Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile it into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. Detailed reporting instructions have been distributed to your hospital's community benefit contacts, and additional copies can be requested at the email below.

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

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

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

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

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Atlantic General Hospital Corporation	◉	○	
Your hospital's ID is: 210061	◉	○	
Your hospital is part of the hospital system called Atlantic General Hospital/Health System.	◉	○	
The primary hospital community benefit (HCB) Narrative contact at your hospital is Tina Simmons.	◉	○	
The primary HCB Narrative contact email address at your hospital is tsimmons@atlanticgeneral.org	◉	○	
The primary HCB Financial report contact at your hospital is Bruce Todd.	◉	○	
The primary HCB Financial report contact email at your hospital is mtodd@atlanticgeneral.org	◉	○	

Q4. Please select the community health statistics that your hospital uses in its community benefit efforts.

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

Q5. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

AGH FY22-24 CHNA, CDC National Center for Health Stats, CDC Diabetes Public Health Resource, CDC Heart Disease Statistics and Maps, County Health Rankings for Worcester County, National Cancer Institute, CDC Mental Health surveillance and PRC Survey.

Q6. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q7. Section I - General Info Part 2 - Community Benefit Service Area

Q8. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

- [ ] 21792
- [x] 21804
- [x] 21811
- [x] 21813
- [x] 21822
- [x] 21829
- [x] 21841
- [x] 21842
- [x] 21843
- [x] 21851
- [x] 21862
- [x] 21863
- [x] 21864
- [x] 21872

Q34. How did your hospital identify its CBSA?

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

- [x] Based on ZIP codes in your global budget revenue agreement. Please describe.

Definition of Hospital Service Area. The HSCRC will use zip codes and/or counties for market analysis. The primary service area (PSA) of the hospital consists of the following zip codes (or counties): 21811, 21842, 19975, 19945, 21813.

***Review with Bruce: should we add Pocomoke and Snow Hill zipcodes??

- [x] Based on patterns of utilization. Please describe.

ED and IP utilization targeted activities based upon patient volumes for various diagnoses.

- [x] Other. Please describe.

Tri-county partnerships expand CBSA. Close proximity, rural community, and lack of transportation to Delaware expands CBSA to Sussex County, DE and Accomack County, VA.

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

https://www.atlanticgeneral.org/about-us/vision-and-mission/

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

AGH provides clinical site opportunities to various health occupations, i.e. rad tech, pharmacy interns, med student interns, etc., students/interns from local universities and colleges. Distance leaners are provided local clinical site opportunities as well through their online studies and expanded partnerships with other universities in Maryland. AGH supports and provides high school mentoring opportunities to local tech school programs from Worcester, Wicomico and Somerset counties. We also actively support Project SEARCH.

Q37. Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

Q38.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (●) Yes
- ( ) No

Q39. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q40. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

05/01/2022

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

https://www.atlanticgeneral.org/images/AGH-2339-Community-Needs-Assessment-Rpt-2022-WEB.pdf

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

AGH-2339-Community-Needs-Assessment-Rpt 2022-2024.pdf
15.7MB
application/pdf

Q43. Section II - CHNAs and Stakeholder Involvement Part 2 - Internal CHNA Partners

Q44. Please use the table below to tell us about the internal partners involved in the development of your most recent CHNA.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☑	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Physician(s)	☐	☐	☑	☑	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Nurse(s)	☐	☐	☑	☑	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Social Workers	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Hospital Advisory Board	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Other (specify)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal Hospital Community Benefit Partners

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

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

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

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

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

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

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

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

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

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

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

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

Refer to the FY 2023 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2023.

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

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Faith-Based Organizations	☑	☑	☑	☑	☐	☐	☑	☑	☐	☑	☐	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here: Worcester County Public Schools (WCPS)	☑	☑	☑	☐	☐	☐	☑	☑	☐	☐	☐	☐	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here: SU, UMES, DelTech, Univ of DE, Ches College, Frosburg, South Hills, Oakwood, Lynchburg, Wilm Univ.	☑	☑	☐	☐	☐	☐	☑	☑	☐	☐	☐	☐	☑	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here: LBHA, Local Drug & Alcohol Coalition, WoWAOA, CareMind, Hudson Behavioral Health, Sun Behavioral, WCHD.	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☐	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here: Gold, Cricket Center, MD Food Bank, local food pantries/shelters.	☑	☑	☐	☐	☐	☐	☑	☑	☐	☐	☐	☑	☑	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here: Berlin Nursing Home	☑	☑	☐	☐	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here: Hope4Recovery, Atlantic Club, Worcester Gold, Worcester Goes Purple, Worcester Youth and Family.	☑	☑	☑	☑	☐	☐	☑	☑	☐	☐	☐	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Consumer/Public Advocacy Organizations -- Please list the organizations here: Komen, March of Dimes, Red Cross, local chambers, United Way	☑	☑	☐	☐	☐	☐	☑	☑	☑	☐	☐	☐	☐	☐
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Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

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

- (●) Yes
- ( ) No

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

11/14/2022

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

https://www.atlanticgeneral.org/documents/CHNA-2022-Implementation-Plan-sm.pdf

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

CHNA-2022-2024 Implementation-Plan.pdf

2.5MB
application/pdf

Q54. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

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

As noted, most recent CHNA approved in May 2022 and the implementation plan was approved by our board in November 2022. All information in this report is based on this most recent CHNA. Uploaded below are the progress reports for our CHNA Priorities.

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

CHNA-2022-Implementation-Plan-Progress-Report-sm.pdf
5.1MB
application/pdf

Q57. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q58. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q59.
Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q60. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q61. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

We are an active partner in the REACH grant program (Tidal Health is the lead) that is focused on health disparities in minority residents, specifically for patients/community members with Diabetes, Hypertension, and Heart Disease who live in six designated zip codes in the tri-county area of Worcester, Wicomico and Somerset counties. We continued the partnership developed during the Covid-19 pandemic with our faith-based partners to provide flu and Covid vaccine clinics and educational outreach in underserved areas of the county. This outreach was very important in providing vaccines in populations impacted by health disparities. In addition, we are partnering with St. Paul to develop a Social Determinants of Health report. We transitioned our organizational health equity team into a Social Determinant of Health Committee. Our Social Determinants of Health committee developed a Social Determinants of health screening tool, which was piloted in our behavioral health crisis center. The screening tool will be deployed throughout our hospital and outpatient locations on December 12, 2022.

Q62. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

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

Q63. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q64. Section III - CB Administration

Q65. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [x] Yes, by the hospital's staff
- [ ] Yes, by the hospital system's staff
- [ ] Yes, by a third-party auditor
- [ ] No

Q66. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q67. Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

Q68. Please describe the community benefit narrative audit process.

The community benefit narrative is completed by the director of population health, with input from the director of finance. The report is reviewed by the VP of Operations, and other senior leaders as appropriate prior to submission.

Q69. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (●) Yes
- ( ) No

Q70. Please explain:

This question was not displayed to the respondent.

Q71. Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

Q72. Please explain:

This question was not displayed to the respondent.

Q73. Does your hospital include community benefit planning and investments in its internal strategic plan?

- ( ) Yes
- (●) No

Q74. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

This question was not displayed to the respondent.

Q75. If available, please provide a link to your hospital's strategic plan.

This question was not displayed to the respondent.

Q76. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents

We provide diabetes self-management education, diabetes support groups, pre-diabetes and diabetes screenings. We also perform BMI screenings in the community and within our primary care and endocrinology offices. Our nutrition department is also actively engaged in providing healthy eating education as well as management of our community garden, which encourages healthy eating.

- [x] Opioid Use Disorder - Improve overdose mortality

Our population health and Emergency department leadership participates on a monthly OIT (Opioid intervention team) committee. Population Health director participates on the Worcester County Alcohol and Drug Council. AGH has a Behavioral Health Opioid Stewardship Committee that has representatives internally from various AGH departments, as well as from multiple county agencies and community partner organizations. In conjunction with Worcester County health department and Worcester Goes Purple, we track EDCC measures and Narcan training throughout the county.

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

The Director of Population Health is now on the MHA Council for Clinical & Quality Issues. Maternal morbidity data is reviewed at this council meeting and moving forward in 2024 will be analyzed by hospital with increased focus. However, maternal health was not one of the priorities identified on our CHNA most likely because our hospital and health system do not provide obstetric services.

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

- [ ] None of the Above

Q77. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q78. Section IV - Physician Gaps & Subsidies

Q79. (Optional) Please attach any files containing further information and data justifying physician subsidies at your hospital.

(This year, all information on physician gap subsidies is collected on the financials. However, if you have additional information on these subsidies to report, you may do so through attachments here.)

Q80. Section V - Financial Assistance Policy (FAP)

Q81. Upload a copy of your hospital's financial assistance policy.

Financial-Assistance-Policy-Approved-by-Board-02-05-2021.pdf
2.2MB
application/pdf

Q82. Provide the link to your hospital's financial assistance policy.

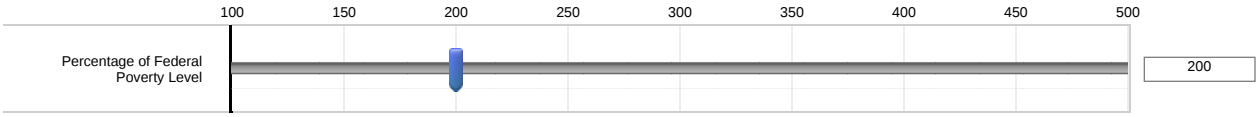
https://www.atlanticgeneral.org/documents/financial%20assistnce/Financial-Assistance-Policy-Approved-by-Board-02-05-2021.pdf

Q83. Has your FAP changed within the last year? If so, please describe the change.

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

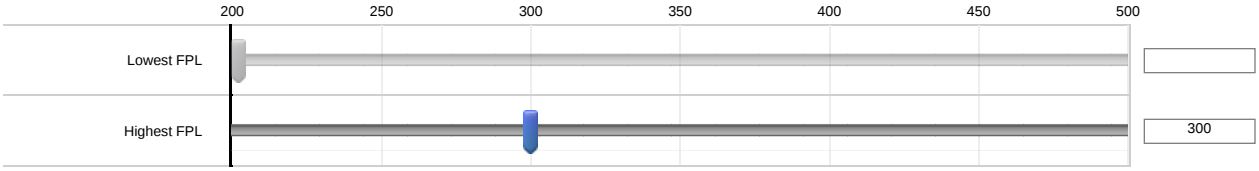
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



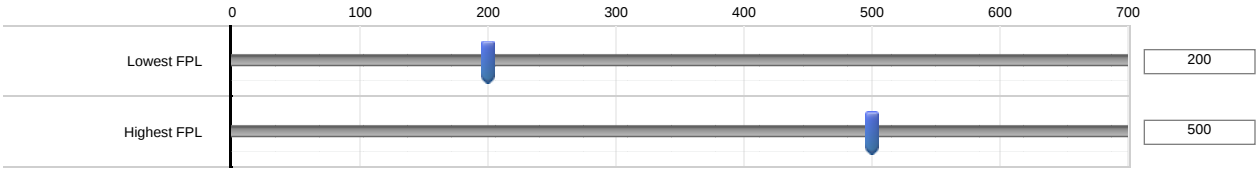
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

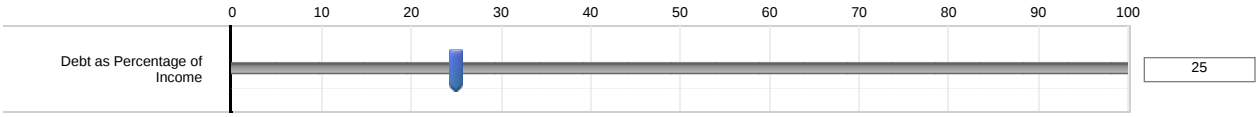


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

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



Q87. Please select the threshold for medical debt as a percentage of family income above which qualifies as a financial hardship.



Q88. Section VI - Tax Exemptions

Q89. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [ ] Local property tax (real and personal)
- [x] Other (Describe) We have some property tax exemptions depending on usage, but not all local property taxes.

Q90. Summary & Report Submission

Q91.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

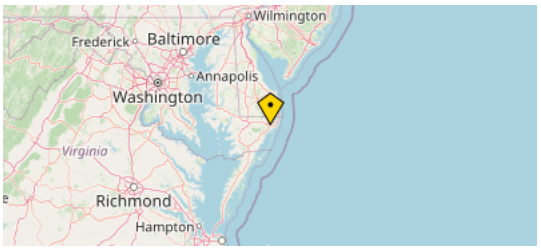
We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (38.346, -75.1833)

Source: GeoIP Estimation



Atlantic General Hospital

Community Health Needs Assessment

2022-2024

ATLANTIC GENERAL HOSPITAL

care.givers

Table of Contents

Atlantic General Hospital

Community Health Needs Assessment

2022 - 2024

Background and Purpose

The Atlantic General Hospital Corporation (AGH) is an independent, not-for-profit, full-service, acute care, inpatient and outpatient facility located in the city of Berlin, Maryland, providing 24-hour emergency services, inpatient and outpatient diagnostic and surgical services, and intensive care services. Since opening our doors in May of 1993, AGH has remained steadfast in serving the healthcare needs of our region's residents and visitors. Our hospital values and recognizes all the communities it serves. We combine the latest medical treatments with personalized attention in a caring environment.

The Patient Protection and Affordable Care Act (ACA) of March 23, 2010, includes requirements for nonprofit hospitals to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. The regulations include a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) every three years, and develop an implementation strategy to address those needs. A Community Health Needs Assessment provides an overview of the health needs and priorities of the community. The CHNA must be made publicly available.

This CHNA represents the fourth time that Atlantic General Hospital has collaborated and completed the Community Health Needs Assessment process. A Community Health Needs Assessment is intended to provide information to help hospitals and other community organizations identify opportunities to improve the health of the community. The CHNA process identifies factors that influence the health of a population and determine the availability of resources that adequately address health concerns.

With the information provided in this report, hospital leaders and partners develop plans to address community health priorities and build upon the capacity, resources and partnerships of existing programs. AGH participates closely with Worcester County Health Department, Wicomico County Health Department, Somerset County Health Department, and Tidal Health to provide Community Health Assessment data, surveys and programs. Worcester County Health Department document links are used extensively throughout the CHNA *(Appendix A)*.

> A community health needs assessment provides an overview of the health needs and priorities of the community.

Atlantic General Hospital Overview

Atlantic General Hospital was built with the support of a dedicated community. Since opening our doors in May of 1993, Atlantic General has remained steadfast in serving the healthcare needs of our region's residents and visitors, which grows from 30,000 to 300,000 during the summer months. Our not-for-profit hospital is independently owned – and managed by a local board of trustees that are active and involved members of the community.

Located in the city of Berlin, MD, AGH is the only hospital located in Worcester County, which is a federally-designated medically underserved area for primary care, dental health and mental health. We serve Maryland, Virginia and Delaware residents and visitors.

AGH is a full-service, acute care, inpatient and outpatient facility providing 24-hour emergency services, inpatient and outpatient diagnostic and surgical services, and intensive care services. It is Joint Commission-accredited, a member of the American Hospital Association and the Maryland Hospital Association, and is consistently recognized as one of the most efficient hospitals in the State of Maryland. Our patients can expect individualized standards of care. We combine the latest medical treatments with personalized attention. Our Centers of Excellence at AGH include the Atlantic Endoscopy Center, Center for Joint Surgery, Bariatric Services, Emergency Services, Eunice Q. Sorin Women's Diagnostic Center, Regional Cancer Care, Sleep Disorders Diagnostic Center, Stroke Center, Women's Health Center and Wound Care Center. AGH also provides the Diabetes Outpatient Education Program, Full-Service Imaging, Occupational Health Services, Medication Management and a Behavioral Health Clinic.

In addition to the acute care and specialty services we provide at our main campus in Berlin, MD, we have several family physicians, internists, and specialists with offices in locations throughout the region that comprise Atlantic General Health System, plus Atlantic ImmediCare, which provides walk-in primary care and urgent care.

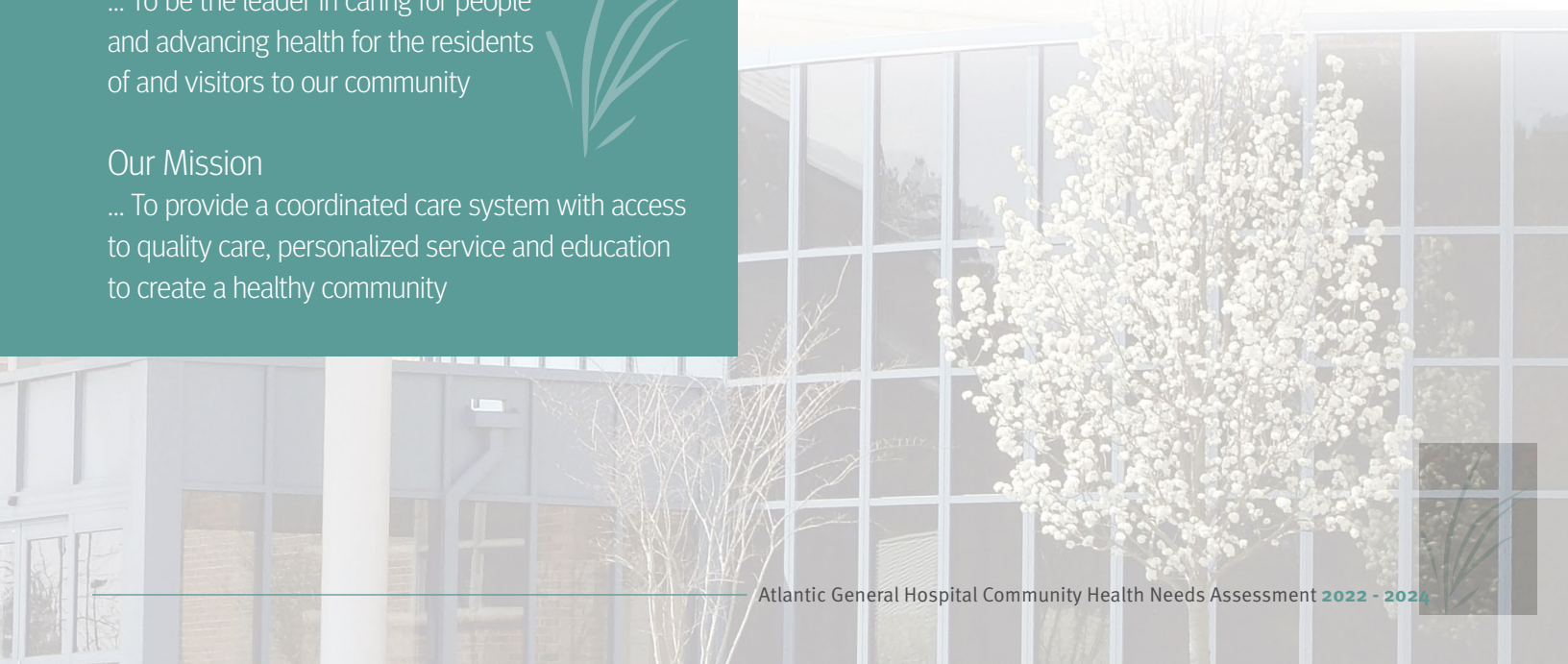
AGH employs over 940 year-round full- and part-time associates with an annual payroll of nearly $63 million, making AGH the second largest employer in Worcester County. Our staff is here to counsel you in making the right choices for your health and quality of life. Even more valuable than our excellent, award-winning programs is the genuine warmth and concern our staff exudes in caring for each and every patient on a personal level.

Our Vision

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

Our Mission

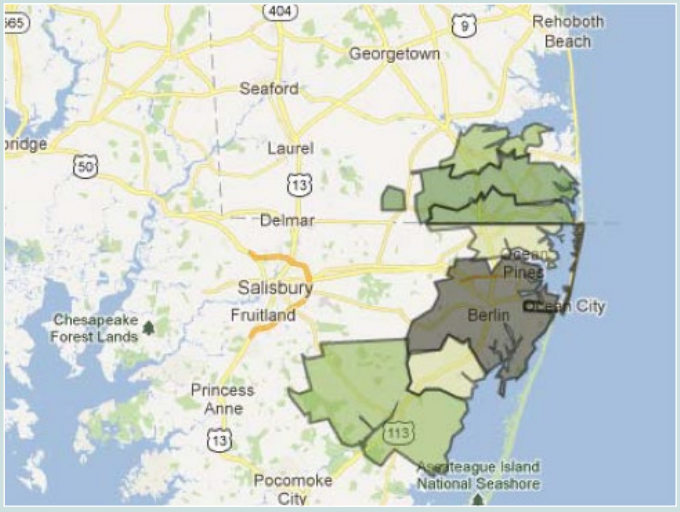
... To provide a coordinated care system with access to quality care, personalized service and education to create a healthy community



The Community Description

Atlantic General Hospital's primary service area is defined as those zip codes that represent the majority of patient admissions, emergency or outpatient visits from the residents and/or there is a contiguous geographic relationship. Worcester and Sussex County are rural areas. There is a lack of public transportation, making geographic location a factor in defining primary market.

Primary Service Area



Primary Market

Zip Code	City	County	State
19939	Dagsboro	Sussex County	DE
19945	Frankford	Sussex County	DE
19975	Selbyville	Sussex County	DE
21811	Berlin	Worcester County	MD
21813	Bishopville	Worcester County	MD
21841	Newark	Worcester County	MD
21842	Ocean City	Worcester County	MD
21843	Ocean City	Worcester County	MD
21862	Showell	Worcester County	MD
21872	Whaleyville	Worcester County	MD
21874	Willards	Worcester County	MD

Population Statistics

During summer weekends, the Worcester County resort destination Ocean City hosts between 320,000 and 345,000 vacationers and up to 8 million visitors annually. During the summer, Ocean City becomes Maryland's second most populated town. Lower Sussex County has similar characteristics of seasonality and retirees. Frankford, DE and Dagsboro, DE have similar demographic profiles as Worcester County, MD. Selbyville, DE has some differing characteristics.

Population

County: Worcester, MD

52,524 Persons

State: Maryland 6,070,335 Persons

Percent Population Change: 2010 to 2021

County: Worcester, MD

2.08%

State: Maryland 5.14%

Population

Zip Code: 19975

10,281 Persons

County: Sussex, DE	State: Delaware
241,079 Persons	985,717 Persons

Percent Population Change: 2010 to 2021

Zip Code: 19975

26.52%

County: Sussex, DE	State: Delaware
22.29%	9.78%

Population by Race	County: Worcester, MD		State: Maryland	
	Persons	% of Population	Persons	% of Population
White	42,960	81.79%	3,270,215	53.87%
Black/African American	6,664	12.69%	1,842,429	30.35%
American Indian/Alaskan Native	177	0.34%	24,131	0.40%
Asian	826	1.57%	413,251	6.81%
Native Hawaiian/Pacific Islander	19	0.04%	4,123	0.07%
Some Other Race	770	1.47%	295,602	4.87%
2+ Races	1,108	2.11%	220,584	3.63%

Population by Race	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
White	8,728	84.89%	189,551	78.63%	641,371	65.07%
Black/African American	640	6.23%	28,511	11.83%	223,573	22.68%
American Indian/Alaskan Native	83	0.81%	1,860	0.77%	4,862	0.49%
Asian	144	1.40%	3,252	1.35%	41,336	4.19%
Native Hawaiian/Pacific Islander	0	0.00%	203	0.08%	566	0.06%
Some Other Race	475	4.62%	11,269	4.67%	41,179	4.18%
2+ Races	211	2.05%	6,433	2.67%	32,830	3.33%

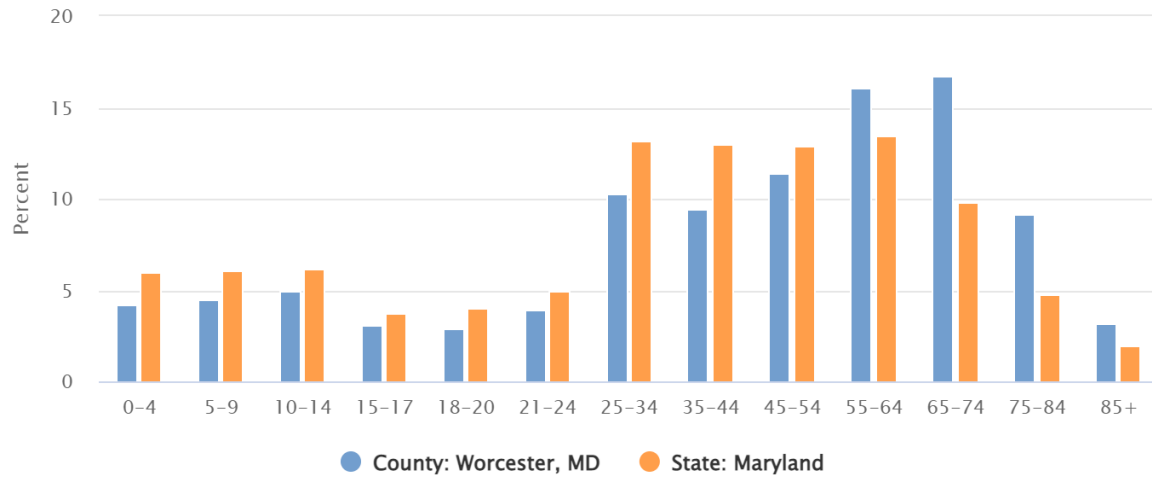
Population by Ethnicity	County: Worcester, MD		State: Maryland	
	Persons	% of Population	Persons	% of Population
Hispanic/Latino	1,876	3.62%	639,709	10.49%
Non-Hispanic/Latino	49,909	96.38%	5,458,711	89.51%

Population by Ethnicity	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
Hispanic/Latino	1,163	12.07%	22,540	9.71%	94,055	9.64%
Non-Hispanic/Latino	8,470	87.93%	209,708	90.29%	881,437	90.36%

Selbyville (zip code 19975) has a higher percentage of Hispanic/Latino ethnicity due to a large poultry employer, Mountaire.

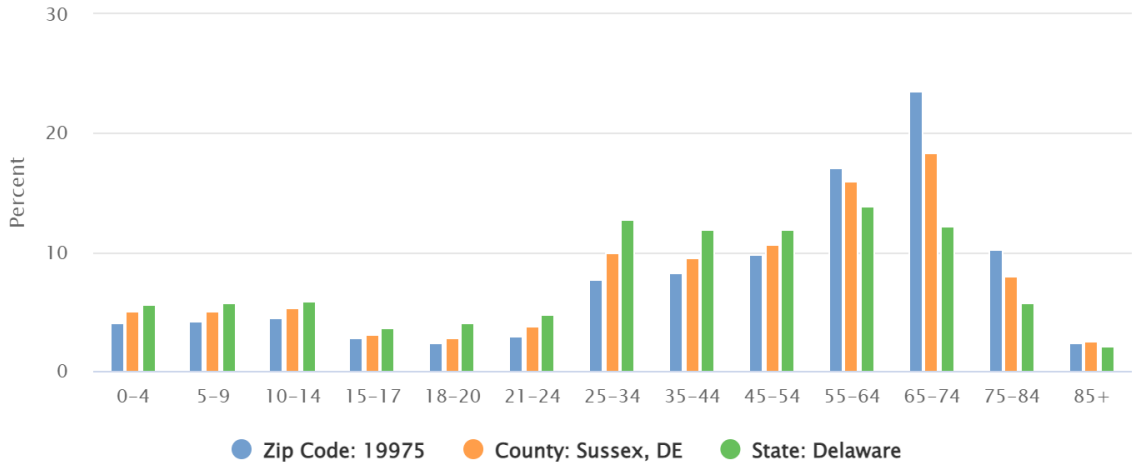
Population by Age Group

County: Worcester, MD



Population by Age Group

Zip Code: 19975



Median Age

County: Worcester, MD

50.8 Years

State: Maryland 39.6 Years

Median Age

Zip Code: 19975

57.0 Years

County: Sussex, DE
50.1 Years

State: Delaware
41.4 Years

Previously, the Selbyville zip code showed a median age of 55.9 years while Worcester County remained essentially the same.

Population Age 5+ by Language Spoken at Home	County: Worcester, MD		State: Maryland	
	Persons	% of Population Age 5+	Persons	% of Population Age 5+
Speak Only English	46,030	91.51%	4,588,469	80.38%
Speak Spanish	2,083	4.14%	576,814	10.11%
Speak Asian/Pac Islander Lang	683	1.36%	235,066	4.12%
Speak Indo-European Lang	1,208	2.40%	242,925	4.26%
Speak Other Lang	299	0.59%	64,890	1.14%

Population Age 5+ by Language Spoken at Home	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population Age 5+	Persons	% of Population Age 5+	Persons	% of Population Age 5+
Speak Only English	8,196	83.05%	201,155	87.89%	792,261	85.19%
Speak Spanish	1,281	12.98%	18,904	8.26%	80,850	8.69%
Speak Asian/Pac Islander Lang	133	1.35%	2,673	1.17%	20,764	2.23%
Speak Indo-European Lang	246	2.49%	5,707	2.49%	31,135	3.35%
Speak Other Lang	13	0.13%	420	0.18%	4,999	0.54%

Population Age 15+ by Marital Status	County: Worcester, MD		State: Maryland	
	Persons	% of Population Age 15+	Persons	% of Population Age 15+
Never Married	11,951	26.36%	1,748,747	35.19%
Married, Spouse present	22,240	49.05%	2,199,869	44.27%
Married, Spouse absent	1,964	4.33%	249,222	5.02%
Divorced	5,262	11.60%	502,790	10.12%
Widowed	3,928	8.66%	268,255	5.40%

Population Age 15+ by Marital Status	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population Age 15+	Persons	% of Population Age 15+	Persons	% of Population Age 15+
Never Married	1,879	20.93%	54,139	26.55%	278,560	34.13%
Married, Spouse present	5,295	58.99%	104,446	51.22%	364,224	44.63%
Married, Spouse absent	254	2.83%	8,328	4.08%	34,940	4.28%
Divorced	731	8.14%	22,962	11.26%	89,864	11.01%
Widowed	817	9.10%	14,024	6.88%	48,505	5.94%

Community Healthcare Utilization and COVID-19 Update

When Atlantic General Hospital began its tri-annual CHNA process, Worcester County and the state of Maryland were in the midst of dealing with the novel coronavirus (COVID-19) pandemic. At the time of writing of the CHNA, AGH had just gone through a third surge of COVID-19 patients due to the Omicron and Delta variants. The impact over the last three years shows a larger volume variation than historical utilization trends would have predicted, likely due to the pandemic.

Declines in inpatient admissions and emergency department visits were anticipated due to the work of our strategic plan *2020 Vision: The Right Path to Good Health*. It reflects the continued efforts to make sure that people get the right care at the right time in the right setting. Hospital care that is unplanned can be prevented through improved care coordination, effective primary care and improved population health. Care coordination, for which AGH has invested significant resources, involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people – and that this information is used to provide safe, appropriate and effective care to the patient. Telehealth initiatives were adopted quicker when the COVID-19 pandemic closed services.

	Volumes			Growth
AGH	FY19	FY20	FY21	FY19-FY21
Inpatient Admissions	3,112	2,678	2,582	-17.0%
Emergency Department Visits	36,541	31,668	28,940	-20.8%
Atlantic General Health System Visits	112,456	115,875	118,649	5.5%

The Right Path to Good Health

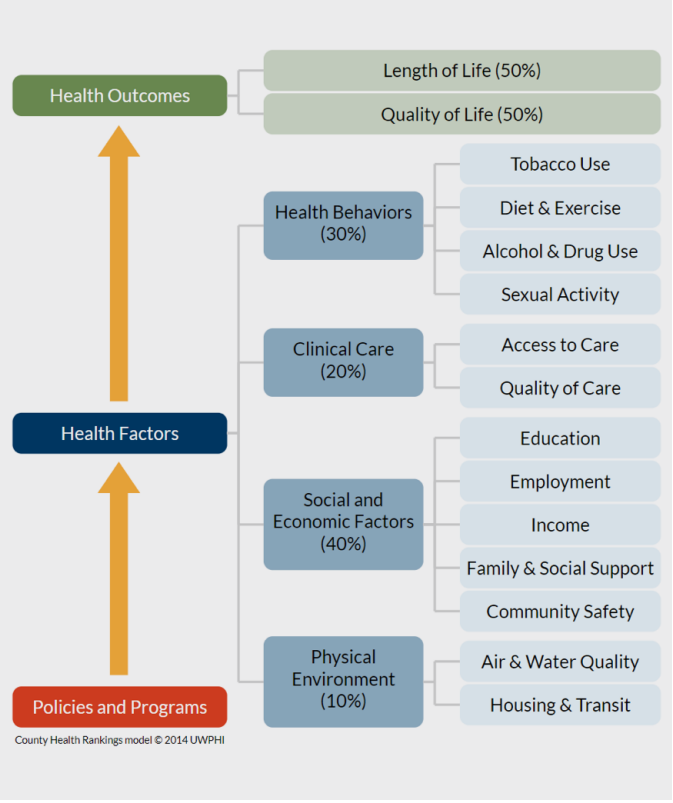
AGH Emergency Visits FY2021			
	Black	White	Total
Heart Disease	151	1,762	1,913
Diabetes	409	1,565	1,974
Cancer	13	113	126
Smoking / Drug / ETOH	373	2,330	2,703
HTN / Stroke	9	60	69
Overweight / Obesity	16	35	51
Depression / Anxiety	177	1,864	2,041
Total	1,148	7,729	8,877

AGH Inpatient Visits FY2021			
	Black	White	Total
Heart Disease	137	1,537	1,674
Diabetes	138	680	818
Cancer	4	106	110
Smoking / Drug / ETOH	57	781	838
HTN / Stroke	72	547	619
Overweight / Obesity	53	238	291
Depression / Anxiety	50	852	902
Total	511	4,741	5,252

AGH Emergency & Inpatient Visits FY2021			
	Black	White	Total
Heart Disease	288	3,299	3,587
Diabetes	547	2,245	2,792
Cancer	17	219	236
Smoking / Drug / ETOH	430	3,111	3,541
HTN / Stroke	81	607	68
Overweight / Obesity	69	273	342
Depression / Anxiety	227	2,716	2,943
Total	1,659	12,470	14,129

Key Demographic and Socioeconomic Characteristics

The factors affecting health are much more than access to healthcare. Using the illustration from the County Health Rankings, clinical care comprises about 20% of the total health picture along with health behaviors (30%), social and economic factors (40%) and physical environment (10%). The environmental and social factors that affect the county residents helped shape our understanding of both primary and secondary data in the community health needs assessment.



Families Below Poverty

County: Worcester, MD

947 Families (6.36% of Families)

State: Maryland 92,575 Families (6.09% of Families)

Families Below Poverty with Children

County: Worcester, MD

537 Families (3.61% of Families)

State: Maryland 66,955 Families (4.41% of Families)

Families Below Poverty

Zip Code: 19975

162 Families (5.34% of Families)

County: Sussex, DE 5,178 Families (7.88% of Families)

State: Delaware 21,515 Families (8.48% of Families)

Families Below Poverty with Children

Zip Code: 19975

40 Families (1.32% of Families)

County: Sussex, DE 3,698 Families (5.63% of Families)

State: Delaware 15,836 Families (6.24% of Families)

Population 25+ by Educational Attainment	County: Worcester, MD		State: Maryland	
	Persons	% of Population Age 25+	Persons	% of Population Age 25+
Less than 9th Grade	974	2.43%	160,198	3.82%
Some High School, No Diploma	2,667	6.65%	244,973	5.84%
High School Grad	12,687	31.64%	1,026,181	24.46%
Some College, No Degree	8,681	21.65%	787,502	18.77%
Associate Degree	2,889	7.21%	282,499	6.73%
Bachelor's Degree	7,772	19.39%	907,009	21.62%
Master's Degree	3,409	8.50%	545,932	13.01%
Professional Degree	724	1.81%	132,537	3.16%
Doctorate Degree	289	0.72%	108,148	2.58%

Families below poverty and families below poverty with children have reported a decrease from previous CHNA, both in Worcester County (1,115 families or 7.6%) and 19975 zip code (192 families or 6.82%). A similar trend is in families below poverty with children.

Worcester County has a higher graduation rate than Sussex County at 94% and 87% respectively. Both have improved from previous CHNA.

Population 25+ by Educational Attainment	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population Age 25+	Persons	% of Population Age 25+	Persons	% of Population Age 25+
Less than 9th Grade	479	5.89%	7,581	4.20%	25,754	3.71%
Some High School, No Diploma	496	6.10%	12,962	7.18%	44,425	6.40%
High School Grad	2,393	29.44%	58,931	32.64%	228,164	32.89%
Some College, No Degree	1,696	20.86%	34,363	19.03%	125,063	18.03%
Associate Degree	695	8.55%	16,472	9.12%	53,145	7.66%
Bachelor's Degree	1,483	18.24%	28,672	15.88%	126,591	18.25%
Master's Degree	752	9.25%	16,644	9.22%	66,741	9.62%
Professional Degree	89	1.09%	2,743	1.52%	11,723	1.69%
Doctorate Degree	46	0.57%	2,162	1.20%	12,120	1.75%

Median Household Income by Race/Ethnicity	County: Worcester, MD	State: Maryland
	Value	Value
All	$68,939	$90,160
White	$72,374	$99,846
Black/African American	$39,778	$72,856
American Indian/Alaskan Native	$27,813	$73,136
Asian	$133,824	$112,300
Native Hawaiian/Pacific Islander	$181,250	$85,910
Some Other Race	$91,250	$69,929
2+ Races	$135,556	$86,766
Hispanic/Latino	$61,880	$79,426
Non-Hispanic/Latino	$69,163	$91,240

Median Household Income has increased from $62,944 in Worcester County and significantly decreased in 19975 zip code from $92,308.

Median Household Income by Race/Ethnicity	Zip Code: 19975	County: Sussex, DE	State: Delaware
	Value	Value	Value
All	$62,286	$65,595	$68,758
White	$65,212	$69,148	$73,682
Black/African American	$50,974	$41,790	$50,061
American Indian/Alaskan Native	$143,750	$42,925	$44,877
Asian	$79,167	$91,299	$101,494
Native Hawaiian/Pacific Islander	$0	$62,245	$58,846
Some Other Race	$23,077	$47,670	$52,368
2+ Races	$17,500	$48,102	$56,683
Hispanic/Latino	$43,811	$53,488	$56,339
Non-Hispanic/Latino	$64,104	$66,251	$69,810

** Statistics available through Healthy Communities Institute at www.atlanticgeneral.org*

LARGEST PRIVATE SECTOR EMPLOYERS

Employer	Product/Service	Employment
Harrison Group	Hotels and Restaurants	1170
Atlantic General Hospital	Medical Services	860
Bayshore Development	Entertainment, Recreation	520
OC Seacrets	Hotel and Restaurant	470
Dough Roller	Restaurant	360
Ocean Enterprise 589 / Casino Ocean Downs	Casino Gambling	350
Carousel Resort Hotel & Condominiums	Hotel and Condominiums	340
Clarion Resort Fontainebleau	Hotel and Restaurant	340

Worcester County, MD unemployment rate is at 7.00%, compared 11.20% last year. This is lower than the long-term average of 9.57%. Selbyville (zip 19975) has an unemployment rate of 6.4%. The US average is 6.0%. Selbyville (zip 19975) has seen the job market increase by 1.3% over the last year. Future job growth over the next ten years is predicted to be 37.5%, which is higher than the US average of 33.5%.

For 2021, Sussex and Worcester County are at 10.4% and 7.4% respectively for uninsured patients, as stated by US Census Bureau – both increasing over previously reported data.

Health Factors and Status Indicators

Worcester and Sussex County Health status indicators are updated periodically by several organizations. Sources include the Healthy Communities Institute's database found on Atlantic General Hospital's website, which is used extensively as a secondary data source.

www.atlanticgeneral.org/community-health-wellness/creating-healthy-communities/?hcn=CommunityDashboard

The Robert Woods Johnson's county rankings are based on a model of population health and build on America's Health Rankings. These are summarized for Worcester and Sussex County in Appendix C. Areas to explore for health improvement are adult smoking rates, adult obesity, excessive drinking, alcohol impaired driving, and unemployment in Worcester County. Additionally in Sussex County, the areas of physical inactivity, teen births, uninsured, graduation rates, children in poverty and violent crimes stand out as areas below top US performers or the State.

Another source of community health indicators is found in the Maryland State Health Improvement Process (SHIP) indicators and goal attainment summarized in Appendix D. The goal of the State Health Improvement Process is to advance the health of Maryland residents. To achieve this goal, SHIP provides a framework for accountability, local action, and public engagement. Using 39 measures, SHIP highlights the health characteristics of Marylanders. These measures align with Healthy People (HP) 2020, soon to move to Healthy People (2030) objectives established by the Department of Health and Human Services.

SHIP data primarily supports the development and strategic direction of Local Health Improvement Coalitions. These coalitions – comprising of local health departments, nonprofit hospitals, community members, and other community-based organizations – provide a forum to collectively analyze and prioritize community health needs based on SHIP data.

Resources Available to Address Significant Health Needs

Resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report are listed on the Worcester County Health Department's and Atlantic General Hospital's website. This listing is not exhaustive and is continually developing. Their links are:

www.worcesterhealth.org/resources

AtlanticGeneral.org

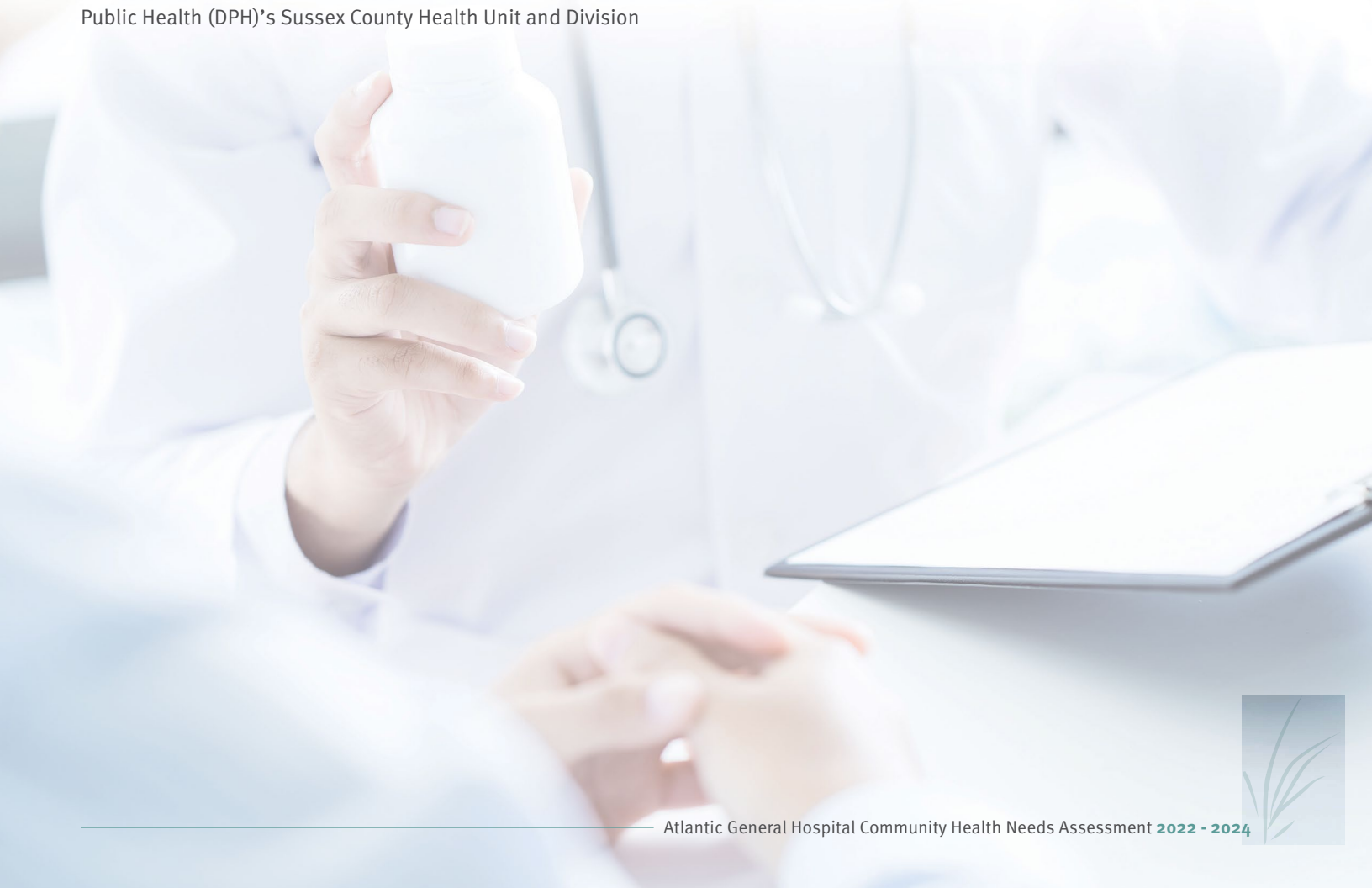
2-1-1 Maryland is a partnership of four agencies working together to provide simple access to health and human services information. 2-1-1 is an easy-to-remember telephone number that connects people with important community services. Trained specialists answer calls 24 hours a day, every day of the year.

www.211md.org

In Sussex County, resources are through State and Local Health Care Resources such as those listed with Division of Public Health – The Thurman Adams State Service Center, Division of State Service Centers (DSSC), Emergency Assistance Service (EAS), Division of Social Services (DSS), Division of Public Health (DPH)'s Sussex County Health Unit and Division of Substance Abuse and Mental Health (DSAMH). Beebe Medical Center services Dagsboro, Selbyville and Frankford with outpatient and emergency services.

La Esperanza Community Center – This is the only bi-cultural and bilingual 501(c)(3) social services agency that provides free culturally appropriate programs and services in the areas of family development, immigration, victim services, and education to help Hispanic adults, children and families living in Sussex County.

La Red Health Center – There are three locations available in Georgetown, Seaford and Milford. Services include: Adult and Senior, Behavioral Health, Customized Services for Small Businesses, Oral Health, Patient Enabling, Pediatric and Adolescent, Women's Health, Community Outreach, Medication, Delaware Marketplace, Medicaid Enrollment Assistance, Referrals for WIC, Screening for Life, The Community Healthcare Access program (CHAP), After-hours Coverage and Emergencies, Access to Transportation, Case Management for the Homeless Population, Laboratory Services, Gynecological Care Program. The center accepts: Uninsured, Underinsured, Private Insurance, Medicare, and Medicaid. All income levels accepted. Fees: Sliding scale available. Languages Spoken: English, Spanish.



Approach and Resources

CHNA Methodology

This CHNA combines population health statistics in addition to feedback gathered from the community in the form of surveys and focus groups. AGH uses the Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs.

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (surveys) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes information gathered through ongoing key community groups.

Secondary Data Collection

AGH partners with surrounding hospitals, health departments and state agencies to bring to together a multitude of information. This CHNA, a follow-up to similar studies conducted in 2012, 2015, and 2018, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area of Atlantic General Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

The information as well as other surveys, research and community data are used to identify issues of greatest concern, and guide resource allocation to those areas – thereby making the greatest possible impact on community health status.

The CHNA is a primary tool used by the Hospital to determine its community benefit priorities, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. The assessment incorporates components of primary data collection and secondary data analysis that focuses on the health and social needs of our service area.

A sampling of resources utilized to complete the assessment is listed below. (A comprehensive list is found under References.)

- **Community meetings with persons representing the broad interests of the community**
- **AGH Community Needs Survey**
- **Maryland State Health Improvement Process (SHIP)**
- **Tri-County Health Improvement Plan (T-CHIP)**
- **Healthy People 2020 - 2030**
- **Worcester County Community Health Improvement Plan (CHIP) LHIC Local Health Improvement Coalition**
- **Community Education Events**
- **2020/2021 County Health Outcomes & Roadmaps**
- **State of Delaware Health Needs Assessment** https://dhss.delaware.gov/dhss/dph/files/ship2019.pdf
- **Beebe Medical Center Community Health Needs Assessment** https://www.beebehealthcare.org/sites/default/files/Official%20Beebe%20CHNA%20June%202019_FINAL.pdf
- **US Census Bureau**

Who Was Involved in the Assessment? (Appendix B)

Representatives from AGH participate on a number of community boards and attend a variety of community meetings, councils, and events to discuss and provide education on the health-related needs and priorities of our common communities as well as discuss opportunities for collaboration. Likewise, diverse community members serve internally on hospital committees providing a forum to communicate the community health needs to the organization. Unlike years past, much of this was accomplished online in Zoom or other internet forums. Of particular importance is the CHNA completed by the Worcester County Health Department. Data and objectives are closely aligned. A representative list of community involvement is displayed in Appendix B.

AGH Community Needs Survey (Appendix E)

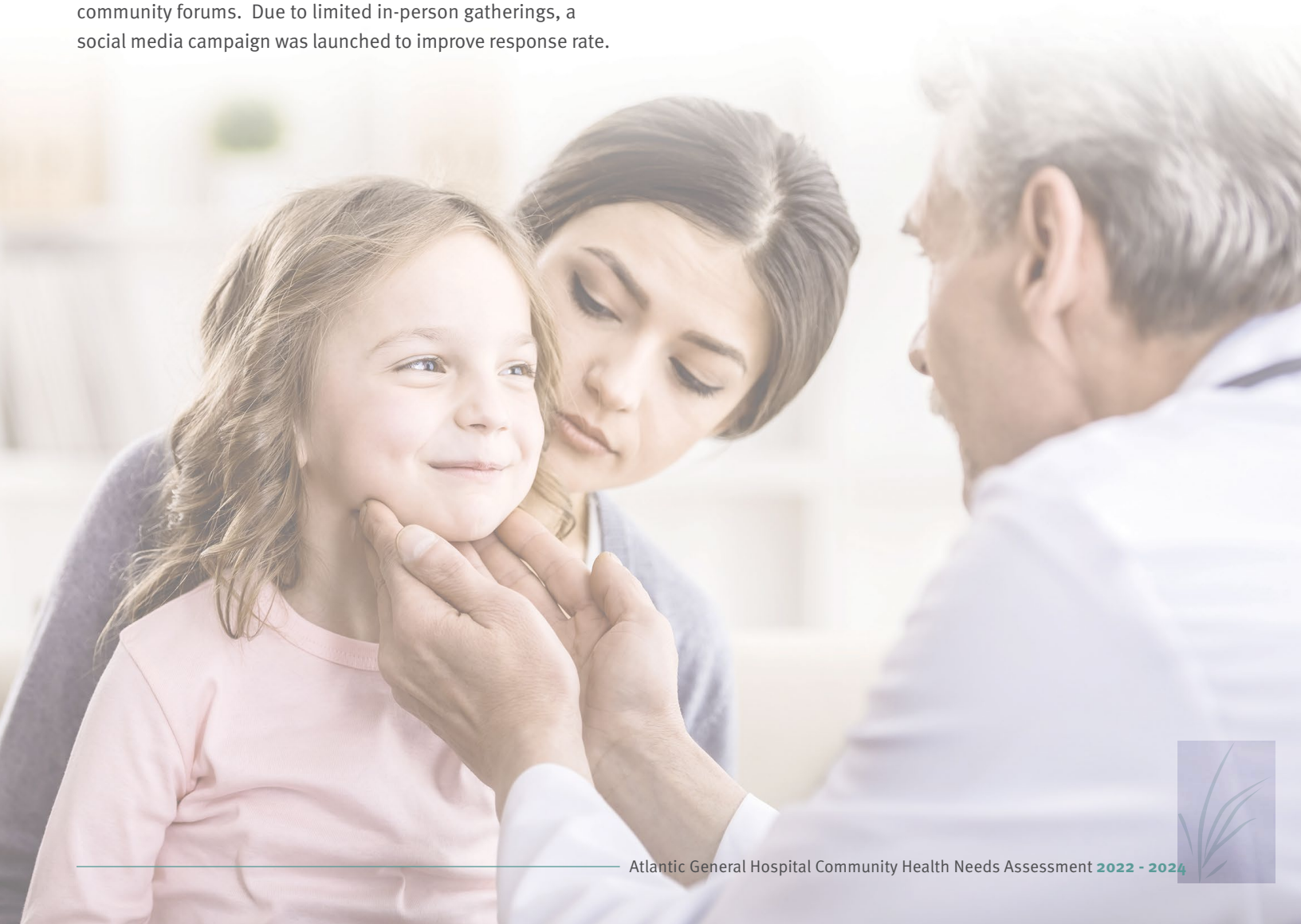
The survey was designed to obtain feedback from the community about health-related concerns. It was administered via paper at FLU clinics, COVID-19 Vaccine clinics, community groups and churches. Through the Internet, an electronic form of the survey was administered through a link that was prominently placed on AGH websites and other advertised community forums. Due to limited in-person gatherings, a social media campaign was launched to improve response rate.

Maryland State Health Improvement Process (SHIP) Plan

Maryland's State Health Improvement Plan (SHIP) provides a framework for continual progress toward a healthier Maryland. The SHIP includes 39 measures in six focus areas that represent what it means for Maryland to be healthy. Each measure has a data source and a target and, where possible, can be assessed at the county level. Detailed information is provided for each objective, organized by Vision Areas, (healthy beginnings, healthy living, healthy communities, access to healthcare and quality preventive care).

2021 County Health Outcomes & Roadmaps

County Health Rankings measure and compare the health of counties/cities within a state. Four types of health factors are measured and compared: health behaviors, clinical care, social and economic, and physical environment factors. Health outcomes are used to rank the overall health of each county and city.



Community Health Needs Assessment Survey Results

The Community Health Needs Assessment survey was distributed by community outreach personnel and the Atlantic General Hospital website. Stakeholder interviews, public forums and focus groups were conducted by the Population Health Department. Community surveys represent information that is self-reported.

Top Health Concerns

The top health concerns among 2021 survey respondents were prioritized as follows:

- #1 High Blood Pressure / Stroke
- #2 Overweight / Obesity
- #3 Diabetes / Sugar
- #4 Cancer
- #5 Heart Disease
- #6 Smoking, Drug or Alcohol Use
- #7 Mental Health Issues *(depression, anxiety)*
- #8 Access to Healthcare / No Health Insurance
- #9 Asthma / Lung Disease
- #10 Dental Health

Top Health Concern Priorities Over the (4) CHNA

	2012	2015	2018	2021
High Blood Pressure / Stroke	6	6	7	1
Overweight / Obesity	3	2	3	2
Diabetes / Sugar	4	3	2	3
Cancer	1	1	1	4
Heart Disease	2	4	5	5
Smoking, Drug or Alcohol Use	5	5	4	6
Mental Health	7	7	6	7
Access to Healthcare No Health Insurance	8	8	8	8
Asthma / Lung Disease	9	9	10	9
Dental Health	10	10	9	10
Injuries	11	11	11	11
Infectious Disease	NA	NA	NA	12
Sexually Transmitted Disease & HIV	12	12	12	13

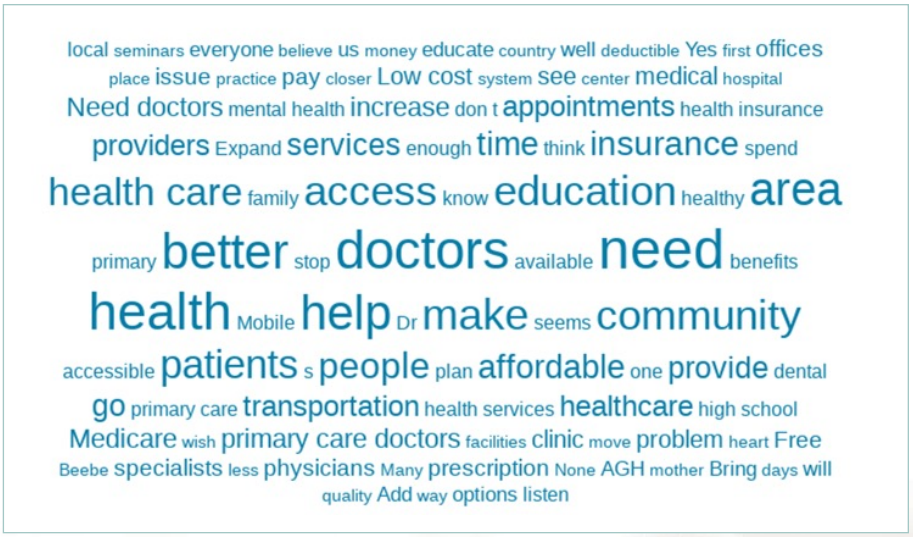
Top Barriers to Healthcare

What do you think are the problems that keep you or other community members from getting the healthcare they need?

Answer Choices	Responses
Too expensive/cannot afford	54.50%
No health insurance	51.08%
Couldn't get an appointment with my doctor	29.32%
No transportation	22.66%
Service is not available in our community	17.27%
Local doctors are not on my insurance plan	15.83%
Other	13.31%
Doctor is too far away from my home	11.15%

Written Responses

Q9 Do you have any ideas or recommendations to help decrease the health problems in our community or to solve the problems with access to health services?



Social Determinants of Health

What are social determinants of health?

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

SDOH can be grouped into 5 domains:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

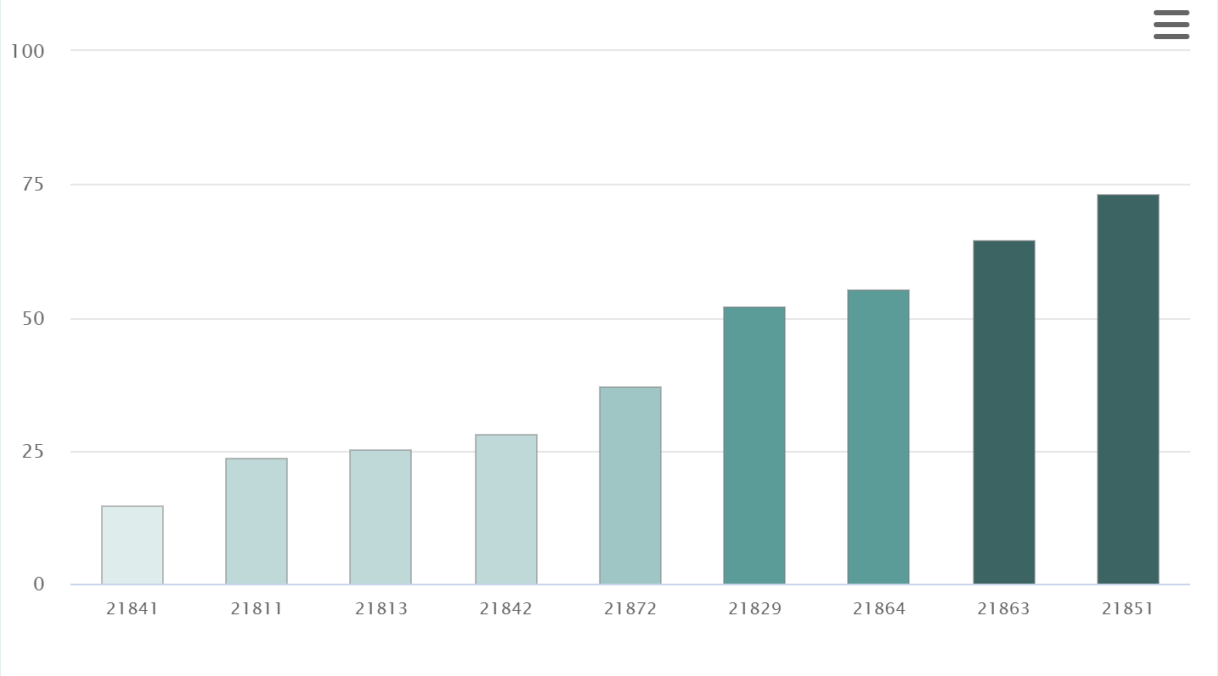
**Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 3/3/2022, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health*

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

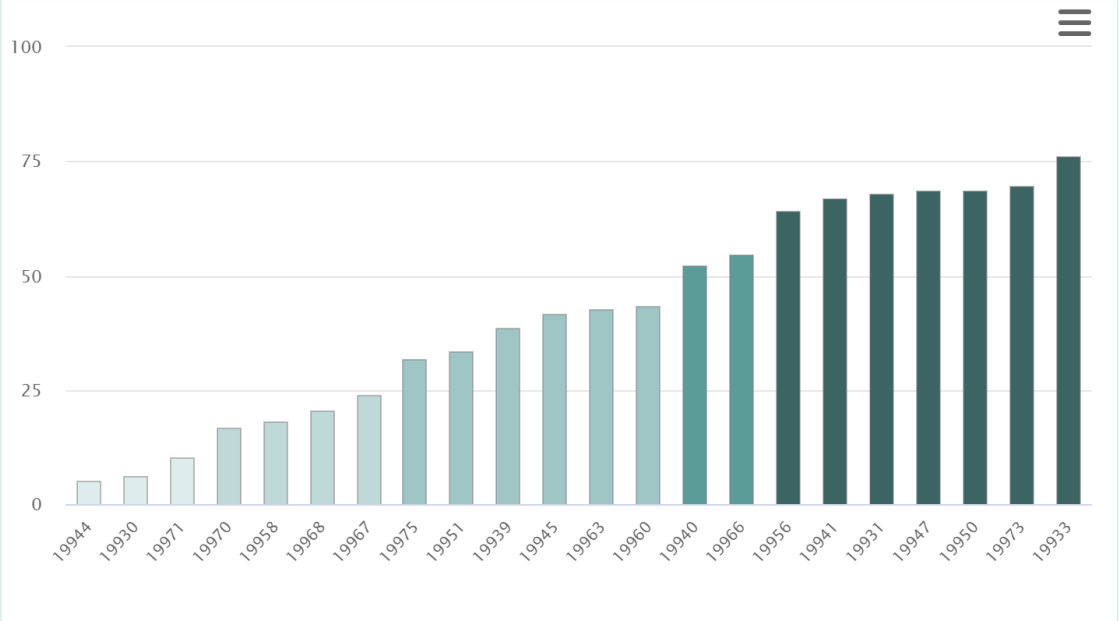
The 2021 SocioNeeds Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes. All zip codes, census tracts, counties and county equivalents in the United States are given an index value from 0 (low need) to 100 (high need). The selected locations are ranked from 1 (low need) to 5 (high need) based on their index value.

County: Worcester, MD Index Data: Zip Code



Zip Code	Index	Rank	Pop.	County
21851	73.1	5	6,827	Worcester, MD
21863	64.6	5	4,657	Worcester, MD
21864	55.3	4	554	Worcester, MD
21829	52.1	4	503	Worcester, MD
21872	37.0	3	658	Worcester, MD
21842	28.0	2	13,237	Worcester, MD
21813	25.3	2	2,685	Worcester, MD
21811	23.5	2	22,633	Worcester, MD
21841	14.7	1	882	Worcester, MD

County: Sussex, DE Index Data: Zip Code



Zip Code	Index	Rank	Pop.	County
19941	66.8	5	3,032	Sussex, DE
19956	64.0	5	16,801	Sussex, DE
19966	54.5	4	32,035	Sussex, DE
19940	52.3	4	6,500	Sussex, DE
19960	43.4	3	7,674	Sussex, DE
19963	42.6	3	21,090	Sussex, DE
19945	41.7	3	8,465	Sussex, DE
19939	38.4	3	7,500	Sussex, DE
19951	33.5	3	1,682	Sussex, DE
19975	**31.6**	**3**	**10,281**	**Sussex, DE**
19967	23.8	2	1,988	Sussex, DE
19968	20.5	2	13,683	Sussex, DE
19958	18.1	2	24,834	Sussex, DE
19970	16.7	2	7,930	Sussex, DE
19971	10.1	1	16,508	Sussex, DE
19930	6.1	1	3,584	Sussex, DE
19944	5.0	1	779	Sussex, DE

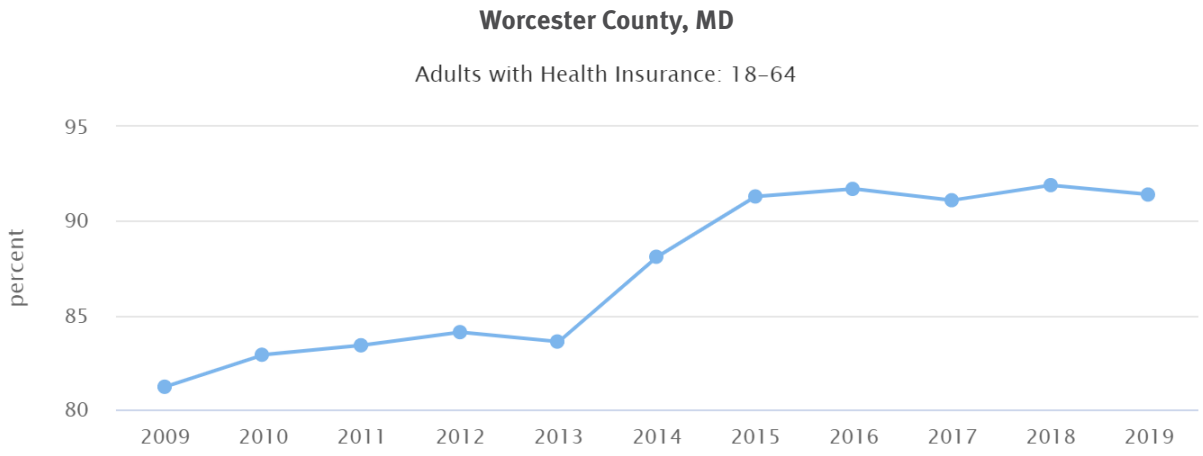
Impact of Previous Actions Taken

2018-2021 Community Needs

The community needs prioritized in previous CHNAs include: access to care, heart disease and stroke, cancer, respiratory disease (including smoking), nutrition, physical activity and weight, diabetes, opioid abuse, arthritis, osteoporosis and chronic back pain, and behavioral health. The identified needs were prioritized based on the following criteria: size and severity of the problem, health systems' ability to impact, and availability of resources that exist. The goal and actions taken are found in the associated Implementation Plans *(Appendix F)*.

Community Health Progress

Priority Area: Access to Health Services



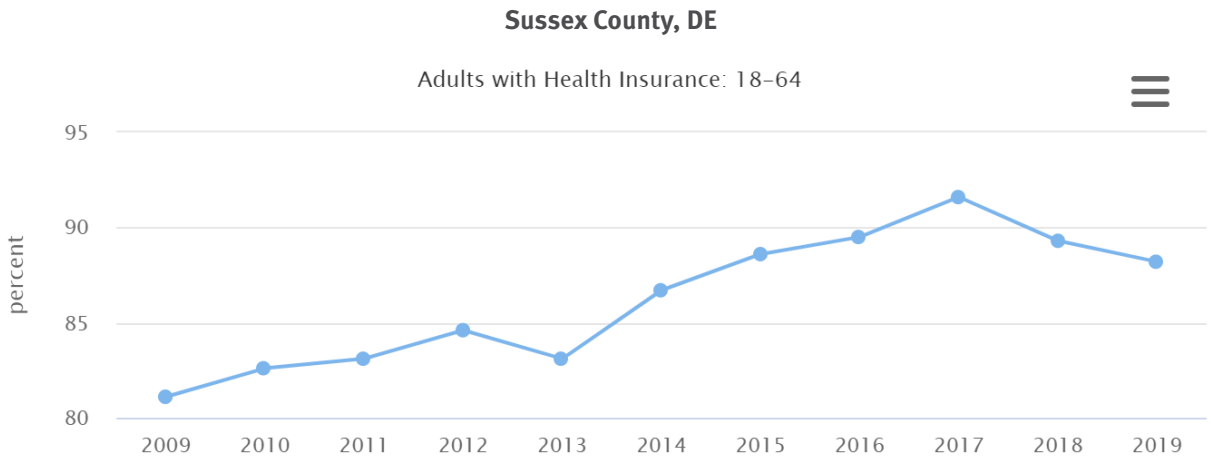
Persons with Health Insurance

92.6%

(2019)

HP 2020 Target (100.0%)

HP 2030 Target (92.1%)



88.2%

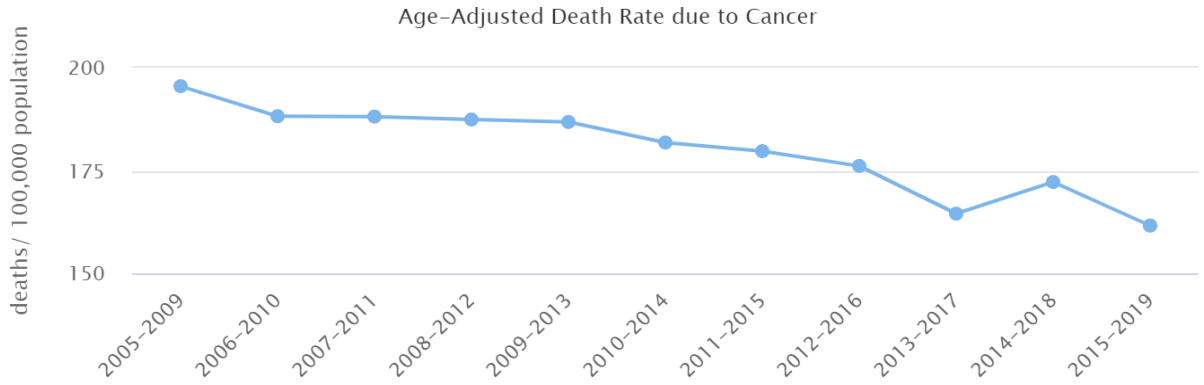
Source: U.S. Census Bureau - Small Area Health Insurance Estimates
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: August 2021
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties	DE Value	Prior Value	Trend
	(90.9%)	(89.3%)	

HP 2020 Target
(100.0%)

Worcester County, MD



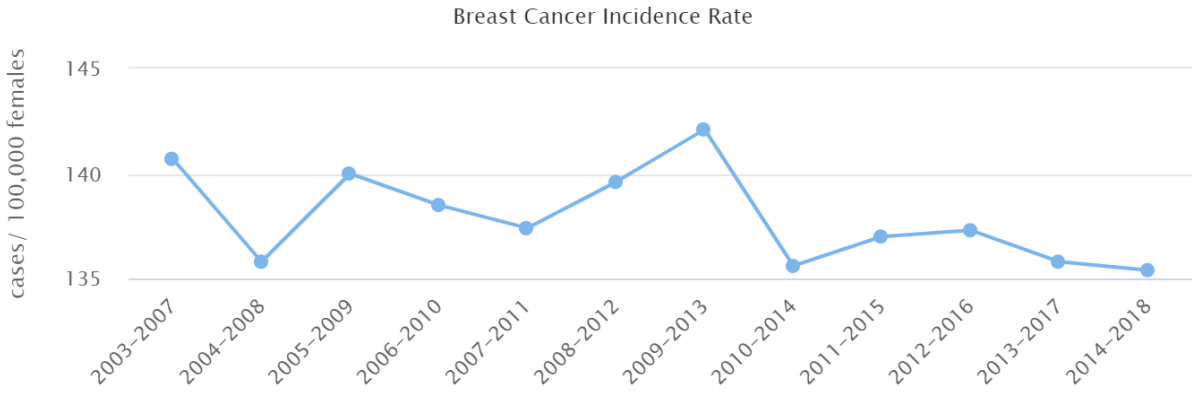
161.6

deaths/ 100,000 population

Source: National Cancer Institute
Measurement period: 2015-2019
Maintained by: Conduent Healthy Communities Institute
Last update: December 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value (151.5)	US Value (152.4)
Prior Value (172.2)	Trend	Maryland SHIP 2017 (147.4)	Maryland SHIP 2014 (169.2)
HP 2020 Target (161.4)	HP 2030 Target (122.7)		



135.4

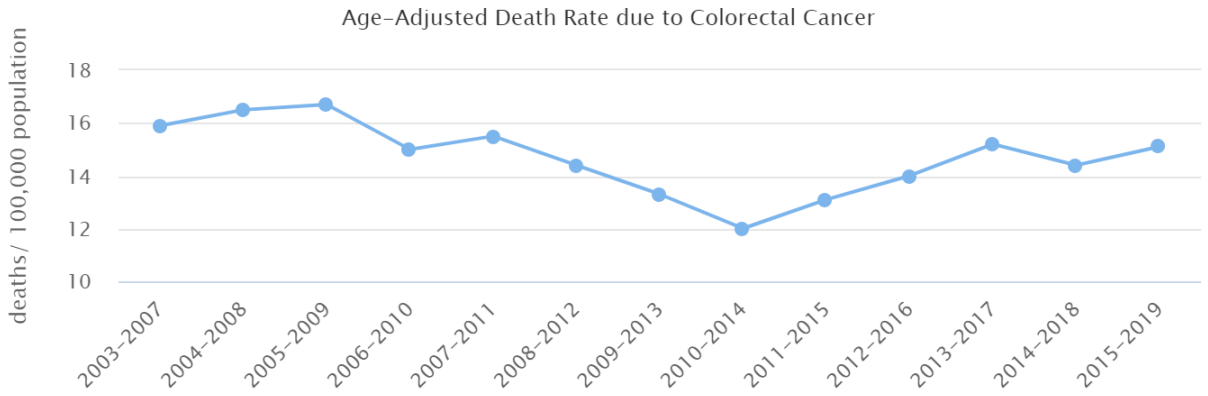
cases/ 100,000 females

Source: National Cancer Institute
Measurement period: 2014-2018
Maintained by: Conduent Healthy Communities Institute
Last update: December 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value	US Value
		(132.2)	(126.8)

Prior Value	Trend
(135.8)	



15.1

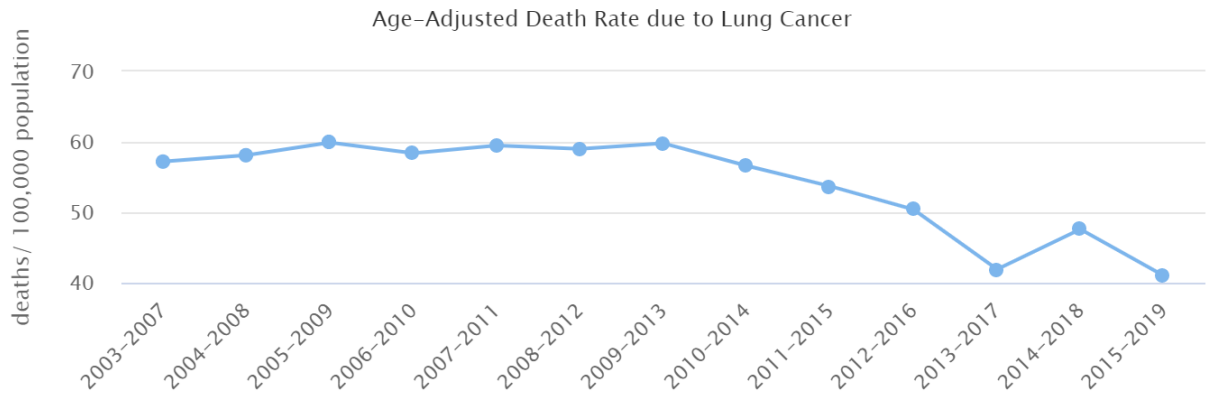
deaths/ 100,000 population

Source: National Cancer Institute
Measurement period: 2015-2019
Maintained by: Conduent Healthy Communities Institute
Last update: December 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value	US Value
		(13.4)	(13.4)

Prior Value	Trend	HP 2020 Target	HP 2030 Target
(14.4)		(14.5)	(8.9)



41.0

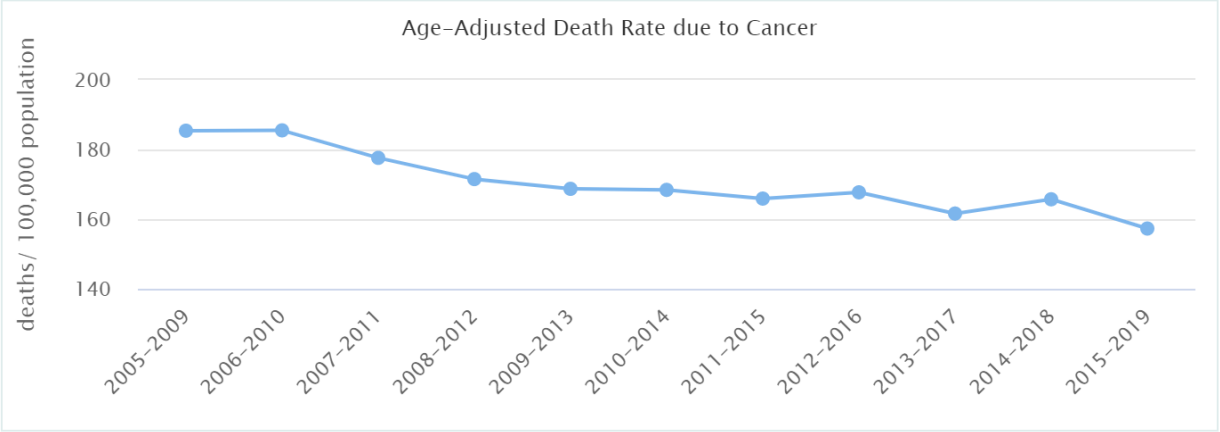
deaths/ 100,000 population

Source: National Cancer Institute
Measurement period: 2015-2019
Maintained by: Conduent Healthy Communities Institute
Last update: December 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value (35.2)	US Value (36.7)
Prior Value (47.6)	Trend	HP 2020 Target (45.5)	HP 2030 Target (25.1)

Sussex County, DE



157.3

deaths/ 100,000 population

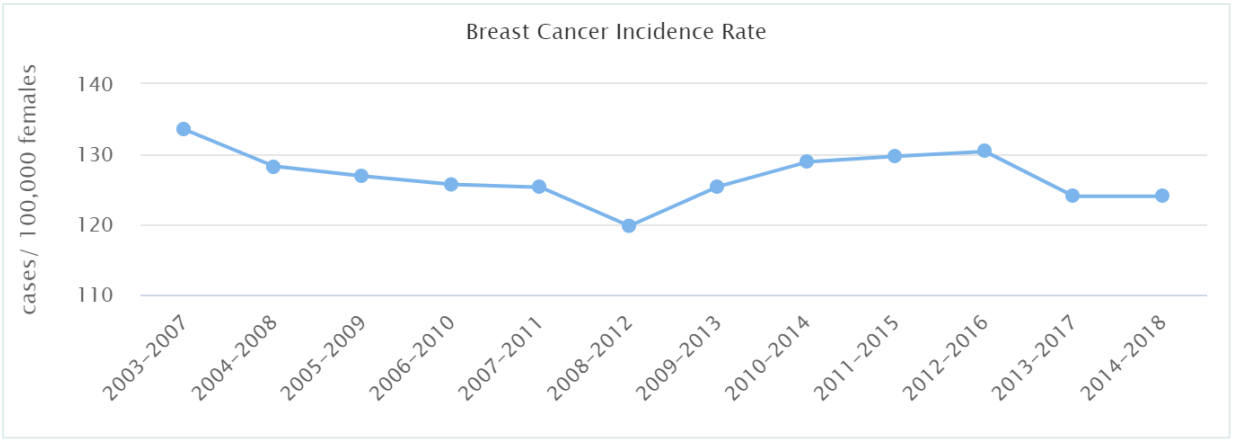
Source: National Cancer Institute
Measurement period: 2015-2019
Maintained by: Conduent Healthy Communities Institute
Last update: December 2021
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties	DE Value	US Value	Prior Value
	(161.5)	(152.4)	(165.7)

Trend	Maryland SHIP 2017	Maryland SHIP 2014	HP 2020 Target
	(147.4)	(169.2)	(161.4)

HP 2030 Target
(122.7)



124.0

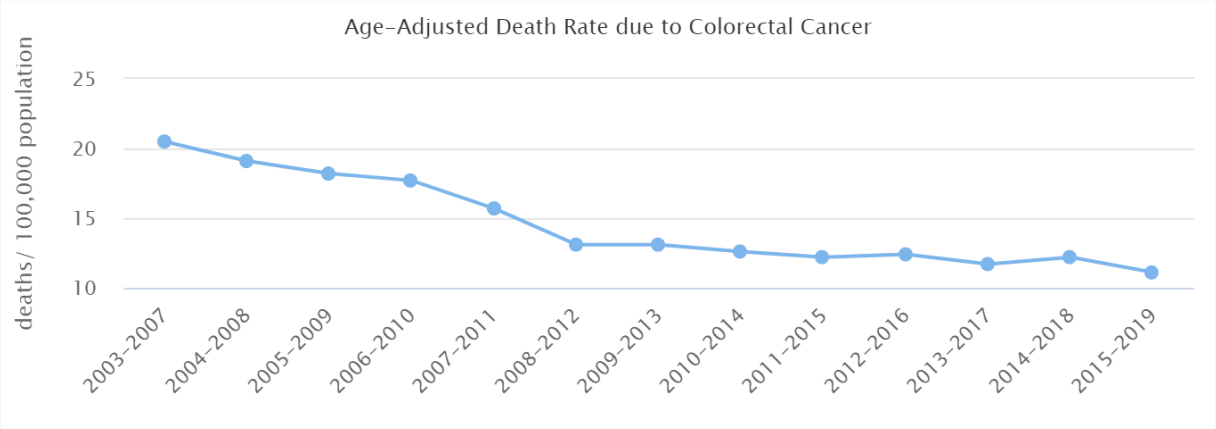
cases/ 100,000 females

Source: National Cancer Institute
Measurement period: 2014-2018
Maintained by: Conduent Healthy Communities Institute
Last update: December 2021
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties	DE Value	US Value	Prior Value
	(133.7)	(126.8)	(124.0)

Trend



11.1

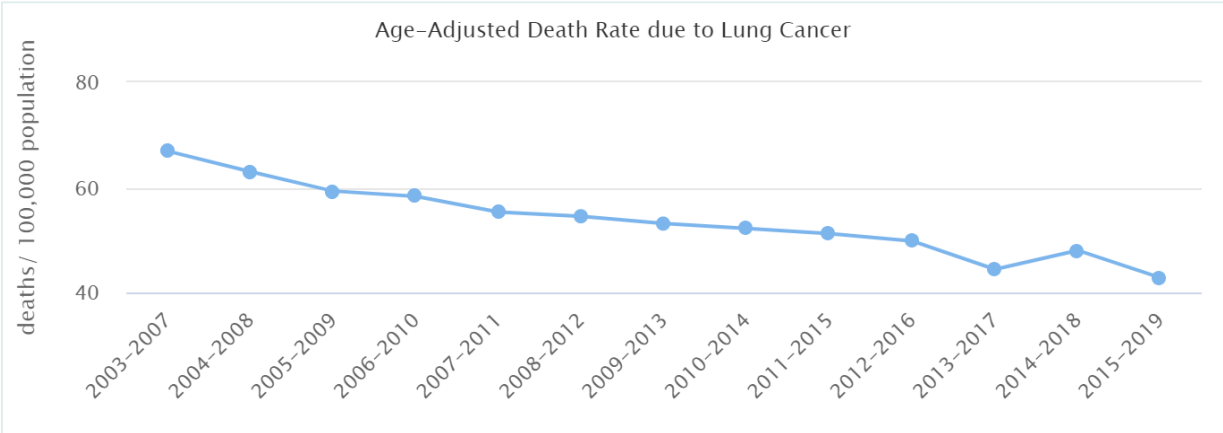
deaths/ 100,000 population

Source: National Cancer Institute
Measurement period: 2015-2019
Maintained by: Conduent Healthy Communities Institute
Last update: December 2021
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties	DE Value	US Value	Prior Value
	(13.1)	(13.4)	(12.2)

Trend	HP 2020 Target	HP 2030 Target
	(14.5)	(8.9)



Priority Area: Cancer, *cont.*

42.8

deaths/ 100,000 population

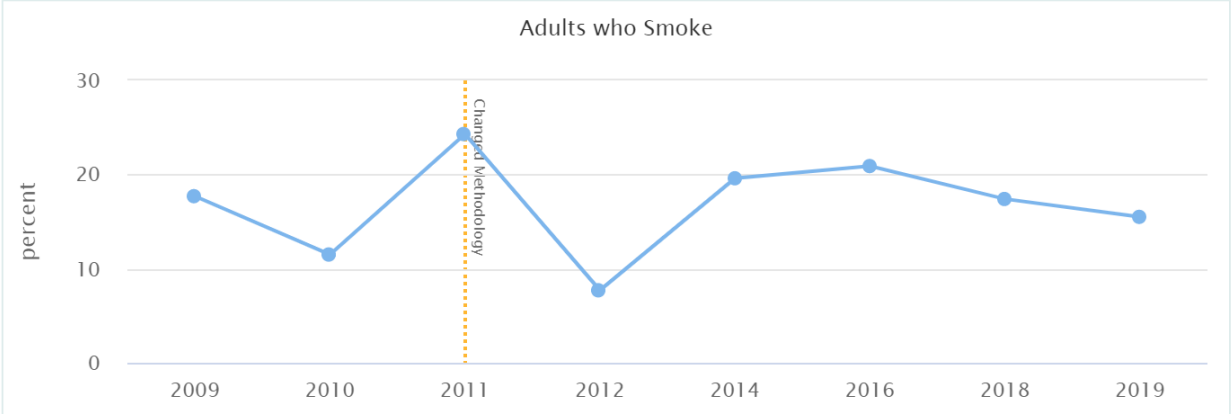
Source: National Cancer Institute
Measurement period: 2015-2019
Maintained by: Conduent Healthy Communities Institute
Last update: December 2021
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties	DE Value (41.1)	US Value (36.7)	Prior Value (48.0)
Trend	HP 2020 Target (45.5)	HP 2030 Target (25.1)	

Priority Area: Respiratory Disease, including Smoking

Worcester County, MD

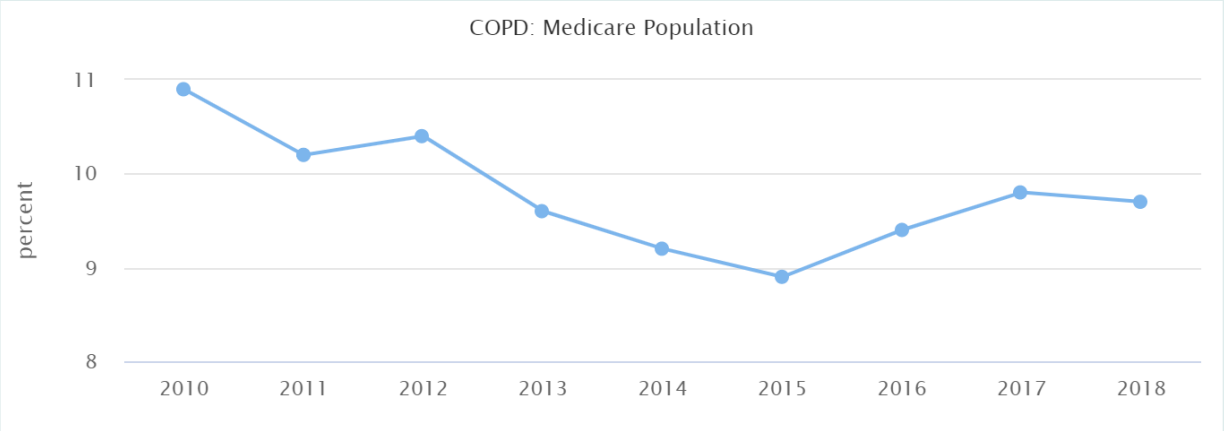


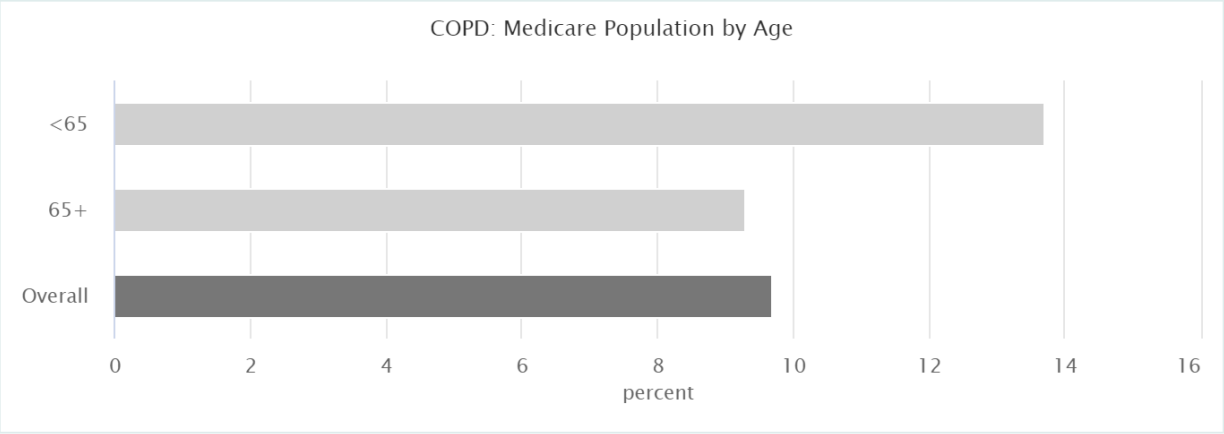
15.5%

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value (13.1%)	US Value (16.0%)	Prior Value (17.4%)
Trend	Maryland SHIP 2017 (15.5%)	Maryland SHIP 2014 (14.4%)	HP 2020 Target (12.0%)
HP 2030 Target (5.0%)			



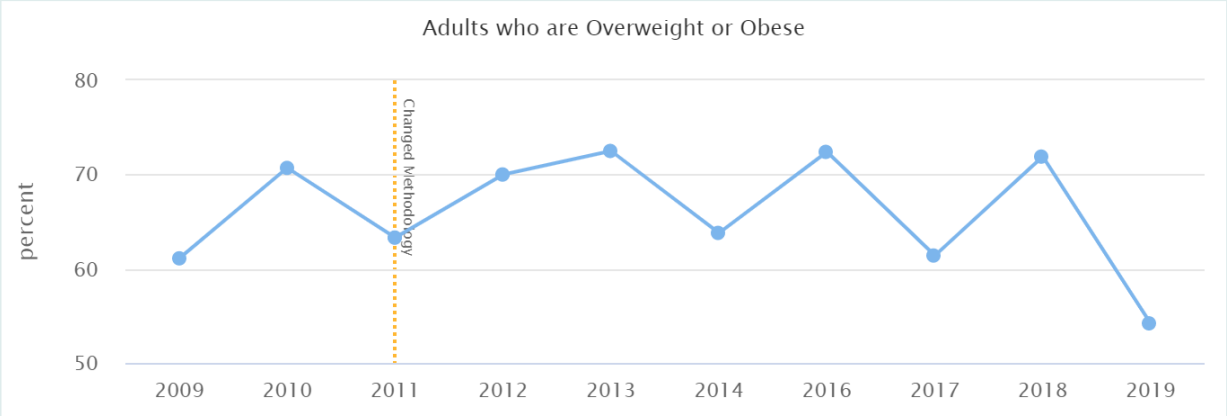


Sussex County, DE

Health / Tobacco Use

	VALUE	COMPARED TO:	
Adults who Smoke	18.8% (2019)	HP 2020 Target (12.0%)	HP 2030 Target (5.0%)

Worcester County, MD



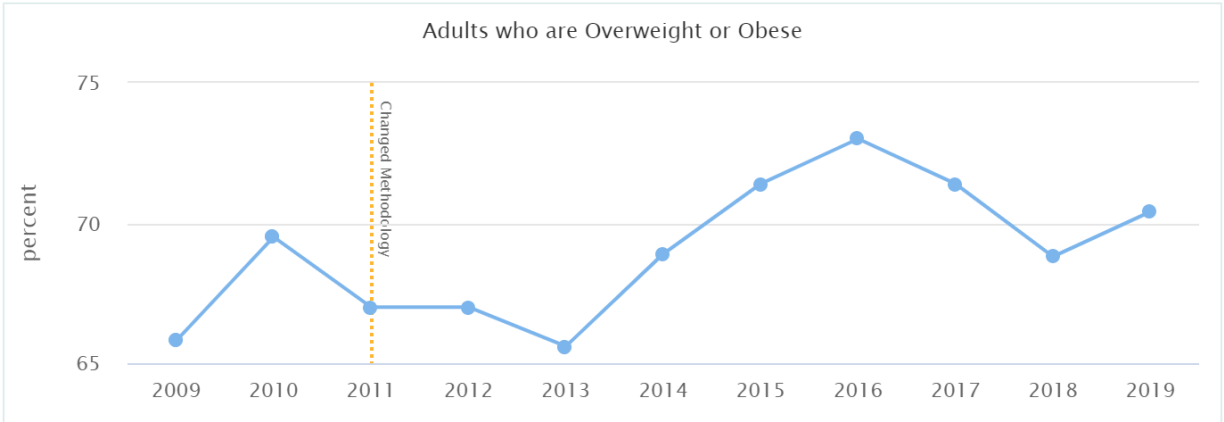
54.2%

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value (66.1%)	US Value (66.7%)	Prior Value (71.9%)
Trend			

Sussex County, DE



Priority Area: Nutrition, Physical Activity & Weight, *cont.*

70.4%

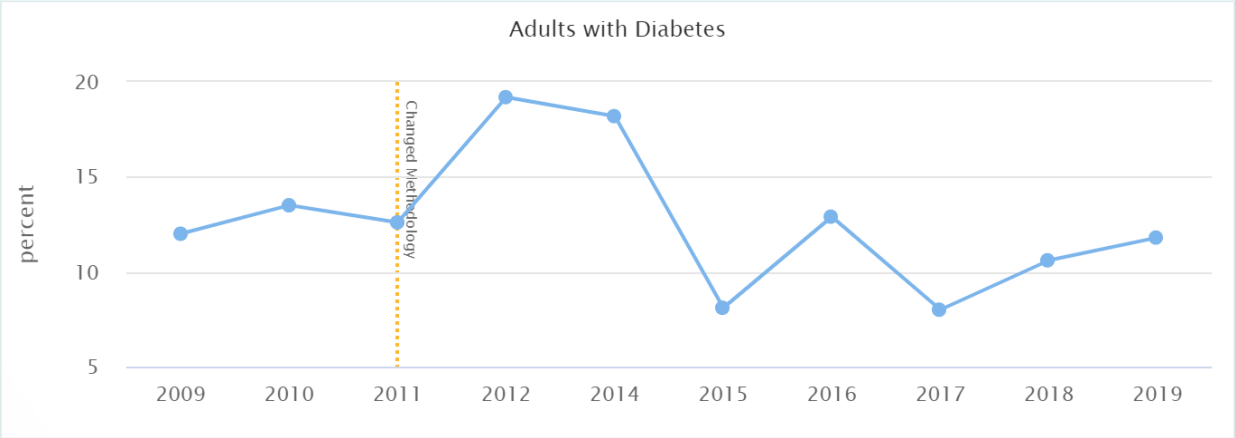
Source: Behavioral Risk Factor Surveillance System
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: June 2021
Filter(s) for this location: State: Delaware

COMPARED TO

DE Value	US Value	Prior Value	Trend
(68.9%)	(66.7%)	(68.8%)	

Priority Area: Diabetes

Worcester County, MD



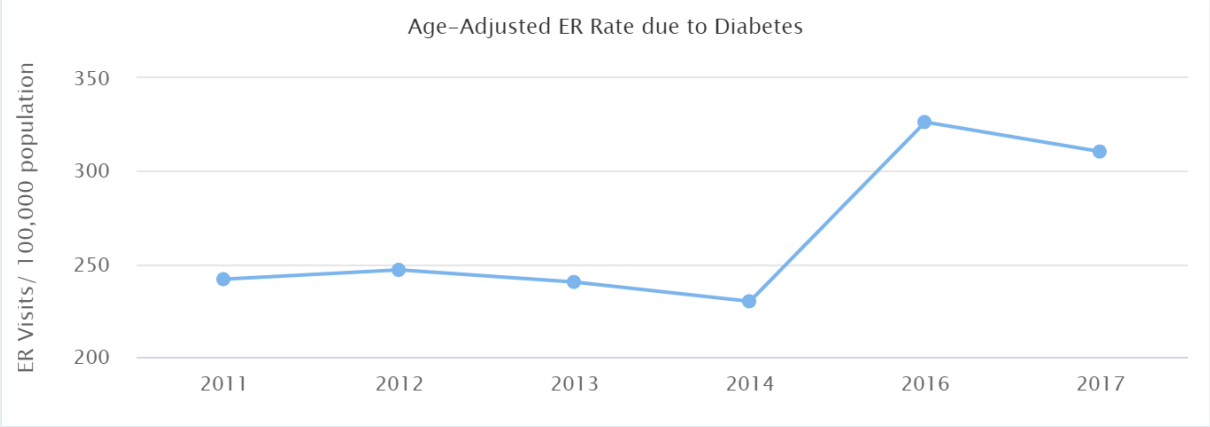
11.8%

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value	US Value	Prior Value
	(10.0%)	(10.7%)	(10.6%)

Trend



310.5

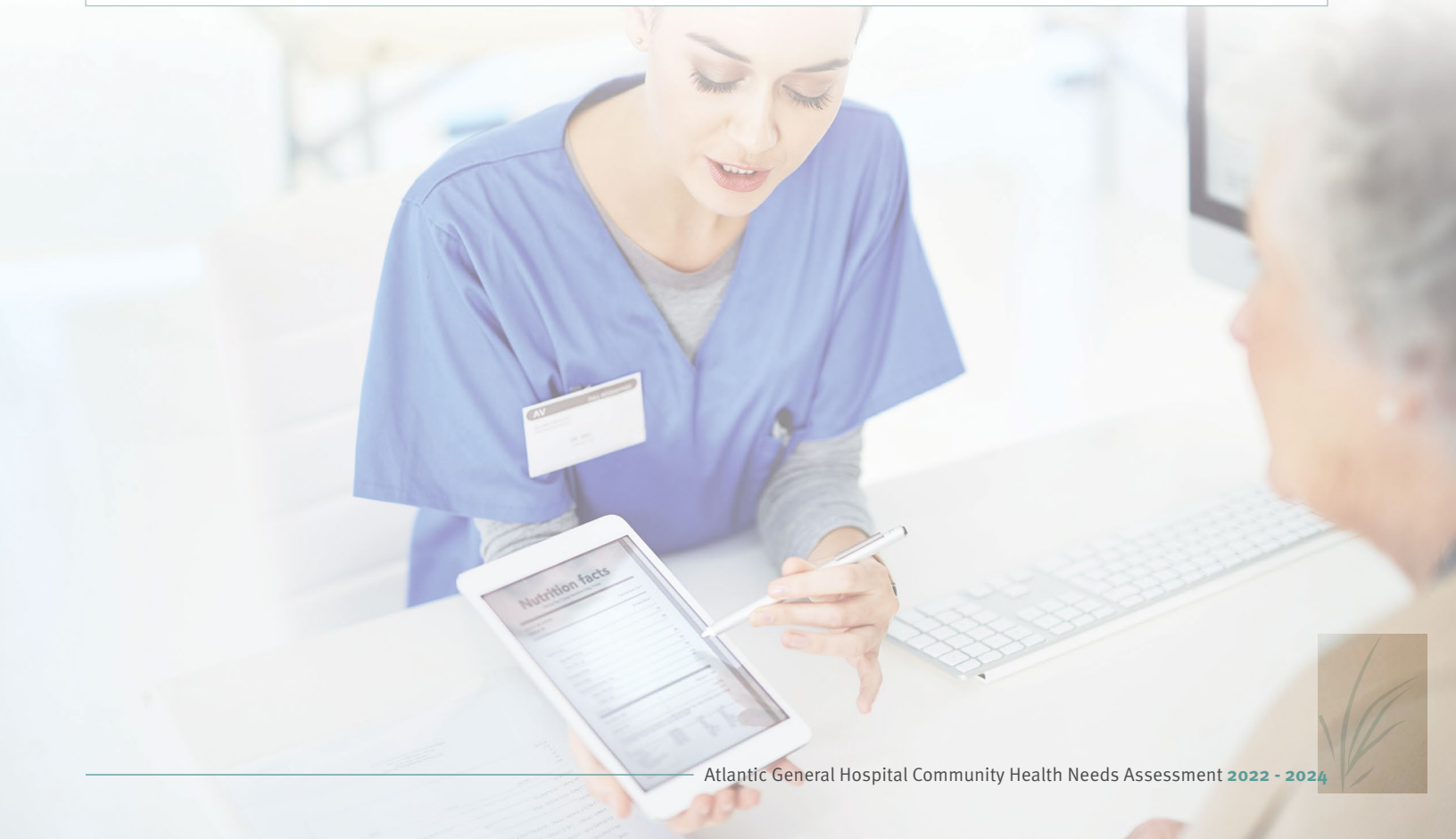
ER Visits/ 100,000 population

Source: Maryland Department of Health
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: May 2019
Filter(s) for this location: State: Maryland

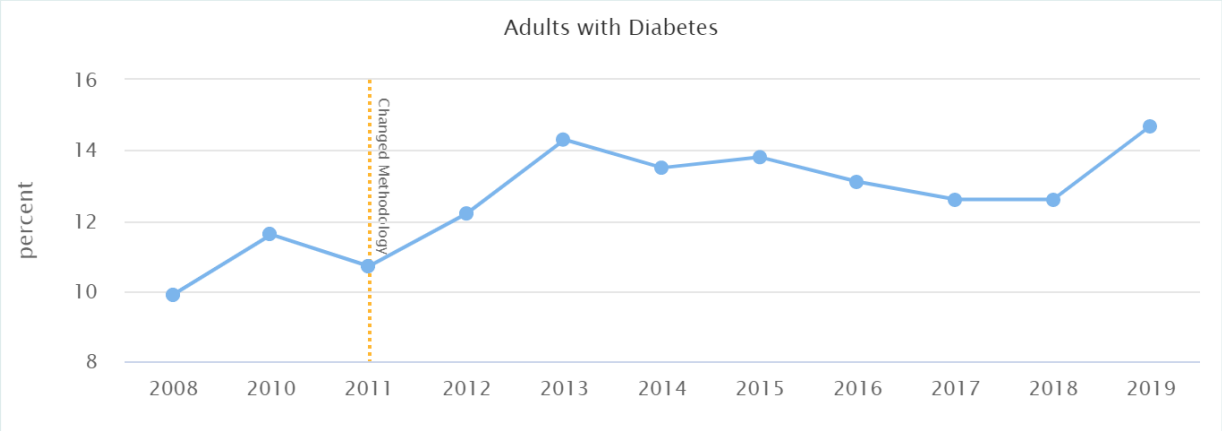
COMPARED TO

MD Counties	MD Value	Prior Value	Trend
	(243.7)	(326.4)	

Maryland SHIP 2017	Maryland SHIP 2014
(186.3)	(300.2)



Sussex County, DE



14.7%

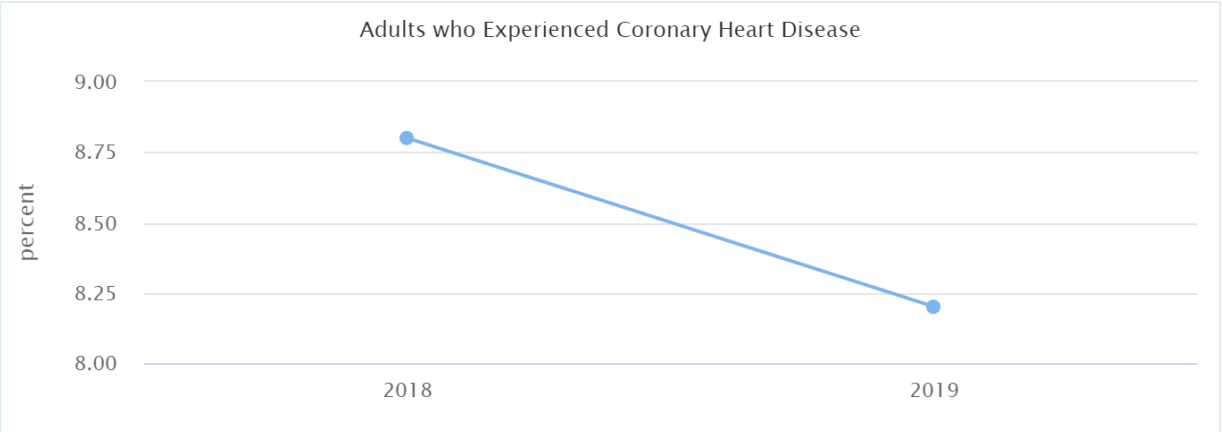
COMPARED TO

DE Value	US Value	Prior Value	Trend
(12.8%)	(10.7%)	(12.6%)	

Source: Behavioral Risk Factor Surveillance System
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: June 2021
Filter(s) for this location: State: Delaware

Priority Area: Heart Disease & Stroke

Worcester County, MD



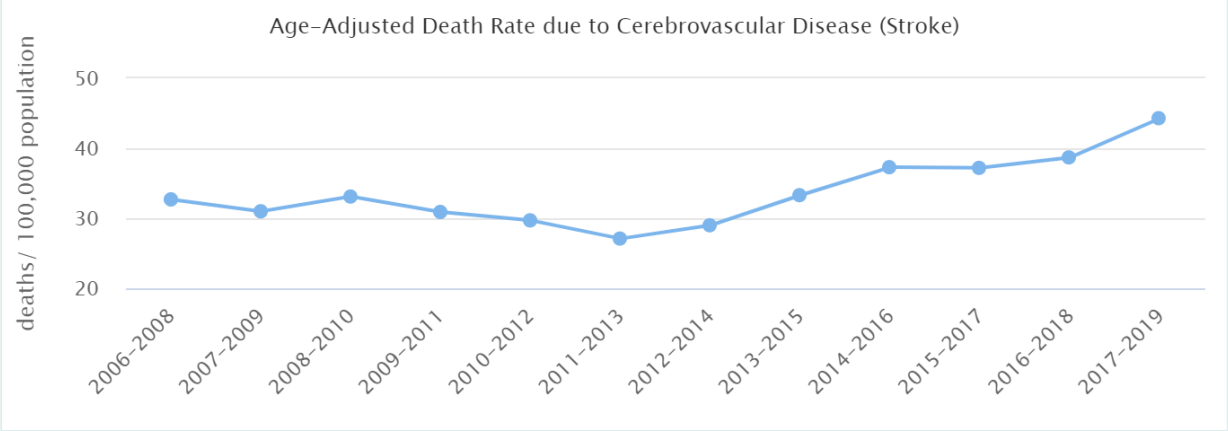
8.2%

Source: CDC - PLACES
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: January 2022
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	US Value (6.2%)	Prior Value (8.8%)

Technical note: Sub-county small area estimates use state and county data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) in tandem with demographic data for census tracts and cities. It is not appropriate to use this data for evaluation purposes.



44.3

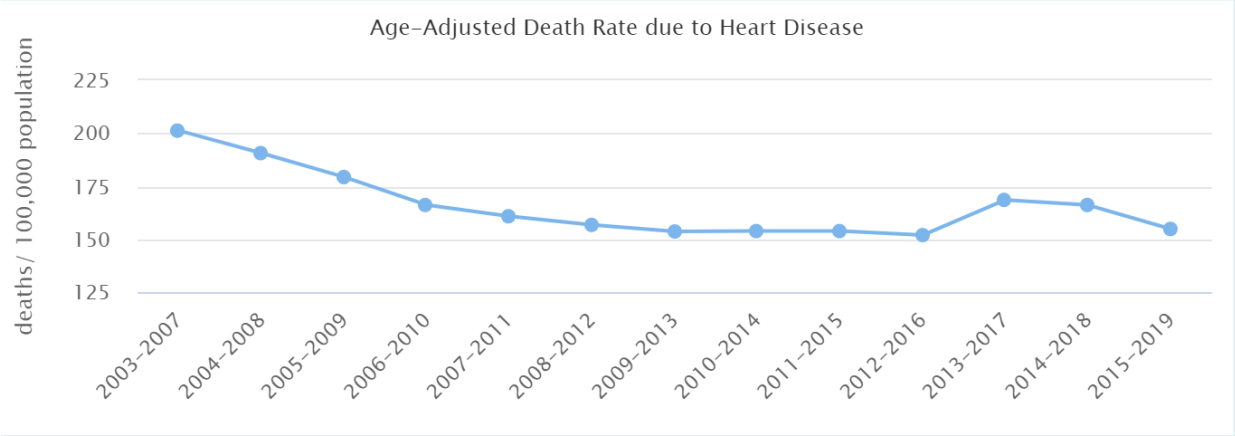
deaths/ 100,000 population

Source: Maryland Department of Health
Measurement period: 2017-2019
Maintained by: Conduent Healthy Communities Institute
Last update: June 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value (40.7)	US Value (37.2)	Prior Value (38.7)
Trend	HP 2020 Target (34.8)	HP 2030 Target (33.4)	

Sussex County, DE



154.8

deaths/ 100,000 population

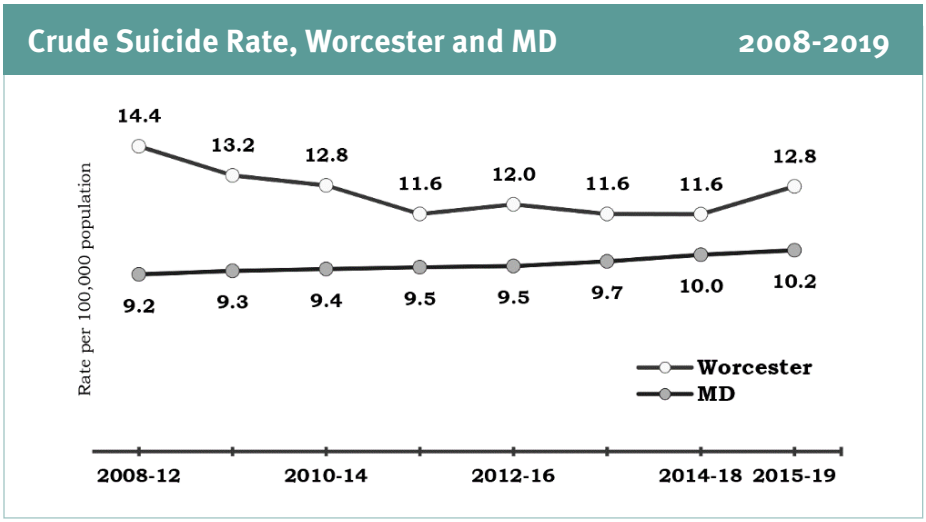
Source: Delaware Department of Health and Social Services, Division of Public Health
Measurement period: 2015-2019
Maintained by: Conduent Healthy Communities Institute
Last update: October 2021
Filter(s) for this location: State: Delaware

COMPARED TO

DE Value	US Value	Prior Value	Trend
(155.6)	(726.3)	(166.1)	

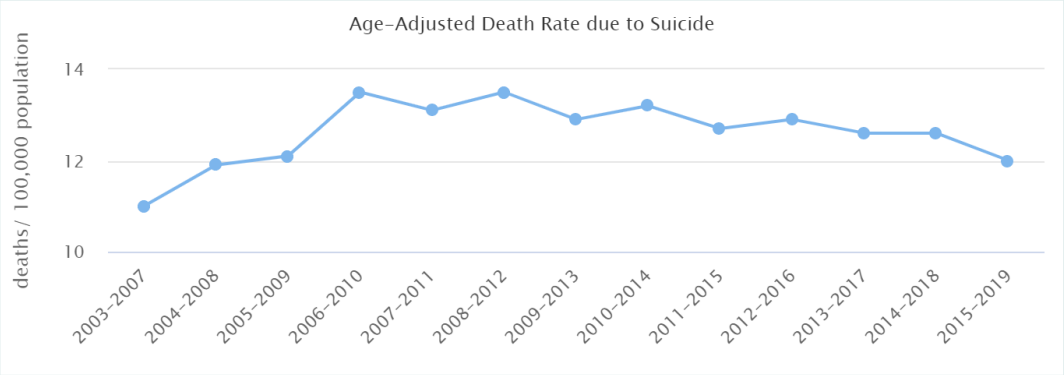
Maryland SHIP 2017	Maryland SHIP 2014
(166.3)	(173.4)

Worcester County, MD



Source: MD Vital Statistics Administration

Sussex County, DE



12.0

deaths/ 100,000 population

Source: Delaware Department of Health and Social Services, Division of Public Health
Measurement period: 2015-2019
Maintained by: Conduent Healthy Communities Institute
Last update: October 2021
Filter(s) for this location: State: Delaware

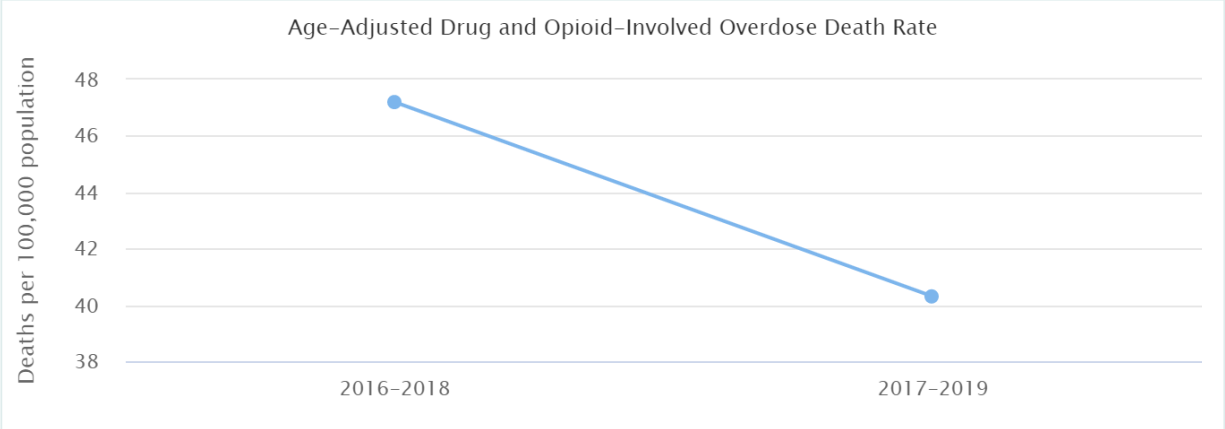
COMPARED TO

DE Value	US Value	Prior Value	Trend
(11.6)	(13.8)	(12.6)	

Maryland SHIP 2017	Maryland SHIP 2014	HP 2020 Target	HP 2030 Target
(9.0)	(9.1)	(10.2)	(12.8)

Priority Area: Opioid Abuse

Worcester County, MD



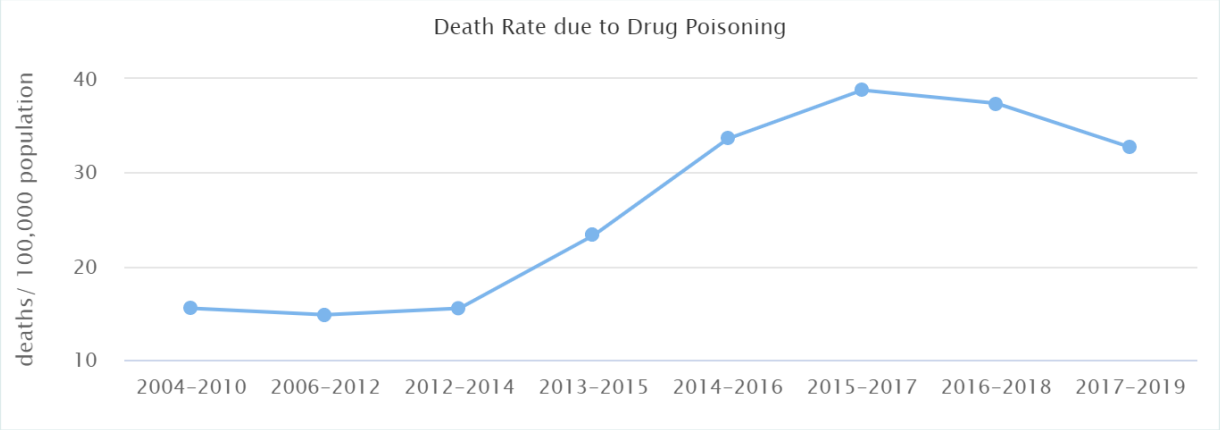
40.3

Deaths per 100,000 population

Source: Centers for Disease Control and Prevention
Measurement period: 2017-2019
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value	US Value	Prior Value
	(38.2)	(22.8)	(47.2)



32.7

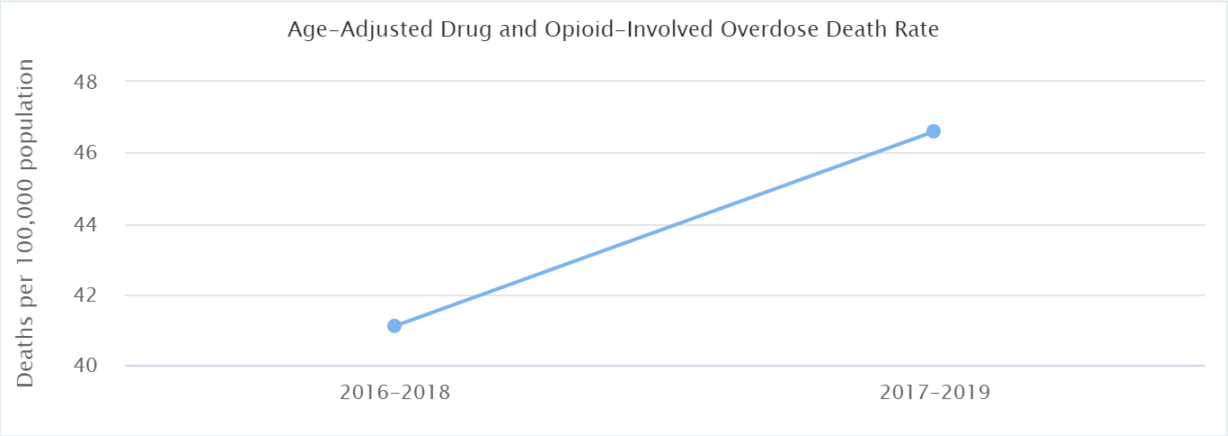
deaths/ 100,000 population

Source: County Health Rankings
Measurement period: 2017-2019
Maintained by: Conduent Healthy Communities Institute
Last update: May 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value	US Value	Prior Value	Trend
		(38.3)	(21.0)	(37.4)	

Sussex County, DE



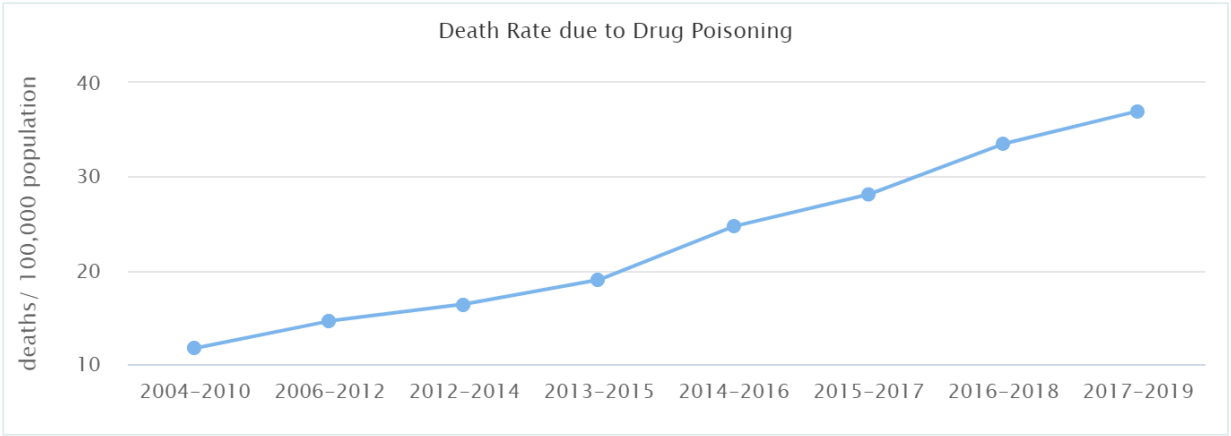
46.6

Deaths per 100,000 population

Source: Centers for Disease Control and Prevention
Measurement period: 2017-2019
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Delaware

COMPARED TO

DE Value	US Value	Prior Value
(43.8)	(22.8)	(41.1)



Priority Area: Opioid Abuse, *cont.*

37.0

deaths/ 100,000 population

Source: County Health Rankings
Measurement period: 2017-2019
Maintained by: Conduent Healthy Communities Institute
Last update: May 2021
Filter(s) for this location: State: Delaware

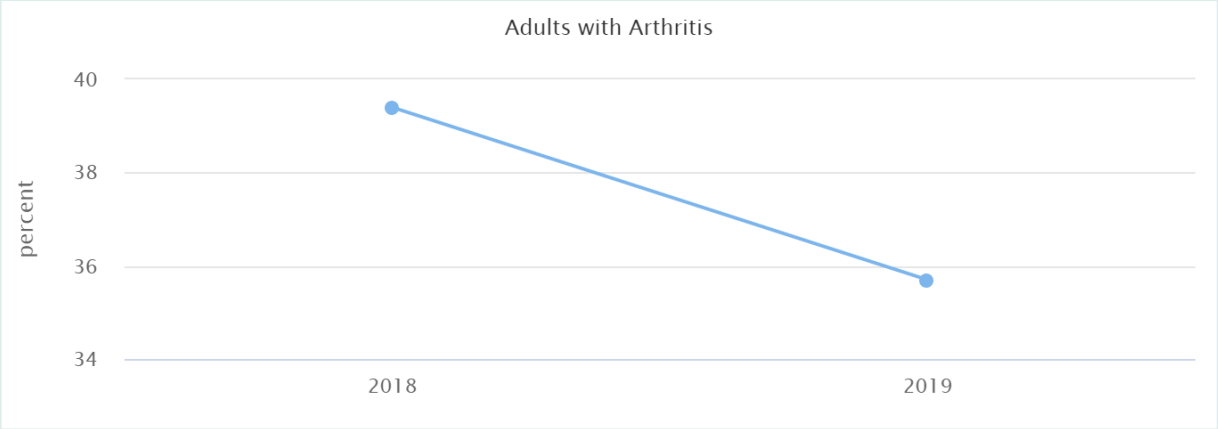
COMPARED TO

U.S. Counties	DE Value	US Value	Prior Value
	(40.4)	(21.0)	(33.5)

Trend

Priority Area: Arthritis, Osteoporosis & Chronic Back Pain

Worcester County, MD



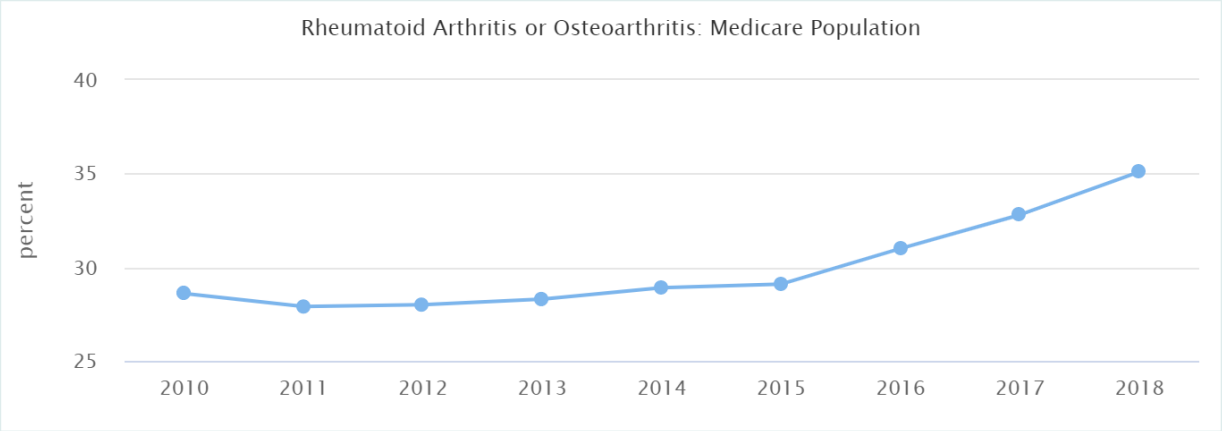
35.7%

Source: CDC - PLACES
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: January 2022
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	US Value	Prior Value
		(25.1%)	(39.4%)

Technical note: Sub-county small area estimates use state and county data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) in tandem with demographic data for census tracts and cities. It is not appropriate to use this data for evaluation purposes.



35.1%

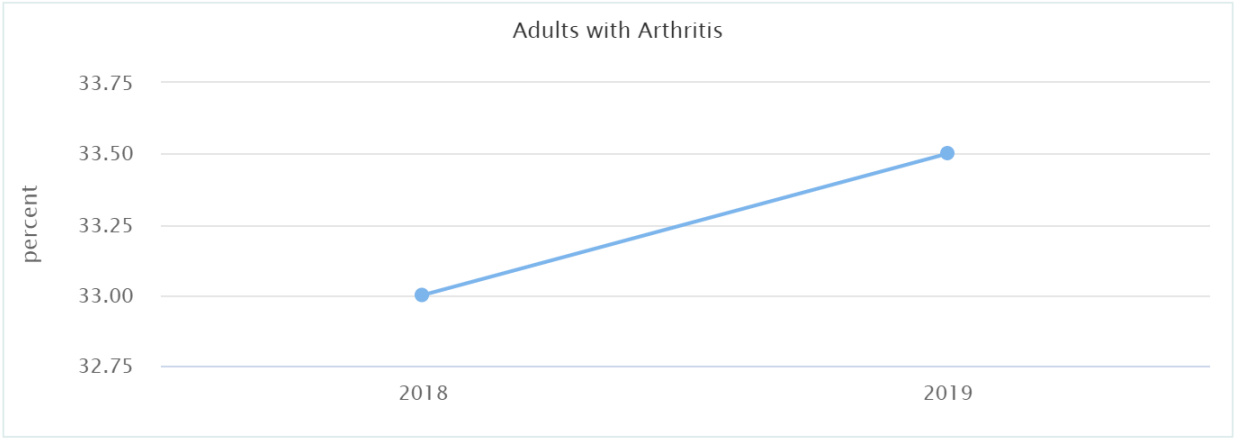
Source: Centers for Medicare & Medicaid Services
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value (34.6%)	US Value (33.5%)

Prior Value (32.8%)	Trend

Sussex County, DE



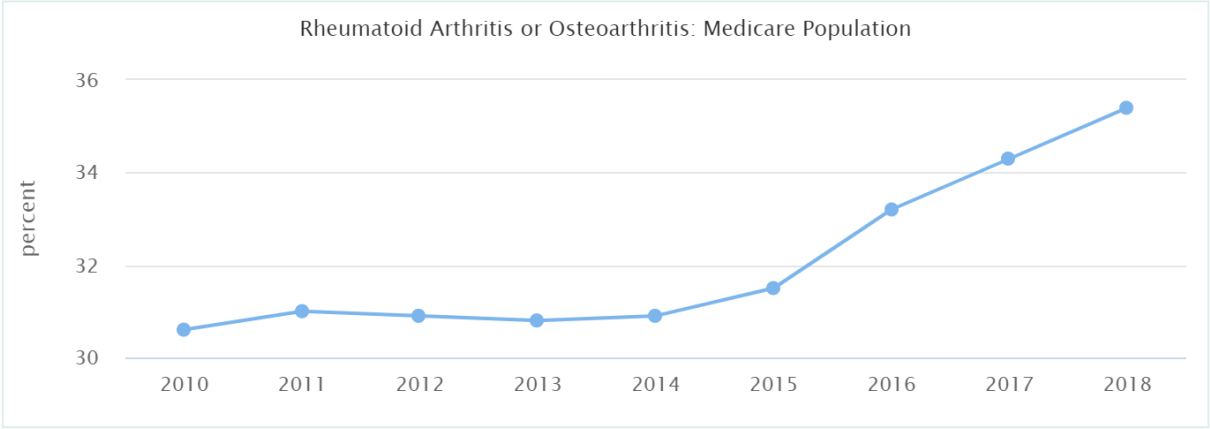
33.5%

Source: CDC - PLACES
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: January 2022
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties	US Value	Prior Value
	(25.1%)	(33.0%)

Technical note: Sub-county small area estimates use state and county data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) in tandem with demographic data for census tracts and cities. It is not appropriate to use this data for evaluation purposes.



35.4%

Source: Centers for Medicare & Medicaid Services
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties	DE Value	US Value	Prior Value
	(34.7%)	(33.5%)	(34.3%)

Trend

Community Benefit Priorities

Key findings from all resources were used as a framework to develop community benefit priorities. These are closely aligned with local, state, and national priority areas. The process for determining the priorities of the Community Outreach programs involves many people inside and outside the organization. AGH's strategic initiatives are determined by the Hospital Board of Trustees, the Medical Staff and the Leadership of the Hospital. Each year those long-term initiatives are evaluated and updated with environmental information, such as the most recent CHNA. In addition to input from those groups, there are additional committees that have a part in setting our priorities: the AGH Planning Committee, Patient & Family Advisory Committee, Community Benefits Committee, and Healthy Happenings Committee.

The Patient & Family Advisory Committee is made up of Hospital and community members who have a health connection in the community. Through this board, we are able to keep our pulse on the needs of the community.

Each department in the hospital has an appointee who sits on the Community Benefits Committee. The purpose of this committee is to oversee the Community Outreach of AGH and comply with the government regulations regarding reporting Community Benefits. Because the committee is made up of all departments, the views are varied. Annual evaluations of each initiative's success are found in the HSCRC Community Benefit Report provided to the State of Maryland.

AGH leaders are involved on many community boards and community entities (both for-profit and not-for-profit). Through these boards we are able to keep abreast of the underserved, low income and/or minority needs in the community. We are involved in the health departments throughout our service area in MD and DE. We coordinate services with them to decrease duplication of services and know what services are needed to fill the gaps. Working with the target areas of the state improvement initiatives influences the priorities we set. Our Population Health outreach providers are out in the community and are able to observe community needs. Through our Patient Centered Medical Home, Care Coordination models and Population Health Department, we are able to have another resource in the community which we can use for assisting us in setting priorities.

The 2022-2024 Community Benefit priorities are based on the criteria of:

- **Size and severity of the problem, determined by what percentage of the population is affected by risks**
- **Health System's ability to impact the need**
- **Availability of resources**
- **Social needs and health inequities**

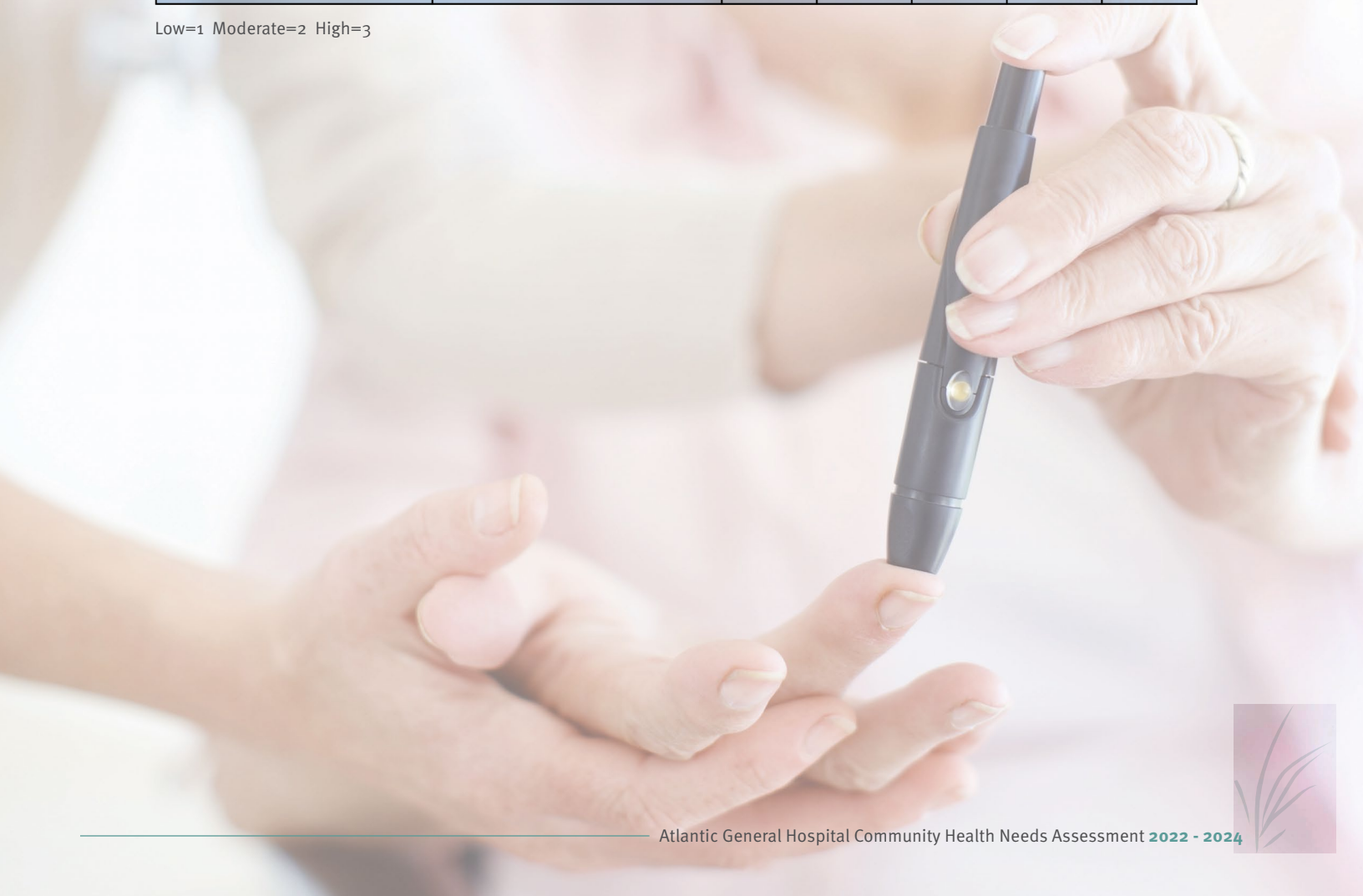
They were graded as high (3), moderate (2) and low (1) to rank the priority, based on self-reported survey data and prioritized as above.

County data and AGH-specific visit data for each of the identified needs were reviewed. In addition, committee feedback was considered in assigning the rankings. Health disparities and social determinants of health were also considered in the priority ranking. The identified needs were graded as high (3), moderate (2) and low (1) to rank the priority based on self-reported survey data and prioritized as above.

Community Health Needs Assessment Priorities

Health Need	Specific Opportunity	Size & Severity of Problem	AGH/S Abilty to Impact the Problem	Availability of Resources	Social Needs/Health Inequities	Impact Rating
High blood pressure/stroke		3	3	3	3	12
Diabetes/sugar	pre-diabetic screenings, education, medication	3	3	3	3	12
Mental Health issues	Depression, Anxiety	3	3	2	3	11
Smoking, drug or alcohol use	alcohol, opiates	3	2	3	3	11
Overweight/obesity	Access to healthy food	3	3	2	3	11
Cancer	Lung, Prostate (CRISP)	1	3	3	3	10
Heart Disease	HF, Afib (CRISP)	3	1	1	3	8

Low=1 Moderate=2 High=3



Vulnerable Populations and Disparities

According to the U.S. Health Resources and Services Administration, health disparities are defined as "population-specific differences in the presence of disease, health outcomes, or access to healthcare." Worcester County, MD residents 6-17 years of age are the largest age group with Healthcare Coverage in Maryland.

The age groups most likely to have health care coverage are 6-17 and 55-64, for men and women respectively. Nationally, 6-17 (for men) and 6-17 (for women) are the age groups most likely to have coverage. A closer look at health disparities in the area through the new Healthy Communities tool, which synthesizes data from several primary sources, provides a clear visual representation of many of the strengths and weakness evident in Worcester and Sussex Counties.

Males have a higher age-adjusted death rate due to cancer.

Improvement in age-adjusted death rate due to cancer in Black/African American Race/Ethnicity is moving from 239.2 to 180. Similar improvement trends in the Lung Cancer death rate are moving from 68.7 to 42.1.

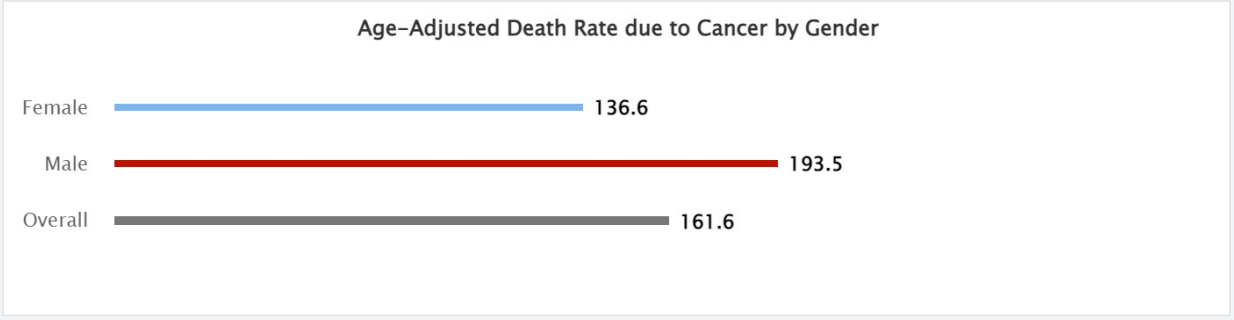
Age-Adjusted Death Rate due to Cancer

161.6

Deaths per 100,000 population

(2015-2019)

MD Counties	U.S. Counties	MD Value (151.5)
US Value (152.4)	Prior Value (172.2)	Trend
Maryland SHIP 2017 (147.4)	Maryland SHIP 2014 (169.2)	HP 2020 Target (161.4)
HP 2030 Target (122.7)		



Age-Adjusted Death Rate due to Lung Cancer

41.0

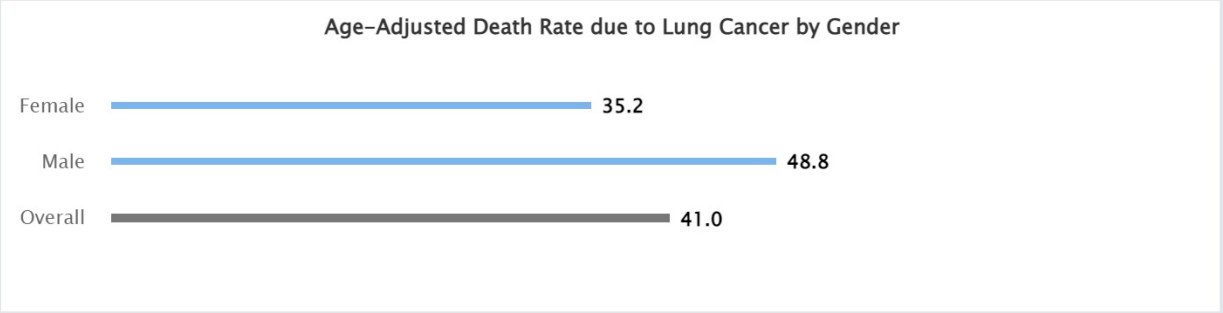
Deaths per 100,000 population

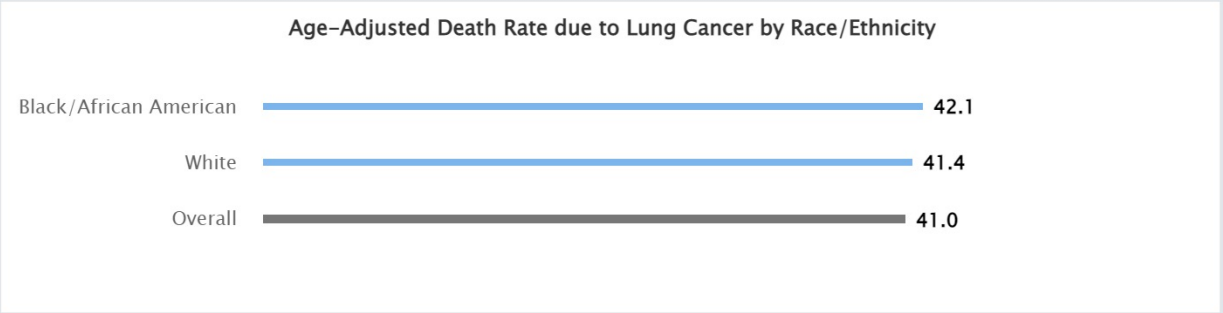
(2015-2019)

MD Counties | U.S. Counties | MD Value (35.2)

US Value (36.7) | Prior Value (47.6) | Trend

HP 2020 Target (45.5) | HP 2030 Target (25.1)





Prostate Cancer Incidence Rate

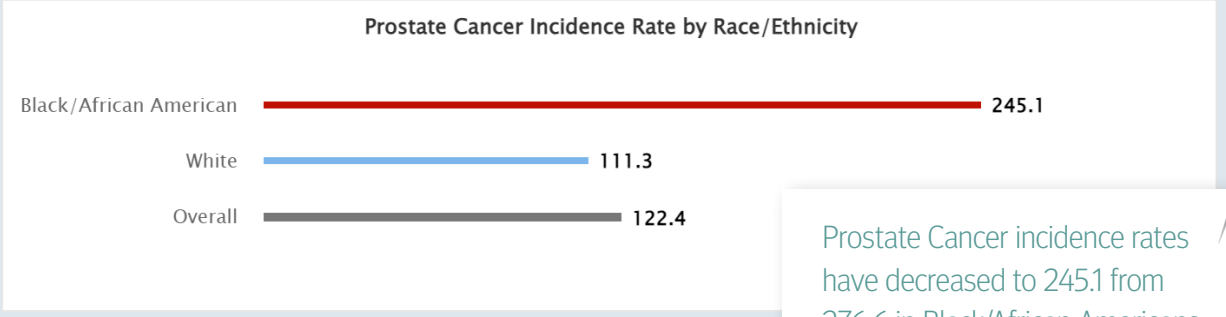
122.4

Cases per 100,000 males

(2014-2018)

MD Counties | U.S. Counties | MD Value (128.1)

US Value (106.2) | Prior Value (121.3) | Trend



Prostate Cancer incidence rates have decreased to 245.1 from 276.6 in Black/African Americans.

Adults who are Overweight or Obese

54.2%

(2019)

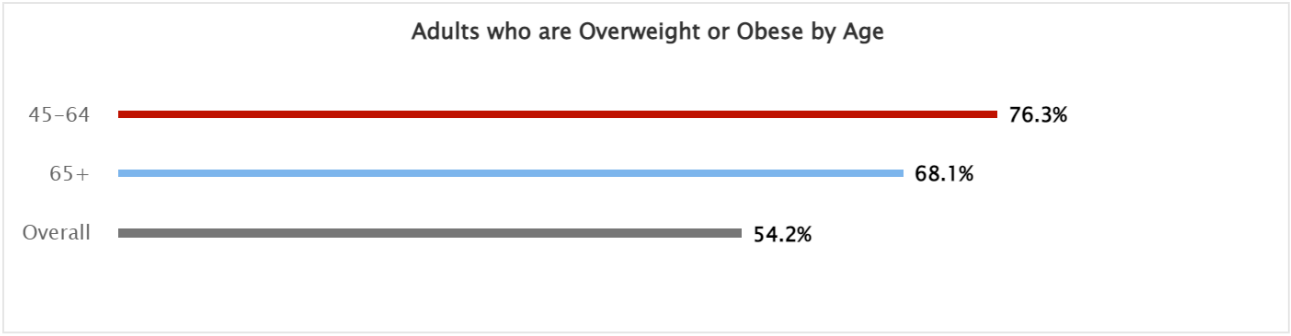
MD Counties

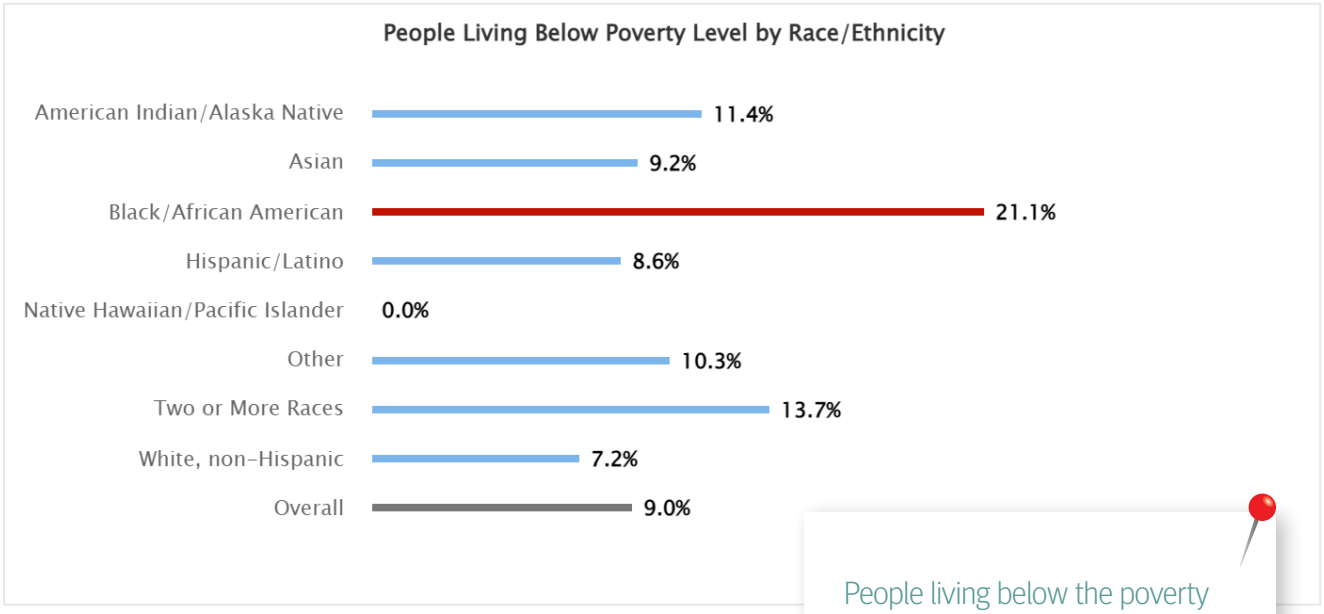
MD Value (66.1%)

US Value (66.7%)

Prior Value (71.9%)

Trend

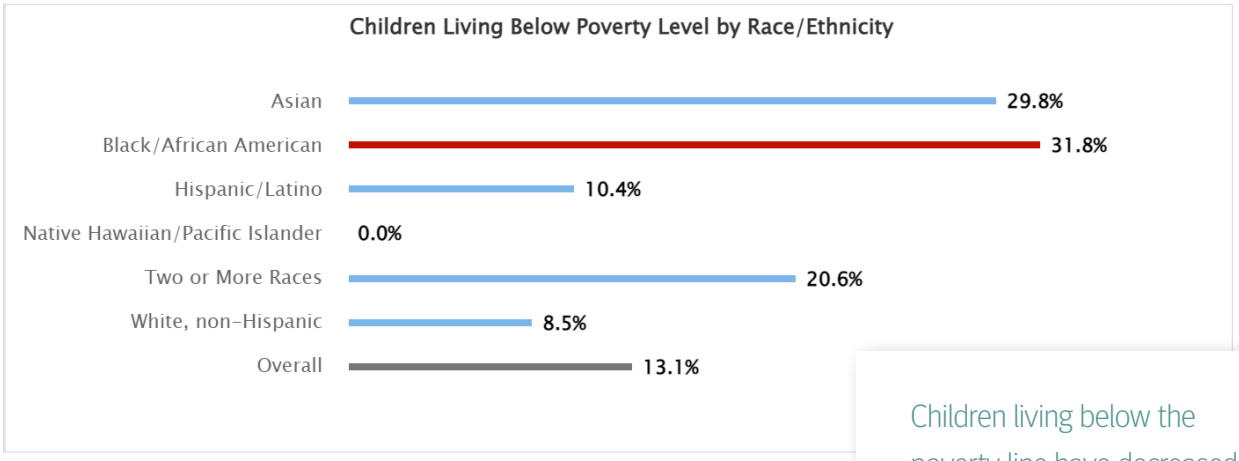




People living below the poverty level are more likely to be in the Black population than any other race or ethnicity group by four-fold percentage, dropping slightly from the previous CHNA (24.7%).

Children Living Below Poverty Level

13.1%	MD Counties	U.S. Counties	MD Value
(2015-2019)			(12.1%)
	US Value	Prior Value	Trend
	(18.5%)	(12.8%)	



Children living below the poverty line have decreased from 14.8%, with Black/ African American being the highest segment at 31.8%.

Priority Needs Not Addressed

Dental Health

At this time AGH/AGHS has no resources to meet this need other than referral services. The Worcester County Health Department does have a dental health program in Berlin, MD. In our neighboring counties (Somerset and Wicomico) there is a federally funded dental health program run through Chesapeake Health Services. TLC clinic (Three Lower County, Mission of Mercy every 2 years free dental clinic). In lower Delaware, these services are provided by La Red, a comprehensive health service center. In 2021 we joined a team, Community Foundation of the Eastern Shore Adult Oral Health Taskforce, focused on improving dental health and access to dental care in the tri-county area.

Communicable Disease

Though not designated as a priority, AGH does provide immunization services to the communities we serve. We provide free flu and COVID-19 immunizations to all our associates and their families, as well as all volunteers at the hospital. We also provide free community flu and COVID vaccine clinics at local businesses, and health fair events by AGH. Our neighboring hospital Tidal Health does a large drive-through flu event which serves Wicomico and Somerset counties. In addition, the Health Departments partnering with AGH provide other services for communicable diseases to assist with any outbreaks, if needed. We also partner with UMES Pharmacy School, WCHD and AGH Vote and Vax initiative.

Cancer

While cancer continues to remain a priority area of focus, when reviewing the county and AGH-specific data sets, there were significantly fewer visits associated with cancer than with the top five priorities identified. In addition, we have two state-of-the-art cancer centers in Worcester county – one right on the campus of AGH – which continue to be available to meet the needs of the community for cancer care. The most recent Worcester county community health needs assessment also aligns with the priorities identified by AGH.

Heart Disease

Although not identified in the top five priorities for 2022-2024, heart disease continues to remain an area of focus and will be prioritized in our regional health equity collaborative with local partners.

While transportation, public or private, remains a barrier in the rural community, there are other community organizations better-aligned to address this priority. It did not rank as high in this CHNA, although still discussed in focus groups. AGH has been addressing some transportation needs through a voucher system.

Data Gaps Identified

While this Community Health Needs Assessment is comprehensive, AGH recognizes that it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups (such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish) are not represented in the survey data. Other population groups (for example, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups) might not be identifiable or might not be represented in numbers sufficient for independent analyses. Available data was extensive, especially in Maryland, however data gaps may exist. Due to the large geographic area that Sussex County, DE encompasses, specific zip code level data was not available for several indicators and may not be fully represented.

In conclusion, the list of identified issues is far too long to provide an exhaustive review in a single document. In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Public Dissemination

This Community Health Needs Assessment is available to the public at the AGH website: www.atlanticgeneral.org/Community-Health-Wellness.aspx

- Informs readers that the CHNA Report is available and provides instructions for downloading it;
- Offers the CHNA Report document in a format that, when accessed, downloaded, viewed and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.
- Documents were made available for public comment via the website, with no comments received on either at the time this report was written.

AGH will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. AGH will also maintain at its facilities a hard-copy of the CHNA report that may be viewed by any person requesting to do so.

References

County Health Outcomes & Roadmaps, 2019, http://www.countyhealthrankings.org

Maryland Department of Public Health: https://coronavirus.maryland.gov/

State of Delaware Healthcare Benchmark Report 2019 https://www.dhss.delaware.gov/dhss/files/benchmarktrendreport2019.pdf

Healthy People 2020-2030 https://health.gov/healthypeople

Maryland State Health Improvement Process (SHIP) Pages - State Health Improvement Process (maryland.gov)

US Census Bureau

Delaware Department of Labor

Behavioral Risk Factor Surveillance System BRFSS State Information | CDC

Beebe Medical Center Community Health Assessment 2019 Beebe Healthcare Community Health Needs Assessment

Atlantic General Hospital. Creating Healthy Communities. http://www.atlanticgeneral.org/Community-Health-Wellness/Creating-Healthy-Communities.aspx?hcn=CommunityDashboard

CDC National Center for Health Stats (2015). Retrieved from http://www.cdc.gov/nchs/fastats

NCI (2015). National Cancer Institute: Obesity, National Institute of Health. Retrieved August 25, 2016, from http://www.cancer.gov/about-cancer/causes-prevention/risk/obesity

Internal Revenue Bulletin: 2015-5 February 2, 2015 TD 9708 Additional Requirements Community Health Needs Assessments for Charitable Hospitals; Requirement of a Sect and Time for Filing the Return. See https://www.irs.gov/irb/2015-5_IRB/ar08.html

Appendices

Appendix A

Worcester County Health Department Community Health Document Links

Worcester County 2021 Community Health Assessment
https://worcesterhealth.org/images/21_CommunityHealthAssessment.pdf

Worcester County 2020 Community Themes and Strengths Assessment
https://www.worcesterhealth.org/images/CTSA2020.pdf

Community Health Data
https://worcesterhealth.org/planning-sidebar/local-health-improvement-coalition/90-general/latest-news/news-section/1135-yrbs-worcester-data

Appendix B

Master List: Who Was involved in Assessment?

Atlantic Club Board – The Atlantic Club is a non-profit service organization dedicated to helping individuals and their families recover from the disease of addiction. Provides the support necessary to live a healthy life in recovery and become an active member of our community. Offers 12-step programs and sober events.

Leader/Member:
Sue Rodden, Colleen Wareing

Faith Based Partnership – A group of community members from various places of worship in our area who meet to plan programming to meet health needs.

Leader/Member:
Gail Mansell

Healthy Happenings Committee – Hospital and Community members who plan and implement health education in the community.

Leader/Member:
Donna Nordstrom

Local Health Improvement Coalition (LHIC) Worcester – Groups of jurisdictional-level stakeholders. Each LHIC sets public health priorities for their respective communities. LHICs address these health priorities through programs, policies, and coordinated efforts with programmatic, data, and infrastructure support from the state and county.

Leader/Member:
Teresa Tyndall
Chairs: Kim Justice, Donna Nordstrom

Executive Care Committee – Our Executive Care Coordination programs have put into place a number of layered strategies across the tri-county area to support regional efforts to decrease total costs of care, enhance access to primary care, and improve patient outcomes. The success of our programs is possible through an integrated care delivery system, dependent upon data analytics and collaborative partnerships with our community stakeholders to assist in the management of high risk and rising risk populations.

Leader/Member:
Sally Dowling

AGHS Provider Committee – The committee is comprised of all of the employed providers within AGHS as well as representation from Hospital and Health System leadership. The purpose of this committee is to review clinical and operational best practice standards.

Leader/Member:
Sally Dowling
Tim Whetstine

Patient & Family Advisory Committee – The Patient and Family Advisory Council (PFAC) are a key component for practice quality improvement and an ongoing mechanism to support meaningful partnerships among patient and family advisors, staff, clinicians, and organizational leaders.

Leader/Member:
Ann Bergey

Community Benefit Committee – Each department in AGH has an appointee who sits on the Community Benefits Committee. The purpose of this committee is to oversee the Community Outreach of the Hospital and comply with the government regulations regarding reporting Community Benefits. Because the committee is made up of all departments, the views are varied. Community Benefit (CB) reporting is an IRS requirement for the not-for-profit status of AGH. CB are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They increase access to health care and improve community health. Annual evaluations of each initiative's success are found in the HSCRC Community Benefit Report sent to the State of Maryland.

Leader/Member:
Tina Simmons
Kaylee Hanway

Behavioral Health and Opioid Stewardship Committee – The purpose of this workgroup is to collaborate with internal and external partners to develop and implement a community-focused strategy to provide support across the continuum of care related to behavioral health, substance use, pain management, safe use of opioid medications, and the prevention of opioid addiction.

Leader/Member:
Tina Simmons
Jeff Kukel

Worcester County Health Department – The Health Department is committed to the health and well-being of Worcester County. A staff of health care professionals provides quality services pertaining to mental health, substance abuse counseling, maternal child health, family planning, personal health, adult health, environmental health, communicable disease, developmental disabilities, and prevention programs.

Leader/Member:
Mike Trader
Sandy Kerrigan

Worcester Goes Purple – Worcester Goes Purple is an awareness project to engage the community in preventing substance abuse and promotion of hoealthy life choices.

Leader/Member:
Debbie Smullen

Appendix C

www.countyhealthrankings.org

Worcester and Sussex County 2021 Health Rankings

	Sussex, DE	**Worcester, MD** Peer County
HEALTH OUTCOMES		
LENGTH OF LIFE		
Premature Death	8,100	7,400
Quality of Life		
Poor or fair health **	19%	16%
Poor physical health days **	4.3	3.7
Poor mental health days **	4.3	4.0
Low birthweight	8%	6%
HEALTH FACTORS		
HEALTH BEHAVIORS		
Adult smoking **	19%	17%
Adult obesity **	33%	37%
Food environment index **	8.3	7.8
Physical inactivity	31%	27%
Access to exercise opportunities	74%	90%
Excessive drinking **	20%	20%
Alcohol-impaired driving deaths	27%	44%
Sexually transmitted infections **	454.9	381.1
Teen births	31	19
CLINICAL CARE		
Uninsured	9%	7%
Primary care physicians	1,610:1	1,180:1
Dentists	4,110:1	3,740:1
Mental health providers	510:1	400:1
Preventable hospital stays	4,212	3,078
Mammography screening	52%	45%
Flu vaccinations	57%	52%
SOCIAL & ECONOMIC FACTORS		
High school completion	88%	91%
Some college	56%	67%
Unemployment **	3.8%	2.4%
Children in poverty	23%	16%
Income inequality	4.1	4.4
Children in single-parent households	25%	29%
Social associations	10.2	17.4
Violent crime **	406	334
Injury deaths	85	84
PHYSICAL ENVIRONMENT		
Air pollution – particulate matter	7.2	7.5
Drinking water violations	Yes	No
Severe housing problems	14%	17%
Driving alone to work	83%	81%
Long commute – driving alone	37%	30%

*** Compare across states with caution*

Appendix D

Maryland State Health Improvement Process (SHIP) Indicators

Maryland's State Health Improvement Process (SHIP) provides a framework for continual progress toward a healthier Maryland. The SHIP includes 39 measures in five focus areas that represent what it means for Maryland to be healthy. Each measure has a data source and a target, and where possible, can be assessed at the county level. Detailed information is provided for each objective organized by Vision Areas on the URL provided.

Healthy Beginnings

- Infant death rate
- Babies with low birth weight
- Sudden unexpected infant death rate (SUIDs)
- Teen birth rate
- Early prenatal care
- Students entering kindergarten ready to learn
- High school graduation rate
- Children receiving blood lead screening

Healthy Living

- Adults who are a healthy weight
- Children and adolescents who are obese
- Adults who currently smoke
- Adolescents who use tobacco products
- HIV incidence rate
- Chlamydia infection rate
- Life expectancy
- Increase physical activity

https://health.maryland.gov/pophealth/pages/ship-lite-home.aspx

Healthy Communities

- Child maltreatment rate
- Suicide rate
- Domestic violence
- Children with elevated blood lead levels
- Life expectancy
- Increase physical activity
- Fall-related death rate
- Pedestrian injury rate on public roads
- Affordable Housing

Access to Health Care

- Adolescents who received a wellness checkup in the last year
- Children receiving dental care in the last year
- Persons with a usual primary care provider
- Uninsured ED Visits

Quality Preventive Care

- Age-adjusted mortality rate from cancer
- Emergency Department visit rate due to diabetes
- Emergency Department visit rate due to hypertension
- Drug-induced death rate
- Emergency Department visits related to mental health conditions
- Hospitalization rate related to Alzheimer's or other dementias
- Children (19-35 months old) who receive recommended vaccines
- Annual season influenza vaccinations
- Emergency Department visit rate due to asthma
- Age-adjusted mortality rate from heart disease
- Emergency Department visits for addiction-related conditions
- Emergency Department visit rate for dental care

Appendix E

Atlantic General Hospital Community Health Needs Assessment Survey

Help us build a healthier Community by taking our Community Needs Assessment Survey. This information will help to provide much needed outreach and wellness programs in the area, keeping you and your family as healthy as possible. The results from this survey are confidential.

DEMOGRAPHICS

1. What is your zip code? _____

2. Gender: ☐ Male ☐ Female ☐ Prefer not to answer

Not listed other *(please specify)* _____

3. Age range:

- ☐ Under 18 years
- ☐ 19 - 24 years
- ☐ 25 - 30 years
- ☐ 31 - 40 years
- ☐ 41 - 50 years
- ☐ 51 - 60 years
- ☐ 61 - 65 years
- ☐ Older than 65 years

4. Highest Level of Education:

- ☐ Some High School
- ☐ High School Diploma or GED
- ☐ Some College
- ☐ Associates Degree
- ☐ Bachelor Degree
- ☐ Graduate Degree
- ☐ Post Graduate
- ☐ Prefer not to answer

5. Household Income

- ☐ Less than $10,000
- ☐ $10,000 to $29,000
- ☐ $30,000 to $49,000
- ☐ $50,000 to $99,000
- ☐ $100,000 or above
- ☐ Prefer not to answer

6. What is your race/ethnicity? *Circle*:

a. African American
b. American Indian or Alaskan Native
c. Asian/Pacific Islander
d. Caucasian
e. Hispanic or Latino
f. Native Hawaiian or Other Pacific Islander
g. Other _____
h. Prefer not to answer

HEALTH NEEDS

1. What do you believe to be the biggest health problem in your community? *(Check all that you think apply)*

- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes/Sugar
- ☐ Asthma/Lung Disease
- ☐ Smoking, drug or alcohol use
- ☐ Mental Health Issues (Depression, Anxiety)
- ☐ Dental Health
- ☐ Infectious Disease
- ☐ High Blood Pressure/Stroke
- ☐ Injuries
- ☐ Overweight/Obesity
- ☐ Access to Healthcare/ No Health Insurance
- ☐ HIV
- ☐ Sexually Transmitted Diseases
- ☐ Other

If selected "other," please tell us what you think: _____
_____

2. **What do you think are the problems that keep you or other community members from getting healthcare they need?** *(Check all that you think apply)*
   - ☐ No health insurance
   - ☐ Too expensive/can't afford
   - ☐ Couldn't get an appointment with my doctor
   - ☐ Doctor is too far away from my home
   - ☐ No transportation
   - ☐ Service is not available in our community
   - ☐ Local doctors are not on my insurance plan
   - ☐ Other

If selected "other," please tell us what you think: _____

_____

3. **Do you have any ideas or recommendations to help decrease the health problems in the community or to solve the problems with access to health services** *(Use the back if you need more space)***?** _____

_____

SOCIAL NEEDS

What are the greatest strengths of your community?
(Check boxes for all that apply.)

- ☐ Education
- ☐ Employment/job skills
- ☐ Health care
- ☐ Healthy eating
- ☐ Parks/green space
- ☐ Community safety
- ☐ Affordable housing options
- ☐ Community activities
- ☐ Personal space
- ☐ Insurance
- ☐ Transportation
- ☐ Workplace safety
- ☐ Language
- ☐ Family
- ☐ Mental Health treatment access
- ☐ Substance abuse treatment access

Other: _____

_____

What are the greatest weaknesses of your community?
(Check boxes for all that apply.)

- ☐ Education
- ☐ Job skills
- ☐ Employment
- ☐ Substance abuse
- ☐ Mental health
- ☐ Lack of healthy food
- ☐ Community safety
- ☐ Lack of community activities
- ☐ Police
- ☐ Lack of personal space
- ☐ Lack of affordable housing
- ☐ Legal issues
- ☐ Poor access to health care
- ☐ Insurance
- ☐ Limited transportation
- ☐ Workplace safety
- ☐ Language skills
- ☐ Family
- ☐ Minimal recreation/green access

Other: _____

_____

On a scale of 1 to 4, please rank the level of need for each of the following areas as they exist within your community.
(Circle one in each row)

Health Care: **What is the greatest health care need?**

	1 High	2 Low	3 No Need	4 Don't Know
Primary care	1	2	3	4
Specialty care	1	2	3	4
Dental care	1	2	3	4
Eye care	1	2	3	4
Substance abuse	1	2	3	4
Mental health	1	2	3	4
Transportation to healthcare appointments	1	2	3	4

Nutrition: **What is the greatest nutritional need?**

	1 High	2 Low	3 No Need	4 Don't Know
Access to affordable healthy foods	1	2	3	4
Access to healthy food in schools	1	2	3	4
Access to healthy food in stores	1	2	3	4

Stress: **What is a source of stress in your daily life?**

	1 High	2 Low	3 No Need	4 Don't Know
Relationships	1	2	3	4
Fear of domestic violence	1	2	3	4
Access to health care services	1	2	3	4
Access to food	1	2	3	4
Access to transportation	1	2	3	4
Access to safe housing	1	2	3	4
Access to education	1	2	3	4
Community violence	1	2	3	4

Transportation: **What is the greatest transportation need?**

	1 High	2 Low	3 No Need	4 Don't Know
Transportation to health care	1	2	3	4
Transportation to work	1	2	3	4
Transportation to grocery stores	1	2	3	4
Reliable, scheduled transportation	1	2	3	4
Affordable transportation	1	2	3	4
Transportation to community activities	1	2	3	4

On a scale of 1 to 4, please rank the level of need for each of the following areas as they exist within your community.
(Circle one in each row)

Language: **What language barriers do you experience in your community?**

	1 High	2 Low	3 No Need	4 Don't Know
Access to multi-lingual services	1	2	3	4
Access to language skill education	1	2	3	4
Access to employment in your first language	1	2	3	4

Substance Abuse: **What is the greatest substance abuse need?**

	1 High	2 Low	3 No Need	4 Don't Know
Prevention programs	1	2	3	4
Reduction of drug use	1	2	3	4
Reduction of prescription drug use	1	2	3	4
Access to treatment – outpatient	1	2	3	4
Access to treatment - residential	1	2	3	4
Reduction of alcohol abuse	1	2	3	4
Drug specific treatment: _____	1	2	3	4

Mental Health: **What is the greatest mental health need?**

	1 High	2 Low	3 No Need	4 Don't Know
Residential mental health treatment	1	2	3	4
Mental health professionals	1	2	3	4
Prevention	1	2	3	4
Access to treatment	1	2	3	4

Housing: **What is the greatest housing need?**

	1 High	2 Low	3 No Need	4 Don't Know
Resident advocacy	1	2	3	4
Senior housing	1	2	3	4
Affordable housing	1	2	3	4
Access to loans	1	2	3	4
Financial literacy	1	2	3	4

On a scale of 1 to 4, please rank the level of need for each of the following areas as they exist within your community.
(Circle one in each row)

Employment: **What is the greatest employment need?**

	1 High	2 Low	3 No Need	4 Don't Know
Job search and placement assistance	1	2	3	4
Income generating skills	1	2	3	4
Internships, paid, leadership, or volunteer work opportunities	1	2	3	4

Quality of Life: **What would improve the quality of life for you within your community?**

	1 High	2 Low	3 No Need	4 Don't Know
Educational opportunities	1	2	3	4
Housing	1	2	3	4
Recreational opportunities	1	2	3	4
Community safety	1	2	3	4
Health care access	1	2	3	4
Dental care access	1	2	3	4
Public transportation	1	2	3	4
Substance abuse support	1	2	3	4
Mental health services	1	2	3	4
Employment opportunities	1	2	3	4
Community activities	1	2	3	4
After school programs	1	2	3	4
Partnership with local police department	1	2	3	4
Connections to resources/community agencies	1	2	3	4
Access to local parks and community classes	1	2	3	4
Trails and paths	1	2	3	4

Education: **What is the greatest education need?**

	1 High	2 Low	3 No Need	4 Don't Know
Childhood development	1	2	3	4
Youth development	1	2	3	4
Access to the outdoors	1	2	3	4
Nutrition and physical exercise	1	2	3	4
Life skills trainings	1	2	3	4
Parenting classes	1	2	3	4
Health education	1	2	3	4
Adult education	1	2	3	4
Day care	1	2	3	4
Quality of available education	1	2	3	4

Appendix F

2018-2021 Goals and Actions Implemented

Implementation Plan of Needs Identified in the Community Health Needs Assessment FY19-FY21 Final Progress Report

https://www.atlanticgeneral.org/community-health-wellness/community-health-needs-assessments/

BACKGROUND

Community Needs Assessment – In 2018-19 AGH, in coordination with the local health departments, neighboring hospitals and community stakeholders, conducted a community needs assessment. The needs assessment is a primary tool used by the Hospital to determine its community benefit plan, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of our service area. The Community Health Needs Assessment (CHNA) was approved by the Hospital's Board of Trustees in May 2019.

Needs Identified – This 2019-2021 CHNA combines population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH uses Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs.

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (surveys) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes information gathered through ongoing key community groups.

Secondary Data Collection AGH partners with surrounding hospitals, health departments and state agencies to bring to together a multitude of information. This Community Health Needs Assessment, a follow-up to similar studies conducted in 2012 and 2015, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area of Atlantic General Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness. The information as well as other surveys, research and community data are used to identify issues of greatest concern and guide resource allocation to those areas, thereby making the greatest possible impact on community health status. The needs assessment is a primary tool used by the Hospital to determine its community benefit priorities, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focuses on the health and social needs of our service area. A sampling of resources utilized to complete the assessment is listed below. A comprehensive list is found under CHNA FY19-21 references.

- Community meetings with persons representing the broad interests of the community
- AGH Community Needs Survey
- Maryland State Health Improvement Process (SHIP) www.dhmh.maryland.gov/ship
- Tri-County Health Improvement Plan (T-CHIP)
- Healthy People 2020
- Worcester County Community Health Improvement Plan (CHIP) LHIC Local Health Improvement Coalition
- 2018 Medical Staff Development Plan
- Health Fairs
- Community Education Events
- 2018 County Health Outcomes & Roadmaps

- State of Delaware Health Needs Assessment www.dhss.delaware.gov/dhss/dph/fles/shaship.pdf
- Delaware Health and Social Services through the Delaware Health Tracker www.delawarehealthtracker.com
- Beebe Medical Center Community Health Needs Assessment www.beebehealthcare.org/sites/default/fles/1-CHNA%20FINAL%20DRAFT_0.pdf
- US Census Bureau

The Community Health Needs Assessment survey was distributed by community outreach personnel and the Atlantic General Hospital website. Stakeholder interviews and focus groups were conducted by community outreach personnel. Community surveys represent information that is self-reported. Results from the paper surveys (286) and electronic versions (222) are found in CHNA FY19-21, Appendix G.

The top health concerns among 2018 survey respondents were prioritized as listed:

#1 Cancer

#2 Diabetes / Sugar

#3 Overweight / Obesity

#4 Smoking, drug or alcohol use

#5 Heart Disease

#6 Mental Health

#7 High Blood Pressure / Stroke

#8 Access to Healthcare / No Health Insurance

#9 *Dental Health*

#10 Asthma / Lung Disease

#11 *Injuries*

#12 *Sexually transmitted disease & HIV*

(**Bold** items are addressed as priority areas in implementation plan. *Italicized* items are not addressed as priority areas in implementation plan.)

Top Health Concern Priorities Over the (3) CHNA

	2012	2015	2018
Cancer	1	1	1
Diabetes/Sugar	4	3	2
Overweight/Obesity	3	2	3
Smoking, drug or alcohol use	5	5	4
Heart Disease	2	4	5
Mental Health	7	7	6
High Blood Pressure/Stroke	6	6	7
Access to Healthcare / No Health Insurance	8	8	8
Dental Health	10	10	9
Asthma / Lung Disease	9	9	10
Injuries	11	11	11
Sexually transmitted disease & HIV	12	12	12

Prioritized Needs – Key findings from all resources were used as a framework to develop community benefit priorities. These are closely aligned with local, state, and national priority areas. The process for determining the priorities of the Community Outreach programs involves many people inside and outside the organization. The Hospital's strategic initiatives are determined by the Hospital Board of Trustees, the Medical Staff and the Leadership of the Hospital. Each year those long term initiatives are evaluated and updated with environmental information, such as the most recent Community Health Needs Assessment. In addition to input from those groups there are two committees that have a part in setting our priorities: the Community Benefits Committee and the Healthy Happenings Advisory Board.

The Healthy Happenings Board is made up of hospital and community members who have a health connection in the community. Through this board we are able to keep our pulse on the needs of the community. Each department in the Hospital has an appointee who sits on the Community Benefits Committee. The purpose of this committee is to oversee the Community Outreach of the Hospital and comply with the government regulations regarding reporting Community Benefits. Because the committee is made of all departments, the views are varied. Annual evaluations of each initiative's success are found in the HSCRC Community Benefit Report provided to the State of Maryland.

Hospital leaders are involved on many community boards and community entities (both for-profit and not-for-profit). Through these boards, we are able to keep abreast of the underserved, low income and/or minority needs in the

community. We are involved in the health departments throughout our service area in Maryland and Delaware, and coordinate services with them to decrease duplication of services and know what services are needed to fill the gaps. Working with the target areas of the state improvement initiatives influences the priorities we set. Our Population Health outreach providers are out in the community and are able to observe community needs. Through our Patient Centered Medical Home, Care Coordination models and Population Health Department, we are able to have another resource in the community that we can use for assisting us in setting priorities.

The 2019-2021 Community Benefit priorities are based on the criteria of:

- Size and severity of the problem determined by what percentage of the population is affected by risks
- Health system's ability to impact the need
- Availability of resources

They were graded as high (3), moderate (2) and low (1) to rank the priority, based on self-reported survey data and prioritized as above.

Areas of Opportunity

		Ø size and severity of the problem determined by what percentage of the population is effected by risks	Ø health system's ability to impact the need	Ø availability of resources	Total
Access to Health Services	Difficulty getting a physician appointment Physician recruitment Cost of care	high	high	high	9
Cancer	Prevalence of Cancer	high	high	high	9
Diabetes	Prevalence of Diabetes Borderline/Pre-Diabetes	high	mod	high	8
Respiratory Disease	COPD Asthma diagnosis	mod	mod	high	7
Nutrition, Physical Activity & Weight	Prevalence of overweight & obesity Meeting physical activity guidelines lack of leisure time physical activity	high	mod	mod	7
Heart Disease & Stroke	Heart Disease Prevalence High Blood Pressure High blood cholesterol Overall Cardiovascular Risk	high	mod	mod	7
Behavioral Health	Mental Health, Suicide prevention Substance Abuse	high	mod	low	6
Arthritis, Osteoporosis & Chronic back conditions	Prevalence of Sciatica/Chronic Back Pain	mod	low	high	6

FY19-21 Priority Areas

#1 Access to Health Services

#2 Cancer

#3 Diabetes

#4 Respiratory Disease

#5 Nutrition, Physical Activity & Weight

#6 Heart Disease & Stroke

#7 Behavioral Health

#8 Arthritis, Osteoporosis & Chronic Back Conditions

#1 Priority Area: Access to Health Services

Goal: Increase community access to comprehensive, quality health care services.

Healthy People 2020 Goal: Improve access to comprehensive, quality health care services.

Anticipated Impact:

- Reduce unnecessary healthcare costs
- Reduction in hospital admissions and readmissions
- Increase in awareness and self-management of chronic disease
- Reduce health disparities
- Increase community capacity and collaboration for shared responsibility to address unmet health needs
- Increase number of practicing primary care providers and specialists to community

Impact Rationale: Atlantic General Hospital is the only hospital in Worcester County, a DHMH federally-designated medically-underserved area, a state-designated rural community, and a HRSA-designated Health Professional Shortage Area for primary care, mental health, and dental health. In AGH's service area, the top reasons for patients not seeking health care in our communities are cost, transportation, insurance plans or lack of insurance, appointment availability, and lack of providers. According to the Community Health Needs Assessment (CHNA) FY2019, the community rated the follow as the top barriers to access health care:

Too expensive/can't afford it	29.31%
No health insurance	23.53%
Couldn't get and appointment with my doctor	14.06%
No transportation	12.26%
Service is not available in our community	8.28%
Local doctors are not on my insurance plan	7.08%
Doctor is too far away from my home	5.48%

Action:

- Provide community health events to target minority populations
- Partner with homeless shelters and food pantries to promote wellness
- Utilize Faith-based Partnerships to provide access to high risk populations for education about healthy lifestyles and chronic disease management
- Educate community on financial assistance options
- Educate community on ED appropriate use
- Increase the number of practicing primary care providers and specialists to community
- Participate on Worcester County Healthy Planning Advisory Council
- Participate on Homelessness Committee and HOT
- Refer community to local agencies such as Shore Transit and Worcester County Health Department for transportation assistance
- Participate on Tri County Health Planning Council and Local Health Improvement Coalition
- Participate on AGH's Health Equity Steering Committee to promote health equity and reduce disparities
- Pilot School Based Telehealth Program
- Promote patient engagement through adult health literacy initiative

Measurement:

- AGH database
- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/objectives
- Community Survey
- Maryland SHIP http://dhmh.maryland.gov/ship/Pages/home.aspx

Hospital Resources:

- Population Health Department
- AGH/HS
- Human Resources
- Registration/Billing Services
- Emergency Department
- Executive Care Coordination Team
- Health Equity Steering Committee

Community Resources:

- Faith-based Partnership
- Homelessness Committee
- Worcester County Healthy Planning Advisory Council

- Worcester County Health Department
- Worcester County Public Schools
- Diakonia
- Samaritan Shelter
- MD Food Bank and local pantries/soup kitchens
- Shore Transit
- Tri County Health Planning Council
- LHIC
- United Way

#1 Priority Progress: Access to Health Services

- Community Survey: Next CHNA cycle *(FY22-24)*
- AGH database: Zip codes accounting for 65 percent of IP discharges *(FY20)*

Zip- City	IP Visits	% of total
21811-BERLIN	831	31.4%
21842-OCEAN CITY	374	14.1%
19975-SELBYVILLE	310	11.7%
19945-FRANKFORD	106	4.0%
21813-BISHOPVILLE	79	3.0%
All Other	947	35.8%
Total IP Discharges	2,647	100.0%

ED and IP Visits by Select DX Group *(first three DX codes on account pulled)*

FY20 AGH Visits — ED = 28,077 | IP = 2,647

Number of Visits for select DX Groups **DX Group % of Total ED or IP Visits**

There is some overlap – a patient may have Diabetes listed as primary and Heart Disease as secondary DX on their account. They are counted twice-once in each category. There were 6,811 total ED visits and 1,425 total IP visits for the DX codes listed below. 1,134 visits had two or more of the DX codes listed below on their account.

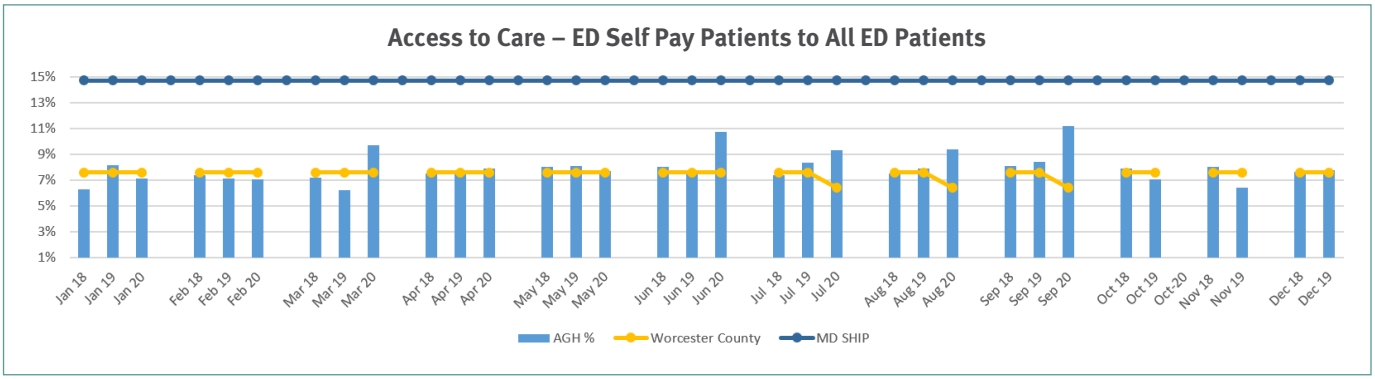
DX Group	ED	IP
Alcohol Abuse	532	53
Asthma	483	28
Cancer	247	130
COPD	353	248
Diabetes	852	241
Heart Disease	3,074	780
Mental Disorder	1,936	95
Opioid Dependency	112	18
RA	17	9
Renal Disease	117	75

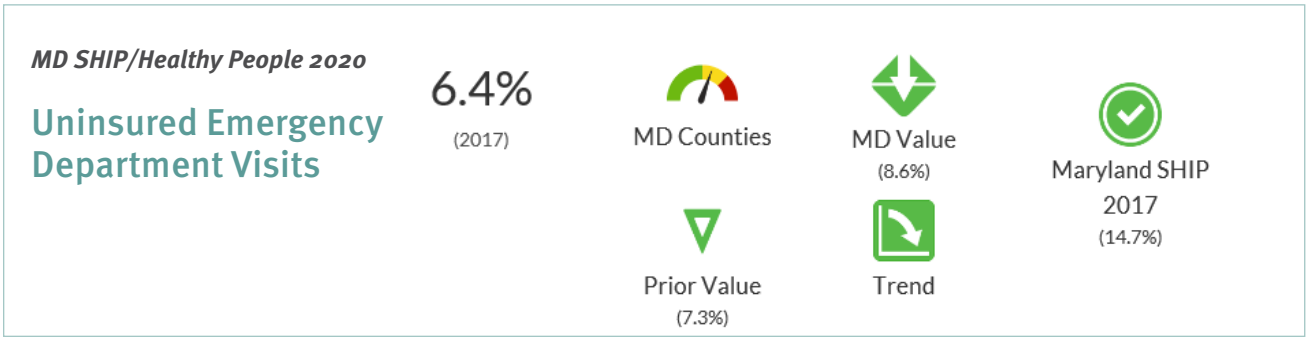
DX Group	ED	IP
Alcohol Abuse	1.89%	2.00%
Asthma	1.72%	1.06%
Cancer	0.88%	4.91%
COPD	1.26%	9.37%
Diabetes	3.03%	9.10%
Heart Disease	10.95%	29.47%
Mental Disorder	6.90%	3.59%
Opioid Dependency	0.40%	0.68%
RA	0.06%	0.34%
Renal Disease	0.42%	2.83%

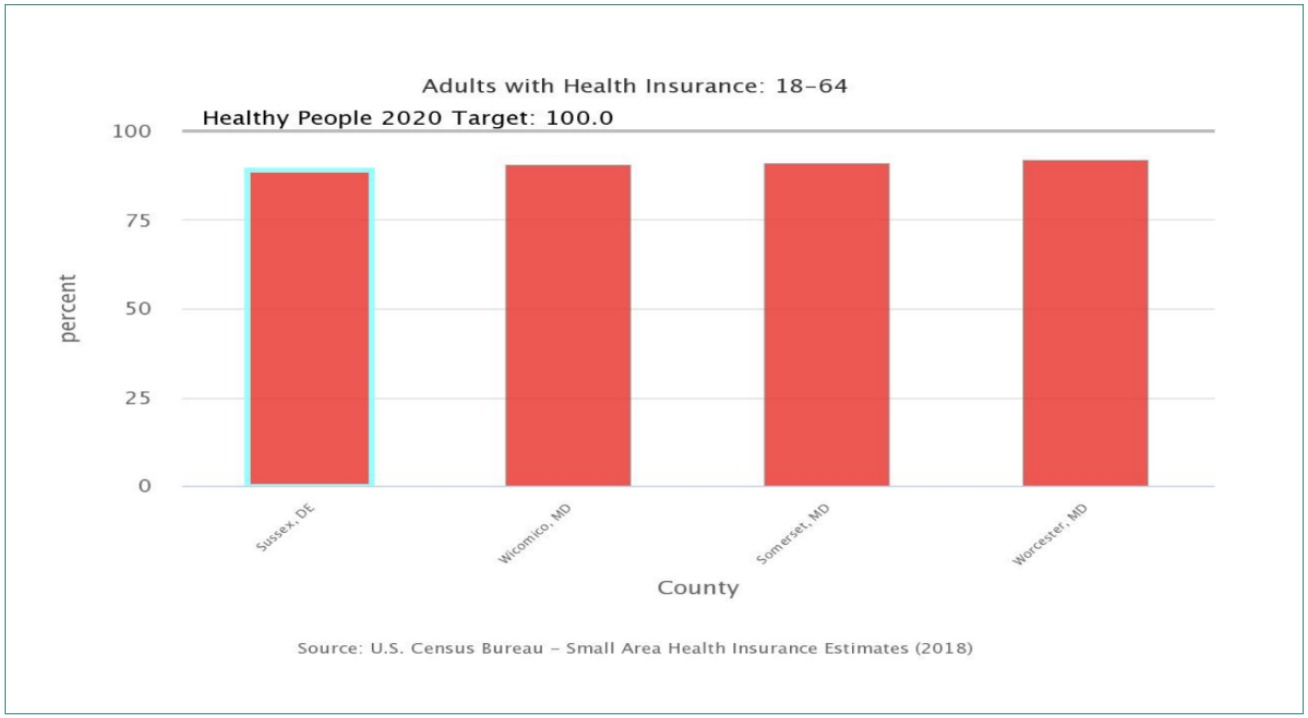
During FY19-20, AGH/AGHS strove to address priority #1 Access to Health Services via the following: health fairs, community education events, free community screenings, flu clinics, physician recruitment, health equity initiatives, and health literacy initiatives – to name a few. Through community benefit priority areas, as defined by the HSCRC and guided by CHNA, AGH has provided to the community 45,679 staff hours, 604 volunteer hours of service, and touched 79,840 community members' lives beyond the Hospital walls. Programs of interest include a school-based telehealth pilot program at Pocomoke High School, our continued partnership with WCPS via the Integrated Health Literacy Program in grades 1-8 county-wide, nutrition initiatives, diabetes and pre-diabetes initiatives, virtual community education, virtual support groups, and patient portal/telehealth service expansion. Through all the challenges of COVID-19, the pandemic challenged us to take a more innovative approach to avenues to access and opportunities to reach our community.

As of April 2020, Atlantic General Health System offers telehealth visits with our primary care providers, specialists and Immedicare locations. The video visits are conducted securely through the FollowMyHealth Patient portal. This direct-to-consumer approach to telehealth promotes access to care by allowing patients to join in the virtual consult through their desktop computer, tablet or smart phone at their preferred location. Preferred location may include the comfort of their home or work location. Since the launch of

our telehealth service line, AGHS providers have performed approximately 2,000 video visits. Over 52 AGHS providers provide video visits. The utilization of these video visits through AGH's FollowMyHealth Patient Portal has increased total connected patients from 10,000 in April 2020 to 13,500 as of September 2020. Additionally, these video visits have increased portal usage by 88.6% from April 2020 to September 2020.







#2 Priority Area: Cancer

Goal: Decrease the incidence of advanced breast, lung, colon, and skin cancer in community.

Healthy People 2020 Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.

Anticipated Impact:

- Increase awareness around importance of prevention and early detection
- Increase provider services in community to provide for cancer related treatment
- Reduce health disparities
- Improve access and referrals to community resources resulting in better outcomes
- Increase support to patients and caregivers
- Increase participation in community cancer screenings – especially at-risk and vulnerable populations

Impact Rationale: According to Healthy People 2020, continued advances in cancer detection, research and cancer treatment have decreased cancer incidences and death rates in the United States. Despite continued advances, cancer remains a leading cause of death second to heart disease in the United States. (Healthy People 2020)

Action:

- Recruit proper professionals in community to provide for cancer related treatment
- Provide community health screenings
- Partner with local health agencies to facilitate grant application to fund cancer programs
- Improve proportion of minorities receiving colonoscopy screenings
- Improve proportion of minorities receiving LDCT screenings
- Improve proportion of minorities receiving women's preventive health services
- Increase the proportion of people who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn through melanoma education and skin cancer screenings.

Measurement:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives
- AGH database
- MD SHIP Measures
- Vital Statistics

Hospital Resources:

- Population Health Department
- Human Resources
- Foundation
- Women's Diagnostic Center
- Endoscopy
- Imaging
- Respiratory Therapy Department
- Regional Cancer Care Center
- AGH Cancer Committee

Community Resources:

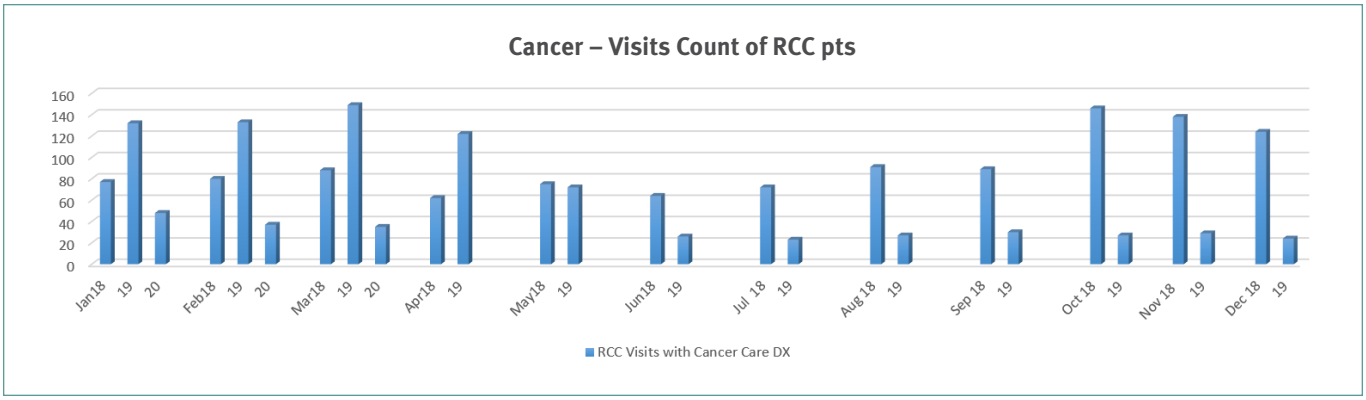
- Worcester County Health Department
- Komen Consortium
- Relay for Life
- Women Supporting Women

#2 Priority Progress: Cancer

CANCER ED/IP VOLUMES (First Three DX Codes)

FY	ED	IP	Totals
FY2019	287	189	476
FY2020	247	130	377

AGH database



-MD SHIP/Healthy People 2020

County: Worcester, MD

176.1

deaths/ 100,000 population

Source: National Cancer Institute
Measurement period: 2012-2016
Maintained by: Conduent Healthy Communities Institute
Last update: October 2019
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value (160.3)
US Value (161.0)	Prior Value (179.7)	Trend
Maryland SHIP 2017 (147.4)	Maryland SHIP 2014 (169.2)	HP 2020 Target (161.4)

County: Sussex, DE

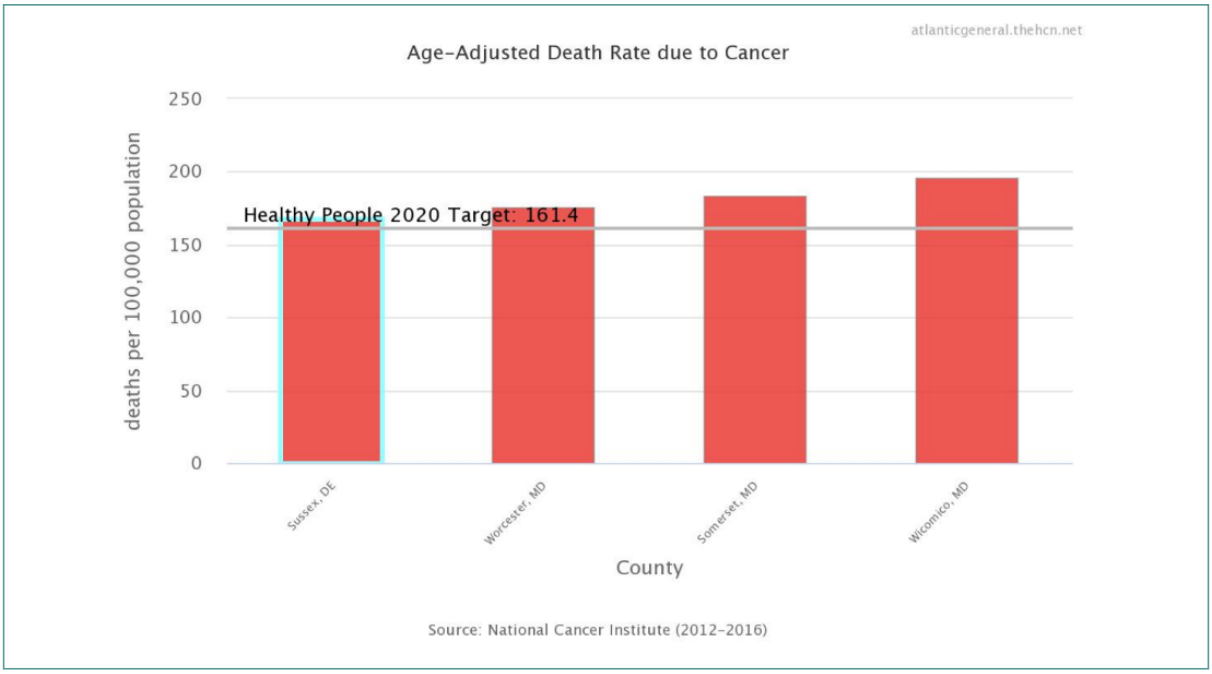
167.7

deaths/ 100,000 population

Source: National Cancer Institute
Measurement period: 2012-2016
Maintained by: Conduent Healthy Communities Institute
Last update: October 2019
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties	DE Value (169.6)	US Value (161.0)
Prior Value (165.9)	Trend	Maryland SHIP 2017 (147.4)
Maryland SHIP 2014 (169.2)	HP 2020 Target (161.4)	



#3 Priority Area: Diabetes

Goal: Decrease incidence of diabetes in the community.

Healthy People 2020 Goal: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.

Anticipated Impact:

- Increase care for individuals suffering from chronic conditions
- Reduce unnecessary healthcare costs
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Increase awareness around importance of prevention of diabetes and early detection
- Increase provider services in community to provide for diabetes related treatment
- Increase participation in community glucose screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs

Impact Rationale: According to the CDC National Center for Health Stats (2015), national data trends for people with Diabetes show a significant rise in diagnoses. In the U.S., Diabetes is becoming more common. Diagnoses from 1980 – 2014 increased from 5.5 million to 22 million.

	Worcester County	Maryland	Sussex County	Delaware
Diabetic Monitoring (Medicare)	88%	85%	89%	86%
Diabetes Prevalence	13%	10%	13%	11%

County Health Rankings, 2016

Action:

- Partner with local health agencies to facilitate grant applications to fund diabetes programs
- Provide Diabetes Support Group
- Explore Diabetes Education opportunities via telehealth
- DPP for AGH Associates
- Provide diabetes screenings in community
- Increase prevention behaviors in persons at high risk for diabetes with pre-diabetes
- Wellness Workshops DSMP for chronic disease self-management

Measurement:

- Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes/objectives
- Incidence of adult diabetes
- SHIP Measure
- Decrease ED visits due to acute episodes related to diabetes condition
- County Health Rankings

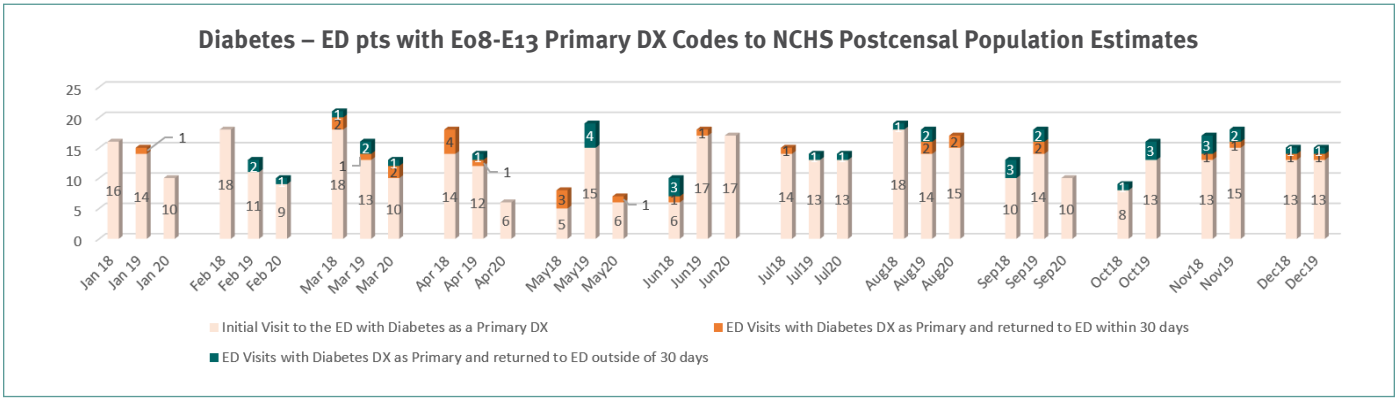
Hospital Resources:

- Diabetes Outpatient Education Program
- Diabetes Support Group
- Population Health Department
- Emergency Department
- Foundation
- Endocrinology
- Outpatient Lab Services

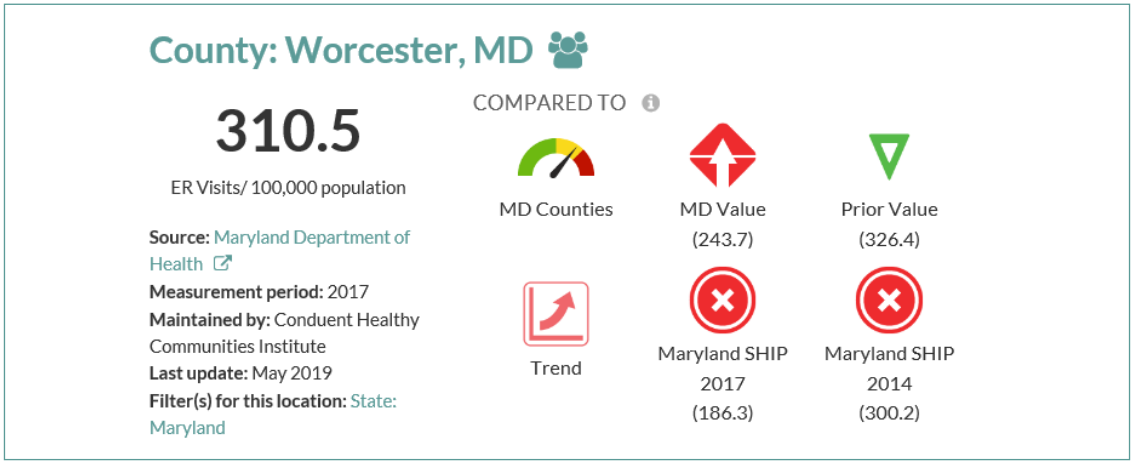
Community Resources:

- Worcester County Health Department
- MAC, Inc.

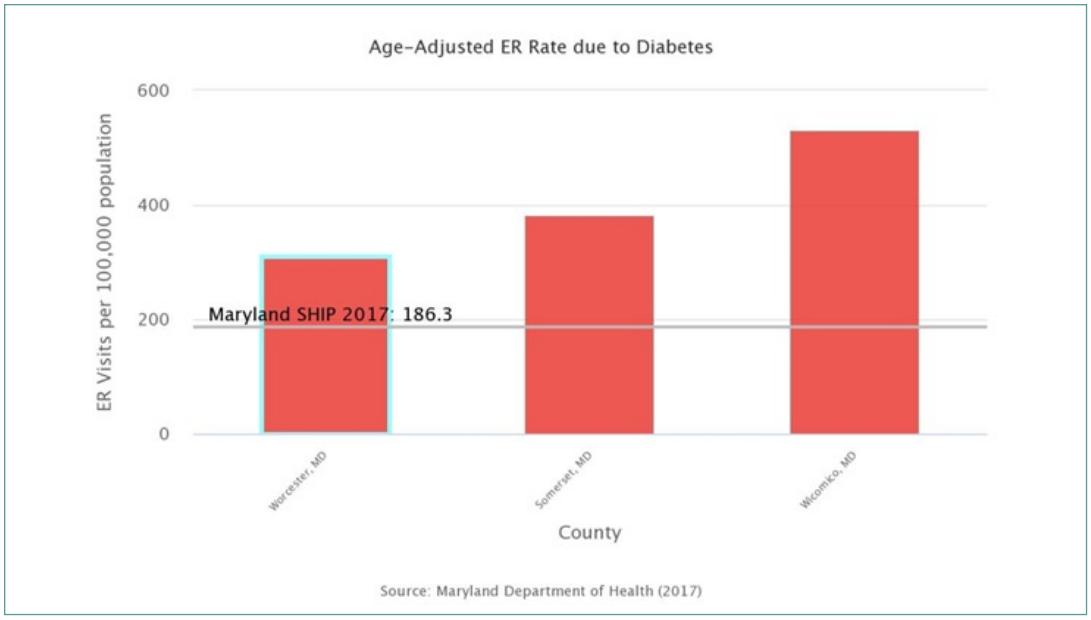
#3 Priority Progress: Diabetes



AGH Database



MD SHIP/Healthy People 2020



County: Worcester, MD

8.0%

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: May 2019
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value (9.6%)	US Value (10.5%)
Prior Value (12.9%)	Trend	

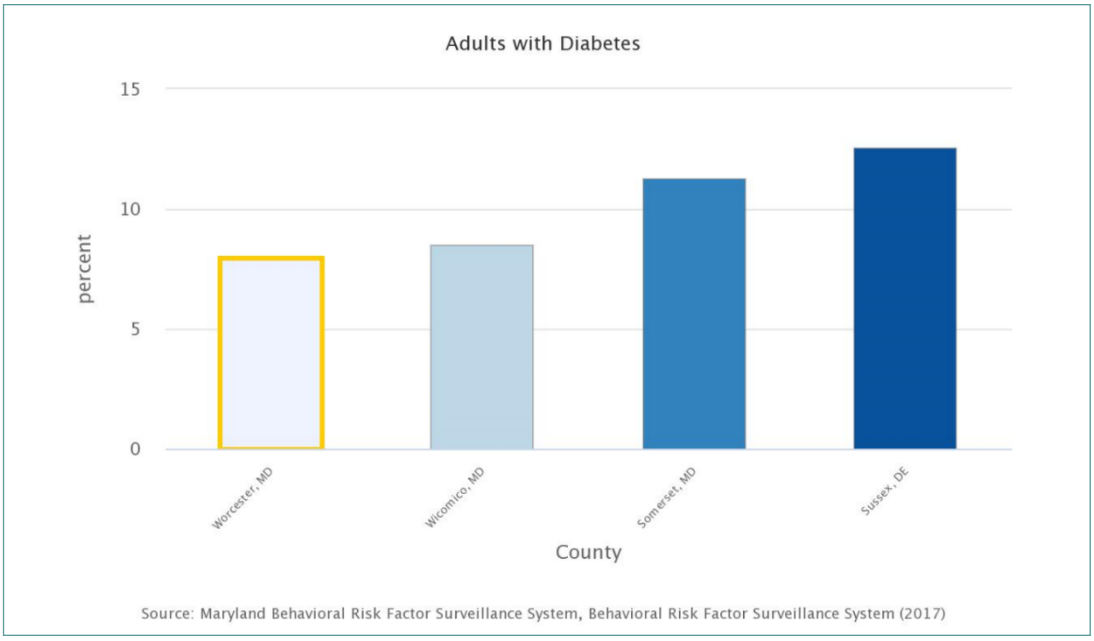
County: Sussex, DE

12.6%

Source: Behavioral Risk Factor Surveillance System
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: October 2018
Filter(s) for this location: State: Delaware

COMPARED TO

DE Value (11.3%)	US Value (10.5%)
Trend	Prior Value (13.1%)



#4 Priority Area: Respiratory Disease, including Smoking

Goal: Promote community respiratory health through better prevention, detection, treatment, and education efforts.

Healthy People 2020 Goal: Promote respiratory health through better prevention, detection, treatment, and education efforts.

Anticipated Impact:

- Increase care for individuals suffering from chronic conditions
- Decrease tobacco, e-cigarettes and vaping use in Worcester County
- Increase health literacy and self-management for health conditions/healthy living
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Increase awareness around importance of prevention and early detection
- Increase provider services in community to provide for respiratory related treatment
- Increase participation in community lung/respiratory screenings – especially at-risk and vulnerable populations

Impact Rationale: According to Healthy People 2020, approximately 23 million Americans have asthma and approximately 13.6 million adults have COPD. Healthy People 2020 estimates that there are an equal number of undiagnosed Americans. (Healthy People 2020)

Action:

- Recruit Pulmonologist to community
- Improve proportion of minorities receiving LDCT screenings
- Collaborate with Worcester County Health Department Prevention Department
- Reduce emergency department (ED) visits for chronic obstructive pulmonary disease (COPD) and asthma
- Provide speakers to community groups on smoking cessation
- Improve Health Literacy in middle schools related to tobacco and vaping use

Measurement:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/respiratory- diseases/objectives
- Decrease ED visits due to acute episodes related to respiratory condition
- Maryland SHIP

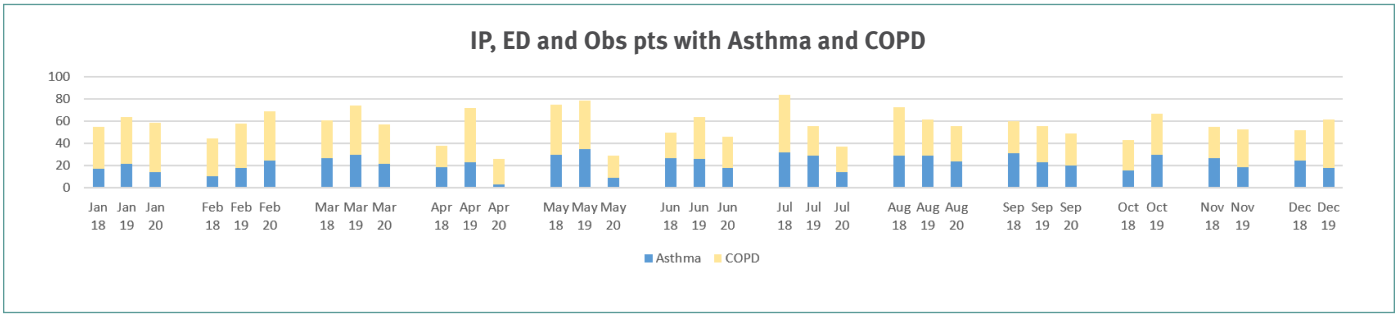
Hospital Resources:

- Respiratory Therapy
- Imaging
- Emergency Department
- Population Health Department
- Human Resources
- Pulmonology

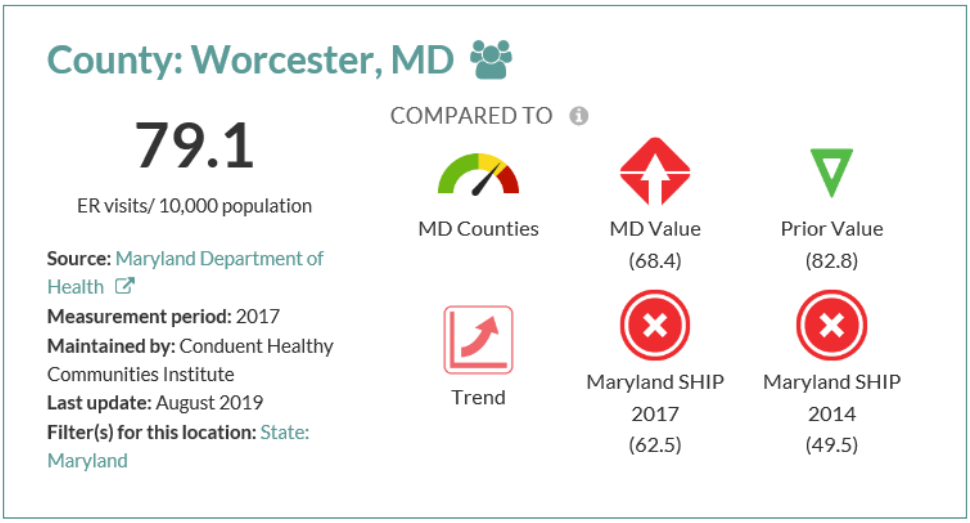
Community Resources:

- Worcester County Health Department
- Worcester County Public Schools

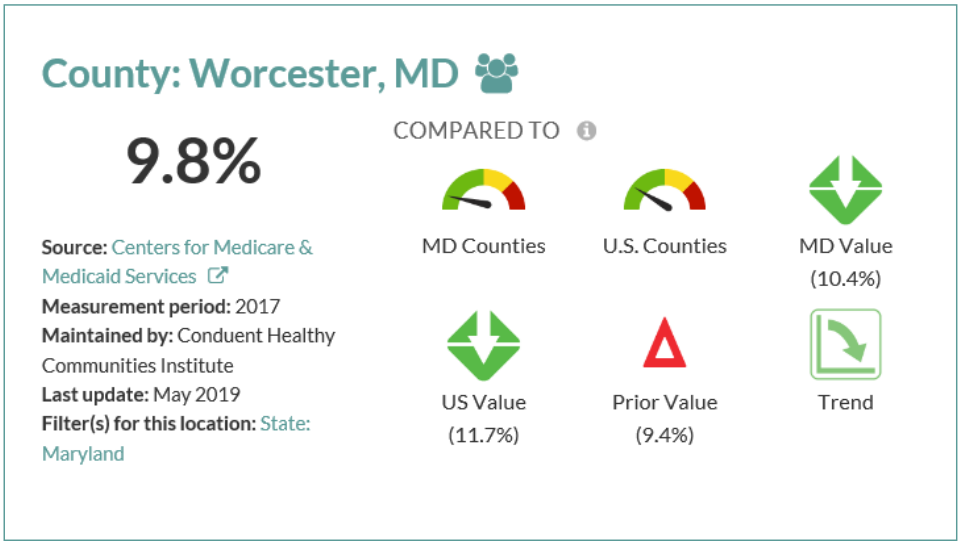
#4 Priority Progress: Respiratory Disease, including Smoking



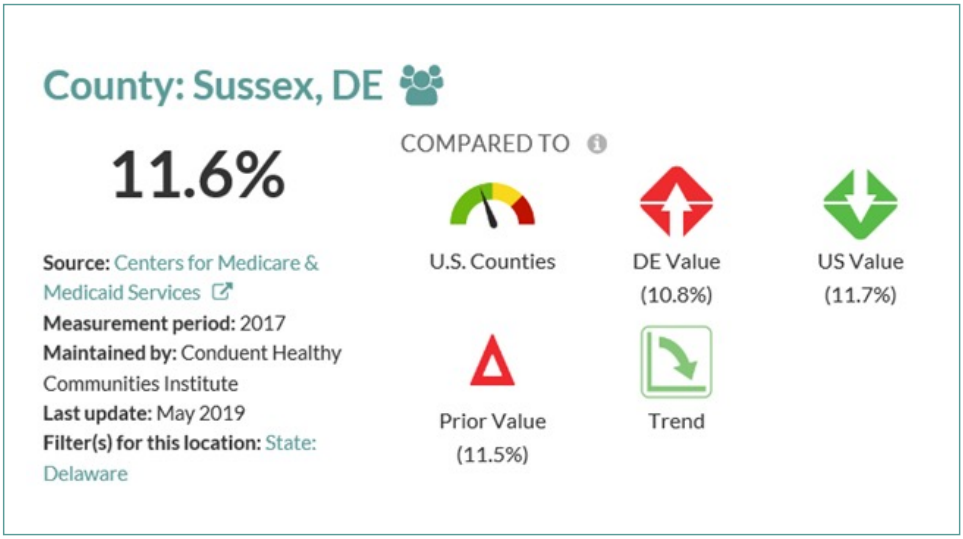
AGH Database



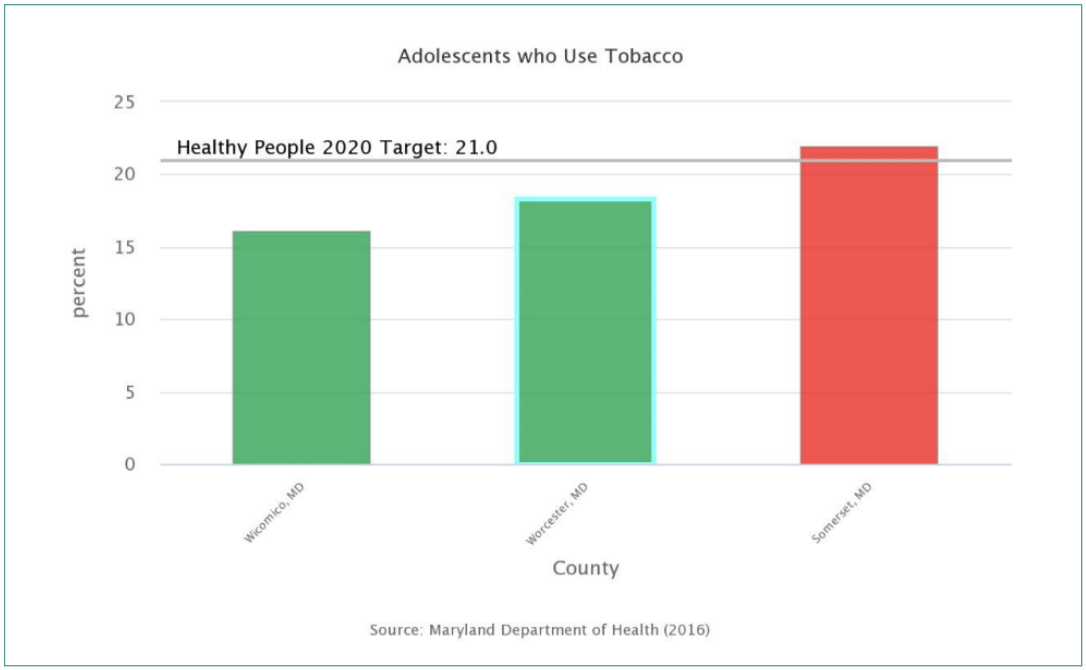
MD SHIP/Healthy People 2020

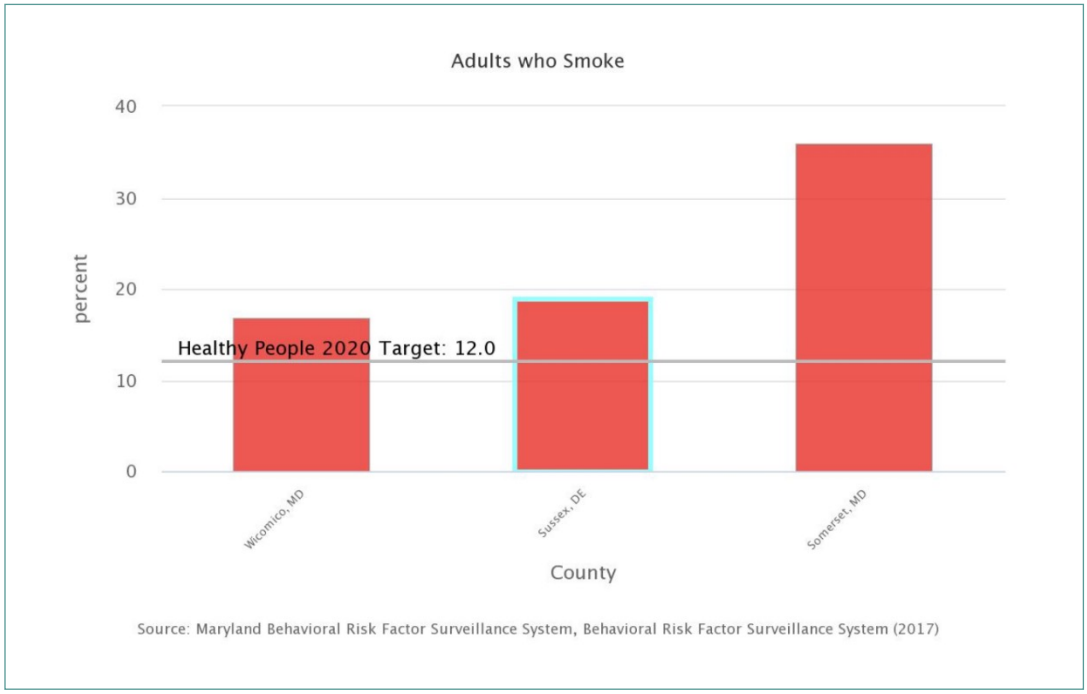


COPD: Medicare Population



COPD: Medicare Population





#5 Priority Area: Nutrition, Physical Activity & Weight

Goal: Support community members in achieving a healthy weight.

Healthy People 2020 Goal: Promote health and reduce chronic disease risk through the consumption of healthful diets to achieve and maintain healthy body weights.

Anticipated Impact:

- Increase health literacy and self-management for health conditions/healthy living
- Increase patient engagement in self-management of chronic conditions

- Decrease hospital admissions and readmissions
- Reduce unnecessary healthcare costs
- Reduce community obesity rate
- Increase access to healthy foods and nutritional information
- Increase awareness around importance of nutrition, exercise and healthy weight
- Increase participation in community BMI screenings – especially at-risk and vulnerable populations
- Increase awareness of community resources, programs and services
- Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs

Impact Rationale: Obesity is defined as having a Body Mass Index (BMI) that is greater than or equal to 30, while being overweight is defined as having a BMI of 25 – 29.9. Obesity has been linked to a variety of cancers and chronic illnesses including diabetes, colorectal cancer, kidney cancer, breast cancer, hypertension and cardiovascular disease (NCI, 2015).

According to the CDC's National Center for Health Statistics (2015), the prevalence of obesity was slightly more than 36 percent in adults and 17 percent in youth.

- The prevalence of obesity was higher in women 38.3% than in men 34.3%. No significant difference was noted by gender among youth.
- The prevalence of obesity was higher among middle-aged and older adults than younger adults. (2013 – 2014)

	Worcester County	Maryland	Sussex County	Delaware
Adult Obesity	30%	28%	31%	29%
Physical Inactivity	27%	23%	27%	25%
Limited Access to Health Foods	4%	3%	5%	6%

County Health Rankings, 2016

Action:

- Improve Health Literacy in elementary and middle schools related to nutrition and exercise
- Participate in the "Just Walk" program of Worcester County
- FAB Program
- Distribution of brochure to public about Farmer's Market and fresh produce preparation
- Provide Hypertension and BMI screenings in the community
- Provide speakers to community groups on nutrition
- Continue to provide education on health living topics to Faith-based Partnership and community senior centers
- Bariatric Support Group
- Participate in community events to spotlight surgical and non-surgical weight loss services

Measurement:

- Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight- status/objectives
- CDC National Center for Health Statistics
- SHIP
- County Health Rankings

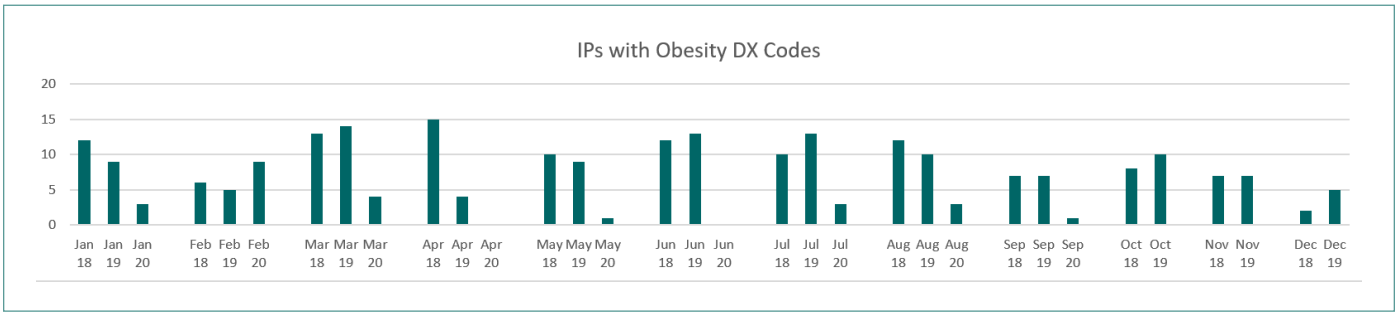
Hospital Resources:

- Population Health Department
- AGHS Offices
- FAB Program and Bariatric Support Group
- Nutrition Services
- Atlantic General Bariatric Center

Community Resources:

- Faith-based Partnership
- Worcester County Public Schools
- Worcester County Health Department
- MAC, Inc.
- Community Senior Centers
- Yoga/Tai Chi Programs
- TOPS of Berlin

#5 Priority Progress: Nutrition, Physical Activity & Weight



AGH Database

Adults Who Are Obese

County: Worcester, MD

39.5%

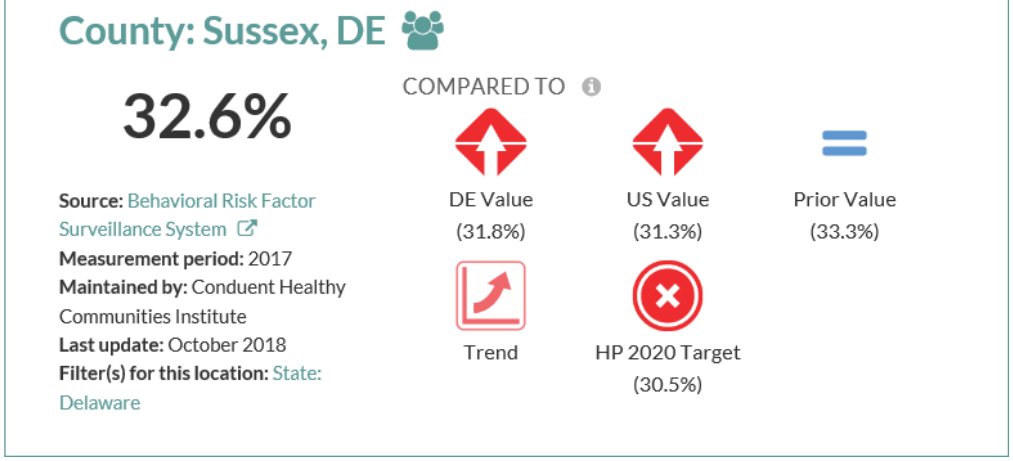
Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: April 2020
Filter(s) for this location: State: Maryland

COMPARED TO

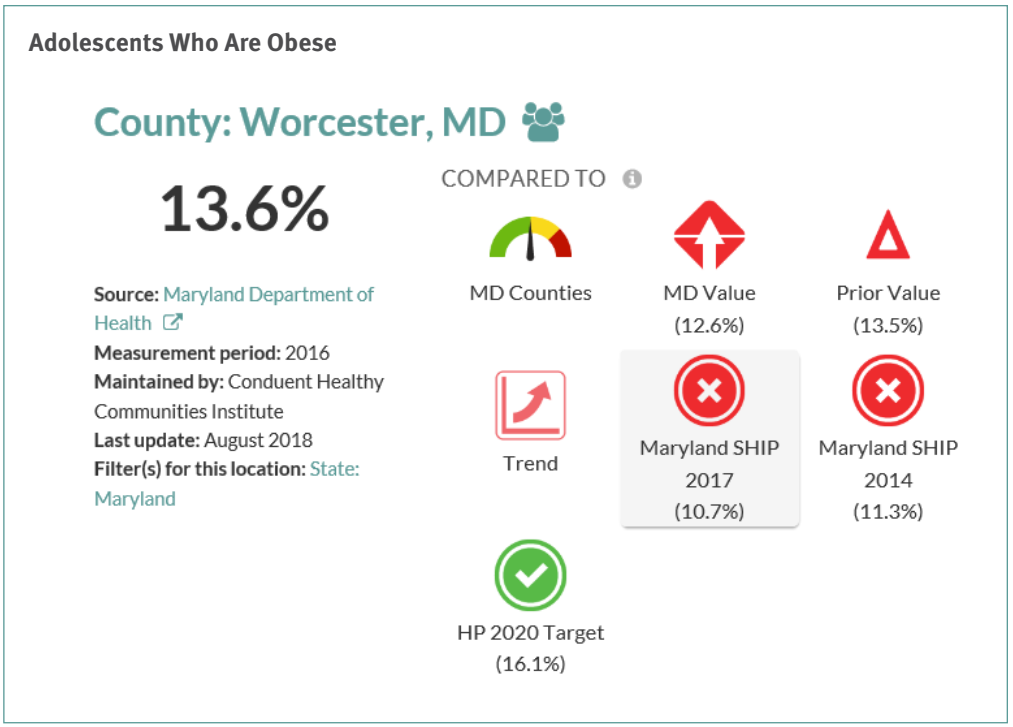
MD Counties	MD Value (31.5%)	US Value (30.9%)
Prior Value (29.6%)	Trend	HP 2020 Target (30.5%)

MD SHIP/Healthy People 2020

Adults Who Are Obese



Adolescents Who Are Obese



#6 Priority Area: Heart Disease & Stroke

Goal: Improve cardiovascular health of community.

Healthy People 2020 Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events.

Anticipated Impact:

- Increase care for individuals suffering from chronic conditions
- Reduce unnecessary healthcare costs
- Decrease tobacco use in Worcester County
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Increase awareness around importance of prevention and early detection of heart disease and hypertension
- Increase provider services in community to provide for cardiovascular related treatment

- Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs
- Increase health literacy and self-management for health conditions/healthy living

Impact Rationale: According to the CDC Heart Disease Statistics and Maps (2015), approximately 610,000 people die of heart disease in the United States yearly. Heart disease is the leading cause death among most ethnic groups. Hypertension, high cholesterol and smoking are key risk factors and 47 percent of Americans have at least one risk factor Heart Disease Statistics and Maps (CDC, 2015).

Action:

- Ensure proper professionals in community to provide vascular care
- Maintain AGH/HS campus and locations as tobacco free
- Increase community health screenings for high blood pressure, carotid artery and cholesterol
- Decrease readmissions to hospital for chronic disease management
- Utilize Faith Based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management
- Improve Health Literacy in elementary and middle schools related to heart health

Measurement:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/heart-disease-and-stroke/objectives
- AGH database
- SHIP Measure
- County Health Rankings

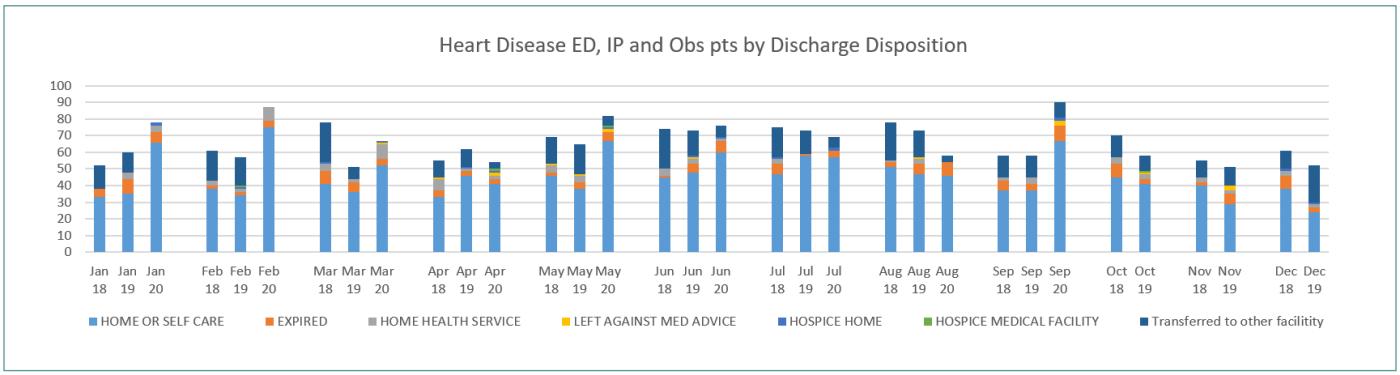
Hospital Resources:

- Population Health Department
- AGH/HS
- Outpatient Lab Services
- Nutrition Services
- Human Resources
- Stroke Center

Community Resources:

- Faith-based Partnership
- MAC, Inc.
- Worcester County Health Department

#6 Priority Progress: Heart Disease & Stroke



AGH database

Worcester County: Age Adjusted Death Rate Due to Hear Disease

County: Worcester, MD

202.0

deaths/ 100,000 population

Source: Maryland Department of Health
Measurement period: 2016-2018
Maintained by: Conduent Healthy Communities Institute
Last update: February 2020
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value (163.8)	US Value (164.7)
Prior Value (198.6)	Trend	Maryland SHIP 2017 (166.3)
Maryland SHIP 2014 (173.4)		

Sussex County: Age Adjusted Death Rate Due to Hear Disease

County: Sussex, DE

166.1

deaths/ 100,000 population

Source: Delaware Department of Health and Social Services, Division of Public Health
Measurement period: 2014-2018
Maintained by: Conduent Healthy Communities Institute
Last update: February 2020
Filter(s) for this location: State: Delaware

COMPARED TO

DE Value (159.4)	US Value (164.7 in 2016-2018)	Prior Value (168.5)
Trend	Maryland SHIP 2017 (166.3)	Maryland SHIP 2014 (173.4)

Worcester County: Age Adjusted Death Rate Due to Stroke

County: Worcester, MD

38.7

deaths/ 100,000 population

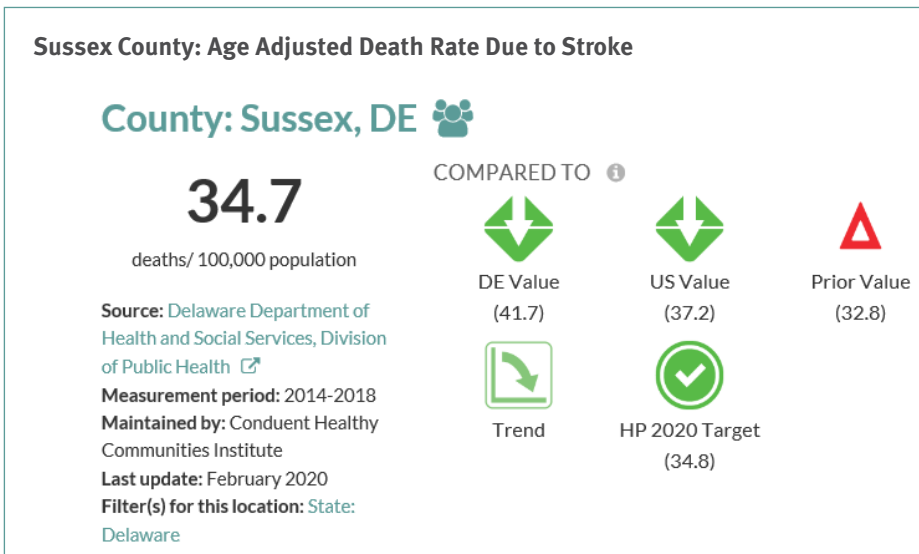
Source: Maryland Department of Health
Measurement period: 2016-2018
Maintained by: Conduent Healthy Communities Institute
Last update: February 2020
Filter(s) for this location: State: Maryland

COMPARED TO

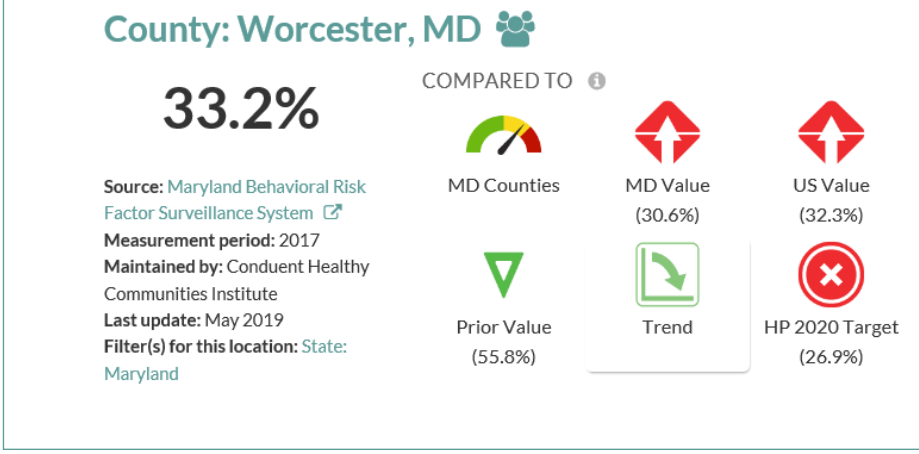
MD Counties	MD Value (40.1)	US Value (37.3)
Prior Value (37.2)	Trend	HP 2020 Target (34.8)

MD SHIP/Healthy People 2020

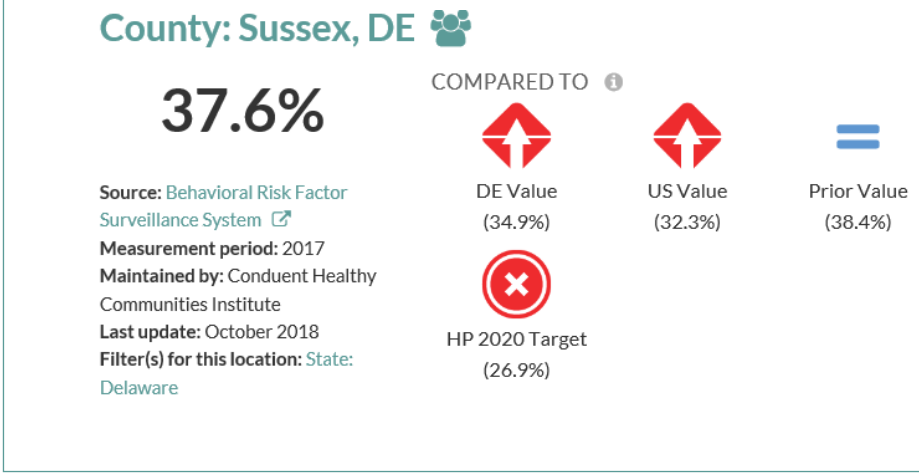
Sussex County: Age Adjusted Death Rate Due to Stroke



Worcester County: High Blood Pressure Prevalence



Sussex County: High Blood Pressure Prevalence



MD SHIP/Healthy People 2020

#7 Priority Area: Behavioral Health

Goal: Promote and ensure local resources are in place to address behavioral health services.

Healthy People 2020 Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.

Healthy People 2020 Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

Anticipated Impact:

- Increase accurate and up-to-date information and referral service
- Improve Health Literacy in elementary and middle schools related to mental health and substance use.
- Decrease opioid abuse and overdose rates in Worcester County
- Increase awareness of community resources, programs and services
- Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs
- Increase provider services in community to provide for behavioral health related treatment

Impact Rationale: According to the CDC Mental Health Surveillance (2013), mental illness affects approximately 25 percent of the U.S. population and is associated with a variety of chronic illnesses.

	Worcester County	Maryland	Sussex County	Delaware
Mental Health Providers	520:1	470:1	610:1	440:1
Poor Mental Health Days	3.5	3.4	3.5	3.7

County Health Rankings, 2016

According to Healthy People 2020, approximately 22 million Americans struggle with addiction to alcohol and/or drugs, and approximately 95 percent are unaware they have a substance use issue. An emerging area of substance use issues includes opiate use. Teen rates of prescription drug abuse have increased over the last 5 years, including nonmedical use of drugs such as Vicodin and OxyContin. (Healthy People 2020)

	Worcester County	Maryland	Sussex County	Delaware
Drug Death Overdose	15	16	16	18
Drug Death Overdose - modeled	18.1-20.0	17.4	16.1-18.0	20.9

County Health Rankings, 2016

Action:

- Increase access and continue to collaborate with Sheppard Pratt telemedicine services to provide additional psychiatry professional services
- Participate in community events to spotlight behavioral health services
- Engage critical response teams when a mental health crisis is discovered
- Partner with WCHD (Peer Support and Case Managers) in AGH ED
- Improve Health Literacy in middle schools related to mental and emotional health

- Recruit LSCW to the community
- Behavioral Health Integration into Primary Care
- Participate on WOW Committee
- Participate on Behavioral Health/Opioid Task Force/Pain Management Team
- Participate in Worcester County Health Department nal-oxone training sessions sponsored by Opiate Overdose Prevention Program
- Increase the proportion of persons who are referred for follow-up care for opioid problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED)
- Evaluate and educate organization and community on appropriate prescribing practices
- Utilize Prescription Drug Maintenance Program (PDMP) via CRISP

Measurement:

- Healthy People 2020
- Behavioral Risk Factor Surveillance System
- County Health Rankings
- AGH database
- SHIP Measure

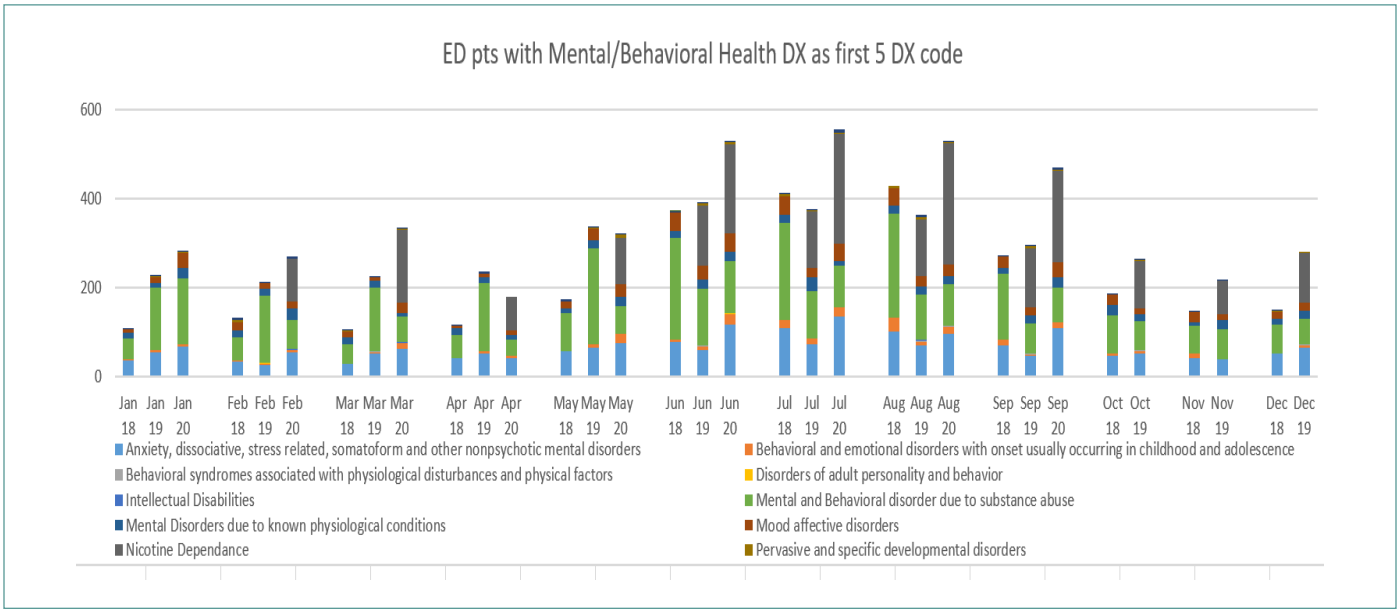
Hospital Resources:

- Population Health Department
- Atlantic Health Center
- Human Resources
- Pastoral Care Services
- Bereavement Support Group
- Pain Rehabilitation Program
- AGH Pharmacy

Community Resources:

- Sheppard Pratt
- Worcester County Health Department
- Worcester Youth and Family Services
- Hudson Health Services
- NAMI Lower Shore Support Group
- Worcester County Public Schools
- WOW
- CRISP

#7 Priority Progress: Behavioral Health



AGH database

Worcester County: Age Adjusted Death Rate Due To Drug Use

County: Worcester, MD

48.7

deaths/ 100,000 population

Source: Maryland Department of Health
Measurement period: 2015-2017
Maintained by: Conduent Healthy Communities Institute
Last update: August 2019
Filter(s) for this location: State: Maryland

COMPARED TO

MD Value	US Value	Prior Value
(30.9)	(20.3)	(28.0)

Trend	Maryland SHIP 2017	HP 2020 Target
	(12.6)	(11.3)

Worcester County: Age Adjusted Death Rate Due To Alcohol/Substance Abuse

County: Worcester, MD

1,977.1

ER visits/ 100,000 population

Source: Maryland Department of Health
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: May 2019
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value	Prior Value
	(2,017.0)	(2,084.5)

Trend	Maryland SHIP 2017
	(1,400.9)

Worcester County: Age Adusted Suicide Rate

County: Worcester, MD

12.0

deaths/ 100,000 population

Source: Maryland Department of Health
Measurement period: 2011-2013
Maintained by: Conduent Healthy Communities Institute
Last update: April 2015
Filter(s) for this location: State: Maryland

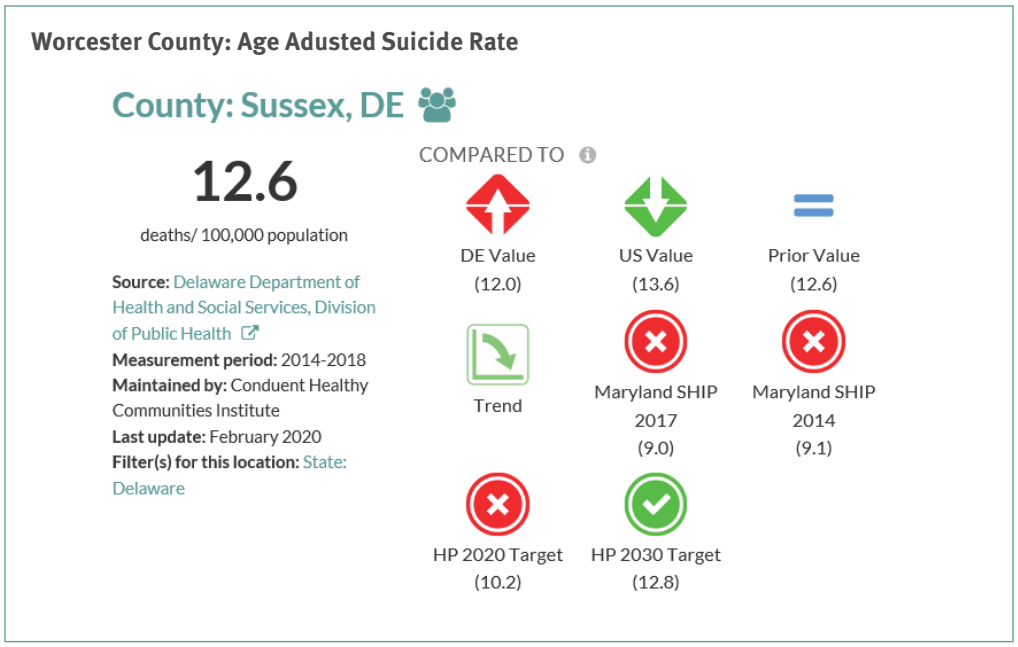
COMPARED TO

MD Value	US Value	Prior Value
(9.0)	(12.5)	(13.5)

Trend	Maryland SHIP 2017	Maryland SHIP 2014
	(9.0)	(9.1)

HP 2020 Target	HP 2030 Target
(10.2)	(12.8)

MD SHIP/Healthy People 2020



#8 Priority Area: Arthritis, Osteoporosis & Chronic Back Pain

Goal: Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions in the community.

Healthy People 2020 Goal: Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions.

Anticipated Impact:

- Reduce unnecessary healthcare costs
- Increase provider services to community to provide for arthritis and other rheumatic conditions, osteoporosis, and chronic back condition related treatments
- Increase health literacy and self-management for chronic health conditions/healthy living

Impact Rationale: According to Healthy People 2020, arthritis, osteoporosis and chronic back pain impact quality of life, activities of daily living and ability to work. Arthritis affects one in five adults. Osteoporosis affects approximately 5.3 million adults aged 50 years and older in the United States. Also, approximately 80 percent of people in the United States experience chronic back conditions. Successful and underused interventions include weight management, physical activity and self-management. (Healthy People 2020)

According to CHNA Survey summary of findings, an area of significant need includes prevalence of sciatica and chronic back pain in the community.

Action:

- Utilize Faith Based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic pain workshops
- Explore osteoporosis clinic program
- Utilize Women's Diagnostic Health Services to provide access to high risk populations about healthy lifestyles and bone density screenings
- Provide educational opportunities to raise community awareness about osteopenia/osteoporosis and provide bone density screenings
- Increase accurate and up-to-date information and referral service

Measurements:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/Arthritis-Osteoporosis-and-Chronic-Back-Conditions
- CPSMP Workshop attendance
- SHIP
- County Health Ranking
- Community Survey

Hospital Resources:

- Population Health Department
- Human Resources
- Atlantic Health Center/Pain Management
- Women's Diagnostic Health Services

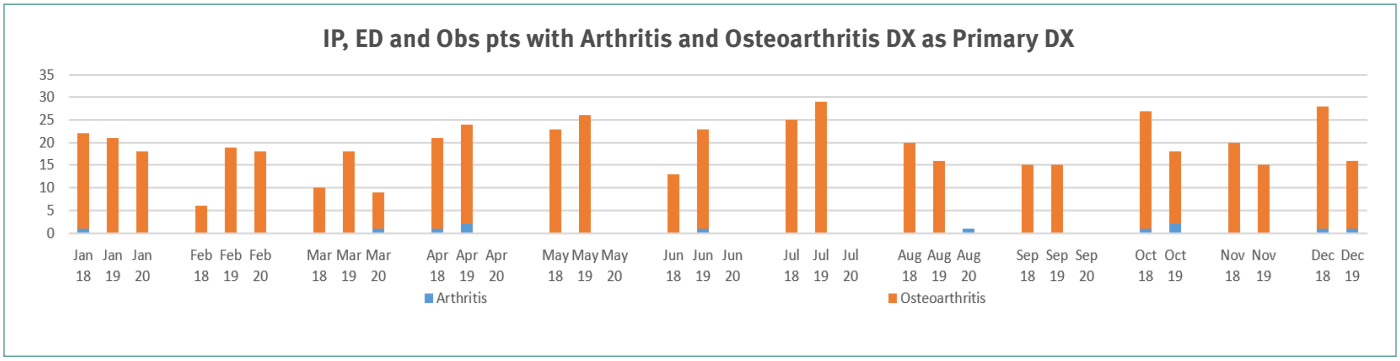
Community Resources:

- MAC, Inc.
- Faith-based Partnership

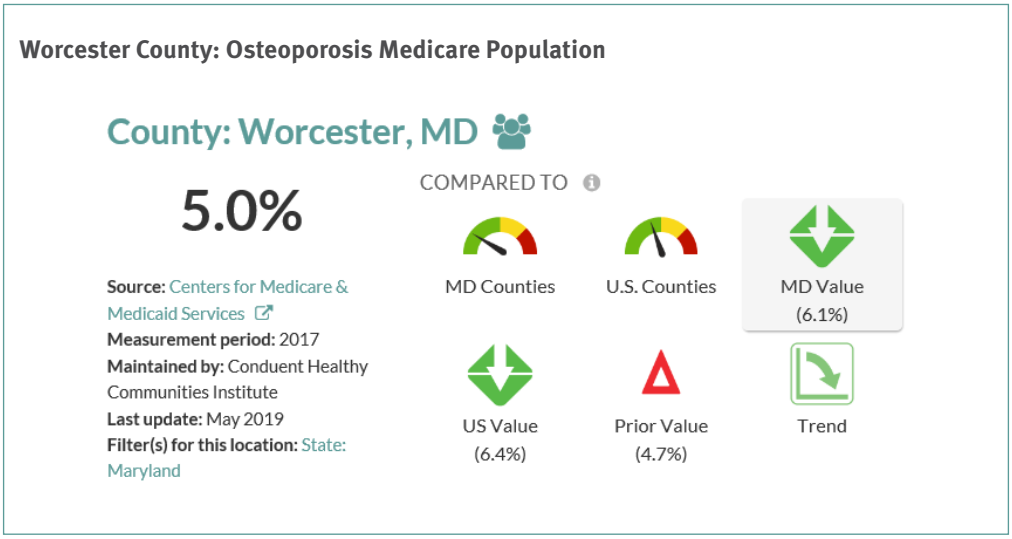
#8 Priority Progress: Arthritis, Osteoporosis & Chronic Back Pain

Community Survey: Next CHNA Cycle FY22-24

MAC Workshop Attendance: During FY19-20, through a contract with MAC's evidence-based Living Well and Stepping on Programs, community members were provided both Chronic Pain Self-Management Workshops (CPSMP) and Stepping On Falls Prevention/Malnutrition Workshops. Through this programming, 68 persons were served with a completer rate of 88.2%.



-AGH database



-MD SHIP/Healthy People 2020

Sussex County: Osteoporosis Medicare Population

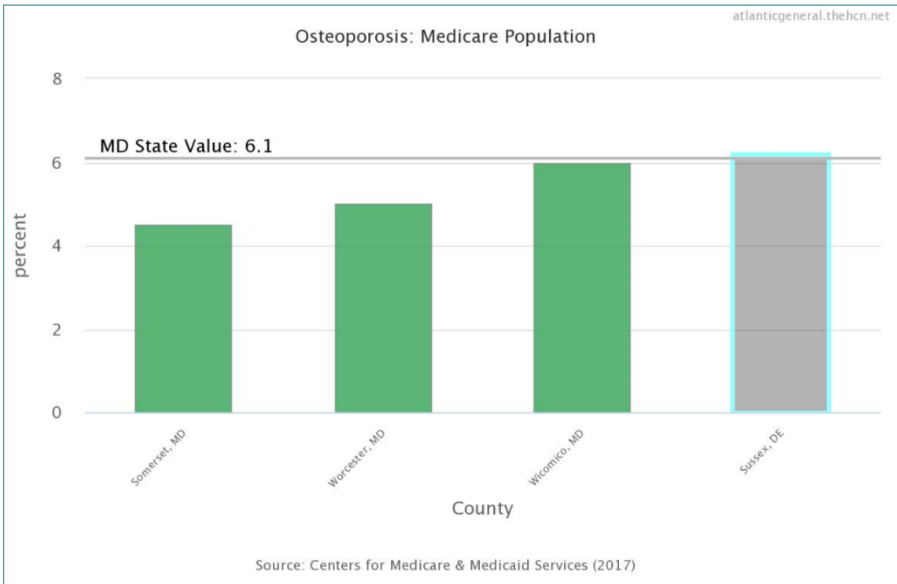
County: Sussex, DE

6.2%

Source: Centers for Medicare & Medicaid Services
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: May 2019
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties	DE Value (5.7%)	US Value (6.4%)
Prior Value (5.8%)	Trend	



Worcester County: Rheumatoid or Other Osteoarthritis

County: Worcester, MD

32.8%

Source: Centers for Medicare & Medicaid Services
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: May 2019
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value (33.8%)
US Value (33.1%)	Prior Value (31.0%)	Trend

Sussex County: Rheumatoid or Other Osteoarthritis

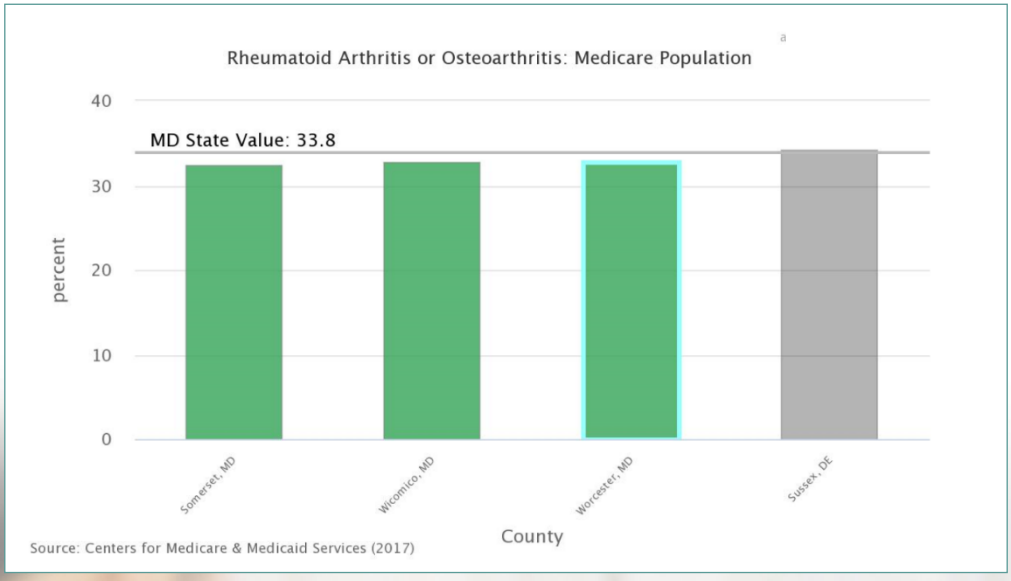
County: Sussex, DE

34.3%

COMPARED TO

U.S. Counties	DE Value (34.0%)	US Value (33.1%)
	Prior Value (33.2%)	Trend

Source: Centers for Medicare & Medicaid Services
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: May 2019
Filter(s) for this location: State: Delaware



Other Needs Identified

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

Needs Not Addressed In Plan Rationale

Dental/ Oral Health	• Need addressed by Worcester Health Department's Dental Services for pregnant women and children under 21 • Priority Area Worcester CHIP • Need addressed by Lower Shore Dental Task Force & Mission of Mercy for adult population • Need addressed by AGH ED referral to community resources • Need addressed by Chesapeake Health Services, a federally funded dental clinic for Somerset and Wicomico Counties
Injury & Violence	• Need addressed by Worcester Health Department Programs: Child Passenger Safety Seats (refer to Worc GOLD) • Injury Prevention • Highway Safety Program • Safe Routes to School • Need addressed by Worcester County Sheriff's Department, State Police and Municipal Law Enforcement Agencies • Need addressed by AGH Health Literacy Program
HIV & STD (<2% ea)	• Need addressed by Worcester County Health Department Communicable Disease Programs

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Community Health Needs Assessment FY2019-2021

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ATLANTIC
GENERAL HOSPITAL
care.givers

Atlantic General Hospital

Implementation Plan of Needs Identified in the Community Health Needs Assessment

FY2022 - 2024

ATLANTIC GENERAL HOSPITAL

care.givers

Community Health Needs Assessment

This CHNA represents the fourth time that Atlantic General Hospital has collaborated and completed the Community Health Needs Assessment process. A Community Health Needs Assessment is intended to provide information to help hospitals and other community organizations identify opportunities to improve the health of the community. The CHNA process identifies factors that influence the health of a population and determine the availability of resources that adequately address health concerns.

With the information provided in this report, hospital leaders and partners develop plans to address community health priorities and build upon the capacity, resources and partnerships of existing programs. AGH participates closely with Worcester County Health Department, Wicomico County Health Department, Somerset County Health Department, and Tidal Health to provide Community Health Assessment data, surveys and programs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of our service area. The Community Health Needs Assessment (CHNA) was approved by the Hospital's Board of Trustees in May 2022.

A community health needs assessment provides an overview of the health needs and priorities of the community.

Needs Identified

This CHNA combines population health statistics in addition to feedback gathered from the community in the form of surveys and focus groups. AGH uses the Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feed- back are particularly useful in identifying priority health needs and developing action plans to meet those needs.

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (surveys) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes information gathered through ongoing key community groups.

AGH partners with surrounding hospitals, health departments and state agencies to bring to together a multitude of information. This CHNA, a follow-up to similar studies

Needs Identified *(cont.)*

conducted in 2012, 2015, and 2018, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area of Atlantic General Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

The information as well as other surveys, research and community data are used to identify issues of greatest concern, and guide resource allocation to those areas – thereby making the greatest possible impact on community health status.

The CHNA is a primary tool used by the Hospital to determine its community benefit priorities, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. The assessment incorporates components of primary data collection and secondary data analysis that focuses on the health and social needs of our service area.

A sampling of resources utilized to complete the assessment is listed to the right. (A comprehensive list is found under References.)

- **Community meetings with persons representing the broad interests of the community**
- **AGH Community Needs Survey**
- **Maryland State Health Improvement Process (SHIP)**
- **Tri-County Health Improvement Plan (T-CHIP)**
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Our Vision

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

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... To provide a coordinated care system with access to quality care, personalized service and education to create a healthy community

Needs Identified

The Community Health Needs Assessment survey was distributed by community outreach personnel and the Atlantic General Hospital website. Stakeholder interviews, public forums and focus groups were conducted by the Population Health Department. Community surveys represent information that is self-reported.

#1 High Blood Pressure/Stroke
#2 Overweight/Obesity
#3 Diabetes/Sugar
#4 Cancer
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#6 Smoking, drug or alcohol use
#7 Mental Health Issues (depression, anxiety)
#8 Access to Healthcare / No Health Insurance
#9 Asthma / Lung Disease
#10 Dental Health

Bold items addressed as priority areas in implementation plan.
Italicized items not addressed as priority areas in implementation plan.

Top Health Concern Priorities Over the (4) CHNA

	2012	2015	2018	2021
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Asthma / Lung Disease	9	9	10	9
Dental Health	10	10	9	10
Injuries	11	11	11	11
Infectious Disease	NA	NA	NA	12
Sexually Transmitted Disease & HIV	12	12	12	13

Prioritized Needs

Key findings from all resources were used as a framework to develop community benefit priorities. These are closely aligned with local, state, and national priority areas. The process for determining the priorities of the Community Outreach programs involves many people inside and outside the organization.

AGH's strategic initiatives are determined by the Hospital Board of Trustees, the Medical Staff and the Leadership of the Hospital. Each year those long-term initiatives are evaluated and updated with environmental information, such as the most recent CHNA. In addition to input from those groups, there are additional committees that have a part in setting our priorities: the AGH Planning Committee, Patient & Family Advisory Committee, Community Benefits Committee, and Healthy Happenings Committee.

The Patient & Family Advisory Committee is made up of Hospital and community members who have a health connection in the community. Through this board, we are able to keep our pulse on the needs of the community.

Each department in the hospital has an appointee who sits on the Community Benefits Committee. The purpose of this committee is to oversee the Community Outreach of AGH and comply with the government regulations regarding reporting Community Benefits. Because the committee is made up of all departments, the views are varied. Annual evaluations of each initiative's success are found in the HSCRC Community Benefit Report provided to the State of Maryland.

AGH leaders are involved on many community boards and community entities (both for-profit and not-for-profit). Through these boards we are able to keep abreast of the underserved, low income and/or minority needs in the community. We are involved in the health departments throughout our service area in MD and DE. We coordinate services with them to decrease duplication of services and know what services are needed to fill the gaps.

Working with the target areas of the state improvement initiatives influences the priorities we set. Our Population Health outreach providers are out in the community and are able to observe com- munity needs. Through our Patient Centered Medical Home, Care Coordination models and Population Health Department, we are able to have another resource in the community which we can use for assisting us in setting priorities.

The 2022-2024 Community Benefit priorities are based on the criteria of:

- Size and severity of the problem, determined by what percentage of the population is affected by risks
- Health System's ability to impact the need
- Availability of resources
- Social needs and health inequities

They were graded as high (3), moderate (2) and low (1) to rank the priority, based on self-reported survey data and prioritized as above.

Community Health Needs Assessment Priorities

Health Need	Specific Opportunity	Size & Severity of Problem	AGH/S Ability to Impact the Problem	Availability of Resources	Social Needs/Health Inequities	Impact Rating
High blood pressure/stroke		3	3	3	3	12
Diabetes/sugar	pre-diabetic screenings, education, medication	3	3	3	3	12
Mental Health issues	Depression, Anxiety	3	3	2	3	11
Smoking, drug or alcohol use	alcohol, opiates	3	2	3	3	11
Overweight/obesity	Access to healthy food	3	3	2	3	11
Cancer	Lung, Prostate (CRISP)	1	3	3	3	10
Heart Disease	HF, Afib (CRISP)	3	1	1	3	8

FY22-24 Priority Areas

- High Blood Pressure/Stroke
- Diabetes/Sugar
- Cancer
- Heart Disease
- Smoking, drug or alcohol use
- Mental health issues (depression, anxiety)
- Overweight and Obesity

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

HIGH BLOOD PRESSURE AND STROKE

AGH GOAL

Improve cardiovascular health of the community.

HEALTHY PEOPLE 2030 GOAL

Increase control of high blood pressure in adults.

Strategy	Intended Actions
• Implement initiatives to raise awareness and provide education on high blood pressure and stroke throughout our organization and in the community.	• Increase enrollment in care coordination for hypertension related issues • Increase compliance with hypertension HEDIS measures within our AGHS patient population. • Increase community health screenings for high blood pressure • Increase recruitment of clinical professionals in the community to provide primary care. • Increase access to primary care by increasing the number of available appointments with primary care within AGHS

Measurement

- Exceed the Healthy People target of 18.9% of adults aged 18 and older with high blood pressure under control. (data reported annually, Health.gov, Healthy People 2030)
- HEDIS measures for hypertension. Maintain compliance to hit top tier/star level performance. (MDPCP dashboard, CPM reports and third party payer reports)
- Decrease in the State Health Insurance Program (SHIP) measure Emergency Department visit rate due to hypertension. (health.maryland.gov)
- County Health Rankings. Improvement in county health rankings related to hypertension related illness and mortality. (countyhealthrankings.org)

Hospital Resources	Community Resources
• Population Health Department • Atlantic General Health System • AGH HEDIS nurse • AGH outpatient ancillary services	• Faith-based Partnership • Maintaining Active Citizens, Inc. (MAC, Inc.) • Worcester County Health Department • Tidal Health, Inc.

Anticipated Impact

- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions and reduce unnecessary healthcare costs.
- Increase awareness around importance of prevention and early detection of heart disease and hypertension
- Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs
- Increase health literacy and self-management for health conditions/healthy living

Impact Rationale

According to the CDC (2022), in 2020, more than 670,000 deaths in the United States had hypertension as a primary or contributing cause. Having hypertension puts you at risk for heart disease and stroke, which are leading causes of death in the United States. Nearly half of adults in the United States (47%, or 116 million) have hypertension, defined as a systolic blood pressure greater than 130 mmHg or a diastolic blood pressure greater than 80 mmHg or are taking medication for hypertension (CDC, 2021).

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Diabetes

AGH GOAL

Decrease incidence of diabetes in the community.

HEALTHY PEOPLE 2030 GOAL

Reduce the burden of diabetes and improve the quality of life for all people who have, or are at risk for, diabetes.

Strategy	Intended Actions
• Implement initiatives to raise awareness and provide access to care, education and outreach for diabetes	• Partner with local health agencies to facilitate grant applications to fund diabetes programs • Evaluate and implement Diabetes Education opportunities via telehealth • Implement a Diabetes Prevention Plan (DPP) for AGH Associates • Provide prediabetes and diabetes screenings and education on diabetes prevention behaviors in the community • Increase access to Diabetes Self-Management Education (DSME)and Diabetes Support Groups • Increase access to primary care by increasing the number of available appointments with primary care within AGHS

Measurement

- Exceed the current performance target of Healthy People 2030 for adults with diabetes that get formal diabetes education. (data reported annually, Health.gov, Healthy People 2030)
- Incidence of adult diabetes
- Decrease in the State Health Insurance Program (SHIP) measures for ED visits due to diabetes. (health.maryland.gov)
- County Health Rankings. Improvement in county health rankings related to the prevalence of diabetes in the community. (countyhealthrankings.org)
- HEDIS measures for diabetes (five measures)

Hospital Resources	Community Resources
• Population Health Department • Diabetes Outpatient Education Program • Emergency Department • Foundation • Outpatient Lab Services • Endocrinology (Atlantic General Health System) • Diabetes Support Group	• Worcester County Public Schools • Worcester County Health Department • TidalHealth, Inc.

Anticipated Impact

- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions, readmissions, and ED visits related to Diabetes
- Increase awareness around importance of prevention of diabetes and early detection
- Increase provider services in community to provide for diabetes related treatment
- Increase participation in community glucose screenings, diabetes and pre-diabetes screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs

Impact Rationale

According to the CDC National Center for Health Stats (2021), more than 122 million Americans are living with diabetes (37.3 million) or prediabetes (96 million).

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Cancer

AGH GOAL

Decrease the incidence of advanced breast, lung, colon, and skin cancer in community.

HEALTHY PEOPLE 2030 GOAL

Reduce new cases of cancer and cancer-related illness, disability, and death.

Strategy	Intended Actions
• Implement initiatives to raise awareness and provide education and outreach for cancer prevention and treatment.	• Recruit and retain professionals to provide for cancer related treatment in the community • Provide community health screenings and education on healthy behaviors and cancer prevention • Partner with local health agencies to facilitate grant application to fund cancer programs • Improve proportion of minorities receiving colonoscopy screenings, LDCT screenings, and women's preventative health services

Measurement

- Exceed the current performance target of Healthy People 2030 for cancer death rates in our community. (data reported annually, Health.gov, Healthy People 2030)
- Increase in State Health Insurance Program (SHIP) measure for mammography screenings. (health.maryland.gov)
- HEDIS colorectal screening measure. Maintain compliance to hit top tier/star level performance. (MDPCP and CareFirst dashboard)

Hospital Resources	Community Resources
• Population Health Department • Women's Diagnostic Center • Endoscopy Services • AGH outpatient ancillary services • Regional Cancer Care Center • AGH Cancer Committee • Atlantic General Health System	• Worcester County Health Department • Komen Consortium • Relay for Life • Women Supporting Women • University of Maryland • TidalHealth, Inc. • Beebe Healthcare

Anticipated Impact

- Increase awareness around importance of prevention and early detection
- Increase provider services in community to provide for cancer related treatment
- Reduce health disparities
- Improve access and referrals to community resources resulting in better outcomes
- Increase support to patients and caregivers
- Increase participation in community cancer screenings – especially at-risk and vulnerable populations

Impact Rationale

According to Healthy People 2030, while cancer is the second leading cause of death in the United States, the cancer death rate has declined in recent decades with over 600,000 people still dying from cancer each year. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care. (Healthy People 2030)

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Heart Disease

AGH GOAL

Improve cardiovascular health of the community.

HEALTHY PEOPLE 2030 GOAL

Preventing and treating heart disease and stroke and improving overall cardiovascular health by controlling risk factors like high blood pressure and high cholesterol through treatment.

Strategy	Intended Actions
• Implement initiatives to raise awareness and provide education on heart disease throughout our organization and in the community	• Increase recruitment of clinical professionals in community to provide primary care • Maintain AGH/AGHS campus and locations as tobacco and vaping free • Increase community health screenings for high blood pressure, carotid artery and cholesterol • Increase enrollment in care coordination for chronic disease management • Increase outreach events to provide screenings to high risk and underserved populations. • Increase access to primary care by increasing the number of available appointments with primary care within AGHS

Measurement

- Exceed the current performance target of Healthy People 2030 for cardiovascular health in adults. (data reported annually, Health.gov, Healthy People 2030)
- Increase in the State Health Insurance Program (SHIP) measures for persons with a usual primary care provider. (health.maryland.gov)

Hospital Resources	Community Resources
• Population Health Department • AGH outpatient ancillary services • Stroke Center • Atlantic General Health System	• Faith-based Partnership • Worcester County Health Department • TidalHealth, Inc.

Anticipated Impact

- Decrease hospital admissions and readmissions related to heart disease
- Increase awareness around importance of prevention and early detection of heart disease and hypertension
- Increase provider services in community to provide for cardiovascular related treatment
- Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs
- Increase health literacy and self-management for health conditions/healthy living

Impact Rationale

According to the CDC Heart Disease Statistics (2020), approximately 697,000 people die of heart disease in the United States yearly. Heart disease is the leading cause death among women and men and most ethnic groups. Hypertension, high cholesterol and smoking are key risk factors and 47 percent of Americans have at least one risk factor.

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Smoking, Drug or Alcohol Use

AGH GOAL

Provide access to resources and treatment that supports smoking cessation and alcohol and drug use intervention and treatment.

HEALTHY PEOPLE 2030 GOAL

Reduce illness, disability, and death related to tobacco use and secondhand smoke and reduce misuse of drugs and alcohol.

Strategy	Intended Actions
• Increase access to substance use treatment within our community	• Continued recruitment of psychiatric providers that are certified to address substance use disorders • Recruit Peer Recovery Specialists for behavioral health and substance use interventions
• Increase education within our organization and community related to substance use disorders and resource and appropriate medication use	• Participate in naloxone training and distribution of Narcan kits through the Worcester Goes Purple and Worcester County Health Department for both community members and AGH/S employees • Evaluate and educate organization and community on appropriate prescribing practices • Utilize Prescription Drug Maintenance Program (PDMP) via CRISP within our organization
• Increase education within our organization and community related to smoking risks and cessation options	• Recruit and retain pulmonologist(s) • Increase in smoking cessation screenings at community outreach events and within AGHS

Measurement

- Exceed the current performance target of Healthy People 2030 for adults with a substance use disorder who got treatment in the last year. (data reported annually, Health.gov, Healthy People 2030)
- HEDIS measures for SBIRT and smoking cessation. Maintain compliance to hit top tier/star level performance. (MDPCP and CareFirst dashboard)
- Decrease in the State Health Insurance Program (SHIP) measure for adult smoking rate. (health.maryland.gov)

Hospital Resources	Community Resources
• Respiratory Therapy • AGH outpatient ancillary services • Emergency Department • Population Health Department • Pulmonology – Atlantic General Health System • Behavioral Health Department	• Worcester County Health Department (WCHD) • Maryland Health Department • Worcester Goes Purple • Hope 4 Recovery • Sun Behavioral Health

Anticipated Impact	Impact Rationale
• Decrease tobacco and vaping use in Worcester County • Decrease hospital admissions and readmissions and ED visits related to substance use and COPD • Increase provider services in community to provide for respiratory related treatment and smoking cessation programs • Increase access for individuals requiring urgent intervention for drug and alcohol addiction issues • Increase community education on resources available through the crisis center to connect patients to substance use treatment. • Increase Peer Support for behavioral health and substance use disorder interventions	According to Healthy People 2030, more than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year and more than 20 million adults and adolescents in the United States have had a substance use disorder in the past year.

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Mental Health Issues (depression and anxiety)

AGH GOAL

Provide immediate access to individuals requiring urgent behavioral health assessment and intervention as well as ensure local resources are in place to address ongoing management of behavioral health needs.

HEALTHY PEOPLE 2030 GOAL

Improve mental health through prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. The Mental Health and Mental Disorders objectives also aim to improve health and quality of life for people affected by these conditions.

Strategy	Intended Actions
• Increase access to mental health providers any expand types of mental health services available in the community.	• Partner with Chesapeake Health Care to increase access to mental health services • Continue to collaborate with Kennedy Krieger Institute for telemedicine services to provide additional psychiatry professionals • Increase utilization of Behavioral Health Integration in Primary Care locations
• Increase partnerships in the community to further establish a regional hub of mental health care.	• Continue to expand engagement and partnership with Crisis Response Team (CRT) and local law enforcement to address ongoing mental health crisis issues • Continue to expand community participation on AGH Behavioral Health Opioid Stewardship Committee • Partner with WCHD (Peer Support and Case Managers) in AGH Emergency Department
• Increase community education and awareness of mental health conditions and resources	• Participate in community events to spotlight behavioral health services • Continued collaboration and education for AGHS providers and staff on management of this patient population and resources available

Measurement

- Exceed the current performance target of Healthy People 2030 for adults with serious mental illness and depression that receive treatment. (data reported annually, Health.gov, Healthy People 2030)
- County Health Rankings. Improvement in county health rankings related to mental health. (countyhealthrankings.org)
- HEDIS measures for PHQ2. Maintain compliance to hit top tier/star level performance. (MDPCP and CareFirst dashboard)
- Decrease in the State Health Insurance Program (SHIP) measures for suicide rate and ED visits for mental health. (health.maryland.gov)

Hospital Resources	Community Resources
• Population Health Department • Behavioral Health Department • Pastoral Care Services • Bereavement Support Group • AGHRx RediScripts Pharmacy • Behavioral Health & Opioid Stewardship Committee • Atlantic General Health System	• Worcester County Health Department • Worcester Youth and Family Services • Worcester Goes Purple • Hudson Health Services • NAMI Lower Shore Support Group • Worcester County Public Schools • Chesapeake Health Care

Anticipated Impact

- Increase awareness of community resources, programs and services
- Increase and strengthen capacity and collaboration for shared responsibility to address unmet behavioral health needs
- Increase provider services in community to provide for behavioral health related treatment

Impact Rationale

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime (CDC 2018). In 2020, among the 52.9 million adults with any mental illness, 24.3 million (46.2%) received mental health services in the past year (NIMH 2020).

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Overweight and Obesity

AGH GOAL

Support community members in achieving a healthy weight.

HEALTHY PEOPLE 2030 GOAL

Reduce overweight and obesity by helping people eat healthy and get physical activity.

Strategy	Intended Actions
• Implement initiatives to raise awareness and provide education and outreach on how to improve health through prevention and management of weight and obesity.	• Provide education and activity through the "Just Walk" program of Worcester County and the "Walk with a Doc" program at Atlantic General Hospital • Support the WCHD Farm-To-Library program • Increase awareness of the availability of the AGH Community Garden • Provide Hypertension, BMI and pre-diabetes screenings in the community • Provide education on healthy living topics • Increase participation in Bariatric Support Groups • Recruit appropriate clinicians for surgical and non-surgical weight loss programs in the bariatric service line. • Participate in community events to spotlight surgical and non-surgical weight loss services

Measurement

- Exceed the current performance target of Healthy People 2030 for reducing the proportion of children and adolescents with obesity and reducing the proportion of adults who don't know they have pre-diabetes. (data reported annually, Health.gov, Healthy People 2030)
- Decrease in the State Health Insurance Program (SHIP) measures for adolescents who have obesity. (health.maryland.gov)
- County Health Rankings. Improvement in county health rankings related to adult obesity. (countyhealthrankings.org)
- HEDIS measures for BMI. Maintain compliance to hit top tier/star level performance. (MDPCP and CareFirst dashboard)

Hospital Resources	Community Resources
• Population Health Department • Atlantic General Health System • Food & Body (FAB) Program and Bariatric Support Group • Nutrition Services • Atlantic General Bariatric Center • Diabetes education support groups and classes	• Faith-based Partnership • Worcester County Public Schools • Worcester County Health Department • Community Senior Centers • Take Off Pounds Sensibly (TOPS) of Berlin

Anticipated Impact

- Increase health literacy and self-management of nutrition and weight management
- Increase access to healthy foods and nutritional information
- Increase awareness around importance of nutrition, exercise and healthy weight
- Increase participation in community BMI screenings – especially at-risk and vulnerable populations
- Increase documentation and review of BMI throughout AGHS offices
- Increase awareness of community resources, programs and services for weight management

Impact Rationale

Obesity is defined as having a Body Mass Index (BMI) that is greater than or equal to 30, while being overweight is defined as having a BMI of 25 – 29.9. A common, chronic disease marked by an abnormally high, unhealthy amount of body fat. Having obesity can lead to many health problems, including heart disease, stroke, high blood pressure, diabetes, sleep apnea, arthritis, kidney disease, and certain types of cancer. (NCI, 2022).

Priority Needs Not Addressed

Dental Health

- Need addressed by Worcester County Health Department's Dental Services for pregnant women and children less than 21 years of age
- Need addressed by Adult Oral Health Task Force
- Need addressed by AGH ED referral to community resources
- Need addressed by Chesapeake Health Services (CHS), a federally funded dental clinic for Somerset and Wicomico Counties; CHS also involved in the Adult Oral Health Task Force

Communicable Disease

- Need addressed by Worcester County Health Department Communicable Disease Programs

References

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- State of Delaware Healthcare Benchmark Report 2019 https://www.dhss.delaware.gov/dhss/files/benchmarktrendreport2019.pdf
- Healthy People 2030 https://health.gov/healthypeople
- Maryland State Health Improvement Process (SHIP) Pages - State Health Improvement Process (maryland.gov)
- US Census Bureau
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Approved by Atlantic General Hospital Corporation's governing body November 14, 2022.

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Atlantic General Hospital

Implementation Plan of Needs Identified in the Community Health Needs Assessment

FY2022 - 2024

ATLANTIC GENERAL HOSPITAL

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August 2023 Progress Report

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Prioritized Needs

Key findings from all resources were used as a framework to develop community benefit priorities. These are closely aligned with local, state, and national priority areas. The process for determining the priorities of the Community Outreach programs involves many people inside and outside the organization.

AGH's strategic initiatives are determined by the Hospital Board of Trustees, the Medical Staff and the Leadership of the Hospital. Each year those long-term initiatives are evaluated and updated with environmental information, such as the most recent CHNA. In addition to input from those groups, there are additional committees that have a part in setting our priorities: the AGH Planning Committee, Patient & Family Advisory Committee, Community Benefits Committee, and Healthy Happenings Committee.

The Patient & Family Advisory Committee is made up of Hospital and community members who have a health connection in the community. Through this board, we are able to keep our pulse on the needs of the community.

Each department in the hospital has an appointee who sits on the Community Benefits Committee. The purpose of this committee is to oversee the Community Outreach of AGH and comply with the government regulations regarding reporting Community Benefits. Because the committee is made up of all departments, the views are varied. Annual evaluations of each initiative's success are found in the HSCRC Community Benefit Report provided to the State of Maryland.

AGH leaders are involved on many community boards and community entities (both for-profit and not-for-profit). Through these boards we are able to keep abreast of the underserved, low income and/or minority needs in the community. We are involved in the health departments throughout our service area in MD and DE. We coordinate services with them to decrease duplication of services and know what services are needed to fill the gaps.

Working with the target areas of the state improvement initiatives influences the priorities we set. Our Population Health outreach providers are out in the community and are able to observe com- munity needs. Through our Patient Centered Medical Home, Care Coordination models and Population Health Department, we are able to have another resource in the community which we can use for assisting us in setting priorities.

The 2022-2024 Community Benefit priorities are based on the criteria of:

- Size and severity of the problem, determined by what percentage of the population is affected by risks
- Health System's ability to impact the need
- Availability of resources
- Social needs and health inequities

They were graded as high (3), moderate (2) and low (1) to rank the priority, based on self-reported survey data and prioritized as above.

Community Health Needs Assessment Priorities

Health Need	Specific Opportunity	Size & Severity of Problem	AGH/S Ability to Impact the Problem	Availability of Resources	Social Needs/Health Inequities	Impact Rating
High blood pressure/stroke		3	3	3	3	12
Diabetes/sugar	pre-diabetic screenings, education, medication	3	3	3	3	12
Mental Health issues	Depression, Anxiety	3	3	2	3	11
Smoking, drug or alcohol use	alcohol, opiates	3	2	3	3	11
Overweight/obesity	Access to healthy food	3	3	2	3	11
Cancer	Lung, Prostate (CRISP)	1	3	3	3	10
Heart Disease	HF, Afib (CRISP)	3	1	1	3	8

FY22-24 Priority Areas

- High Blood Pressure/Stroke
- Diabetes/Sugar
- Cancer
- Heart Disease
- Smoking, drug or alcohol use
- Mental health issues (depression, anxiety)
- Overweight and Obesity

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

HIGH BLOOD PRESSURE AND STROKE

AGH GOAL

Improve cardiovascular health of the community.

HEALTHY PEOPLE 2030 GOAL

Increase control of high blood pressure in adults.

Strategy	Intended Actions
• Implement initiatives to raise awareness and provide education on high blood pressure and stroke throughout our organization and in the community.	• Increase enrollment in care coordination for hypertension related issues • Increase compliance with hypertension HEDIS measures within our AGHS patient population. • Increase community health screenings for high blood pressure • Increase recruitment of clinical professionals in the community to provide primary care. • Increase access to primary care by increasing the number of available appointments with primary care within AGHS

Measurement

- Exceed the Healthy People target of 18.9% of adults aged 18 and older with high blood pressure under control. (data reported annually, Health.gov, Healthy People 2030)
- HEDIS measures for hypertension. Maintain compliance to hit top tier/star level performance. (MDPCP dashboard, CPM reports and third party payer reports)
- Decrease in the State Health Insurance Program (SHIP) measure Emergency Department visit rate due to hypertension. (health.maryland.gov)
- County Health Rankings. Improvement in county health rankings related to hypertension related illness and mortality. (countyhealthrankings.org)

Hospital Resources	Community Resources
• Population Health Department • Atlantic General Health System • AGH HEDIS nurse • AGH outpatient ancillary services	• Faith-based Partnership • Maintaining Active Citizens, Inc. (MAC, Inc.) • Worcester County Health Department • Tidal Health, Inc.

Anticipated Impact

- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions and reduce unnecessary healthcare costs.
- Increase awareness around importance of prevention and early detection of heart disease and hypertension
- Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs
- Increase health literacy and self-management for health conditions/healthy living

Impact Rationale

According to the CDC (2022), in 2020, more than 670,000 deaths in the United States had hypertension as a primary or contributing cause. Having hypertension puts you at risk for heart disease and stroke, which are leading causes of death in the United States. Nearly half of adults in the United States (47%, or 116 million) have hypertension, defined as a systolic blood pressure greater than 130 mmHg or a diastolic blood pressure greater than 80 mmHg or are taking medication for hypertension (CDC, 2021).

COMMUNITY HEALTH NEED PROGRESS REPORT

HEALTH PRIORITY

HIGH BLOOD PRESSURE AND STROKE

AGH GOAL

Improve cardiovascular health of the community.

HEALTHY PEOPLE 2030 GOAL

Increase control of high blood pressure in adults.

Progress Report

Atlantic General Hospital has made significant progress implementing initiatives that raise awareness and provide education on high blood pressure and stroke throughout our organization and in the community.

Intended Actions:

- Increase enrollment in care coordination for hypertension related issues
- Increase compliance with hypertension HEDIS measures within our AGHS patient population.
- Increase community health screenings for high blood pressure
- Increase recruitment of clinical professionals in the community to provide primary care.
- Increase access to primary care by increasing the number of available appointments with AGHS PCPs.

Progress:

- Referrals for enrollment in Care Coordination for patients with HTN has increased by 8% from 2020 to 2022.
- Compliance with hypertension HEDIS Measures has increased in all of our major programs. For Medicare patients in our Maryland Primary Care Program, compliance increased from 74% in 2021 to 75% in 2022.
- Community blood pressure screenings resumed in 2022, post-Covid. We will continue to track this measure.
- AGH continues to actively recruit primary care and specialty providers and has added two additional primary care providers.

Measurement

- HEDIS Measure – Controlling High Blood Pressure, 50th is 62.41%, 80th Percentile is 78.76%; AGHS is currently at 75%, placing us between the 75-80th percentile, (AGH EMR (CPM), Jan-Apr 2023)
- Decrease in the State Health Improvement Process (SHIP) measure Emergency Department visit rate due to hypertension. 2017 SHIP measure 417.2 visits per 100K population. SHIP data measures after 2017 will be updated by July 2023.
- Hypertension related ED visits decreased by 1.87% in 2022 (4263) compared to 2021 (4344). CRISP data.
- Hypertension related readmission rate decreased by 2.08% in 2022 (12.64%) compared to 2021 (14.72%). CRISP data.
- Hypertension related admission rate increased by 10% in 2022 (1897) compared to 2021 (1706). CRISP data. **Note: Due to COVID, both ED and outpatient visits were lower in 2021 than in prior years.*
- Exceeded Healthy People target of having less than 42.6% (2017-2020) of adults with high blood pressure; the 2021 rate is 40.5% for Worcester County. The 2022 numbers have not yet been released. BRFSS data.
- 2019-2021 – Hypertension was the 10th Leading Causes of Death in Maryland. In 2020, the Maryland mortality rate was 10.5 per 100K population. In 2021, that figure dropped to 10 per 100K population. The 2022 numbers have not yet been released. CDC data.

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Diabetes

AGH GOAL

Decrease incidence of diabetes in the community.

HEALTHY PEOPLE 2030 GOAL

Reduce the burden of diabetes and improve the quality of life for all people who have, or are at risk for, diabetes.

Strategy	Intended Actions
• Implement initiatives to raise awareness and provide access to care, education and outreach for diabetes	• Partner with local health agencies to facilitate grant applications to fund diabetes programs • Evaluate and implement Diabetes Education opportunities via telehealth • Implement a Diabetes Prevention Plan (DPP) for AGH Associates • Provide prediabetes and diabetes screenings and education on diabetes prevention behaviors in the community • Increase access to Diabetes Self-Management Education (DSME)and Diabetes Support Groups • Increase access to primary care by increasing the number of available appointments with primary care within AGHS

Measurement

- Exceed the current performance target of Healthy People 2030 for adults with diabetes that get formal diabetes education. (data reported annually, Health.gov, Healthy People 2030)
- Incidence of adult diabetes
- Decrease in the State Health Insurance Program (SHIP) measures for ED visits due to diabetes. (health.maryland.gov)
- County Health Rankings. Improvement in county health rankings related to the prevalence of diabetes in the community. (countyhealthrankings.org)
- HEDIS measures for diabetes (five measures)

Hospital Resources	Community Resources
• Population Health Department • Diabetes Outpatient Education Program • Emergency Department • Foundation • Outpatient Lab Services • Endocrinology (Atlantic General Health System) • Diabetes Support Group	• Worcester County Public Schools • Worcester County Health Department • TidalHealth, Inc.

Anticipated Impact

- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions, readmissions, and ED visits related to Diabetes
- Increase awareness around importance of prevention of diabetes and early detection
- Increase provider services in community to provide for diabetes related treatment
- Increase participation in community glucose screenings, diabetes and pre-diabetes screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs

Impact Rationale

According to the CDC National Center for Health Stats (2021), more than 122 million Americans are living with diabetes (37.3 million) or prediabetes (96 million).

COMMUNITY HEALTH NEED PROGRESS REPORT

HEALTH PRIORITY

Diabetes

AGH GOAL

Decrease incidence of diabetes in the community.

HEALTHY PEOPLE 2030 GOAL

Reduce the burden of diabetes and improve the quality of life for all people who have, or are at risk for, diabetes.

Progress Report

Atlantic General Hospital has made significant progress in partnership with other community agencies to develop a strategic action plan to address diabetes needs in the community. The most noteworthy example of this partnership is the REACH grant collaborative-a partnership between TidalHealth, Atlantic General Hospital, all three lower county health departments, and numerous other community agencies. The REACH collaborative is focused on outreach, education and follow-up services for patients with Diabetes and Hypertension.

Intended Actions:

- Partner with local health agencies to facilitate grant applications to fund diabetes programs.
- Evaluate and implement Diabetes Education opportunities via telehealth
- Implement a Diabetes Prevention Plan (DPP) for AGH Associates
- Provide prediabetes and diabetes screenings and education on diabetes prevention behaviors in the community
- Increase access to Diabetes Self-Management Education (DSME)and Diabetes Support Groups
- Increase access to primary care by increasing the number of available appointments with primary care within AGHS

Progress:

- As noted, REACH collaborative grant funding provides outreach and resources in five zip codes that have identified health disparities. For Worcester County, these areas include Pocomoke and Snow Hill.
- As part of the REACH grant collaborative, additional diabetes support groups and diabetes education classes are being scheduled in Pocomoke and Snow Hill.
- Our Diabetes Education team is partnering with Employee Health to launch employee diabetes education modules and pre-diabetes screenings.
- Pre-diabetes screening assessments have been integrated into all of our community outreach events and diabetes screenings are being increased as well.
- Nurse-driven protocol referral process for Diabetes Education is being implemented
- Diabetes Education nurse present weekly in Wound Care Center
- In 2020, 43.2% of patients in care coordination had a diabetes diagnosis compared to 40.5% in 2023; partnership established between Care Coordination and Diabetes Education.
- AGH continues to actively recruit primary care and specialty providers and has added two additional primary care providers

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COMMUNITY HEALTH NEED PROGRESS REPORT

HEALTH PRIORITY

Diabetes

AGH GOAL

Decrease incidence of diabetes in the community.

HEALTHY PEOPLE 2030 GOAL

Reduce the burden of diabetes and improve the quality of life for all people who have, or are at risk for, diabetes.

Measurements

- Exceed the current performance target of Healthy People 2030 for adults with diabetes that get formal diabetes education. (data reported annually, Health.gov, Healthy People 2030). The current target set by Healthy People 2030 is 55.2% and based on the most recent survey data from 2019, we are presently at 55.1%.
- Incidence of adult diabetes. AGH experienced an 8.8% decrease in diabetes related Emergency Department visits from calendar year 2021 to 2022. For Inpatient visits with a primary diabetes diagnosis, AGH experience a 3.5% increase in related admissions, but saw a 2.2% reduction in readmission rates for this population.
- Decrease in the State Health Improvement Program (SHIP) measures for ED visits due to diabetes. (health.maryland.gov). In a response from the SHIP program in June 2023, data measures after 2017 will be updated in July 2023.
- County Health Rankings. Improvement in county health rankings related to the prevalence of diabetes in the community. (countyhealthrankings.org). The County Health Rankings indicated in 2021 that both Worcester County, Maryland, and Sussex County, Delaware, had a 13% rate of adults living with diagnosed diabetes. In 2023, each county showed an equal improvement with a current rate of 9% of adults living with diabetes.
- HEDIS measures for diabetes. For Medicare patients, metric Diabetes Poor Control, 50th is 42.63%, 80th percentile is 22.92%; AGHS is currently at 28%, putting us on track for reaching the 80th percentile. (AGH EMR (CPM), Jan-May 2023).

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Cancer

AGH GOAL

Decrease the incidence of advanced breast, lung, colon, and skin cancer in community.

HEALTHY PEOPLE 2030 GOAL

Reduce new cases of cancer and cancer-related illness, disability, and death.

Strategy	Intended Actions
• Implement initiatives to raise awareness and provide education and outreach for cancer prevention and treatment.	• Recruit and retain professionals to provide for cancer related treatment in the community • Provide community health screenings and education on healthy behaviors and cancer prevention • Partner with local health agencies to facilitate grant application to fund cancer programs • Improve proportion of minorities receiving colonoscopy screenings, LDCT screenings, and women's preventative health services

Measurement

- Exceed the current performance target of Healthy People 2030 for cancer death rates in our community. (data reported annually, Health.gov, Healthy People 2030)
- Increase in State Health Insurance Program (SHIP) measure for mammography screenings. (health.maryland.gov)
- HEDIS colorectal screening measure. Maintain compliance to hit top tier/star level performance. (MDPCP and CareFirst dashboard)

Hospital Resources	Community Resources
• Population Health Department • Women's Diagnostic Center • Endoscopy Services • AGH outpatient ancillary services • Regional Cancer Care Center • AGH Cancer Committee • Atlantic General Health System	• Worcester County Health Department • Komen Consortium • Relay for Life • Women Supporting Women • University of Maryland • TidalHealth, Inc. • Beebe Healthcare

Anticipated Impact

- Increase awareness around importance of prevention and early detection
- Increase provider services in community to provide for cancer related treatment
- Reduce health disparities
- Improve access and referrals to community resources resulting in better outcomes
- Increase support to patients and caregivers
- Increase participation in community cancer screenings – especially at-risk and vulnerable populations

Impact Rationale

According to Healthy People 2030, while cancer is the second leading cause of death in the United States, the cancer death rate has declined in recent decades with over 600,000 people still dying from cancer each year. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care. (Healthy People 2030)

COMMUNITY HEALTH NEED PROGRESS REPORT

HEALTH PRIORITY

Cancer

AGH GOAL

Decrease the incidence of advanced breast, lung, colon, and skin cancer in community.

HEALTHY PEOPLE 2030 GOAL

Reduce new cases of cancer and cancer-related illness, disability, and death.

Progress Report

Atlantic General Hospital has made significant progress in increasing awareness and providing education on cancer screenings and treatments available throughout our organization and community.

Intended Actions:

- Recruit and retain professionals to provide for cancer related treatment in the community
- Provide community health screenings and education on healthy behaviors and cancer prevention
- Partner with local health agencies to facilitate grant application to fund cancer programs
- Improve proportion of minorities receiving colonoscopy screenings, LDCT screenings, and women's preventative health services

Progress:

- New hematology/oncology physician joined our team in January 2023.
- New cancer center director started in May 2023, with significant nursing experience in oncology.
- New cancer prevention program launched in 2023; cancer risk assessment provided to all patients receiving a mammogram. Based upon responses, high-risk patients are offered a free telehealth consultation with a genetic counselor.
- New skin clinic started in 2023-patients whose health care provider has noted a suspicious lesion can be referred to the skin clinic for evaluation.
- Breast cancer support group is held at the Burbage Regional Cancer Care Center monthly.
- Community outreach events for 2022-2023 included 7 cancer walks, 2 AGH physician speaking events, the American Cancer Society Fashion Show, screenings offered at two health fairs, prostate screening event at AGH cancer center, and cancer screening education provided at numerous community outreach events.
- For FY24, increased outreach efforts and education regarding screenings and preventative health services for our minority population is a priority focus.

Measurement

- Exceed the current performance target of Healthy People 2030 for cancer death rates in our community (data reported annually, Health.gov, Healthy People 2030). The baseline rate set by Healthy People 2030 in 2018 is 149.1 deaths per 100K population. The most recent rate for Worcester County based on data from the State Health Improvement Program (SHIP), is 149.4 per 100K population and the State of Maryland is 145.5. According to the CDC in 2021, the State of Maryland decreased to 139.2 per 100K population.
- Increase in Maryland BRFSS System measure for mammography screenings. (health.maryland.gov). The State of Maryland BRFSS system (2020) average was 27.7% and Worcester County was 30.1% for women 40 and over who had not had a mammogram in the past two years. While data has not been published by BRFSS since 2020, AGH has experienced a 3.3% increase in mammography screenings during the same period in 2022 compared to 2023.
- HEDIS colorectal screening measure. Maintain compliance to hit top tier/star level performance. (MDPCP and CareFirst dashboard). The most current national average from 2021 has the rate of screening at 66.8% for adults age 50-75. According to BRFSS in 2020, Worcester County screening rate was 75.1% for those age 50-75. Currently, AGH is at 59% for this population (CPM, MDPCP/DePCF data).

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Heart Disease

AGH GOAL

Improve cardiovascular health of the community.

HEALTHY PEOPLE 2030 GOAL

Preventing and treating heart disease and stroke and improving overall cardiovascular health by controlling risk factors like high blood pressure and high cholesterol through treatment.

Strategy	Intended Actions
• Implement initiatives to raise awareness and provide education on heart disease throughout our organization and in the community	• Increase recruitment of clinical professionals in community to provide primary care • Maintain AGH/AGHS campus and locations as tobacco and vaping free • Increase community health screenings for high blood pressure, carotid artery and cholesterol • Increase enrollment in care coordination for chronic disease management • Increase outreach events to provide screenings to high risk and underserved populations. • Increase access to primary care by increasing the number of available appointments with primary care within AGHS

Measurement

- Exceed the current performance target of Healthy People 2030 for cardiovascular health in adults. (data reported annually, Health.gov, Healthy People 2030)
- Increase in the State Health Insurance Program (SHIP) measures for persons with a usual primary care provider. (health.maryland.gov)

Hospital Resources	Community Resources
• Population Health Department • AGH outpatient ancillary services • Stroke Center • Atlantic General Health System	• Faith-based Partnership • Worcester County Health Department • TidalHealth, Inc.

Anticipated Impact

- Decrease hospital admissions and readmissions related to heart disease
- Increase awareness around importance of prevention and early detection of heart disease and hypertension
- Increase provider services in community to provide for cardiovascular related treatment
- Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs
- Increase health literacy and self-management for health conditions/healthy living

Impact Rationale

According to the CDC Heart Disease Statistics (2020), approximately 697,000 people die of heart disease in the United States yearly. Heart disease is the leading cause death among women and men and most ethnic groups. Hypertension, high cholesterol and smoking are key risk factors and 47 percent of Americans have at least one risk factor.

COMMUNITY HEALTH NEED PROGRESS REPORT

HEALTH PRIORITY

Heart Disease

AGH GOAL

Improve cardiovascular health of the community.

HEALTHY PEOPLE 2030 GOAL

Preventing and treating heart disease and stroke and improving overall cardiovascular health by controlling risk factors like high blood pressure and high cholesterol through treatment.

Progress Report

Atlantic General Hospital has made progress in partnering with community agencies, in particular the Worcester County Health Department, to provide outreach and education related to heart disease in the community.

Intended Actions:

- Increase recruitment of clinical professionals in community to provide primary care.
- Maintain AGH/AGHS campus and locations as tobacco and vaping free.
- Increase community health screenings for high blood pressure, carotid artery and cholesterol.
- Increase enrollment in care coordination for chronic disease management.
- Increase outreach events to provide screenings to high risk and underserved populations.
- Increase access to primary care by increasing the number of available appointments with primary care within AGHS.

Progress:

- Atlantic General has been actively recruiting nurses both in the hospital and outpatient settings.
- Atlantic General continues to maintain and reinforce tobacco and vape-free campuses at all locations.
- Community blood pressure, carotid artery and cholesterol screenings resumed in 2022, post-Covid. We will continue to track this measure.
- The referral workflow for care coordination has been revised to include recommendations from Case management, wound care and community outreach teams.
- Participation in the REACH collaborative is driving outreach targeted to high-risk, underserved populations in the southern end of Worcester County.
- AGH continues to actively recruit primary care and specialty providers and has added two additional primary care providers.

Measurement

- Exceed the current performance target of Healthy People 2030 to reduce coronary heart disease deaths--target of 71.1 deaths per 100K population. *Note in 2021, this baseline rate for Healthy People increased from 71.1 to 90.9 deaths per 100K, indicating a definite opportunity locally and nationally. The most current SHIP data (2018-2020) released in May 2023 has Worcester County at 172.9 per 100K and the State of Maryland at 163.3 per 100K.

- Increase in the State Health Improvement Process (SHIP) measures for persons with a usual primary care provider. (health.maryland.gov). The SHIP rate (2020) is 86.6% of people report having at least one personal doctor or healthcare provider. Based on BRFSS data from 2021, Worcester County has a rate of 87% and the State of Maryland was 85.8%.

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Smoking, Drug or Alcohol Use

AGH GOAL

Provide access to resources and treatment that supports smoking cessation and alcohol and drug use intervention and treatment.

HEALTHY PEOPLE 2030 GOAL

Reduce illness, disability, and death related to tobacco use and secondhand smoke and reduce misuse of drugs and alcohol.

Strategy	Intended Actions
• Increase access to substance use treatment within our community	• Continued recruitment of psychiatric providers that are certified to address substance use disorders • Recruit Peer Recovery Specialists for behavioral health and substance use interventions
• Increase education within our organization and community related to substance use disorders and resource and appropriate medication use	• Participate in naloxone training and distribution of Narcan kits through the Worcester Goes Purple and Worcester County Health Department for both community members and AGH/S employees • Evaluate and educate organization and community on appropriate prescribing practices • Utilize Prescription Drug Maintenance Program (PDMP) via CRISP within our organization
• Increase education within our organization and community related to smoking risks and cessation options	• Recruit and retain pulmonologist(s) • Increase in smoking cessation screenings at community outreach events and within AGHS

Measurement

- Exceed the current performance target of Healthy People 2030 for adults with a substance use disorder who got treatment in the last year. (data reported annually, Health.gov, Healthy People 2030)
- HEDIS measures for SBIRT and smoking cessation. Maintain compliance to hit top tier/star level performance. (MDPCP and CareFirst dashboard)
- Decrease in the State Health Insurance Program (SHIP) measure for adult smoking rate. (health.maryland.gov)

Hospital Resources	Community Resources
• Respiratory Therapy • AGH outpatient ancillary services • Emergency Department • Population Health Department • Pulmonology – Atlantic General Health System • Behavioral Health Department	• Worcester County Health Department (WCHD) • Maryland Health Department • Worcester Goes Purple • Hope 4 Recovery • Sun Behavioral Health

Anticipated Impact	Impact Rationale
• Decrease tobacco and vaping use in Worcester County • Decrease hospital admissions and readmissions and ED visits related to substance use and COPD • Increase provider services in community to provide for respiratory related treatment and smoking cessation programs • Increase access for individuals requiring urgent intervention for drug and alcohol addiction issues • Increase community education on resources available through the crisis center to connect patients to substance use treatment. • Increase Peer Support for behavioral health and substance use disorder interventions	According to Healthy People 2030, more than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year and more than 20 million adults and adolescents in the United States have had a substance use disorder in the past year.

COMMUNITY HEALTH NEED PROGRESS REPORT

HEALTH PRIORITY

Smoking, Drug or Alcohol Use

AGH GOAL

Provide access to resources and treatment that supports smoking cessation and alcohol and drug use intervention and treatment.

HEALTHY PEOPLE 2030 GOAL

Reduce illness, disability, and death related to tobacco use and secondhand smoke and reduce misuse of drugs and alcohol.

Progress Report

Atlantic General Hospital has made progress in expanding access to substance use disorder treatment.

Intended Actions:

- Continued recruitment of psychiatric providers that are certified to address substance use disorders
- Recruit Peer Recovery Specialists for behavioral health and substance use interventions
- Participate in naloxone training and distribution of Narcan kits through the Worcester Goes Purple and Worcester County Health Department for both community members and AGH/S employees
- Evaluate and educate organization and community on appropriate prescribing practices
- Utilize Prescription Drug Maintenance Program (PDMP) via CRISP within our organization
- Recruit and retain pulmonologist(s)
- Increase in smoking cessation screenings at community outreach events and within AGHS

Progress:

- All three outpatient behavioral health prescribers were waivered to prescribe buprenorphine.
- We obtained grant funding to hire a peer recovery specialist for behavioral health and substance use interventions. Peer recovery specialist started October 2022.
- All staff in the behavioral health center received (Narcan) naloxone training and Narcan kits.
- Community Narcan training was coordinated through Worcester Goes Purple and the WCHD.
- Prescription Drug Maintenance Program (PDMP) in CRISP is utilized by providers to evaluate their prescribing practices.
- AGH is actively recruiting for pulmonologists.
- Information on smoking cessation has been integrated into community education.

Measurement

- Exceed the current performance target of Healthy People 2030 for adults with a substance use disorder who got treatment in the last year (data reported annually, Health.gov, Healthy People 2030). The Healthy People 2030 target was set at 14%. A baseline of 11.1% was set in 2018. The most recent data from 2019 reflects a rate of 12.2%.
- HEDIS measures for SBIRT and smoking cessation. Maintain compliance to hit top tier/star level performance (MDPCP and CareFirst dashboard). We did not track a HEDIS smoking cessation measure in 2022 but are tracking this measure for 2023.
- Decrease in the State Health Improvement Process (SHIP) measure for adult smoking rate (health.maryland.gov). The 2017 SHIP measure for adults in Worcester County that smoke was 17.4%. SHIP data beyond 2017 has not been released yet, but the County Health Rankings in 2020 show Worcester County as having 16.0% of adults who smoke.

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Mental Health Issues (depression and anxiety)

AGH GOAL

Provide immediate access to individuals requiring urgent behavioral health assessment and intervention as well as ensure local resources are in place to address ongoing management of behavioral health needs.

HEALTHY PEOPLE 2030 GOAL

Improve mental health through prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. The Mental Health and Mental Disorders objectives also aim to improve health and quality of life for people affected by these conditions.

Strategy	Intended Actions
• Increase access to mental health providers any expand types of mental health services available in the community.	• Partner with Chesapeake Health Care to increase access to mental health services • Continue to collaborate with Kennedy Krieger Institute for telemedicine services to provide additional psychiatry professionals • Increase utilization of Behavioral Health Integration in Primary Care locations
• Increase partnerships in the community to further establish a regional hub of mental health care.	• Continue to expand engagement and partnership with Crisis Response Team (CRT) and local law enforcement to address ongoing mental health crisis issues • Continue to expand community participation on AGH Behavioral Health Opioid Stewardship Committee • Partner with WCHD (Peer Support and Case Managers) in AGH Emergency Department
• Increase community education and awareness of mental health conditions and resources	• Participate in community events to spotlight behavioral health services • Continued collaboration and education for AGHS providers and staff on management of this patient population and resources available

Measurement

- Exceed the current performance target of Healthy People 2030 for adults with serious mental illness and depression that receive treatment. (data reported annually, Health.gov, Healthy People 2030)
- County Health Rankings. Improvement in county health rankings related to mental health. (countyhealthrankings.org)
- HEDIS measures for PHQ2. Maintain compliance to hit top tier/star level performance. (MDPCP and CareFirst dashboard)
- Decrease in the State Health Insurance Program (SHIP) measures for suicide rate and ED visits for mental health. (health.maryland.gov)

Hospital Resources	Community Resources
• Population Health Department • Behavioral Health Department • Pastoral Care Services • Bereavement Support Group • AGHRx RediScripts Pharmacy • Behavioral Health & Opioid Stewardship Committee • Atlantic General Health System	• Worcester County Health Department • Worcester Youth and Family Services • Worcester Goes Purple • Hudson Health Services • NAMI Lower Shore Support Group • Worcester County Public Schools • Chesapeake Health Care

Anticipated Impact

- Increase awareness of community resources, programs and services
- Increase and strengthen capacity and collaboration for shared responsibility to address unmet behavioral health needs
- Increase provider services in community to provide for behavioral health related treatment

Impact Rationale

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime (CDC 2018). In 2020, among the 52.9 million adults with any mental illness, 24.3 million (46.2%) received mental health services in the past year (NIMH 2020).

HEALTH PRIORITY

Mental Health Issues (depression and anxiety)

AGH GOAL

Provide immediate access to individuals requiring urgent behavioral health assessment and intervention as well as ensure local resources are in place to address ongoing management of behavioral health needs.

HEALTHY PEOPLE 2030 GOAL

Improve mental health through prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. The Mental Health and Mental Disorders objectives also aim to improve health and quality of life for people affected by these conditions.

Progress Report

Atlantic General Hospital has made significant progress in providing access to behavioral health care in Worcester County

Intended Actions:

- Partner with Chesapeake Health Care to increase access to mental health services
- Continue to collaborate with Kennedy Krieger Institute for telemedicine services to provide additional psychiatry professionals
- Increase utilization of Behavioral Health Integration in primary care locations
- Continue to expand engagement and partnership with Crisis Response Team (CRT) and local law enforcement to address ongoing mental health crisis issues
- Continue to expand community participation on AGH Behavioral Health Opioid Stewardship Committee
- Partner with WCHD (peer support and case managers) in AGH Emergency Department
- Participate in community events to spotlight behavioral health services
- Continued collaboration and education for AGHS providers and staff on management of this patient population and resources available

Progress:

- The AGH Behavioral Health Crisis Center had over 1,100 visits during its first year of operations, providing critical access to care for an underserved population.
- In an effort to expand behavioral health resources throughout our community, AGH made the decision to transition behavioral health outpatient services, including both outpatient behavioral health and the Behavioral Health Crisis Center to Chesapeake Health Care, who has a well-established outpatient behavioral health presence, with over 70 behavioral health practitioners in Worcester and Wicomico counties. AGH will still support the TRIBE (Tri-county Behavioral Health Engagement Regional Catalyst grant program as a community partner).
- Kennedy Krieger will continue to offer services to Worcester County via telemedicine. Tele-video visits can be schedule to occur directly with Kennedy Krieger or can be scheduled to occur via tele-video connected onsite at Chesapeake Health Care.
- Behavioral Health Primary Care Integration can still occur in partnership with Chesapeake Health Care with our primary care teams facilitating connection to Chesapeake Health Care providers directly from the primary care offices.
- Quarterly meetings with CRT and local law enforcement were established and well received. These meetings will continue under Chesapeake Health Care services.
- The Behavioral Health Opioid Stewardship Committee with its current outpatient focus will transition to Chesapeake Health Care for redesign and facilitation. AGH will convene an Opioid Stewardship Committee focused on the continuum of care.
- The WCHD continues its partnership with AGH Emergency Dept. and the EDCC program.

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COMMUNITY HEALTH NEED PROGRESS REPORT

HEALTH PRIORITY

Mental Health Issues (depression and anxiety)

AGH GOAL

Provide immediate access to individuals requiring urgent behavioral health assessment and intervention as well as ensure local resources are in place to address ongoing management of behavioral health needs.

HEALTHY PEOPLE 2030 GOAL

Improve mental health through prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. The Mental Health and Mental Disorders objectives also aim to improve health and quality of life for people affected by these conditions.

Measurement

- Exceed the current performance target of Healthy People 2030 for adults with serious mental illness and depression that receive treatment (data reported annually, Health.gov, Healthy People 2030).
    - Healthy People 2030 target is 68.8% of adults with a serious mental illness who get treatment. According to the National Alliance on Mental Illness (NAMI) in 2021, 68.7% of Marylanders got needed counseling or therapy. Data for 2022 and 2023 is pending.
    - The AGH Behavioral Health Crisis Center had over 1,100 visits during its first year, providing vital access to services that would have otherwise been unavailable.
- County Health Rankings. Improvement in county health rankings related to mental health (countyhealthrankings.org).
    - In 2023, County Health Rankings reports 15% of adults in Worcester County report 14 or more days of poor mental health per month. This is up 2% from the 2021 reporting period. This increase is attributed to an overall increase in mental health issues related to the Covid-19 pandemic, as well as higher reporting due to more access to mental health care.
- HEDIS measures for SBIRT (PHQ2). Maintain compliance to hit top tier/star level performance (MDPCP and CareFirst dashboard).
    - We will continue to track this measure as we make progress. In 2023, AGH is currently at 47% for "CMS2 – Screening for depression and follow up plan". The 30th percentile is 38.63% and the 80th percentile is 74.04%.
- Decrease in the State Health Improvement Program (SHIP) measures for suicide rate and ED visits for mental health (health.maryland.gov).
    - The SHIP rate for mental health ED visits (2017) for Worcester County was 3,502 visits per 100K population. The overall State of Maryland rate was 4,291 visits per 100K. SHIP has never produced a suicide rate for Worcester County. The County Health Ranking reports in 2023 that for Worcester County, there were 11 deaths per 100K population. This is a slight increase from 2021, in which there was 10 deaths per 100K population in Worcester County. We will continue to track and report.

COMMUNITY HEALTH NEED:

HEALTH PRIORITY

Overweight and Obesity

AGH GOAL

Support community members in achieving a healthy weight.

HEALTHY PEOPLE 2030 GOAL

Reduce overweight and obesity by helping people eat healthy and get physical activity.

Strategy	Intended Actions
• Implement initiatives to raise awareness and provide education and outreach on how to improve health through prevention and management of weight and obesity.	• Provide education and activity through the "Just Walk" program of Worcester County and the "Walk with a Doc" program at Atlantic General Hospital • Support the WCHD Farm-To-Library program • Increase awareness of the availability of the AGH Community Garden • Provide Hypertension, BMI and pre-diabetes screenings in the community • Provide education on healthy living topics • Increase participation in Bariatric Support Groups • Recruit appropriate clinicians for surgical and non-surgical weight loss programs in the bariatric service line. • Participate in community events to spotlight surgical and non-surgical weight loss services

Measurement

- Exceed the current performance target of Healthy People 2030 for reducing the proportion of children and adolescents with obesity and reducing the proportion of adults who don't know they have pre-diabetes. (data reported annually, Health.gov, Healthy People 2030)
- Decrease in the State Health Insurance Program (SHIP) measures for adolescents who have obesity. (health.maryland.gov)
- County Health Rankings. Improvement in county health rankings related to adult obesity. (countyhealthrankings.org)
- HEDIS measures for BMI. Maintain compliance to hit top tier/star level performance. (MDPCP and CareFirst dashboard)

Hospital Resources	Community Resources
• Population Health Department • Atlantic General Health System • Food & Body (FAB) Program and Bariatric Support Group • Nutrition Services • Atlantic General Bariatric Center • Diabetes education support groups and classes	• Faith-based Partnership • Worcester County Public Schools • Worcester County Health Department • Community Senior Centers • Take Off Pounds Sensibly (TOPS) of Berlin

Anticipated Impact

- Increase health literacy and self-management of nutrition and weight management
- Increase access to healthy foods and nutritional information
- Increase awareness around importance of nutrition, exercise and healthy weight
- Increase participation in community BMI screenings – especially at-risk and vulnerable populations
- Increase documentation and review of BMI throughout AGHS offices
- Increase awareness of community resources, programs and services for weight management

Impact Rationale

Obesity is defined as having a Body Mass Index (BMI) that is greater than or equal to 30, while being overweight is defined as having a BMI of 25 – 29.9. A common, chronic disease marked by an abnormally high, unhealthy amount of body fat. Having obesity can lead to many health problems, including heart disease, stroke, high blood pressure, diabetes, sleep apnea, arthritis, kidney disease, and certain types of cancer. (NCI, 2022).

COMMUNITY HEALTH NEED PROGRESS REPORT

HEALTH PRIORITY

Overweight and Obesity

AGH GOAL

Support community members in achieving a healthy weight.

HEALTHY PEOPLE 2030 GOAL

Reduce overweight and obesity by helping people eat healthy and get physical activity.

Progress Report

Atlantic General Hospital has made progress in community engagement with healthy activities and a focus on healthy eating.

Intended Actions:

- Provide education and activity through the "Just Walk" program of Worcester County and the "Walk with a Doc" program at Atlantic General Hospital.
- Support the WCHD Farm-To-Library program.
- Increase awareness of the availability of the AGH Community Garden.
- Provide hypertension, BMI and pre-diabetes screenings in the community.
- Provide education on healthy living topics.
- Increase participation in Bariatric Support Groups.
- Recruit appropriate clinicians for surgical and non-surgical weight loss programs in the bariatric service line.
- Participate in community events to spotlight surgical and non-surgical weight loss services.

Progress:

- We established a designated location for our Walk with a Doc program, and participation is increasing. We continue to participate in the "Just Walk" program with Worcester County Health Dept.
- Our partnership with WCHD Farm-To-Library program continues.
- We continue to highlight our community garden, our surgical and non-surgical weight loss programs, as well as healthy living habits at our community outreach education events.
- We have integrated hypertension, BMI and pre-diabetes screenings into all of our outreach events and have begun tracking the number of screenings completed at each event.
- We continue tracking participation in Bariatric Support Groups and periodically include a team member from our bariatric program into our outreach events.
- We continue to actively recruit clinicians for our surgical and non-surgical weight loss programs.

Measurement

- Exceed the current performance target of Healthy People 2030 for reducing the proportion of children and adolescents with obesity and reducing the proportion of adults who don't know they have pre-diabetes (Data reported annually, Health.gov, Healthy People 2030).
    - Healthy People 2030 target rate is 15.5% for ages 2-19 with obesity and 33.2% for adults. In 2020, the rate for 2-19 was 19.7%. In 2016, the rate for adults was 38%. We are awaiting updated data, but performance indicates we have opportunity to improve these rates.
- Decrease in the State Health Improvement Process (SHIP) measures for adolescents who have obesity (health.maryland.gov).
    - The most recent SHIP measure for Worcester County from 2016 shows a rate of 13.6% of adolescents are obese. We are awaiting updated data.
- County Health Rankings. Improvement in county health rankings related to adult obesity (countyhealthrankings.org).
    - In 2021, 37% of Worcester County adults had a BMI greater than 30. In 2023, it is 32%, which is a 5% improvement.
- HEDIS measures for BMI. Maintain compliance to hit top tier/star level performance (MDPCP and CareFirst dashboard).
    - AGH currently has a 22% score for BMI screenings and follow up. The 50th percentile is 41.80% and the 80th percentile is 81.63%, so BMI screening in our outpatient offices is an opportunity for us over the next year.

Priority Needs Not Addressed

Dental Health

- Need addressed by Worcester County Health Department's Dental Services for pregnant women and children less than 21 years of age
- Need addressed by Adult Oral Health Task Force
- Need addressed by AGH ED referral to community resources
- Need addressed by Chesapeake Health Services (CHS), a federally funded dental clinic for Somerset and Wicomico Counties; CHS also involved in the Adult Oral Health Task Force

Communicable Disease

- Need addressed by Worcester County Health Department Communicable Disease Programs

References

- County Health Outcomes & Roadmaps, 2019, http://www.countyhealthrankings.org
- Maryland Department of Public Health: https://coronavirus.maryland.gov/
- State of Delaware Healthcare Benchmark Report 2019 https://www.dhss.delaware.gov/dhss/files/benchmarktrendreport2019.pdf
- Healthy People 2030 https://health.gov/healthypeople
- Maryland State Health Improvement Process (SHIP) Pages - State Health Improvement Process (maryland.gov)
- US Census Bureau
- Delaware Department of Labor
- Behavioral Risk Factor Surveillance System BRFSS State Information | CDC
- Beebe Medical Center Community Health Assessment 2019 Beebe Healthcare Community Health Needs Assessment
- Atlantic General Hospital. Creating Healthy Communities. http://www.atlanticgeneral.org/Community-Health-Wellness/Creating-Healthy-Communities.aspx?hcn=CommunityDashboard
- CDC National Center for Health Stats (2022). Retrieved from http://www.cdc.gov/nchs/fastats
- NCI (2022). National Cancer Institute: Obesity, National Institute of Health. http://www.cancer.gov/about-cancer/causes-prevention/risk/obesity
- National Institute of Mental Health, 2020, https://www.nimh.nih.gov/health/statistics/mental-illness
- Worcester County Health Department, 2021 Community Needs Assessment, https://www.worcesterhealth.org/images/21_CommunityHealthAssessment.pdf

Approved by Atlantic General Hospital Corporation's governing body November 14, 2022.

ATLANTIC
GENERAL HOSPITAL

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POLICY AND PROCEDURE

TITLE:	**FINANCIAL ASSISTANCE POLICY**
DEPARTMENT:	**PATIENT FINANCIAL SERVICES**

Effective Date:	7/1/16	Number:	
Revised:	8/18	Pages:	Five (5)
Reviewed:	8/18, 01/2021	Approval Date:	9/6/18

Signature:

Vice President, Finance	Director, Patient Financial Services Author

APPROVAL DATES:

9/6/18, 02/05/2021 Board of Trustees	Finance Committee

POLICY:

It is the policy of Atlantic General Hospital/Health System (AGH/HS) to provide medically necessary services without charge or at a reduced cost to all eligible patients who lack healthcare coverage or whose healthcare coverage does not pay the full cost of their bill for AGH/HS services. The intent of this policy is to ensure access to AGH/HS services regardless of an individual's ability to pay, and to provide those services on a charitable basis to qualified indigent persons consistent with this policy. Financial Assistance (FA) is granted after all other avenues have been exhausted, including, but not limited to Medical Assistance, private funding, grant programs, credit cards, and/or payment arrangements. FA applies only to bills related to services provided by the AGH/HS. Fees for healthcare and professional services that are not provided by AGH/HS are not included in this policy. Emergent and urgent services, including those services provided at the AGH ambulatory surgery facility, may be considered for FA. All hospital regulated services will be charged consistently as established by the Health Services Cost Review Commission (HSCRC), and the amounts generally billed (AGB). All patients requesting charity care services from an AGHS provider in an unregulated area will be charged the fee schedule plus the

standard mark-up, unless a final determination of eligibility for FA is made for services provided to a qualified indigent individual consistent with the procedures set forth below. A roster of providers that deliver emergent, urgent, and other medically necessary care is updated quarterly and available on the hospital website at www.atlanticgeneral.org, indicating which providers are covered and which are not under the FA policy. This information is also available by calling a Financial Counselor at (410) 629-6025. The patient must have a valid social security number, valid green card or valid visa. A patient's payment for reduced-cost care for AGH shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission (HSCRC).

Definitions:

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

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

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

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

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

Medical Hardship: Medical debt incurred by a family over the course of the previous twelve months that exceeds 25% of the family's income. The hospital will provide reduced-cost, medically necessary care to patients with family income at or below 500% of the Federal Poverty Level.

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.

Medical Debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs for medical costs by AGH/HS.

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

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

Income: The amount of income as defined on the tax returns, pay stubs, social security award letter, unemployment report, etc.

Procedures:

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

1. Available upon request by calling (410) 629-6025.
2. Applications are located in the registration areas and AGHS Offices
3. Downloaded from the hospital website;

   www.atlanticgeneral.org/FAP
4. The PLS is inserted in the Admission packet
5. FA language is included on all the patient's statement and includes the telephone number to call and request a copy and the website address where copies may be obtained.
6. FA notification signs are posted in the main registration areas
7. An annual notification is posted in the local newspaper
8. Patients who have difficulty in completing the application can orally provide the information
9. The PLS is sent with each collection statement.

No ECA will be taken within 120 days of the first post-discharge billing statement. A message will be on the statement thirty days prior to initiating ECA notifying the patient. During the 120 day period, the patient will be reminded of the FA program during normal collection calls. If the application is ineligible, normal collection actions will resume, which includes notifying the agency if applicable to proceed with ECA efforts. If the application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all Extraordinary

Collection Actions (ECA) until the application and all appeal rights have been processed. A list of approved ECA actions may be found in the Credit and Collection Policy. The patient may appeal a denied application by submitting a letter to the Director of Patient Financial Services indicating the reason for the request.

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

Approved FA applies to all applicable open balances at the time the application is approved, and shall remain in effect for future medically necessary services for 6 months. For patients that have paid $5.00 or more, and within a two-year period was found to be eligible for FA at 100%, any amount paid exceeding $5.00 shall be refunded.

Within two business days following a patient's request for charity care services, application for medical assistance, or both, AGH/HS shall make a determination of probable eligibility and communicate the determination to the patient and/or the patient's representative. The determination of probable eligibility will be made on the basis of an interview with the patient and/or the patient's representative. The interview will cover family size, insurance and income. The determination of probable eligibility will be made based on the information provided in the interview. No application form, verification or documentation of eligibility will be requested or required for the determination of probable eligibility to be made. A final eligibility determination for charity care for qualified indigent persons will be provided in writing within 2 business days of receipt of a completed application for FA.

Automatic Eligibility:

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

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

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

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

Eligibility Consideration:

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

1. The amount requested is greater than $20,000
2. The tax return shows a significant amount of interest income
3. The patient has a savings or checking account greater than $10,000
4. If the patient/guarantor is self-employed, a current tax return may be required
5. If AGH/HS has reason to believe the information is unreliable or incorrect, or obtained under duress, or through the use of coercive practices, FA may be denied.

The following assets are excluded:

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

FA approval is based on the following income level:

- 0% to 200% of the Federal Poverty Guideline – 100% reduction for Medically Necessary care
- Between 201% and 225% of the Federal Poverty Guidelines – Reduced cost Medically Necessary care at 75%
- Between 226% and 250% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 50%
- Between 251% and 300% of the Federal Poverty Guidelines - Reduced cost care Medically Necessary care at 25%

Medical Hardship is based on the following income level:

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

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

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