indicators related to Nutrition and Exercise with poor comparisons included:*** • *Child Food Insecurity Rate* • *Food Insecurity Rate* • *Food Environment Index* • *Access to Exercise Opportunities* • *Low-Income and Access to a Grocery Store* *When looking at sub-populations with disparities for Exercise, Nutrition, and Weight, we see racial and ethnic disparities as well as gender. In Worcester County adults, Blacks (47%) are more obese than Whites (27.1%). In Somerset County adults, Blacks (74%) and Latinos (60.3%) are more obese than Whites (40.8%); women (62.4%) are more obese than men (39.9%). COMMUNITY INPUT Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area.* ***COMMUNITY INPUT*** Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area. Yes, this was identified through the CHNA process.
b. Hospital Initiative	Healthy Day Care Program.
c. Total Number of People Within the Target Population	Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community wide health care initiative. As part of our "Healthy Day Care Program "our target population is the (100 +-) children within the program and their parents.  *Source: Maryland Department of Health and Mental Hygiene*
d. Total Number of People Reached by the Initiative Within the Target Population	Total Community Benefit Obesity encounters or "touchpoints" in FY2016 included the 180+ Day Care Children and their parents.
e. Primary Objective of the Initiative	The primary objective is to educate our children on how to make better healthy lifestyle choices at a young age, and to involve the parents in healthy lifestyle activities so that they will start to commit to a healthier lifestyle and reinforce this with their children.

f. Single or Multi-Year Initiative –Time Period	This is a multi-year initiative that will continue into the future.	
g. Key Collaborators in Delivery of the Initiative	PRMC Health and Wellness Committee PRMC Day Care Parents	
h. Impact/Outcome of Hospital Initiative?	Continuance of the monthly healthy choices educational program, and have expanded to include other educational health initiatives. (12 classes a year). • Healthy Heart Curriculum • Healthy Body Curriculum • Cleanliness • Importance of Exercise • Plate Portions • Pretend Food Activity (*Interactive with heart model, dance routines, films, coloring books etc.)* The children now have baseline health information to make wise lifestyle choices. Exercise/gym class every Friday for 7 child classes. "Active Group" activities twice a day for 20 minutes is part of the routine. • Jump Frog • Water Exercise • Dance & Music • Red Light, Green Light • Jumping Jacks Dramatically improved the nutritional value of the Child Care lunch and snack options. Replaced most of the prepackaged and processed foods with fruits and wheat products. Instituted a Healthy Kids and Parents Program. Teachers, students and parents participate and discuss healthy food choices and try various healthy food options. Includes healthy snack/party celebrations.	
i. Evaluation of Outcomes:	Develop healthy habits program for day care participants and develop program materials appropriate for preschooler's. Feedback from children during Q & A. Implement and continue to develop the healthy choices educational program. Evaluate healthy snack alternatives and children's response to the initiative.	
j. Continuation of Initiative?	Plan to continue.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $ 0	b. Direct Offsetting Revenue from Restricted Grants: N/A

Initiative 3- Partnership with Tri-County Diabetes Alliance

a. 1. Identified Need 2. Was this identified through the CHNA process?	**OBESITY- EXERCISE, NUTRITION, and WEIGHT** SHIP 31. Reduce the proportion of children and adolescents who are considered obese. *The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included:* • *Adults who are Obese* • *Child Food Insecurity Rate* ***In Wicomico County, which has the largest population of the tri-county area, several indicators had multiple, extremely poor comparisons:*** • *Adults who are Obese — the Wicomico County value of 34.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%* • *Adults with a Healthy Weight — the Wicomico County value of 31.3% in 2014 was lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%* • *Other environmental indicators related to Nutrition and Exercise with poor comparisons included:* o *Child Food Insecurity Rate* o *Food Environment Index* o *Food Insecurity Rate* o *Grocery Store Density* o *Low-Income and Low Access to a Grocery Store* o *Fast Food Restaurant Density* o *Workers who Walk to Work* ***In Worcester County, several indicators had multiple extremely poor comparisons, mostly related to environment:*** • *Child Food Insecurity Rate* • *65+ with Low Access to a Grocery Store* • *Fast Food Restaurant Density* ***Somerset County had the most indicators with very poor comparisons:*** • *Adults who are Obese — the Somerset County value of 49.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%. Also, Somerset County fell in the bottom quartile of Maryland counties.* • *Adults with a Healthy Weight — the Somerset County value of 21.2% in 2014 was much lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adults who are overweight or obese — the Somerset County value of 79.8% in*

	2014 was much higher than the U.S. value of 65% and Maryland value of 64.9%. Also, Somerset County fell in the bottom quartile of Maryland counties • *Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties* ***Other environmental indicators related to Nutrition and Exercise with poor comparisons included:*** • *Child Food Insecurity Rate* • *Food Insecurity Rate* • *Food Environment Index* • *Access to Exercise Opportunities* • *Low-Income and Access to a Grocery Store* *When looking at sub-populations with disparities for Exercise, Nutrition, and Weight, we see racial and ethnic disparities as well as gender. In Worcester County adults, Blacks (47%) are more obese than Whites (27.1%). In Somerset County adults, Blacks (74%) and Latinos (60.3%) are more obese than Whites (40.8%); women (62.4%) are more obese than men (39.9%). COMMUNITY INPUT Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area.* ***COMMUNITY INPUT*** Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area. Yes, this was identified through the CHNA process.
b. Hospital Initiative	Create public awareness and education regarding healthy lifestyles within the tri-county region (Wicomico, Worcester & Somerset).
c. Total Number of People Within the Target Population	PRMC services a rural population where the percentage of adults who are obese is very high. The percentage of overweight adults is an indicator of overall health and lifestyle in the community. Losing weight helps to prevent and control diabetes and significantly reduces the cost of health care spending and lost earnings. The statistics indicate that over 125,000 residents are living an unhealthy lifestyle. **Adults who are Overweight or Obese** VALUE — COMPARED TO: County: Somerset, MD — 79.8% (2014) — MD Counties County: Wicomico, MD — 68.7% (2014) — MD Counties County: Worcester, MD — 63.8% (2014) — MD Counties

	Source: 2016 HCI Community Health Needs Assessment	
d. Total Number of People Reached by the Initiative Within the Target Population	The Tri-County Diabetes Alliance provides support and a presence at many public events, elevating healthy lifestyle choices and diabetes awareness in collaboration with their partners.	
e. Primary Objective of the Initiative	Create diabetes community awareness and provide education regarding healthy lifestyles within the tri-county region (Wicomico, Worcester & Somerset).	
f. Single or Multi-Year Initiative –Time Period	This is a multi-year initiative that will continue into the future.	
g. Key Collaborators in Delivery of the Initiative	• Tri-County Diabetes Alliance and Partners • Local Health Departments • Local Hospitals	
h. Impact/Outcome of Hospital Initiative?	Create awareness around healthy lifestyles and choosing the right foods. TCDA partners promotes use of existing resources available to the students i.e. support groups, screenings, health lifestyle education, etc. In addition provides education and counseling for health needs. TCDA and partners administer the ADA risk assessment paper screening to individuals for diabetes throughout region.	
i. Evaluation of Outcomes:	The Tri-County Diabetes Alliance walk brings public attention to the importance of exercising and knowing if you are at risk for diabetes. Worksite Wellness Symposium UMES Health Fair included screenings and healthy foods focus.	
j. Continuation of Initiative?	Yes we will continue into the future our long standing partnership with the Tri-County Diabetes Alliance.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $ 2,757	b. Direct Offsetting Revenue from Restricted Grants: N/A

Initiative 4- Health Fest Expo

a. 1. Identified Need 2. Was this identified through the CHNA process?	**OBESITY- EXERCISE, NUTRITION, and WEIGHT** SHIP 31. Reduce the proportion of children and adolescents who are considered obese. *The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included:* • *Adults who are Obese* • *Child Food Insecurity Rate* ***In Wicomico County, which has the largest population of the tri-county area, several indicators had multiple, extremely poor comparisons:*** • *Adults who are Obese — the Wicomico County value of 34.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%* • *Adults with a Healthy Weight — the Wicomico County value of 31.3% in 2014 was lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%* • *Other environmental indicators related to Nutrition and Exercise with poor comparisons included:* o *Child Food Insecurity Rate* o *Food Environment Index* o *Food Insecurity Rate* o *Grocery Store Density* o *Low-Income and Low Access to a Grocery Store* o *Fast Food Restaurant Density* o *Workers who Walk to Work* ***In Worcester County, several indicators had multiple extremely poor comparisons, mostly related to environment:*** • *Child Food Insecurity Rate* • *65+ with Low Access to a Grocery Store* • *Fast Food Restaurant Density* ***Somerset County had the most indicators with very poor comparisons:*** • *Adults who are Obese — the Somerset County value of 49.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%. Also, Somerset County fell in the bottom quartile of Maryland counties.* • *Adults with a Healthy Weight — the Somerset County value of 21.2% in 2014 was much lower than the Maryland value of 35.1% and the U.S. value of 35.2%,*

	and lower than the Maryland SHIP 2017 objective of 36.6%. Also, Somerset County fell in the bottom quartile of Maryland counties • *Adults who are overweight or obese — the Somerset County value of 79.8% in 2014 was much higher than the U.S. value of 65% and Maryland value of 64.9%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties* ***Other environmental indicators related to Nutrition and Exercise with poor comparisons included:*** • *Child Food Insecurity Rate* • *Food Insecurity Rate* • *Food Environment Index* • *Access to Exercise Opportunities* • *Low-Income and Access to a Grocery Store* *When looking at sub-populations with disparities for Exercise, Nutrition, and Weight, we see racial and ethnic disparities as well as gender. In Worcester County adults, Blacks (47%) are more obese than Whites (27.1%). In Somerset County adults, Blacks (74%) and Latinos (60.3%) are more obese than Whites (40.8%); women (62.4%) are more obese than men (39.9%). COMMUNITY INPUT Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area.* ***COMMUNITY INPUT*** Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area. Yes, this was identified through the CHNA process.
b. Hospital Initiative	Health Fest Expo
c. Total Number of People Within the Target Population	The target population focused on the indigent, uninsured and those that have limited access to health care (7,000 residents) in and around the city of Salisbury, Maryland. Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community wide health care initiative. *Source: 2016 Truven Health Analytics*
d. Total Number of People Reached by the Initiative Within the Target Population	Total Health Expo encounters or “touchpoints” in FY2016 was over 700 residents.
e. Primary Objective of the Initiative	Provide screenings and education for underserved and uninsured members of the community.
f. Single or Multi-Year Initiative –Time Period	This is an annual event.

g. Key Collaborators in Delivery of the Initiative	Peninsula Regional Wicomico County Board of Education	
h. Impact/Outcome of Hospital Initiative?	Approximately 700 local residents attended. **Over 20 different screenings were available.** • Sample: • Blood Pressure • Height • Weight • Waist Measurement • Body Fat • Kidney Health • Mental Health Assessment • Oral Cancer • Colorectal • Breast Exam • Bone Density • Hearing • Vision • Diabetes Assessment • Glaucoma • Foot Sensation	
i. Evaluation of Outcomes:	Promote programs, perform screenings, refer to specialists, and provide resource material to residents. Well received by public, and referrals to providers.	
j. Continuation of Initiative?	Yes, PRMC will continue to plan this as an annual event.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	C. Total Cost of Initiative $38,959	D. Direct Offsetting Revenue from Restricted Grants: N/A

New Initiative 5- Pediatric Weight Loss and Diabetes Management

a. 1. Identified Need 2. Was this identified through the CHNA process?	**OBESITY- EXERCISE, NUTRITION, and WEIGHT** SHIP 31. Reduce the proportion of children and adolescents who are considered obese. *The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included:* • *Adults who are Obese* • *Child Food Insecurity Rate* ***In Wicomico County, which has the largest population of the tri-county area, several indicators had multiple, extremely poor comparisons:*** • *Adults who are Obese — the Wicomico County value of 34.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%* • *Adults with a Healthy Weight — the Wicomico County value of 31.3% in 2014 was lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%* • *Other environmental indicators related to Nutrition and Exercise with poor comparisons included:* o *Child Food Insecurity Rate* o *Food Environment Index* o *Food Insecurity Rate* o *Grocery Store Density* o *Low-Income and Low Access to a Grocery Store* o *Fast Food Restaurant Density* o *Workers who Walk to Work* ***In Worcester County, several indicators had multiple extremely poor comparisons, mostly related to environment:*** • *Child Food Insecurity Rate* • *65+ with Low Access to a Grocery Store* • *Fast Food Restaurant Density* ***Somerset County had the most indicators with very poor comparisons:*** • *Adults who are Obese — the Somerset County value of 49.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%. Also, Somerset County fell in the bottom quartile of Maryland counties.* • *Adults with a Healthy Weight — the Somerset County value of 21.2% in 2014 was much lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adults who are overweight or obese — the Somerset County value of 79.8% in*

	2014 was much higher than the U.S. value of 65% and Maryland value of 64.9%. • *Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties* ***Other environmental indicators related to Nutrition and Exercise with poor comparisons included:*** • *Child Food Insecurity Rate* • *Food Insecurity Rate* • *Food Environment Index* • *Access to Exercise Opportunities* • *Low-Income and Access to a Grocery Store* *When looking at sub-populations with disparities for Exercise, Nutrition, and Weight, we see racial and ethnic disparities as well as gender. In Worcester County adults, Blacks (47%) are more obese than Whites (27.1%). In Somerset County adults, Blacks (74%) and Latinos (60.3%) are more obese than Whites (40.8%); women (62.4%) are more obese than men (39.9%). COMMUNITY INPUT Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area.* ***COMMUNITY INPUT*** Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area. Yes, this was identified through the CHNA process.
b. Hospital Initiative	Develop Healthy US Pediatric Weight Management Program using telemedicine and diabetic clinic promoting nutrition and healthy weight lifestyle.
c. Total Number of People Within the Target Population	Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community health care initiative. County: Somerset, MD — 21.3 — Maryland Department of Health and Mental Hygiene County: Wicomico, MD — 14.9 — Maryland Department of Health and Mental Hygiene County: Worcester, MD — 12.4 — Maryland Department of Health and Mental Hygiene *Source: 2013 Maryland Risk Factor Behavioral Surveillance System. Maryland Department of Health and Mental Hygiene*
d. Total Number of People Reached by the Initiative Within the Target Population	This program is an 8 week program that typically has 12-15 children.

e. Primary Objective of the Initiative	Focus is on accurate diagnoses and treatment for patients with the onset of diabetes, the program includes medication and diet management, family support, exercise program and school nurse support. Provide pediatric obesity screenings and education for under and uninsured community members. Increase breast feeding rates to help lower pediatric obesity. Promote physical activity.
f. Single or Multi-Year Initiative –Time Period	Multi-Year 3 years
g. Key Collaborators in Delivery of the Initiative	• PRMC • Children's National Medical Center • YMCA
h. Impact/Outcome of Hospital Initiative?	**Pediatric Obesity Program:** **FY 2015 Class** Participants: 36 Avg. Weight Loss: 1.6 BMI Decrease: 1.8 Decrease Mile Time: 1.35 minutes ***FY2015 Success Stories:** Child loss 125 lbs. Child loss 40 lbs. Child loss 25lbs. **FY 2016 Class** The pediatric impact for FY2016 for education, weight loss and healthy lifestyle choices was 359 physician visits. 10 adolescents lost weight ranging between 10-50 pounds and have maintained as measured at follow up visits. 2 of these adolescents were recognized by Wicomico County Health Department and awarded certificates for initiating major lifestyle changes for health living. 2 of the 10 are college students who have gone away to college as freshmen and lost weight rather than gaining the typical freshmen 15 pounds. Peninsula Regional's breastfeeding rates: 2016- 80% (Healthy People 2020 Goal 82%)
i. Evaluation of Outcomes:	Hold several 8-week programs to educate children & families on health lifestyle choices. Evaluate the lifestyle changes. Increase breast feeding rates to lower pediatric obesity
j. Continuation of	We plan to continue our partnership with the YMCA promoting pediatric weight loss.

Initiative?	In 2016 PRMC partnered with the local YMCA (Chesapeake Region 7 locations) signing an MOU that enters into a strategic relationship extending the continuum of health, wellness, weight loss, preventive and educational programs to the Delmarva community. Plan to continue.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $ 0	b. Direct Offsetting Revenue from Restricted Grants: N/A

New Initiative 6- Heart Vascular Screenings with Weight Loss Component

a. 1. Identified Need 2. Was this identified through the CHNA process?	**OBESITY- EXERCISE, NUTRITION, and WEIGHT** SHIP 31. Reduce the proportion of children and adolescents who are considered obese. *The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included:* • *Adults who are Obese* • *Child Food Insecurity Rate* ***In Wicomico County, which has the largest population of the tri-county area, several indicators had multiple, extremely poor comparisons:*** • *Adults who are Obese — the Wicomico County value of 34.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%* • *Adults with a Healthy Weight — the Wicomico County value of 31.3% in 2014 was lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%* • *Other environmental indicators related to Nutrition and Exercise with poor comparisons included:* o *Child Food Insecurity Rate* o *Food Environment Index* o *Food Insecurity Rate* o *Grocery Store Density* o *Low-Income and Low Access to a Grocery Store* o *Fast Food Restaurant Density* o *Workers who Walk to Work* ***In Worcester County, several indicators had multiple extremely poor comparisons, mostly related to environment:*** • *Child Food Insecurity Rate* • *65+ with Low Access to a Grocery Store* • *Fast Food Restaurant Density* ***Somerset County had the most indicators with very poor comparisons:*** • *Adults who are Obese — the Somerset County value of 49.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%. Also, Somerset County fell in the bottom quartile of Maryland counties.* • *Adults with a Healthy Weight — the Somerset County value of 21.2% in 2014 was much lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adults who are overweight or obese — the Somerset County value of 79.8% in 2014 was much higher than the U.S. value of 65% and Maryland value of 64.9%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than*

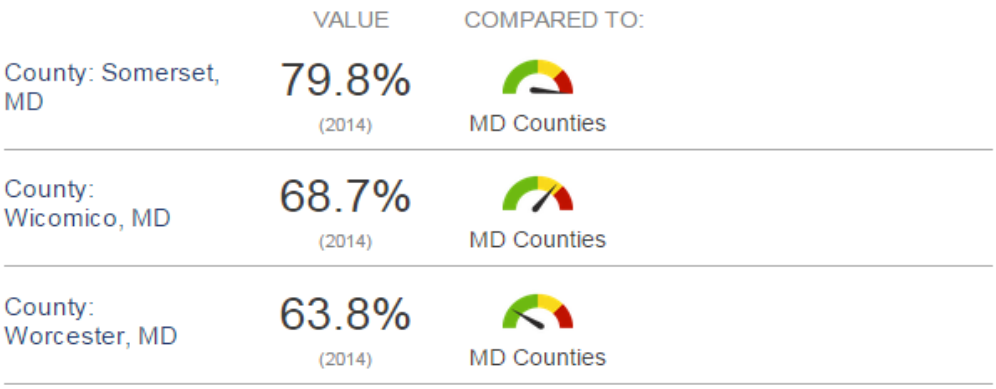
	three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties ***Other environmental indicators related to Nutrition and Exercise with poor comparisons included:*** • *Child Food Insecurity Rate* • *Food Insecurity Rate* • *Food Environment Index* • *Access to Exercise Opportunities* • *Low-Income and Access to a Grocery Store* *When looking at sub-populations with disparities for Exercise, Nutrition, and Weight, we see racial and ethnic disparities as well as gender. In Worcester County adults, Blacks (47%) are more obese than Whites (27.1%). In Somerset County adults, Blacks (74%) and Latinos (60.3%) are more obese than Whites (40.8%); women (62.4%) are more obese than men (39.9%). COMMUNITY INPUT Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area.* ***COMMUNITY INPUT*** Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area. Yes, this was identified through the CHNA process.
b. Hospital Initiative	Develop community wide awareness and education regarding heart disease, hypertension, **obesity** and healthy lifestyles. Peninsula Regional's Wagner Wellness Van visits underserved areas and screens for heart disease and provides education regarding healthy lifestyles.
c. Total Number of People Within the Target Population	PRMC services a rural population in Wicomico and Somerset County where the percentage of adults who are overweight or obese is very high. **Adults who are Overweight or Obese** VALUE — COMPARED TO: County: Somerset, MD — 79.8% (2014) — MD Counties County: Wicomico, MD — 68.7% (2014) — MD Counties County: Worcester, MD — 63.8% (2014) — MD Counties *Source: 2016 HCI Community Health Needs Assessment*
d. Total Number of People Reached by the Initiative Within the Target Population	The total number of underserved residents screened by this specific initiative in FY2016 was 239.

e. Primary Objective of the Initiative	Provide healthy heart screenings to residents of Delmarva using a mobile van to reach communities that have limited access to healthcare. The two healthy heart initiatives include: • Cardiac/Vascular Screenings • Women's Heart Screenings **Obesity Component** An integral component of these heart screenings includes an educational session that highlights reducing obesity, exercising, healthy food choices all which contribute to a healthy heart. • Obesity Screening Component Includes: • Height • Weight • BMI • Body Fat % • Educational Session on Nutrition and Healthy Lifestyles • Resources Available • Potential Referral if Needed	
f. Single or Multi-Year Initiative – Time Period	Multi-year initiative that will continue into the future.	
g. Key Collaborators in Delivery of the Initiative	PRMC to underserved community locations.	
h. Impact/Outcome of Hospital Initiative?	**Vascular/Obesity Screening Component** Patients Screened: 97 Referred: 8 **Women's Heart/Nutrition Session Component** Patients Screened: 142 Referred: 12	
i. Evaluation of Outcomes:	Number of underserved residents screened and low access areas visited.	
j. Continuation of Initiative?	Response is very positive, we plan to continue.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $ 10,138	b. Direct Offsetting Revenue from Restricted Grants: N/A

Initiative 7- PRMC Weight Loss and Wellness Center

l. 1. Identified Need 2. Was this identified through the CHNA process?	**OBESITY- EXERCISE, NUTRITION, and WEIGHT** SHIP 31. Reduce the proportion of children and adolescents who are considered obese. *The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included:* • *Adults who are Obese* • *Child Food Insecurity Rate* ***In Wicomico County, which has the largest population of the tri-county area, several indicators had multiple, extremely poor comparisons:*** • *Adults who are Obese — the Wicomico County value of 34.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%* • *Adults with a Healthy Weight — the Wicomico County value of 31.3% in 2014 was lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%* • *Other environmental indicators related to Nutrition and Exercise with poor comparisons included:* o *Child Food Insecurity Rate* o *Food Environment Index* o *Food Insecurity Rate* o *Grocery Store Density* o *Low-Income and Low Access to a Grocery Store* o *Fast Food Restaurant Density* o *Workers who Walk to Work* ***In Worcester County, several indicators had multiple extremely poor comparisons, mostly related to environment:*** • *Child Food Insecurity Rate* • *65+ with Low Access to a Grocery Store* • *Fast Food Restaurant Density* ***Somerset County had the most indicators with very poor comparisons:*** • *Adults who are Obese — the Somerset County value of 49.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%. Also, Somerset County fell in the bottom quartile of Maryland counties.* • *Adults with a Healthy Weight — the Somerset County value of 21.2% in 2014 was much lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adults who are overweight or obese — the Somerset County value of 79.8% in 2014 was much higher than the U.S. value of 65% and Maryland value of 64.9%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than*

	three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties ***Other environmental indicators related to Nutrition and Exercise with poor comparisons included:*** • *Child Food Insecurity Rate* • *Food Insecurity Rate* • *Food Environment Index* • *Access to Exercise Opportunities* • *Low-Income and Access to a Grocery Store* *When looking at sub-populations with disparities for Exercise, Nutrition, and Weight, we see racial and ethnic disparities as well as gender. In Worcester County adults, Blacks (47%) are more obese than Whites (27.1%). In Somerset County adults, Blacks (74%) and Latinos (60.3%) are more obese than Whites (40.8%); women (62.4%) are more obese than men (39.9%). COMMUNITY INPUT Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area.* ***COMMUNITY INPUT*** Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area. Yes, this was identified through the CHNA process.
m. Hospital Initiative	In 2016 opened a satellite" Weight Loss and Wellness Center" located several miles from the Hospital. This Center is comprised of a multidisciplinary team including physicians, nurse practitioner, registered nurses, dietician, medical assistants, social workers and exercise specialists. This center guides clients with a medically-monitored and nutrition-based education weight loss programs. Programs all incorporate support groups, physical activity, nutrition, situational and behavioral modification techniques while being medically monitored. In addition it also includes a personalized physical activity program and a 12-month gym membership.
n. Total Number of People Within the Target Population	PRMC services a rural population in Wicomico and Somerset County where the percentage of adults who are overweight or obese is very high. Based upon Truven Health Analytics there are over 125,000 residents in our area that are leading an elevated unhealthy lifestyle when compared to the norm of Maryland and the Nation.

	Adults who are Overweight or Obese  *Source: 2016 HCI Community Health Needs Assessment*
o. Total Number of People Reached by the Initiative Within the Target Population	The Weight Loss and Wellness Center provides services to residents in Wicomico, Worcester and Somerset Counties.
p. Primary Objective of the Initiative	Provide resources to residents of the Tri-County area to assist them with their weight loss goals, educate regarding healthy lifestyles and to reduce the comorbidities associated with unhealthy weight.
q. Single or Multi-Year Initiative – Time Period	Multi-year initiative that will continue into the future.
r. Key Collaborators in Delivery of the Initiative	• PRMC • MAC (Maintaining Active Citizens) • YMCA
s. Impact/Outcome of Hospital Initiative?	*New program- Impact and outcomes are currently being developed.*
t. Evaluation of Outcomes:	*New program to be developed* o *Weight Loss* o *Physical Activity* o *Self Confidence*

u. Continuation of Initiative?	Yes	
v. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	c. Total Cost of Initiative $ 29,063	d. Direct Offsetting Revenue from Restricted Grants: N/A

Identified Need	PRMC is seeking to further enhance its population health efforts by focusing on the following nine future initiatives that address specific community health needs: access to care, health education, chronic disease management, care management and filling gaps in services like behavioral health. We are currently seeking additional funding through the HSCRC Care Coordination Grant process to enhance these initiatives as our strategic intent is to pursue the following (1-9) in collaboration and partnership with others as was outlined in our "Population Health Strategic Transformation Plan."
	1. Development of a satellite Chronic Disease Clinic in FY 2017 Chronic Disease is an epidemic in our country, our region, and our community, and its effects are responsible for the majority of our nation's healthcare costs. Projections for the future are grim at best, predicting the burden of chronic disease to rise exponentially over the next decade and beyond. Locally, diabetes, hypertension, and obesity are prevalent, with Wicomico and Somerset among the worst counties in the state for health factors, ranking #21 and #23 of a total of 24 (*Robert Wood Johnson county health rankings: http://www.countyhealthrankings.org/app/maryland/2016/rankings/factors/3).* The rate of hospitalizations, readmissions, and ED utilization secondary to chronic disease is also on the rise and shares the same trajectory. We at PRMC know that chronic disease encompasses the top diagnoses responsible for the majority of our hospitalizations and ED visits. Among those top diagnoses loom the chronic conditions of congestive heart failure, chronic obstructive pulmonary disease, and diabetes or diabetes associated conditions (i.e. chronic kidney disease). Below is a chart showing ED usage for the above-mentioned conditions from July 1, 2014 – June 30, 2015. With the proper management and access to care, many of these visits could be avoided. While certainly not a new concept, chronic disease clinics are something not currently offered to our patients, but something that has proven to be effective in reducing the burden of chronic illness and improving the quality of life for patients and their families. By working closely with the patients to provide intense education, self-management skills, diet instruction, disease management, and care coordination, a clinic can function as a health home for those with chronic disease, greatly improving outcomes and slowing progression of the disease process. The clinics also offer an alternative to the ED for exacerbations of conditions that can be caught early enough to be treated at the clinic on an urgent basis. Services such as IV Lasix and inotropes, fluid and electrolyte replacement, breathing treatments, labs and other testing, and medication management would be offered. Additional services would include referral to cardiac rehabilitation, assistance in affording expensive medications, access to research studies, tele-monitoring, and palliative care referral. Staffing for the Chronic Disease Clinic would be multi-disciplinary and would include nurse practitioners, RNs, Dietitians, a Social Worker, a Transitions nurse or Care Coordinator, and Patient Service Reps. There would also need to be close collaboration with a Cardiologist, Nephrologist, Pulmonologist, and Endocrinologist. These doctor "champions" would help to establish guidelines and

	protocols, be available for questions and consultation, and may also choose to see patients at the clinic from time-to-time (self-billing). Additionally, other ancillary services, including Physical Therapy, Behavioral Health, and Palliative Care would also play a role and need to be available for some components of the clinic. Target population would be CHF patients who are high-utilizers (at least 2 inpatient admissions in a year with EF <40) and CKD patients with eGFR <30. Criteria would expand to newly diagnosed CHF patients and CKD patients with eGFR <45 within six months of opening. COPD and diabetic patients would also be served, with the highest utilizers being seen initially, expanding to other sub-sets– including those referred from PCP and specialty practices and newly diagnosed patients within the first few months of the clinic's inception. Additional considerations could include acute kidney injury follow-up post-discharge; heart and kidney transplant workup and evaluation (in person or through e-care); an infusion clinic; and some level of collaboration with SNF's – to name a few! Having a clinic that provides care for multiple chronic conditions is an atypical yet novel approach. Since many of these illnesses, particularly CHF and CKD, exist together, and even play a role in the development of each other, then it makes sense that the treatment plan encompass measures that consider outcomes for all conditions present. This clinic will provide that level of expertise, and do it in the right place, at the right time.
	2. Mobile Health Van- moving forward in FY2017 a) A medical van that was originally outfitted for wellness checks will now be used to make "rounds" on patients in their communities b) The van is targeting communities with high ED utilization and readmissions as well as isolated and disparate communities where access to primary care and/or transportation is problematic c) The van will assist patients in managing their chronic conditions but live remotely from providers d) PRMC is collaborating with Atlantic General Hospital and McCready Health to assist with their high utilizers in remote and disparate communities
	3. In Collaboration with Atlantic General Hospital and McCready Health a) Provide Care Management and communication between PRMC's, AGH's and McCready's emergency rooms b) To assist patients in accessing the appropriate chronic care management and mental health professionals to reduce ED utilization c) Utilizing CRISP to establish a "community plan of care" for patients who utilize all three institutions
	4. Community Case Management and Transitions of Care a) Provide case managers in employed primary care practices and in affiliated primary care practices to manage Medicare high utilizers who are attributed to these practices b) Additional high risk for readmission patients not attributed to these primary

	care practices will be managed for up to 90 days c) The Care Manager will assist the primary care physician in actively managing the patients chronic conditions to prevent avoidable utilization of PRMC's acute care setting d) Care Managers/Nurse Practitioner who provide care in patients homes to support extremely sick patients whose chronic conditions are at the end of their disease state e) Patients and their health partners (family, friends) are taught to assist patients in management of their health
	5. In collaboration with 7 SNF's/Rehab: i) Work with 7 nursing homes who have agreed to work on pathways to telecommunicate with hospitalist at PRMC to discuss high risk patient who may need care within the nursing home versus care in the acute care setting
	6. Smith Island/Crisfield Clinic: Telemedicine a) Working with EMT's who will assess patients within the home setting and work with hospitalist at PRMC via telemedicine for patients who need care but may or may not need to be admitted to PRMC
	7. Health, Wellness and Chronic Disease Management Competencies. a) Engage PRHS's self-insured covered lives in health and wellness programs b) Engage PRHS's self-insured covered lives with chronic disease controlled through case management or other disease management programs. c) Formulate a health and wellness program for the community.
	8. Develop clinical integration including physician alignment and new partnerships a) Stand up an Accountable Care Organization b) Develop a path to connect community physicians with the new EMR **PRCIN** Peninsula Regional Clinically Integrated Network, LLC Medicare Shared Savings Program Accountable Care Organization was established in FY2016 (PRCIN). The mission of the ACO is to: • Provide coordinated care to improve cost, quality, and health • Focus on 34 quality measures and Medicare savings • Focus on the chronically ill, avoid unnecessary duplication, improve health, and prevent medical errors The PRCIN application to CMS was a plan to improve care, engage patients, practice evidence-based guidelines, improve health and lower cost of care. • 10,000 Medicare Beneficiaries • 212 Providers
	9. Cultivate an environment that encourages inquiry and innovation contributing to solutions, improvements and generalizable knowledge that positively impacts our community. Develop research based protocols.

Priorities

On June 8, 2016, PRMC's Community Benefit team and other members from various departments in the hospital came together to prioritize the significant health needs in a session led by consultants from HCI. The team reviewed the significant health needs using the following prioritization criteria:

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

Using the Prioritization Matrix method, the following three topics were identified as priorities to address:

- Diabetes
- Exercise, Nutrition, and Weight
- Behavioral Health (focusing on the topic areas of Mental Health and Mental Disorders as well as Substance Abuse)

Other significant health needs not chosen were: Access to Health Services, Cancer, Heart Disease and Stroke, and Prevention and Safety. These needs were not selected because they did not meet the prioritization criteria as strongly as the selected topics. PRMC has other programs in these areas, but they are not the focus of this report.

1. 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)

   As part of Maryland's SHIP (State Health Improvement Process) initiative, the Tri-County Health Improvement Plan (T-CHIP) is adopting SHIP objective 27: reduce diabetes complications and reduce diabetes-related emergency department visits; and SHIP objective 31: reduce the proportion of children and adolescents who are considered obese or overweight. Peninsula Regional will continue to partner with T-CHIP and Wicomico County Health Department to create strategies and tactics around SHIP objectives 27 and 31. By adopting the same health

improvement objectives, we create alignment, synergy and efficient resource allocation for establishing and promoting these community healthcare improvement objectives.

Some of the goals and initiatives include: reducing the number of diabetes related emergency room visits; tracking the number of tri-county diabetes risk assessment tests administered; and increasing community participation in diabetes management and education programs. In response to SHIP objective 31, Peninsula Regional established a pediatric weight-loss clinic in addition to creating an education module on obesity for our Child Care Center. Peninsula Regional is an active participant and member of the Tri-County Diabetes Alliance, which was created to identify and educate individuals at risk of developing diabetes and to develop programs that will help individual with diabetes reduce their risk of developing medical complications associated with the disease.

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

V. 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.

ECG was engaged by Peninsula Regional to assist in the development of a medical staff development plan based upon the healthcare needs of its medical service area. The report included bath analysis of PRMC service area and specific recommendations regarding appropriate staffing levels in a variety of medical specialties. The plan serves as a guide for strategic staff planning and contributes to an effort to document community need for physicians,.

The approach to evaluating physician need is based upon the following factors:

- Defining the demographic profile and payor mix of the client's service area
- Researching unique service area factors that might influence the demand for healthcare services within the area
- Identifying the total number of physicians by specialty in the defined service area
- Developing a profile of the current medical staff using quantitative data and qualitative data from the medical staff survey and physician focus interviews
- Developing a profile of the patient market, including demographic data
- Utilizing six established physician needs assessment models to identify potential physician surpluses or deficits in each medical specialty
- Evaluating results of the above efforts in the context of our medical staffing and consulting experience

Deficiencies and surpluses in the current supply of physicians was determined by reviewing physician-to-population ratios, physician patient volumes, population data, and other factors.

The consultant ECG noted that PRMC may be vulnerable in the specialty area for which succession planning may be prudent. Within each of the following specialties, at least half of the PRMC active medical staff are 55 or older.

- Cardiac/Thoracic Surgery
- Dermatology
- Gastroenterology
- Hematology/Oncology
- Infectious Disease
- Medical Genetics
- Neurology
- Oral/Maxillofacial Surgery
- Otolaryngology
- Psychiatry
- Rheumatology

These specialties are considered to be" significant risk" by ECG and recommends the Hospital adopt a formal succession and/or contingency plan for these specialties over the next several years.

Conservative estimates of primary care physicians needed within the service area suggest a slight shortage in supply of primary care providers. Qualitative data indicates access problems for some patients with lengthy wait times for new patient appointments.

ECG currently projects the following recruitment needs for Primary Care:

	Current Community-Wide Need for Physician	**PRMC Succession Planning Need**	**Total Need to Evaluate for Gaps**
Primary Care-Family Medicine	11.0	2.0	13.0
Primary Care-Internal Medicine	11.0	5.5	16.5
Primary Care-Pediatrics	3.00	2.8	5.8
Total	**25.0**	**10.3**	**35.3**

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	ECG Management Consultants was engaged by Peninsula Regional to assist in developing a "Medical Staff Development Plan" based on the healthcare needs of our medical service area. The current Plan *(11/11/2015)* includes an analysis of PRMC's service area and specific recommendations regarding appropriate staffing levels in a variety of medical specialties. Peninsula Regional feels it is important to continually monitor specialties where a significant amount of patient care within the service area is provided by older physicians, as a sudden or unexpected loss of coverage could have an adverse effect on provision of medical services to the community. Succession planning and recruitment go hand-in-hand, as does socio-demographics and governmental initiatives all which must be considered to assess appropriate physician recruitment. Key findings according to the most recent Medical Staff Development Plan indicate an immediate need for recruitment of 4 Primary Care Physicians to engage in chronic disease management as part of our population health initiatives. Succession planning is a key objective as 10 primary care physicians are above the age of 55 which will leave a void in an already underserved area. Demographics also play a key role as the Medicare population is growing at a faster rate than the State of Maryland and the Nation. As a growing retirement community, there is an increased need for additional primary care physicians and certain specialties. There will be a 22.7% growth of those between the ages of 65 to 74 over the next 5 years.

	Deficiencies and surpluses in the current supply of physicians were determined by reviewing physician to-population ratios, physician patient volumes, population data, and other data. ECG Management Consultants recommend evaluating potential recruitment of the following over the next several years: **Primary Care Recruitment** Primary Care Family Medicine 11 FTEs Primary Care Internal Medicine 11 FTEs Primary Care Pediatrics 3 FTEs Other key findings according to the most recent Medical Staff Development Report indicate that certain specialties have long wait times: **Peer Reported Wait Times** Dermatology- 133 days Endocrinology- 74 days Neurology- 50 days Pulmonology- 54 days Rheumatology- 56 days Psychiatry- 41 days Pain Management- 61 days Medical specialty needs are driven by the overall market supply, wait times for new patient appointments, and call coverage and inpatient consultation needs. Current medical specialty recommendations include recruitment of the following physicians a recruiting for the following specialties due to community needs assessment, market demand and retirement: Allergy/immunology, Dermatology, Endocrinology, Infectious Disease, Neurology, OB/GYN, Pain Management, Psychiatry and Rheumatology. Of the medical staff, 32% is either at or above the age of 55, which poses

	succession risk. Peninsula Regional a rural hospital, and other like-kind rural communities are typically challenged in both recruitment and retention of physicians due to numerous factors. Some of these challenges are due to the location and geography of the area and availability of healthcare resources. Retaining and recruiting resources in sub-specialties can be hard for regional rural hospitals and Peninsula Regional Medical Center is no exception. To address specific community healthcare needs the Medical Center has had to recruit, retain, employ and subsidize some of the following sub-specialties; Pulmonary, Neuro-Hospitalist, Neurosurgery, Medical Oncology & Hematology, Gastroenterology, Pediatric Specialties, Endocrinology, Cardiology, Cardiovascular Surgery, and Pain Management . Rural communities lack the cultural and educational resources that larger urban centers provide making it harder to retain and recruit these physicians, the spouse/significant other and children. Low population patterns by geography make it more costly and harder for communities and businesses to provide various types of services especially specialty physician services. Overall our local economy is not as robust as the urban centers as acknowledged by our low average household income in the Tri-County area: Wicomico $67,745 Worcester $82,169 Somerset $50,547 Compared to Maryland $98,950 *Source: Truven Health Analytics* Lower average household income, higher

	unemployment rates, lower educational attainment, fewer higher paying job opportunities and many other factors may put rural communities at a disadvantage in providing some of these specialty healthcare services that metropolitan centers more readily provide.
Non-Resident House Staff and Hospitalists	N/A
Coverage of Emergency Department Call	As the only Level III trauma center that serves the region and an emergency room with close to 90,000 visits annually, Peninsula Regional must have certain specialties on-call and exclusive contracts with provider groups to guarantee coverage and meet patient demand for these services. Peninsula Regional is the 6th most busy Emergency Room in the State and also receives emergency patients from Sussex County, Delaware and Accomack County, Virginia. The regulatory requirements and benefits of having exclusive arrangements for a large rural tertiary hospital include some of the following: ➢ On-call Trauma Surgeon within 30 minutes of call ➢ On-call Anesthesiologists with CRNA who is in the hospital ➢ On-call Orthopedic Surgeon within 30 minutes of call ➢ On-call Neurosurgeon within 30 minutes of call ➢ Enhances providers' response time to critical care patients in a rural setting ➢ Assures competent coverage and availability of services ➢ Aids in supervision, administration, training and scheduling of coverage

	In order to maintain an adequate number of sub-specialties, sufficient response times and be available to over 450,000 residents in our primary and secondary service area we must provide for Emergency Department Call Coverage. The Medical Center's challenge as a large rural regional tertiary care provider has been to recruit and retain for underserved specialties, and to create comprehensive succession planning that supports the diverse medical needs of the region spread throughout a large geographical area ECG Management Consultants recommends the recruitment of the following medical specialties: **Medical Specialties** Dermatology- 1 FTE OB/GYN- 4 FTEs Infectious Dis 1 FTE Neurology 1 FTE Rheumatology 1 FTE Psychiatry 4 FTEs **Surgical Specialties** Neurosurgery 1 FTE Oral/maxilla. 1 FTE Otolaryngology 1 FTE Plastics 1 FTE Urology 1 FTE Vascular Surgery 1 FTE
Physician Provision of Financial Assistance	N/A
Physician Recruitment to Meet Community Need	There is a very high demand for hospitalist recruitment and other physician recruitment on the Delmarva Peninsula. The implementation of the ACA and Medicare reforms has helped hospitals improve patient satisfaction, reduce length of stay and prevent readmissions. Somerset County is designated as a HPSA

	(Health Professional Shortage Area) for primary care and certain census tracks around the city of Salisbury located in Wicomico County are also designated. A clear advantage is that the addition of hospitalists has reduced the patient load of overburdened community-based primary care physicians. Freeing up community based physicians effectively allows them more time to provide patient visits/care to our patients in rural underserved locations. Another issue is that the Delmarva Peninsula is a very rural area and does not attract everyone. Millennials desire a metro location and many times have to be "sold" on the area. This requires a more direct and personal approach in contacting candidates individually through many forms of communication. Our recruiter attends physician conferences and represents PRMC and its services in attempt to recruit physicians to work here.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	**Mission Driven Statement** Behavioral health and substance abuse services ranked very high as part the latest Community Health Needs Assessment. Eleven community-based key informants discussed both addiction and mental health issues more than any other topic, making this a significant health issue in the region. Due to increasing demand for behavioral health and addiction services, coupled with behavioral health provider shortages, ECG Management Consultants made recommendations that Peninsula Regional recruit 4 Psychiatrists immediately. In 2015, Peninsula Regional and Adventist Behavioral Health and Wellness Services entered into a partnership that will lead the behavioral health service line for the

	Salisbury-based Peninsula Regional Medical Center's behavioral health unit. They will bring their knowledge and expertise to help enhance and expand behavioral health services to the underserved Tri-County Area. A community assessment for gaps in behavioral health services for the region has led to the establishment of a Partial Hospitalization Program at Peninsula Regional. The program is directed towards adults needing to step down from the twelve-bed inpatient psychiatric unit. The transition into the community is an important step and provides more intensive therapy than a primary practice setting could provide, but yet does not need to continue as an inpatient. Peninsula Regional also dedicated a new Rebecca & Leighton Moore Child and Adolescent Outpatient Behavioral Health Unit. Prior to this program being developed there were very limited adolescent services available in the community and to some extent non-existent. To access child behavioral health services, many families would have to travel outside of the area for treatment, inconvenient at best and for some impractical due to time and job constraints. Addressing these issues at the onset and treating at an earlier stage the hope is to lessen the effects of long-term behavioral health issues The goal is to make this convenient and accessible to families in the area. In addition Lower Shore Clinic and Peninsula Regional are collaborating on a 'CareWrap' initiative establishing an outreach team of health professionals, called CareWrap, whose goal will be to enhance access to community based primary and mental health care by targeting people at risk of thirty-day

	readmission. Thirty-day readmission refers to a patient returning to the hospital within thirty days of discharge, which is an expensive and undesirable outcome for both patient and hospital. ***Conclusion:*** Rural providers and rural residents have issues unlike other more metropolitan areas of our State. Over the next three years, Peninsula Regional is committed to working on a Regional approach with our Tri-County Health Care Partners and several local hospitals on the selected identified State Healthcare Improvement Processes objectives (Diabetes, Obesity, Behavioral Health/Addiction). We will continue to work with our other local and national healthcare organizations to promote our third initiative, healthy lifestyles. Peninsula Regional will continue to strengthen its community education & screening initiatives as it relates to diabetes, obesity and living a healthy lifestyle. We continually strive to meet the needs of the underserved/underinsured by providing free wellness screenings at local festivals, churches, civic organization and health fairs in the three lower counties, Wicomico, Worcester and Somerset.

ATTACHMENT A – Expansion of Community Benefit Initiatives

This report summarizes the plans for PRMC to develop and collaborate on community benefit programs that address the prioritized needs identified in the 2016 CHNA. PRMC provides additional support for community benefit activities in the community, but those additional activities will not be covered in this report.

Community Health Needs Assessment (CHNA) (taken from CHNA exec summary)

In June 2016, Peninsula Regional Medical Center (PRMC) published their 2016 Community Health Needs Assessment (CHNA). This CHNA report was developed to provide an overview of the health needs in the PRMC tri-county service area, including Somerset, Wicomico, and Worcester counties. PRMC partnered with Healthy Communities Institute (HCI), a Xerox Company, to conduct the CHNA. The goal of this report was to offer a meaningful understanding of the greatest health needs across the PRMC service area, as well as to guide planning efforts to address those needs. Special attention was given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

Priorities

On June 8, 2016, PRMC's Community Benefit team and other members from various departments in the hospital came together to prioritize the significant health needs in a session led by consultants from HCI. The team reviewed the significant health needs using the following prioritization criteria:

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

Using the Prioritization Matrix method, the following three topics were identified as priorities to address:

Priority Areas:

1. **Diabetes**
2. **Exercise, Nutrition, and Weight**
3. **Behavioral Health (focusing on the topic areas of Mental Health and Mental Disorders as well as Substance Abuse)**

Other significant health needs not chosen were: Access to Health Services, Cancer, Heart Disease and Stroke, and Prevention and Safety. These needs were not selected because they did not meet the prioritization criteria as strongly as the selected topics. PRMC has other programs in these areas, but they are not the focus of this report.

1. Priority Area: Diabetes

Strategies

1. Offer Chronic Disease Self-Management Classes (CDSM) throughout the tri-county area
2. Expand Wagner Wellness Van mobile clinic services frequency and outreach

Goal *Improve health of people with diabetes or pre-diabetes in the tri-county area.*

Anticipated Impact

- **Objectives:**
  - By December, 2017, increase the number of 6 week educational classes with identified diabetic patients and their supporting caregivers from 26 to 52 per year
  - By December, 2017, PRMC will expand the Wagner Wellness Van mobile clinic services from monthly trips to Salisbury Urban Ministries to 5 days a week throughout the tri-county area

- **Evaluation Measures:**
  - # of participants educated
  - % completion rate
  - % knowledge change
  - # of community members reached
  - reduction in ED visits
  - patient survey used to track improved referral rate for local resources related to health education
  - patient satisfaction survey to track improved access to care for communities

Strategy 1: CDSM Classes

- **Activities:**
- Target and identify patients who have diabetes and their caregivers through self-referral or provider referral
- Train Community Peer Trainers and PRMC Community Health Workers to conduct classes
- Offer classes in English, Spanish and American Sign Language
- Explore the possibility to offer classes in Haitian-Creole, Korean and Mandarin languages
- Offer 6-week classes at least weekly
- Educate participants on diabetes self-management and have them set and track personal goals weekly and share goals with their providers
- Partner with MAC, Inc. to collect data on pre and post A1C values

Strategy 2: Wagner Wellness Van Expansion

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

System Resources

- PRMC staff
- Data
- Marketing materials
- Training materials
- Mobile van

Collaborators

- PRMC
- MAC, Inc.
- Atlantic General Hospital (AGH)
- McCready Health
- Peninsula Regional Clinically Integrated Network (PRCIN)
- Local Health Departments in the tri-county area
- Local community centers and churches

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2. Priority Area: Exercise, Nutrition, and Weight

Strategies

1. Implement an after-school program for weight loss in collaboration with the YMCA (Healthy Us)
2. Develop and implement Improving Walkability in Wicomico County program

Goal Increase awareness of and engagement in healthy lifestyle behaviors.

Anticipated Impact

- **Objectives:**
  - By November, 2017, PRMC will develop a sustainable program that continues after the current Healthy Us 10-week program in Wicomico County
  - ~~o~~ PRMC will help develop a walkability program in Wicomico County through collaboration with the Wicomico County Health Department and the Eastern Shore Regional GIS Cooperative
- **Evaluation Measures:**
  - # of participants
  - % increased health knowledge
  - % of participants with improved biometrics
  - % of participants that follow-up with sustainable program at 3-, 6-month, and 1 year intervals

Strategy 1: Healthy Us follow up program

- **Activities:**
  - Attend planning sessions with YMCA
  - Develop program content for maintenance of healthy behaviors
  - Determine timeline to expand beyond Wicomico County

Strategy 2: Improving Walkability

- **Activities:**
  - Attend planning sessions of collaborative
  - Determine regions of focus within Wicomico County
  - Explore expansion to other counties
  - Create walkability maps for community members
  - Develop communications plan to message to community

System Resources

- PRMC staff
- Data
- Marketing materials, forms

Collaborators

- Pediatric referring physicians
- Schools
- YMCA
- Wicomico County Health Department
- Eastern Shore Regional GIS Cooperative

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3. Priority Area: Behavioral Health

Strategies

1. Provide coordinated care for identified high utilizers of the hospital and/or emergency room for either medical and/or mental health care (CareWrap).
2. Provide peer support for people who have overdosed or sought help for opioid addiction issues (COAT).

Goal Improve the access to and coordination of care for people with mental health and/or substance abuse issues.

Anticipated Impact

- **Objectives:**
    - PRMC will continue to identify people with mental health issues and medical co-morbidities and enroll into the CareWrap program, to maximize case load capability
    - By December, 2016 PRMC will establish the COAT program and raise awareness of program to referring physicians, nurses, and social workers

- **Evaluation Measures:**
    - Number of participants enrolled
    - # of participants referred
    - Number of participants successfully connected to services
    - % admissions, ED visits and 30 day readmissions pre and post enrollment
    - Monthly data from ED on opioid overdoses collected and reported to county
    - Compare referral cards to services rendered
    - # of participants who have been linked and accepted recovery treatment

Strategy 1: CareWrap

- **Activities:**
    - Educate doctors, nurses, social workers who could refer participants about CareWrap program
    - Identify and refer people with mental health issues and medical co-morbidities to program through doctors, nurses and social workers
    - Connect individuals to resources, drive them to appointments, assist with coordinating medication and therapy resources
    - Hold weekly team meetings to discuss participant progress as well as identify gaps and work towards solutions
    - Review metrics quarterly

Strategy 2: Community Outreach Addictions Team (COAT)

- **Activities:**

- Educate doctors, nurses, social workers, law enforcement who could refer participants to COAT program
- Train peer support specialists
- Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction
- Provide linkages to resources include treatment options
- Provide peer outreach to high risk areas of the community
- Maintain ongoing communications about metrics between PRMC and COAT team
- Monitor ED recidivism for opioid overdose/addictive needs
- Explore ability to expand program outside of Wicomico County

System Resources

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

Collaborators

- Lower Shore Clinic of Salisbury, MD
- Wicomico County Health Department
- Wicomico County Sheriff's Department
- Salisbury City Government- Law Enforcement, EMS, Office of the State's Attorney
- Tri-county community PCPs

Future Strategies

PRMC intends to implement a tele-health program for Behavioral Health in the coming years.

PENINSULA REGIONAL MEDICAL CENTER
Part of Peninsula Regional Health System

ADMINISTRATIVE POLICY MANUAL

Subject: Uncompensated Care / Financial Assistance

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

POLICY

Peninsula Regional Medical Center (PRMC) will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their hospital bill. For purposes of this policy, PRMC shall include the hospital, medical center, and physician services billed by PRMC, commonly referred to as Peninsula Regional Medical Group (PRMG). A patient's payment for reduced-cost care shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission (HSCRC).

Definitions:

a. 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.
b. Medical Necessity: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.
c. Immediate Family: A family unit is defined to include all individuals taken as exemptions on the income tax return for the individual completing the application, whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not been filed, then income from all members living in the household will be considered.
d. Liquid Assets: Cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc. The availability of liquid assets plus annual income may be considered in relation to the current poverty guidelines published in the Federal Register.
e. Medical Debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs for medical costs billed by PRMC.
f. Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

PRMC will provide free medically necessary care to patients with family income at or below 200% of the federal poverty level.

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

PRMC will provide reduced-cost medically necessary care to low-income patients with family income between 301% and 500% of the Federal poverty level who have a financial hardship as defined by Maryland Law. Medical hardship is medical debt, incurred by a family over a 12 month period that exceeds 25% of the family income. Other healthcare fees and professional fees that are not provided by PRMC/PRMG are not included in this policy. Pre-planned service may only be considered for financial assistance when the service is medically necessary. As an example, cosmetic surgery is excluded. Inpatient, outpatient, emergency services, and services rendered by PRMG are eligible.

PRMC's financial assistance is provided only to bills related to services provided at PRMC or at a PRMC site including services provided by physicians employed by PRMC. These services are generally referred to as PRMG. To determine if your physician services are covered by the PRMC financial assistance program, please see the roster of providers that deliver emergency and other medically necessary care, indicating which providers are covered under the policy and which are not. The list of providers is updated quarterly and available on the medical center website. If you prefer, you may contact any financial counselor or patient accounting representative by calling (410) 543-7436 or (800) 235-8640, or in person at the hospital.

PROCEDURE

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

a. Available free of charge and upon request by calling (410) 543-7436 or (800) 235-8640.
b. Are located in the registration areas.
c. Downloaded from the hospital website:
   https://www.peninsula.org/patients-visitors/patient-forms
   https://www.peninsula.org/patients-visitors/billing-center
   https://www.peninsula.org/patients-visitors/billing-center/billing-information
d. The plain language summary is inserted in the Admission packet and with all patient statements.
e. Through signs posted in the main registration areas.
f. Annual notification in the local newspaper.
g. The application is available in English and Spanish. No other language constitutes a group that is 5% or more, or more than 1,000 residents (whichever is less) of the population in our primary service area (Worcester, Wicomico and Somerset Counties) based on U.S. Census data.
h. For patients who have difficulty in filling out an application, the information can be taken orally.

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

a. If the application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all Extraordinary Collection Actions (ECA) until the application and all appeal rights have been processed.

b. If the application is incomplete, all ECA efforts will remain on hold for a reasonable amount of time and assistance will be provided to the patient in order to get the application competed. If there is not a phone contact to call, a written notice that describes the additional information and/or documentation required will be mailed which includes a phone contact to call for assistance.

c. Preliminary eligibility will be made within 2 business days of receipt of a completed application. If approved, a financial assistance discount will be applied to the patient's responsibility in accordance with Finance Division policy FD-030.

d. Patients who are beneficiaries/recipients of certain means-tested social services programs are deemed to have presumptive eligibility and are FA eligible without the completion of an application or submission of supporting documentation. It is the responsibility of the patient to notify the hospital that they are in a means-tested program. This information may be obtained from an outsourced vendor working the account.

e. A patient that has qualified for Maryland Medical Assistance is deemed to automatically qualify for Financial Assistance (FA). The amount due from a patient on these accounts may be written off to FA with verification of Medicaid eligibility. Standard documentation requirements are waived.

f. If the application is ineligible, normal dunning processes will resume, which includes notifying the agency if applicable to proceed with ECA efforts. A copy of the Medical Center Collections Policy may be obtained by calling (410) 543-7436 or (800) 235-8640.

g. The patient may request reconsideration by submitting a letter to the Director of Patient Financial Services indicating the reason for the request.

h. Only income and family size will be considered in approving applications for FA unless one of the following three scenarios occurs:
   - The amount requested is greater than $50,000
   - The tax return shows a significant amount of interest income, or the patient states they have been living off of their savings accounts
   - Documentation indicates significant wealth

i. If one of the above three scenarios are applicable, liquid assets may be considered including:
   - Checking and savings accounts
   - Stocks and bonds
   - CD's
   - Money market or any other financial accounts for the past three months
   - Last year's tax return
   - A credit report may also be reviewed

The following assets are excluded:

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

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

Collection Coordinator

a. If eligible, and under $2,500, the account will be written off to FA when the "Request for Financial Assistance" form is finalized. A copy is retained in the patient's electronic file. If eligible, and the balance is $2,500 or above, the Collection Coordinator will obtain the appropriate adjustment signature(s) as defined in Finance Division Policy FD-30 and complete the process.

b. PRMC will review only those accounts where the patient or guarantor inquire about FA, based on mailing in an application, or in the normal working of the account there is indication that the patient may be eligible. Any patient/customer service representative, financial counselor, or collection representative may begin the application process.

c. Once a request has been approved, service three months before the approval and twelve months after the approval may be included in the adjustment. All encounters included with the application must reference the original encounter number where the electronic image of the application is stored. Service dates outside this fifteen month window may be included if approved by a Supervisor, Manager, or Director. Any amount exceeding $5 that has already been collected from the patient or guarantor for approved dates of service shall be refunded to the patient if the determination is made within two years of the date of care.

Note: Effective 7-1-16, FD-162 (Finance Division policy #162) Financial Assistance was combined into the Medical Center policy. A Division policy is no longer required or maintained.

Attachment I – Provider Roster
Attachment II – Plain Language Summary
Attachment III – Federal Poverty Guidelines
Attachment IV – Financial Assistance Application - English

P. Naleppa

Peggy Naleppa
President/CEO

Bruce Ritchie
Vice President of Finance/CFO

Peninsula Regional Medical Center
Physician List indicates whether the physician is part of Peninsula Regional which also means the physician services / bill is covered by the Peninsula Regional Medical Center Financial Assistance Policy
Excerpt for information purposes only

Provider (Physician and Mid-level)		Group Affiliation	PRMC Provider	Financial Assistance PRMC
Abdella	Sarah	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Acevedo	Jorge	Peninsula Regional Neurosurgery	PRMG Staff	Yes
AfsharImani	SeyedAmirHossein	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Ahmed	Andaleeb	PRMC - Department of Anesthesiology	PRMG Staff	Yes
Akers	Jeremy	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Alu-Parks	Nicole	Peninsula Regional Family Medicine Salisbury	PRMG Staff	Yes
Arnaout	Karim	Peninsula Regional Oncology & Hematology	PRMG Staff	Yes
Asrat	Habtamu	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Baibars	Mohammad Motaz	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Baker	Kathryn	Peninsula Regional Neurosurgery	PRMG Staff	Yes
Barbouletos	Sareen	Peninsula Regional Family Medicine Millsboro	PRMG Staff	Yes
Batool	Aisha	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Coker	Robert	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Crum	Michael	Peninsula Regional Family Medicine Snow Hill	PRMG Staff	Yes
Daniels	Daniel	Peninsula Regional Gastroenterology	PRMG Staff	Yes
Davidson	Michael	Peninsula Regional Pulmonary & Critical Care	PRMG Staff	Yes
Abbott	Trevor	Peninsula Orthopaedic Associates, PA	Independent	No
Achampong	Henry	Fairwood Spine and Pain Center	Independent	No
Acle	Fernando	Drs. Acle & Visioli, PA	Independent	No
Acs	George	TLCCS, Inc Dentistry	Independent	No
Adeyeye	Adeola	Peninsula Regional Hospitalists/Inpatient Providers	Independent	No
Adrignolo	Anthony	Peninsula Orthopaedic Associates, PA	Independent	No
Agarwal	Ramesh	Ramesh K. Agarwal, MD, PA	Independent	No
Ahmad	Zaaira	Retina Consultants of Delmarva	Independent	No
Ali	Shoaib	Peninsula Nephrology Associates, PA	Independent	No
Allen	Robert	Delmarva Internal & Family Medicine, PA	Independent	No
Alvarado	Jose	Jose F. Alvarado, MD & Associates	Independent	No
Amaka	Dorothy	PRMC - Department of Anesthesiology	Independent	No
Ames	Sheena	Alon Davis, MD, PA	Independent	No

Partial list for policy - full list is available on the Peninsula website

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

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

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

Peninsula Regional Medical Group (PRMG) physician charges and physicians outside of PRMG Medical group are not included in the hospital bill and are billed separately. Physician charges outside of PRMG are not covered by Peninsula Regional Medical Center's financial assistance policy. A list of providers that deliver emergency and other medically necessary care at PRMC is provided on the website, indicating which providers are covered under PRMC's financial assistance policy and which are not.

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

Eligibility Determination Process

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

How to Apply

- Applications can be taken orally by calling 1-800-235-8640 between 9:00 a.m. and 4:00 p.m., Monday through Friday
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:30 a.m. and 4:30 p.m., Monday through Friday
- On the internet at https://www.peninsula.org/patients-visitors/patient-forms
  https://www.peninsula.org/patients-visitors/billing-center
  https://www.peninsula.org/patients-visitors/billing-center/billing-information
- Applications are available in English and in Spanish

Qualifications

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

- An independent third party to verify your household income (one of the following)
  - Recent pay stub showing current and year-to-date earnings
  - Most recent tax return showing your Adjusted Gross Income or W-2 form
  - Written documentation of Social Security benefits, SSI disability, VA benefits, etc.

- Letter from an independent source such as clergy, neighbor, former employer, etc.
- Completed application

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

Need Assistance?

If, at any time, you have questions about obtaining financial assistance, your hospital bill, your rights and obligations with regard to the bill, or applying for the Maryland Medical Assistance Program, please contact Peninsula Regional Medical Center's Financial Services Department at 410-543-7436 or 1-800-235-8640.

Maryland Medical Assistance Program

To find out if you are eligible for Maryland Medical Assistance or other public assistance, please apply at your local Department of Social Services (DSS) office, or you may visit mmcp.dhmh.maryland.gov for information about the various Medicaid programs available. You may apply online for Maryland Medicaid at marylandhealthconnection.gov. If you are applying for assistance for a child or are pregnant, you may apply for the Maryland Children's Health Program (MCHP). If you are only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your DSS for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. Delaware Residents may obtain information online at dhss.delaware.gov or apply online at assist.dhss.delaware.gov. Virginia residents may obtain information at www.dmas.Virginia.gov.

Patients' Rights and Obligations

Rights:

- Prompt notification of their preliminary eligibility determination for financial assistance.
- Guidance from Peninsula Regional on how to apply for financial assistance and other programs which may help them with the payment of their hospital bill.
- Receipt of financial assistance for all services not payable by another program that meet the qualifications of Peninsula Regional Medical Center's Financial Assistance Policy.

Obligations:

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

Cómo hacer la solicitud

- Llame al 1-800-235-8640 entre las 9:00 a.m. y las 4:00 p.m., de lunes a viernes
- Acuda en persona a la oficina del consejero financiero (Localizado en el vestibulo Frank B. Hanna del Centro de attencion de Pacientes Externos) entre las 8:30 a.m. y las 4:30 p.m., de lunes a viernes
- A través de Internet, visite www.peninsula.org. Haga clic en Patients & Visitors (Pacientes y vistantes), luego en Patient Financial Services (Servicios financieros para pacientes) y después en Billing Information (Información de facturación)

Date: 05/09/16
Reviewed:
Revised:

2016 Federal Poverty Guidelines
Updated 04/28/2016

If your family size is:	And, your family income is at or below:		
Family Size	200% Federal Poverty Guideline	201% up to 300% Federal Poverty Guideline	301% - 500% Federal Poverty Guideline with Financial Hardship
1	$23,760	$35,640	$59,400
2	$32,040	$48,060	$80,100
3	$40,320	$60,480	$100,800
4	$48,600	$72,900	$121,500
5	$56,880	$85,320	$142,200
6	$65,160	$97,740	$162,900
7	$73,460	$110,190	$183,650
8	$81,780	$122,670	$204,450
You receive a discount off PRMC bills of:	**100%**	**50%**	**25%**

MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION

Information About You

Name: _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated
US Citizen Yes No Permanent Resident: Yes No

Home Address _____

_____

_____ _____
City State Zip Code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip Code

Household Members:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Do you receive any state or County Assistance? Yes No

PRMC - Patient Accounts
100 East Carroll Street
Salisbury, MD 21801

PA-059 (12/05)

I. Family Income

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

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

II. Liquid Assets

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

III. Other Assets

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

Home	Loan Balance _____		Approximate Value_____
Automobile	Make _____	Year_____	Approximate Value_____
Additional Vehicle	Make _____	Year_____	Approximate Value_____
Additional Vehicle	Make _____	Year_____	Approximate Value_____
Other Property			Approximate Value_____
			Total _____

IV. Monthly Expense

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

Do you have any other unpaid medical Bills? **Yes** **No**
For what service? _____
If you have arranged a payment plan, what is the monthly payment? _____

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

Applicant Signature _____ Date _____

Relationship to Patient _____

PA-059 (12/05)

Appendix II

Brief description of how the FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014.

Answer:

The hospital continues to anticipate the community's needs for assistance in regards to navigating through the Health Care Coverage Expansion options. PRMC has an internal process for working with patients and others to assist in obtaining coverage. We coordinate with local county offices to aid patients and community members that need assistance or who may have questions.

Patients' Rights and Obligations

Rights:

- Prompt notification of their preliminary eligibility determination for financial assistance
- Guidance from Peninsula Regional on how to apply for financial assistance and other programs which may help them with the payment of their hospital bill
- Receipt of financial assistance for all services not payable by another program that meet the qualifications of Peninsula Regional's Financial Assistance Policy

Obligations:

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

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

100 East Carroll Street • Salisbury, MD 21801-5493
410-546-6400 • 1-800-955-PRMC (7762)
TTY/TDD 410-543-7355
www.peninsula.org

BRO-086 (8/16)

Financial Assistance With Your Medical Bills

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

Financial Assistance Policy

It is the intention of Peninsula Regional Medical Center to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost.

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

Physician charges are not included in the hospital bill and are billed separately. Peninsula Regional Medical Group physician charges are covered by the Peninsula Regional financial assistance policy, private physician charges are not. To determine if your provider is a Peninsula Regional Medical Group physician, please call (410) 912-4974 or visit www.peninsula.org/prmg.

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

Eligibility Determination Process

1. Interview patient and/or family
2. Obtain annual gross income
3. Determine eligibility *(preliminary eligibility within 2 business days)*
4. Screen for possible referral to external charitable programs
5. If the patient and/or family refuse to disclose financial resources or cooperate, the patient will be subject to standard collection efforts
6. The determination of eligibility *(approval or denial)* shall be made in a timely manner

How To Apply

- Call 1-800-235-8640 between 9:00 a.m. and 4:00 p.m., Monday through Friday
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:00 a.m. and 4:00 p.m., Monday through Friday
- On the internet at www.peninsula.org. Click on Patients & Visitors then Billing Center and Billing Information

Qualifications

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

- An independent third party to verify your household income (one of the following)
  a. Recent pay stub showing current and year to date earnings
  b. Most recent tax return showing your Adjusted Gross Income or W-2 form
  c. Written documentation of Social Security benefits, SSI disability, VA benefits, etc.
  d. Letter from an independent source such as clergy, neighbor, former employer, etc.
- Request, in writing, for help with your hospital bills
- Completed and signed Financial Assistance Application

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APPENDIX IV

THIS NOTICE REQUIRED BY MARYLAND LAW

Financial Assistance Policy

It is the intention of Peninsula Regional Medical Center to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost.

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How To Apply

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- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:30 a.m. and 4:30 p.m., Monday through Friday
- On the internet at www.peninsula.org. Click on Patients & Visitors then Patient Financial Services and Billing Information

Qualifications

Peninsula Regional Medical Center compares patients' income to the Federal Poverty Guidelines. In order to process your application we require the following information:

- An independent third party to verify your household income (one of the following)
    a. Recent pay stub showing current and year to date earnings
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    c. Written documentation of Social Security benefits, SSI disability, VA benefits, etc.
    d. Letter from independent source such as clergy, neighbor, former employer, etc.
- Request, in writing, for help with your hospital bills.
- Completed and signed Financial Assistance Application

APPENDIX IV

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To find out if you are eligible for Medical Assistance or other public assistance, please apply at your Local Department of Social Services (LDSS). If you are applying for assistance for a child or are pregnant, you may apply for the Maryland Children's Health Program (MCHP) at your Local Health Department (LHD). If you are elderly and only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your LDSS for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. To receive an application, call your LDSS or the area Agency on Aging (AAA). For more information, you may call DHMH's Recipient Relations Hotline at 1(800) 492-5231 or (410) 767-5800.

Patients Rights and Obligations

Rights:

- Prompt notification of their preliminary eligibility determination for financial assistance.
- Guidance from Peninsula Regional on how to apply for financial assistance and other programs which may help them with the payment of their hospital bill
- Receipt of financial assistance for all services not payable by another program that meet the qualifications of Peninsula Regional Medical Center's Financial Assistance Policy.

Obligations:

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- A través de Internet, visite www.peninsula.org. Haga clic en Patients & Visitors (Pacientes y visitantes), luego en Patient Financial Services (Servicios financieros para pacientes) y después en Billing Information (Información de facturación)

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

MISSION

Improve the health of the communities we serve.

VALUES

- **Respect for every individual**
- **Delivery of exceptional service**
- **Continuous improvement**
- **Safety, effectiveness**
- **Trust and compassion**
- **Transparency**
- **Stewardship**

VISION

As the Delmarva Peninsula's referral Medical Center, we will be the leader in providing a system of regional access to comprehensive care that is interconnected, coordinated, safe and the most clinically advanced. We will deliver an exceptional patient and family experience, while fostering a rewarding environment for physicians and employees. Together, Peninsula Regional Medical Center and its physicians will be a trusted partner in improving the health of the region.

8/15

Appendix V

Mission

Improve the health of the communities we serve.

Values

- Respect for every individual
- Delivery of exceptional service
- Continuous improvement
- Safety, effectiveness
- Trust and compassion
- Transparency
- Stewardship

Vision

The trusted high performing innovative leader in the integration of people centered, compassionate healthcare resulting in world class community health and wellness for the Delmarva Peninsula.

PENINSULA
REGIONAL HEALTH SYSTEM