Q1.

Introduction:

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

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

The Commission developed a two-part community benefit reporting system that includes an inventory spreadsheet that collects financial and quantitative information and a narrative report to strengthen and supplement the inventory spreadsheet. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. This reporting tool serves as the narrative report. The instructions and process for completing the inventory spreadsheet remain the same as in prior years. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless 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: Peninsula Regional Medical Center	◉	○	
Your hospital's ID is: 210019	◉	○	
Your hospital is part of the hospital system called Peninsula Regional Health System.	◉	○	

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

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

Please see attached file in following question.

Q6. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

FY 2020 Community Benefit Market and Demographics.docx
4.4MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

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

Q8. Please select the county or counties located in your hospital's CBSA.

- ☐ Allegany County
- ☐ Anne Arundel County
- ☐ Baltimore City
- ☐ Baltimore County
- ☐ Calvert County
- ☐ Charles County
- ☐ Dorchester County
- ☐ Frederick County
- ☐ Garrett County
- ☐ Harford County
- ☐ Prince George's County
- ☐ Queen Anne's County
- ☑ Somerset County
- ☐ St. Mary's County
- ☐ Talbot County

- [ ] Caroline County
- [ ] Carroll County
- [ ] Cecil County
- [ ] Howard County
- [ ] Kent County
- [ ] Montgomery County
- [ ] Washington County
- [x] Wicomico County
- [x] Worcester County

Q9. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q11. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q26. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

- [x] 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

Q33. How did your hospital identify its CBSA?

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

Based on patterns of utilization. Please describe.

- [ ] Other. Please describe.

Peninsula Regional's Primary Service Area historically and currently is Wicomico, Worcester, and Somerset Counties.

Q34. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Q35. Section I - General Info Part 3 - Other Hospital Info

Q36. Provide a link to your hospital's mission statement.

https://www.tidalhealth.org/about-us/mission-values

Q37. Is your hospital an academic medical center?

- ( ) Yes
- (•) No

Q38. (Optional) Is there any other information about your hospital that you would like to provide?

Q39. (Optional) Please upload any supplemental information that you would like to provide.

Community Benefit FY 2020 Additional Hospital Information.docx
23.6KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q40. Section II - CHNA Part 1 - Timing & Format

Q41.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (•) Yes
- ( ) No

Q42. 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.

Q43. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/06/2019

Q44. Please provide a link to your hospital's most recently completed CHNA.

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

Q45. Did you make your CHNA available in other formats, languages, or media?

- (●) Yes
- ( ) No

Q46. Please describe the other formats in which you made your CHNA available.

The CHNA is made available in an electronic copy format and a hard copy format that is available to be viewed and distributed to residents of our community. The CHNA is translated into Spanish for our Spanish speaking residents. We also have translated many brochures like Mother/Baby, COVID-19 testing and screening events among other things and are in the process of translating the next CHNA into Creole.

Q47. Section II - CHNA Part 2 - Internal Participants

Q48. Please use the table below to tell us about the internal participants involved in 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)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☑	The Board of Trustees receives a copy of the Community Health Assessment and the Implementation Strategy Plan to review, c and approve. There are also periodic updates to action plans, mi and progress updates.

	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)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☑	The Board of Trustees receives a copy of the Community Health Assessment and the Implementation Strategy Plan to review, c and approve. There are also periodic updates to action plans, mi and progress updates.
	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:
Community Benefit Task Force	☐	☐	☑	☑	☑	☑	☑	☑	☐	☑	Those identified in the preceding positions (nurses, social worke make up the Community Benefit Task Force. Others from Beha Health, Marketing, and Planning were also participants in the Co Benefit Task Force.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your 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) Behavioral Health, Marketing, Planning, Diabetes Department, Emergency Department, Cardiac Rehab, Pediatric Endocrinology, and Employee Health and Wellness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Participants in each of these departments used their knowledg unique expertise to contribute to the CHNA.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:

Q49. Section II - CHNA Part 2 - External Participants

Q50. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the 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 explanation below:
Other Hospitals -- Please list the hospitals here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the 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 explanation below:
Local Health Department -- Please list the Local Health Departments here: Wicomico County Health Department and Somerset County Health Department	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the 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 explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Wicomico County LHIC	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the 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 explanation below:

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the 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 explanation below:
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Area Agency on Aging -- Please list the agencies here: MAC, Inc. The Area Agency on Aging	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Local Govt. Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Faith-Based Organizations	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - K-12 -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the 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 explanation below:
School - Colleges and/or Universities -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Behavioral Health Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Social Service Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Post-Acute Care Facilities -- please list the facilities here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the 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 explanation below:
Community/Neighborhood Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Other -- If any other people or organizations were involved, please list them here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

Q51. Section II - CHNA Part 3 - Follow-up

Q52. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q53. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

11/07/2019

Q54. Please provide a link to your hospital's CHNA implementation strategy.

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

Q55. 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.

Q56. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

- ☑ Access to Health Services: Health Insurance
- ☑ Access to Health Services: Practicing PCPs
- ☑ Access to Health Services: Regular PCP Visits
- ☐ Access to Health Services: ED Wait Times
- ☑ Access to Health Services: Outpatient Services
- ☐ Adolescent Health
- ☐ Arthritis, Osteoporosis, and Chronic Back Conditions
- ☑ Behavioral Health, including Mental Health and/or Substance Abuse
- ☑ Cancer
- ☐ Children's Health
- ☑ Chronic Kidney Disease
- ☐ Environmental Health
- ☐ Family Planning
- ☐ Food Safety
- ☐ Global Health
- ☐ Health Communication and Health Information Technology
- ☑ Health Literacy
- ☑ Health-Related Quality of Life & Well-Being
- ☑ Heart Disease and Stroke
- ☐ HIV
- ☐ Immunization and Infectious Diseases
- ☐ Injury Prevention
- ☑ Oral Health
- ☑ Physical Activity
- ☐ Respiratory Diseases
- ☐ Sexually Transmitted Diseases
- ☐ Sleep Health
- ☐ Telehealth
- ☑ Tobacco Use
- ☐ Violence Prevention
- ☐ Vision
- ☐ Wound Care
- ☐ Housing & Homelessness

- [ ] Community Unity
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [x] Transportation
- [x] Dementias, Including Alzheimer's Disease
- [ ] Maternal & Infant Health
- [x] Unemployment & Poverty
- [x] Diabetes
- [x] Nutrition and Weight Status
- [x] Other Social Determinants of Health
- [ ] Disability and Health
- [x] Older Adults
- [x] Other (specify) Obesity
- [x] Educational and Community-Based Programs

Q57. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

The needs and priorities identified in Peninsula Regional's most recent CHNA are comparable to the needs and priorities identified in the previous CHNA. There is a substantial need when it comes to the population in our CBSA. The same needs and priorities are obesity, diabetes, and behavioral health. The new need added for the 2019 CHNA is Cancer.

Q58. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

On November 7, 2019, the Board of Trustees approved Peninsula Regional's strategic implementation strategy to proceed with the following three themed initiatives: Chronic Disease Management with an emphasis on Diabetes, Cancer and Behavioral Health (Mental Health and Substance Abuse). Link to 2019 CHNA: https://online.fliphtml5.com/cxbl/pjhj/#p=1

Q59. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q60. Section III - CB Administration Part 1 - Internal Participants

Q61. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

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

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	The Board of Trustees receive a copy of the Community Benefit Report (financial & narrative) with a presentation at their monthly education session. Following the education session, the Board fully accepts the Community Benefit Report through the passing of a resolution.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☐	☐	☐	☐	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
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 initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☐	☐	☑	☑	☑	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☑	Oversee and direct the initiatives.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit Task Force	☐	☐	☐	☐	☐	☐	☐	☐	☑	☑	Those identified in the preceding positions (nurses, social workers, etc. make up the Community Benefit Task Force. Others from Behavioral Health, Marketing and Planning were also participants in the Community Benefit Task Force.

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

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

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

Q62. Section III - CB Administration Part 1 - External Participants

Q63. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities									
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: McCready Memorial Hospital, Atlantic General Hospital and Children's National Hospital	☐	☐	☐	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	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:
Local Health Department -- Please list the Local Health Departments here: Wicomico County Health Department, Somerset County Health Department and Worcester County Health Department	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	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:
Local Health Improvement Coalition -- Please list the LHICs here: Wicomico County Health Improvement Coalition, Worcester County Local Health Improvement Coalition and Healthy Somerset	☐	☑	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	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:
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	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:
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	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:
Maryland Department of Natural Resources	☐	☐	☐	☐	☐	☐	☐	☐	☑	The Maryland Natural Resources Police helped collaborate and deliver a Community Benefit objective.

	N/A - Person or Organization was not involved	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:
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	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:
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	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:
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	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:
Area Agency on Aging -- Please list the agencies here: MAC, Inc. (Maintaining Active Citizens)	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	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:
Local Govt. Organizations -- Please list the organizations here: City of Salisbury	☐	☐	☐	☐	☑	☑	☑	☑	☑	The City of Salisbury continues to work on improving the quality of life and healthy wellbeing of its residents.
	N/A - Person or Organization was not involved	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:
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☐	☐	☑	Peninsula Regional works with Faith Based Organizations in the community to provide healthy lifestyle education, flu shots, facilitate the pairing of people with local health-based resources. The organizations we have partnered with are: Union United Methodist, Ewell United Methodist, New Dimensions, New Macedonia Church, Mount Carmel Baptist, Emanuel Wesleyan, St. Paul AME Zion Church - Berlin, St. Paul's - Salisbury, St. James AME Church, St. Peter's Lutheran Church, Grace United Methodist, Holy Redeemer, Mt. Zion Baptist Church, HOPE Ministry and HALO Ministry.
	N/A - Person or Organization was not involved	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:
School - K-12 -- Please list the schools here: Wicomico High School, Wicomico Middle School, Westside Intermediate, Salisbury Middle School, Parkside High School, James M. Bennett High School, James M. Bennett Middle School and Fruitland Intermediate	☐	☐	☐	☐	☐	☐	☑	☑	☑	We are working with the Wicomico County Public Schools to identify, provide education, and help maintain active children and adolescents who have diabetes.
	N/A - Person or Organization was not involved	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:
School - Colleges and/or Universities -- Please list the schools here: UMES, Salisbury University, and Wor-Wic Community College	☐	☐	☐	☐	☐	☐	☐	☐	☑	We partner with the local colleges and universities in various population health capacities that include participating in university sponsored health fairs and COVID-19 activities. In addition, through sponsorship and education, we support their health and wellness initiatives and pharmacy/nursing education programs.
	N/A - Person or Organization was not involved	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:
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	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:
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	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:
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	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:
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	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:
School - Pharmacy School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	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:
Behavioral Health Organizations -- Please list the organizations here: C.O.A.T. and the Resource and Recovery Center	☐	☐	☐	☐	☐	☐	☑	☑	☑	The Resource and Recovery Center provides space for the Community Wellness Team Mobile Outreach Clinic. The C.O.A.T. team is embedded in Peninsula Regional's Emergency Department to help residents who enter the ED in crisis due to alcohol or drugs.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here: Worcester County Behavioral Health/Social Services	☐	☐	☐	☐	☐	☐	☐	☐	☑	The Community Wellness Team Mobile Outreach Clinic has visited the Worcester County site to provide services to residents in Worcester County.
	N/A - Person or Organization was not involved	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:
Post-Acute Care Facilities -- please list the facilities here: Salisbury Genesis, Anchorage, Coastal Hospice, Aurora Nursing Home, Berlin Nursing Home, White Oak SNF, Harrison House, Hartley Hall and Deers Head Hospital	☐	☐	☐	☐	☐	☐	☐	☐	☑	Peninsula Regional continues to work with post-acute care facilities to provide appropriate transitions of care for patients.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here: Local EMT Services, Lower Shore Clinic, Lower Shore Enterprises, Bayshore Services, Salvation Army, Coastal Hospice, Atlantic Club, YMCA, Maryland Food Bank, United Way of the Lower Eastern Shore	☐	☐	☐	☐	☐	☐	☐	☐	☐	Peninsula Regional continues to partner with local community/neighborhood organizations to increase awareness and engagement in healthy lifestyles and behaviors. Peninsula Regional engages in and partners with each neighborhood organization and their vision, whether it's diabetes screenings and education, nutrition and weight loss, social determinants of health and its corresponding correlation to behavioral health, or any unmet identified health need in the community. These organizations provide space for the Community Wellness Team Mobile Outreach Clinic and subsequently refers patients to physician providers and community based services determined by their condition.
	N/A - Person or Organization was not involved	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:
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here: Crisfield Clinic, Chesapeake Health Care, Other Independent and Employed Physicians, (PRCIN - Peninsula Regional Clinically Integrated Network), Dr. Jonathan Patrowicz, Dr. Alon Davis, Dr. Chris Huddleston and Dr. Vel Natesan, National Kidney Foundation	☐	☐	☐	☐	☐	☐	☐	☐	☑	Peninsula Regional continues to partner with these physicians and organizations to provide awareness and engagement in healthy lifestyles and behaviors. These organizations partner with Peninsula Regional to provide screenings to the local community for diabetes, renal disease, heart disease, etc. The local physicians that partner with Peninsula Regional see patients from the Community Wellness Team if they have been referred for a physician office visit.
	N/A - Person or Organization was not involved	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:

Q64. Section III - CB Administration Part 2 - Process & Governance

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

- ☑ Yes, by the hospital's staff

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

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

- (•) Yes
- ( ) No

Q67. Please describe the community benefit narrative audit process.

Both the spreadsheet and narrative component of the Community Benefits Report is reviewed by the Finance Department and the Strategy and Business Development Department. Upon completion of the review, the Vice President of Population Health and the Director of Community Health Initiatives evaluate both components and provide additional input to the narrative component. Following the review and audit by these three departments, the report is forwarded to the Executive Team for final review.

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

- (•) Yes
- ( ) No

Q69. Please explain:

This question was not displayed to the respondent.

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

- (•) Yes
- ( ) No

Q71. Please explain:

This question was not displayed to the respondent.

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

- (•) Yes
- ( ) No

Q73. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

Peninsula Regional's mission is to improve the health of the communities we serve. Community Benefit Planning and our Strategic Plan Vision 2020 work in unison, creating synergy for advancing community health. Peninsula Regional is transforming healthcare within our CBSA as the journey is to partner with our communities and local providers to help them understand how to best manage pre-existing conditions. The System is focused on wellness, providing the appropriate care in the appropriate setting and connecting them to services and information to promote a healthy lifestyle. The goals are to achieve the best possible outcomes through improving care coordination both inside and outside the hospital, while avoiding preventable hospital admissions/readmissions to the emergency room visits. Using the Community Health Needs Assessment as a roadmap to prioritizing community health privations, the integration of System Strategy and Community Benefits creates a strong cooperative and focused approach to population health planning and execution. Vision 2020, Peninsula Regional's Strategic Plan, has four overall arching themes, theme 3.0 is "Meet Consumer's Health Needs in All Stages of Life". This theme has multiple population health and community benefit strategies as evidenced: - Develop a model of care for chronic care management - Promote a sustainable culture of health, well-being, and community engagement - Identify the most important health needs for key population segments during their life journey - Prioritize efforts in areas that drive the best health and efficiency outcomes - Improve health literacy.

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

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

Q75. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

Q76. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Q77. Based on the implementation strategy developed through the CHNA process, please describe *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q78. Section IV - CB Initiatives Part 1 - Initiative 1

Q79. Name of initiative.

Chronic Disease Management/Community Health

Q80. Does this initiative address a community health need that was identified in your most recently completed CHNA?

- (•) Yes
- ( ) No

Q81. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Access to Health Services: Outpatient Services, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Dementias, Including Alzheimer's Disease, Diabetes, Educational and Community-Based Programs, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Tobacco Use, Transportation, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Obesity

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

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

Q82. When did this initiative begin?

01/01/2015

Q83. Does this initiative have an anticipated end date?

- (•) No, the initiative has no anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ( ) The initiative will end when external grant money to support the initiative runs out. Please explain.
- ( ) The initiative will end when a contract or agreement with a partner expires. Please explain.
- ( ) Other. Please explain.

Q84. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

1. MAC Chronic Disease Self-Management - Patients with uncontrolled chronic diseases which are identified via ER visits, the Community Wellness Team, Hospital Referrals, PCP Referrals, and other providers. Most of this population are age 55+ years old and have been referred for health reasons. 2. Community Wellness Team - Residents of Peninsula Regional's primary service area who have barriers to care such as no health insurance, no primary care provider, or no transportation. This population is primarily an indigent population with limited income. 3. Smith Island Telehealth - This population is the total population of Smith Island (approximately 300 residents). 4. Salisbury/Wicomico Integrated First-Care Team (SWIFT) - The targeted population has been updated to not only include Salisbury, MD residents but also Hebron and Fruitland, MD residents who rely heavily on EMS and Peninsula Regional for non-emergency care and/or patients who frequently have medically unnecessary ER visits and/or hospital readmissions within 30 days of discharge. The population may not have insurance and/or are low-income who have comorbidities. 5. Care Management and Disease Management Program for Chronic Conditions – This initiative targets residents who have had an ED or inpatient stay and are determined to be high utilizers of health services. There is a further emphasis on Medicare patients. 6. Remote Patient Monitoring - The targeted population are Medicare patients in Wicomico, Worcester or Somerset County who have had an inpatient stay for CHF, COPD, or Respiratory Failure and have had two or more ED/urgent care/office visits, a change in condition/medications, or hospitalization or skilled nursing facility discharge within the last 90 days. 7. Adult Diabetes Support Group – This initiative targets adults and their support system in the Tri-County area (Somerset, Wicomico, and Worcester counties) who have diabetes and need peer support or additional support from members of the Diabetes Department. 8. Kids and Teens Diabetes Support Group – This initiative targets kids, teens and their families in the Tri-County area (Somerset, Wicomico and Worcester counties) who have diabetes and need peer support or additional support from members of the Diabetes Department. 9. Nutrition & Diabetes Education Department Events – This initiative targets a wide variety of residents from the Tri-County area (Somerset, Wicomico and Worcester counties) of all ages and backgrounds in the hopes of spreading education and awareness and managing diabetes. The Nutrition & Diabetes Education Department staff also help educate local school nurses, Delmarva Peninsula residents via local TV programming, and school-aged children during back-to-school events.

Q85. Enter the estimated number of people this initiative targets.

39,000

Q86. How many people did this initiative reach during the fiscal year?

1. MAC Chronic Disease Self-Management – 220 (See Attachment B). 2. Community Wellness Team - 1,097 patients (See Attachment A). 3. Smith Island Telehealth - 184 patients (See Attachment D). 4. SWIFT - 112 patients (See Attachment E). 5. Care Management and Disease Management Program for Chronic Conditions – 5,377 community members (See Attachment A). 6. Remote Patient Monitoring - 125 patients (See Attachment F). 7. Adult Diabetes Support Group – 131 attendees (See Attachment G). 8. Kids and Teens Diabetes Support Group – 22 attendees (See Attachment G). 9. Nutrition & Diabetes Education & Department Events – 187 people (See Attachment G).

Q87. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention

- [x] Chronic condition-based intervention: prevention intervention
- [x] Acute condition-based intervention: treatment intervention
- [x] Acute condition-based intervention: prevention intervention
- [x] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [x] Community engagement intervention
- [ ] Other. Please specify.

Q88. Did you work with other individuals, groups, or organizations to deliver this initiative?

- [ ]

Yes. Please describe who was involved in this initiative.

1. MAC (Maintaining Active Citizens) Chronic Disease Self-Management - MAC, Inc. the Area Agency on Aging.

2. Community Wellness Team - Wicomico County Health Department, Worcester County Health Department, Somerset County Health Department, Wicomico County Board of Education, Worcester County Board of Education, Somerset County Board of Education, Wicomico County Community Health Providers, Worcester County Community Health Providers, Somerset County Community Health Providers, the City of Salisbury, United Way of the Lower Eastern Shore, HOPE Inc., HALO Shelter, Salisbury Urban Ministries, St. James AME Church, St. Peter's Lutheran Church, Resource and Recovery Center, Atlantic Club, Marion Pharmacy, MAC Inc. the Area Agency on Aging, National Kidney Foundation, Wicomico County Public Schools, Maryland Food Bank, the YMCA, and various other community and faith-based organizations.

3. Smith Island Telehealth – McCready Health, Marion Pharmacy, Crisfield Clinic, Wicomico County Health Department, Somerset County Health Department, National Kidney Foundation, MAC Inc. the Agency on Aging, United Way of the Lower Eastern Shore, and multiple Wicomico and Somerset Community Health providers.

4. SWIFT – Salisbury Fire Department, Salisbury Police Department, City of Salisbury, the Wicomico County Health Department, and the Maryland Community Health Resources Commission (MCHRC).

5. Care Management and Disease Management Program for Chronic Conditions – Wicomico County Health Department, Somerset County Health Department, Worcester County Health Department, Wicomico County Board of Education, Somerset County Board of Education, Worcester County Board of Education, Wicomico County Community Health Providers, Somerset County Community Health Providers, Worcester County Community Health Providers, City of Salisbury, Salisbury Fire Department, Salisbury Police Department, United Way of the Lower Eastern Shore, HOPE, HALO, Salisbury Urban Ministries, Tri-County Mediation, St. James AME Church, St. Peter’s Lutheran Church, Resource and Recovery Center, Atlantic Club, MAC Inc. the Area Agency on Aging, Maryland Food Bank, the YMCA, and Peninsula Regional Clinically Integrated Network (PRCIN).

6. Remote Patient Monitoring – Vivify Health, and Peninsula Regional Clinically Integrated Network (PRCIN).

7. Adult Diabetes Support Group – Peninsula Regional and family and friends.

8. Kids and Teens Diabetes Support Group – Peninsula Regional and family and friends.

9. Nutrition & Diabetes Education Department Events – Salisbury Moose Lodge, WBOC’s TV Show “Delmarva Life”, Somerset County Board of Education, Wicomico County Board of Education, Worcester County Board of Education and the Wicomico County Library.

○ No.

Q89. Please describe the primary objective of the initiative.

1. MAC Chronic Disease Self-Management – The primary objective of the MAC Chronic Disease Self-Management Programs are to teach residents of Wicomico, Somerset, and Worcester counties how to manage chronic diseases. Teaching these ways to manage chronic diseases reduce ER visits, admissions, and readmissions. This is done through programs that are designed to assist with the self-management of chronic diseases, providing the participants awareness and education on controlling their diabetes, hypertension, pain, etc. The programs are available to young adults 18 years of age or older and their families to learn about self-management, but are primarily for older adults 55 years or older. These workshops also give the aging population a higher quality of life and sense of independence, keeping them healthy, strong, and out of the hospital. The goals of this highly interactive community program are to improve individual's self-management skills and self-efficacy, which includes key skill-building activities like action planning, problem-solving, and decision-making. Weekly topics include: nutrition, appropriate exercise for strength, flexibility, and endurance; communicating effectively with family, friends and health care providers; appropriate use of medications; techniques to deal with pain, fatigue, frustration; decision making, action planning and goal setting. Outcomes include improved health literacy, patient activation for self-management, increased physical activity, improvement in depression, unhealthy physical days, medication compliance, better health outcomes (reduced fatigue, pain, shortness of breath, stress, and sleep problems). Fewer sick days and reduced ED and hospitalization are other outcomes from this objective. 2. Community Wellness Team - The primary objective of the Community Wellness Team is to provide residents of the Tri-County area walk-in appointments with a CRNP for health care needs, health screenings and assessments, education on prevention and management of chronic disease, as well as general health education awareness and literacy. The Community Wellness Team connects clients with insurance and primary care resources, community resources to address social determinants of health as well as promotes healthy lifestyle and reducing ED utilization. The team uses a mobile clinic van to visit low-income areas where the social determinants of health indicate the greatest need. It provides care in areas that have a higher prevalence of ER visits, lower median incomes, an indigent population, barriers to care, and overall poor health outcomes. 3. Smith Island Telehealth – The primary objective of Smith Island Telehealth is to increase access of care to Smith Island (a small rural island on the Chesapeake Bay) residents, provide health education and awareness to residents, and reduce ED utilization. Healthcare using telemedicine improved from last year and the program was also able to provide medication refills, office visits, blood pressure screenings, and lab draws that could be processed at McCready Health. 4. SWIFT – The primary objective of SWIFT is to reduce EMS and ED utilization by identifying and providing intervention to the highest ED utilizers in Salisbury, Hebron, and Fruitland, MD. The SWIFT team works collaboratively with high utilizers to reduce overuse of emergency services and improve access to care by connecting these community members to area resources that address behavioral health, chronic disease, and other social determinants of health. The program also connects utilizers with more appropriate care settings such as primary care offices and FQHCs. 5. Care Management and Disease Management Program for Chronic Conditions - The primary objective of this initiative is to provide evidence-based care management services to evolving and high-risk Medicare beneficiaries. It implements disease management protocols and develop patient-centered care plans. These protocols reduce utilization costs and increase health outcomes. 6. Remote Patient Monitoring - The primary objective of this initiative is to monitor Medicare patients who have been discharged from the hospital and diagnosed with CHF, COPD, or Respiratory Failure in order to make sure patients adhere to protocols, medications, and are engaged in their medical instructions. The Remote Patient Monitoring also is focused on reducing readmissions, increasing patient/caregiver engagement, and early identification in changes to a patient's health status. A future goal of the program is to monitor diabetes, blood pressure and other health metrics that weren't captured in FY 2019. 7. Adult Diabetes Support Group – The primary objective of this initiative is to provide support, networking, education, fellowship and to promote community unity to adults with diabetes and their caregivers. 8. Kids and Teens Diabetes Support Group – The primary objective is to provide support, networking, education, fellowship and promote community unity with current kids and teens with diabetes and their caregivers. 9. Nutrition & Diabetes Education Department Events – The primary objective of this initiative is to provide education and training on weight loss, nutrition, diabetes and other chronic diseases that have been established as a community health need in Somerset, Wicomico and Worcester counties.

Q90. Please describe how the initiative is delivered.

1. MAC Chronic Disease Self-Management - Workshops/Classes located at MAC, Inc. the Agency on Aging and other locations throughout the Tri-County area (Wicomico, Somerset, and Worcester counties). 2. Community Wellness Team - The Community Wellness Team serves multiple locations in the Tri-County area (Wicomico, Somerset, and Worcester counties) using a mobile clinic. The staff includes an CRNP, RN, a Medical Assistant, and a Social Worker to help provide care, screenings, and health education to residents. The initiative goes to multiple screening events within the local community. 3. Smith Island Telehealth - Employed Medical Assistants serve as liaisons for telehealth visits with providers. The Medical Assistants provide limited care to residents of Smith Island, while In-person visits by a provider occur every two weeks with weather permitting and telehealth visits are available with the installation of DSL internet on Smith Island. 4. SWIFT - A team consisting of a Paramedic, CRNP, an RN and a Social Worker, visit patients who are identified as high utilizers of EMS services. A large percentage of these patients have co-occurring behavioral health and chronic disease conditions that are diagnosed by the team. A plan is subsequently created based on a home assessment and then the patient is followed by the team for an average of six months. Referrals to local behavioral health and chronic disease health resources are made for the patient. 5. Care Management and Disease Management Program for Chronic Conditions - Care Managers are embedded into Primary Care offices and Emergency Departments to identify Medicare patients who are high utilizers of services or who are at risk of increased medical attention. The Care Managers then enroll these patients into care management programs and establish a relationship with the patient to get him/her to move towards a healthy lifestyle change. 6. Remote Patient Monitoring – This initiative is delivered by installing remote patient monitoring systems into patients' homes that qualify for the Remote Patient Monitoring Program. These patients have to be of Medicare age and have been diagnosed with CHF, COPD, or Respiratory Failure. The patients are first given a training class in the hospital and then the equipment is installed in the patients' homes by a community health worker. The patient is monitored for 60 days and receive training on how to monitor their vitals and take other health measurements the final 30 days of the program. Patients are encouraged to obtain various equipment in order to maintain self-monitoring after the 90-day program period is completed. 7. Adult Diabetes Support Group – This initiative is delivered by holding support group sessions in a designated location during various times of the year. Different education topics are covered each meeting. 8. Kids and Teens Diabetes Support Group - This initiative is delivered by holding support group sessions in a designated location during various times of the year. Different education topics are covered each meeting. 9. Nutrition & Diabetes Education Department Events – This initiative is delivered through a multitude of ways. The Nutrition & Diabetes Education Department go to wellness fairs, back to school events and other community events to provide education and awareness about chronic diseases such as diabetes and what can be done to make diabetes manageable or even avoidable. The Nutrition & Diabetes Education Department also speaks on a local news show called "Delmarva Life" to raise awareness and provide education about chronic diseases and how to make them manageable or even avoidable. The Nutrition & Diabetes Education Department also hosts a collaborative conference for local school nurses in the Tri-County area (Wicomico, Somerset, and Worcester counties) to educate and update school nurses with changes in chronic disease protocols for kids and teens under their care in the school setting.

Q91. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: 1. MAC Chronic Disease Self-Management - 220 participants in 28 workshops (See Attachment B). 2. Community Wellness Team - 1,097 patients (See Attachment A). 3. Smith Island Telehealth – 184 participants with 18 medication refills, 46 telehealth visits, 32 office visits, 14 lab drawls and 27 BP checks (See Attachment D). 4. SWIFT - 112 patients (See Attachment E). 5. Care Management and Disease Management Program for Chronic Conditions – 5377 participants (See Attachment A). 6. Remote Patient Monitoring - 125 participants (See Attachment F). 7. Adult Diabetes Support Group – 131 participants (See Attachment G). 8. Kids and Teens Diabetes Support Group – 22 participants (See Attachment G). 9. Nutrition & Diabetes Education Department Events – 187 participants (See Attachment G).
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [ ] Biophysical health indicators
- [x] Assessment of environmental change: 4. SWIFT - Residents are being connected with local healthcare resources instead of calling 911 and EMS services. 6. Remote Patient Monitoring – Patients are seeing their Primary Care Provider first, instead of immediately visiting the ER. Patients also take more responsibility of their health and self-improvement.
- [ ] Impact on policy change

☑ Effects on healthcare utilization or cost	1. MAC Chronic Disease Self-Management - By residents attending these classes and becoming educated on managing their chronic disease, hypertension, and/or fall risk, ultimately it reduces the chance of a resident needing medical attention and reduces ED utilization and costs. If people take care of their health, it reduces the amount of ED utilization from an episode and increases the overall health of the patient. 2. Community Wellness Team - Patients are getting referred to Primary Care Physicians, which reduces ED costs and utilization. Residents also receive screenings and are directed to the appropriate medical services when needed. Residents are also receiving help with social determinants of health, which can improve a person's health and reduce the possibility of having a health episode. Some examples of help are enrolling in food stamps, insurance, or financial assistance among other things. This is important because it is possible for residents to receive medical services before a condition becomes an emergency and affects ED costs and utilization. 3. Smith Island Telehealth - By having the option to speak to a medical professional remotely instead of heading directly to the ED, the medical professional can give an informed assessment of the situation, possibly eliminating a trip to the ED. This type of telehealth consult decreases ED utilization and cost. The office also had residents that saw the medical assistant for minor inquiries instead of traveling to the ED on the mainland. The medical assistant performed blood pressure checks for residents in the community to make sure that their levels were not dangerous, in order to avoid unnecessary ED utilization. 4. SWIFT – For FY 2020, the SWIFT program saw a total cost reduction of $738,467 and a 46% reduction in healthcare visits (See Attachment E). 5. Care Coordination – By having residents registered for this program, there are a total of 5,377 community members being cared for (See Attachment A). 6. Remote Patient Monitoring – There was a reduction of all type of healthcare visits by 42% and over $1 million dollars in healthcare charges, with almost $350,000 of these charges being due to a readmission (See Attachment F).
☐ Assessment of workforce development	
☐ Other	

Q92. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

1. MAC Chronic Disease Self-Management - There were 28 workshops with a total number of 220 participants for FY 2020. There were 9 workshops with 69 participants for "Stepping On" Falls Prevention Classes, 5 workshops with 46 participants for Living Well with Hypertension, and 14 workshops with 105 participants for Chronic Disease Self-Management classes (See Attachment B). 2. Community Wellness Team - The Community Wellness Team expanded its outreach to at-risk communities throughout the Tri-County area. It also went to screening fairs conducted at migrant camps, community centers, schools, shelters and churches, as well as to Smith Island, MD. Over 1,000 community members received medical services from the Community Wellness Team. The team had 138 outings, 37 screening events and 697 screenings from July through March until COVID-19 forced a change in functionality for the Community Wellness Team (See Attachment C). 3. Smith Island Telehealth – 184 community members were seen at the end of FY 2020. A substantial percentage of the total population of Smith Island is watermen, so having the medical assistant on Smith Island to provide basic care is crucial. These watermen can't take off of work to head to the mainland and see a doctor because it is a lengthy process. DSL internet was also installed last year, greatly improving the efficiency and accessibility to telehealth services on Smith Island (See Attachment D). 4. SWIFT - There was a reduction of ED visits to PRMC of 46% for enrollees in FY 2020. There was also a reduction of $738,467 in total charges for the over 98 community members that are annually being managed by SWIFT (See Attachment E). 5. Care Management and Disease Management Program for Chronic Conditions - Over 5,377 community members have had their care managed by the three hospitals in this program. There have been signs of improved health outcomes, a reduction in ER utilization and visits based on identifying high utilizers and referring them to intervention classes held at MAC, Inc. In total, there are 4,678 community members that are having their care managed by Peninsula Regional Medical Center. 35 community members are care managed in partnership with MAC, Inc. and Atlantic General, with 348 community members are care managed by MAC, Inc. and Peninsula Regional Medical Center (See Attachment A). 6. Remote Patient Monitoring - The program has been implemented for 13 months and there have been a total of 125 patient enrolled in Remote Patient Monitoring (RPM). According to satisfaction surveys by both the patients and physicians, the program is going very well and there has been a reduction in utilizations and healthcare charges (See Attachment F).

Q93. Please describe how the outcome(s) of the initiative addresses community health needs.

1. MAC Chronic Disease Self-Management – MAC Chronic Disease Self-Management identifies the community health needs of Diabetes, Health Literacy, Health-Related Quality of Life and Well-Being, Nutrition and Weight Status, Older Adults, Hypertension and Physical Activity. There is a need for chronic disease self-management in our community. There are a substantial number of residents who are diabetic or pre-diabetic, overweight, hypertensive, or nutritionally deficient. As the baby boomer generation ages, there is a need to help educate this demographic about chronic diseases and the potential effects it can have on health. Through the partnership with MAC, Inc., residents are gaining a better understanding of chronic diseases. In turn, the improved education can decrease ER visits and reduce future cost and utilization of the healthcare system. Action plans are created by attendees of the classes because they gain a better understanding of how to manage their symptoms, but also feel motivated to take control of their health. For FY 2020, there were a total of 220 participants in a total of 28 workshops throughout the year. The workshops included: Chronic Disease Self-Management, Living Well with High Blood Pressure and Stepping on Falls Prevention. Based on participant surveys of the Chronic Disease Self-Management workshops, 83% scored an 8, 9 or 10 on whether they can manage their condition after the workshop. Also, only 5% of participants say that they rate their health as poor after the workshops. This evidence proves that these participants are learning to make healthy lifestyle choices. In the Stepping on Falls Prevention classes, participants learn ways to make modifications to their home, learn how to be steadier on their feet, understand how physical strength can contribute to reducing falls and other ways to reduce their chance of falling. After completing this workshop, there was a 34% reduction in the fear of falling. Also, 95% of participants Agree or Strongly Agree that they are more comfortable talking to family and friends about falling. There was a 34% reduction in concern about falling interfered with normal social activities with friends and family. In the Living Well with High Blood Pressure classes, 72% of participants had Hypertension and 58% of participants had Diabetes. 68% of participants had multiple chronic conditions, so this class helped to teach residents how to manage their High Blood Pressure with other chronic conditions (See Attachment B). 2. Community Wellness Team - The Community Wellness Team helps break down the barriers of care that some of the residents in Peninsula Regional's CBSA experience. This initiative identifies the community health needs of Access to Health Services: Health Insurance, Access to Health Services: Regular PCP Visits, Diabetes, Health Literacy, Health-Related Quality of Life and Well-Being, Heart Disease and Stroke, Immunizations and Infectious Diseases, Nutrition and Weight Status, Older Adults, Chronic Kidney Disease, Respiratory Diseases, Hypertension and Other Social Determinants of Health. For example, the Community Wellness Team visits each county weekly so that people without transportation can come to a location close to their residence to receive health services. The Community Wellness Team also provides services to residents who don't have insurance. The screenings performed can help determine if there is a chronic disease that hasn't been identified by the resident such as diabetes, hypertension, or chronic heart failure. If a chronic disease is present, the Community Wellness Team helps coordinate referrals to the appropriate community health resources or services. The screenings also provide an educational opportunity by providing nutritional and healthy lifestyle counseling. Drug and alcohol screenings can be performed, and counseling referrals can be coordinated. The indigent and Haitian populations are examples of communities that need help getting medical care due to barriers like transportation, language, no insurance, etc. In total, 1,097 community members were impacted by the efforts of the Community Wellness Team in FY 2020 (See Attachment A). 3. Smith Island Telehealth – Smith Island Telehealth identifies the community health needs of Telehealth, Diabetes, Health Literacy, Nutrition and Weight Status, Physical Activity and Respiratory Diseases. The improved access to health care with the installation of telehealth provides chronic disease care management services and preventive care opportunities to residents. With the help of a Community Health Worker and telemedicine Primary Care visits, there was improved health literacy and chronic disease management. In FY 2020, 184 patients were served by the Smith Island Telehealth program. Smith Island has medical assistants on the island who helped perform lab draws, BP checks, assist in telehealth appointments with a Nurse Practitioner, refilled prescriptions and performed basic office visits for residents (See Attachment D). 4. SWIFT - The SWIFT Program identifies the community health needs of Behavioral Health, Access to Health Services: Regular PCP Visits, Health Literacy, Health-Related Quality of Life and Well-Being and Other Social Determinants of Health. High-utilizing residents who used EMS/ED services are educated about their conditions by the Paramedic, CRNP, RN, and Social Worker. By identifying single or multiple social determinants of health affecting SWIFT Program participants, referrals can be made to solutions such as behavioral health resources, life coaches, local health resources or chronic disease management classes. There were 42 new SWIFT enrollments in FY 2020 and 112 SWIFT patients had managed care in FY 2020 with the help of EMS and a CRNP, RN, and Social Worker on the Community Wellness Team (See Attachment E). 5. Care Management and Disease Management Program for Chronic Conditions - This program addresses the community health needs of Diabetes, Health Literacy, Health-Related Quality of Life and Well-Being, Heart Disease and Stroke, Nutrition and Weight Status, Respiratory Diseases and Other Social Determinants of Health by providing wraparound support by multidisciplinary teams in the community. High utilizers of the ED are assigned Social Workers that help direct these patients to healthcare services or community resources to address Social Determinants of Health. 6. Remote Patient Monitoring - This initiative helps to address the community health needs of Respiratory Diseases, Older Adults, and Health Related Quality of Life and Well-Being. By getting Medicare patients who have a respiratory disease into a remote patient monitoring program, it helps the patient understand his/her disease better and keeps a patient accountable with performing protocols assigned by the physician. The monitoring also helps RNs monitor vital signs and symptoms of patients and virtual call patients if needed. The program has been in place for 13 months and has had 125 patients being monitored at the end of FY 2020 with a reduction in charges of $1,047,749 (See Attachment F). 7. Adult Diabetes Support Group – This initiative helps to identify the community health needs of Diabetes, Health Literacy, Health-Related Quality of Life and Well-Being and Nutrition and Weight Status. By having adults with diabetes learn from each other as well as from the Support Group leaders, these adults will have a better quality of life and will be better prepared for challenges they may face in the future when dealing with their diabetes. 8. Kids and Teens Diabetes Support Group – This initiative helps to identify the community health needs of Diabetes, Adolescent Health, Children's Health, Educational and Community-Based Programs, Health Literacy, Health-Related Quality of Life and Well-Being and Nutrition and Weight Status. By having these kids and teens with diabetes learn from each other as well as from the Support Group leaders, they will have a better quality of life and will be better prepared for challenges they may face in the future when dealing with their diabetes. It is also a good learning experience for the caregivers of these kids and teens to care for their children as they grow up with diabetes. 9. Nutrition & Diabetes Education Department Events – This initiative helps to identify the community health needs of Diabetes, Health Literacy, Health-Related Quality of Life and Well-Being, Nutrition and Weight Status, and Educational and Community-Based Programs. By having these events and programs, the community can be more educated on nutrition, diabetes and other chronic diseases that can be caused by poor diet, little exercise, etc. As the community becomes more educated on the subject matter of nutrition, diabetes, weight status, etc., overall, the community will become much healthier and it will have a positive impact on community unity.

Q94. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Q95. (Optional) Supplemental information for this initiative.

Community Benefit FY 2020 All Attachments.pdf
17.9MB
application/pdf

Q96. Section IV - CB Initiatives Part 2 - Initiative 2

Q97. Name of initiative.

Behavioral Health (Substance Abuse/Behavioral Health)

Q98. Does this initiative address a need identified in your most recently completed CHNA?

- (●) Yes
- ( ) No

Q99. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Access to Health Services: Outpatient Services, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Dementias, Including Alzheimer's Disease, Diabetes, Educational and Community-Based Programs, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Tobacco Use, Transportation, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Obesity

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

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

Q100. When did this initiative begin?

07/01/2016

Q101. Does this initiative have an anticipated end date?

- (•) No, the initiative does not have an anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ( ) The initiative will end when external grant money to support the initiative runs out. Please explain.
- ( ) The initiative will end when a contract or agreement with a partner expires. Please explain.
- ( )

Other. Please explain.

Q102. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

1. Community Outreach Addictions Team (COAT) - This initiative primarily targets the Wicomico County population who have substance abuse issues, behavioral health and socialization issues, high utilization of the ED due to drugs or alcohol, and/or social determinants of health. We have also seen residents from Worcester and Somerset counties present at the hospital with these same health needs. 2. Opioid Intervention Team (OIT) and Somerset County Opioid United Team (SCOUT) - This initiative targets the populations of Wicomico County and Somerset County who are struggling with addiction and their families and friends. Any Wicomico County or Somerset County resident who is, has been, or knows of someone who has issues with addiction can benefit from these programs. 3. Programs to Encourage Active and Rewarding Lives (PEARLS) - This initiative targets the aging population 60 years old and over who have thoughts of depression or loss of a spouse and are grieving. 4. Salisbury/Wicomico Integrated First-Care Team (SWIFT) - This initiative targets the populations of Salisbury, Fruitland and Hebron who rely heavily on EMS and Peninsula Regional for non-emergency care and/or patients who frequently have medically unnecessary ER visits and/or have hospital readmissions within 30 days of discharge.

Q103. Enter the estimated number of people this initiative targets.

180,000

Q104. How many people did this initiative reach during the fiscal year?

1. COAT – 240 (See Attachment I). 2. Opioid Intervention Team (OIT) and Somerset County Opioid United Team (SCOUT) – 333,930 exposed to educational messaging (See Attachment J). 3. PEARLS – 128 (See Attachment B). 4. SWIFT – 112 patients (See Attachment A).

Q105. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [x] Acute condition-based intervention: treatment intervention
- [x] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [x] Community engagement intervention
- [ ] Other. Please specify.

Q106. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (•)

Yes. Please describe who was involved in this initiative.

1. COAT - Salisbury Fire Department and EMS, Wicomico County Health Department, City of Salisbury, Wicomico County Sheriff's Office, and the State's Attorney's Office.
2. Opioid Intervention Team and Somerset County Opioid United Team- Peninsula Regional, Wicomico County Executive's Office, Wicomico County Department of Emergency Services, Wicomico County State's Attorney, Wicomico County Sheriff's Office, Maryland State Police Barrack E, Fruitland Police Department, Salisbury Police Department, Maryland Natural Resources Police, Pittsville Police Department, Delmar Police Department, Hudson Health Services, Inc., Maryland Coalition of Families, Clarion Call Restoration Ministries, MAC, Inc. the Area Agency on Aging, Peninsula Addictions and Mental Health, J. David Collins and Associates, Second Wind Inc., Focus Point Behavioral Health, United Way of the Lower Eastern Shore, SonRise Church, Recovery Resource Center, City of Salisbury Fire Department, High Intensity Drug Trafficking Area (HIDTA) Program, Eastern Shore Psychological Center, Wor-Wic Community College, Salisbury University, Wicomico County Public Schools/Board of Education, BNJ Health Services, St. James AME Methodist Church, Department of Social Services, Department of Parole and Probation, Sante Group/Mobile Crisis, Life Crisis Center, Community Behavioral Health, Deer's Head Hospital Center, Comcast Spotlight, Lower Shore Clinic, Inc., DKH Recovery House, Somerset County Emergency Services, Crisfield Police Department, Somerset County Sheriff's Department, McCready Health, Somerset County Department of Social Services, Princess Anne Police Department, Department of Parole & Probation, Crisfield Drug Free Community, University of Maryland Eastern Shore, Somerset Circuit Court, Somerset Recovery Court and Somerset County Public Schools/Board of Education.
3. PEARLS - MAC Inc., the Area Agency on Aging and Peninsula Regional.
4. SWIFT - Salisbury Fire Department, Salisbury Police Department, City of Salisbury, the Wicomico County Health Department, and the Maryland Community Health Resources Commission (MCHRC).

○ No.

Q107. Please describe the primary objective of the initiative.

1. COAT - The primary objective of this initiative is to prevent overdoses, help residents with barriers to treatment, and provide a smooth transition to community and social resources after a discharge from the Emergency Department. 2. Opioid Intervention Team and Somerset County Opioid United Team - The primary objective of this initiative is to bring opioid awareness and treatment options to residents in Wicomico County and Somerset County with substance abuse issues. 3. PEARLS - The primary objective of this initiative is to help older residents age 60+ manage their feelings of loneliness, frustration, anxiousness, restlessness, depression and to improve their quality of life. 4. SWIFT – The primary objective of this initiative is to reduce EMS and ED utilization by identifying and providing intervention to the highest ED utilizers. The SWIFT team works collaboratively with high utilizers to reduce overuse of emergency services and improve access to care by connecting these community members to area resources that address behavioral health, chronic disease health and other social determinants of health. The program also connects utilizers with more appropriate care settings such as primary care offices and FQHCs.

Q108. Please describe how the initiative is delivered.

1. COAT - This initiative is delivered by having 24/7 phone and in-person peer support specialists linked to the Emergency Department of Peninsula Regional. When an overdose comes in, COAT is notified, and a support specialist contacts the patient when it is appropriate. The support specialist then helps the patient connect to treatment, local resources, become educated on the dangers of substance abuse and opioid addiction, and/or provide support for the patient as he/she navigates through life post overdose. 2. Opioid Intervention Team (OIT) and Somerset County Opioid United Team (SCOUT) - This initiative is delivered by creating awareness about substance abuse and the damaging toll it takes not only on the abuser but on the abuser's family, friends, and the community. Awareness campaigns throughout Wicomico County and Somerset County are held and local businesses participate in promoting purple, which is the color used to bring awareness to substance abuse. The Boards of Education in Somerset and Wicomico Counties also participate by having Go Purple events to promote awareness and education about the dangers of opioids. Peninsula Regional also participated by adding a secure prescription drug drop box in its Emergency Department and has limited prescription opioids from being used inappropriately. Narcan education and trainings also took place for residents, friends, and family members of addicted residents to appropriately administer Narcan and save someone from dying of an overdose. 3. PEARLS - This initiative is delivered by offering free one-on-one counseling sessions to help manage feelings of loneliness, frustration, anxiousness, and restlessness and improve the person's quality of life. 4. SWIFT - A team consisting of a Paramedic, CRNP, an RN, and a Social Worker, who visit patients identified as high utilizers of EMS services. A significant percentage of these patients have co-occurring behavioral health and chronic disease conditions that are diagnosed by the team. A plan is subsequently created based on a home assessment and then the patient is followed by the team for an average of six months. Referrals to local behavioral health and chronic disease health resources are also made for the patient.

Q109. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

☑

Count of participants/encounters	1. COAT - 240 unduplicated individuals (See Attachment I). 2. Opioid Intervention Team (OIT) and Somerset County Opioid United Team – 319 individuals Narcan trained (See Attachment J). 3. PEARLS - 128 participants (See Attachment B). 4. SWIFT – 112 patients (See Attachment A).
☑ Other process/implementation measures (e.g. number of items distributed)	2. Opioid Intervention Team (OIT) and Somerset County Opioid United Team (SCOUT) – Gave Narcan training to 319 people, distributed 350 prescription drug deactivation bags in Wicomico County and Somerset County, held 66 educational/training events, 37 SCOUT/OIT meetings held, 14 informational campaigns, 8 schools with Go Purple Clubs and 26 school based educational Go Purple Events (See Attachment J).
☑ Surveys of participants	3. PEARLS – There were 43% of participants with at least a 50% decrease in PHQ9 score, baseline to final. A PHQ9 assessment is a depression screening assessment. 21% of participants who no longer meet criteria for clinical depression at final (See Attachment B).
☑ Biophysical health indicators	3. PEARLS – There were 79% of participants in the PEARLS program who saw at least a 50% decrease in PHQ9 score, baseline to final. A PHQ9 assessment is a depression screening assessment. 65% of participants no longer met criteria for clinical depression at final (See Attachment B).
☑ Assessment of environmental change	2. Opioid Intervention Team (OIT) and Somerset County Opioid United Team (SCOUT) – There is more community engagement and awareness of opioid abuse and opioid intervention. Wicomico County held a “Go Purple” campaign that local businesses contributed to; local schools have Go Purple clubs and have held Go Purple school events. The Somerset County Opioid United Team (SCOUT) is in its first year as an organization and has seen improved community education on opioids through various Go Purple events.
☑ Impact on policy change	2. Opioid Intervention Team (OIT) and Somerset County Opioid United Team (SCOUT) – At Peninsula Regional there is a policy on prescribing opioids that has since limited the number of opioids prescribed to patients who visit the ED, are discharged from a hospitalization, or from Same Day Surgery. The total number of prescriptions written in FY 2020 was 43,594 compared to 49,492 prescriptions written in FY 2019 (See Attachment L). There is also a new policy that restricts the use of Hydromorphone to the operating room only at the hospital and the opioid has been removed from all other areas.
☑	

Effects on healthcare utilization or cost	1. COAT - Continued reduction in heroin overdoses over the years which reduces healthcare utilization and/or cost in the Emergency Department. 2. Opioid Intervention Team (OIT) and Somerset County Opioid United Team (SCOUT) - There is a reduction in opioids prescribed by healthcare professionals, which limits costs and reduces future healthcare utilization due to dependence on opioids. By distributing the prescription drug deactivation bags, the drugs are coming off the street and can reduce overdoses from the misuse of these drugs. 3. PEARLS – There was a 65% achieved remission rate and a 79% achieved response rate for participants in the PEARLS program. These achievements correlate to decreases in depression which can reduce healthcare utilization and cost because of injuries or other healthcare related issues (See Attachment B). 4. SWIFT - There was a reduction of healthcare visits to Peninsula Regional of 46% for total visits. Utilization and costs decreased because participants were connected to the correct care in the correct setting instead of utilizing the ED and EMS services. For FY 2020, SWIFT saw a 46% reduction in total and a $738,467 reduction in charges (See Attachment E).

- [ ] Assessment of workforce development
- [ ] Other

Q110. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

1. COAT - There has been a slight increase in heroin overdoses being seen in the Emergency Department from FY 2019 to FY 2020. There was an increase from 94 overdoses in FY 2019 to 97 overdoses in FY 2020 (See Attachment H). COAT also provided other services such as transportation, insurance assistance, housing, financial assistance, and linking the patient to referrals to healthcare. 201 patients were served by COAT's navigation services. (See Attachment I). The assumption is that with COVID-19 and people losing their jobs, some residents turned to opioids to deal with financial and emotional stress. 2. Opioid Intervention Team (OIT) and Somerset County Opioid United Team (SCOUT)- There has been better opioid awareness and a better understanding of what opioid abuse can do and what it looks like. As a result, there has been an establishment of another organization in Somerset County. There are also more Narcan trainings, informational campaigns, and school-based educational Go Purple events within the community. 3. PEARLS - Participants in the program are happier and are having better mental health days. Participants are also engaged in exercise, stretching and strength training which has helped improve the depression symptoms. 4. SWIFT - There was a reduction of ED visits to Peninsula Regional of 50% for enrollees over a 6-month period. There was also a reduction of $87,000 in total charges for the Emergency Department visits by the members of the community being managed by SWIFT (See Attachment E).

Q111. Please describe how the outcome(s) of the initiative addresses community health needs.

1. COAT - The outcomes of this initiative address Behavioral Health, including Mental Health and/or Substance Abuse by providing support, preventing overdoses due to substance abuse, and providing a smooth transition to behavioral health or mental health services in the community. The COAT team saw 240 unduplicated people in FY 2020. Of those 240, 177 of these people were from Wicomico County. 53% of those Wicomico County residents helped by COAT were linked to treatment of some kind, in order to curb their addictions and receive help (See Attachment I). There has also not been a significant increase in the number of overdoses seen in Peninsula Regional's Emergency Department since the implementation of the COAT program. In FY 2016, there were 245 overdoses and in FY 2020 there were 97 overdoses (See Attachment H). These outcomes support that the COAT program is benefitting the community. 2. Opioid Intervention Team (OIT) and Somerset County Opioid United Team (SCOUT) - The outcomes of this initiative address Behavioral Health, including Mental Health and/or Substance Abuse by providing a prescription drug drop box for unwanted or expired prescription drugs. The OIT and SCOUT also helps to limit the number of opioid prescriptions written by health professionals in the Emergency Department, Inpatient, and Ambulatory sites. Peninsula Regional is below the state of MD and the national average for prescribing opioids to patients. There are 10 drop-off boxes located throughout Wicomico County in order to dispose of unwanted prescription drugs appropriately. OIT and SCOUT also provide Narcan training for residents of Somerset and Wicomico Counties along with holding meetings and educational/training events in Somerset and Wicomico Counties. 3. PEARLS – The outcomes of this initiative address Behavioral Health, including Mental Health and/or Substance Abuse by providing support and one-on-one counseling for older adults who are feeling depressed, as well as feelings of loneliness, frustration, anxiousness, and restlessness. By having the one-on-one counseling, the goal is to improve a person's mental health, leading to improved health, wellness, and independence. The outcomes also address the community health needs of older adults. As a person gets older, he/she may mentally and emotionally hurt from the loss of friends, loved ones, and the sense of independence. PEARLS works to counsel these people and improve their mental health and wellness. In FY 2020 there were 128 total participants. There was a 65% achieved remission rate and a 79% achieved response rate for participants in the PEARLS program. These achievements correlate to decreases in depression which can reduce healthcare utilization and the total cost of care (See Attachment B). 4. SWIFT - The SWIFT Program identifies the community health needs of Behavioral Health, Access to Health Services: Regular PCP Visits, Health Literacy, Health-Related Quality of Life and Well-Being and Other Social Determinants of Health. High utilizing residents who used EMS/ED services are educated about their conditions by the Paramedic, CRNP, RN, and Social Worker. By identifying social determinants of health affecting SWIFT Program participants, referrals can be made to solutions such as behavioral health resources, life coaches, local health resources or chronic disease management classes. 112 SWIFT patients were seen in FY 2020 with the help of EMS and an CRNP, RN and Social Worker with the Community Wellness Team (See Attachment E).

Q112. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Q113. (Optional) Supplemental information for this initiative.

Community Benefit FY 2020 All Attachments.pdf
17.9MB
application/pdf

Q114. Section IV - CB Initiatives Part 3 - Initiative 3

Q115. Name of initiative.

Cancer

Q116. Does this initiative address a need identified in your most recently completed CHNA?

- (●) Yes
- ( ) No

Q117. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Access to Health Services: Outpatient Services, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Dementias, Including Alzheimer's Disease, Diabetes, Educational and Community-Based Programs, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Tobacco Use, Transportation, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Obesity

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

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

Q118. When did this initiative begin?

07/01/2016

Q119. Does this initiative have an anticipated end date?

- (●) No, the initiative does not have an anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( )

The initiative will end when a community or population health measure reaches a target value. Please describe.

- [ ] The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- [ ] The initiative will end when external grant money to support the initiative runs out. Please explain.
- [ ] The initiative will end when a contract or agreement with a partner expires. Please explain.
- [ ] Other. Please explain.

Q120. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

1. Gentle Exercise Group – This initiative targets cancer patients and their caregivers of all ages who need conditioning, strengthening or balance improvements. 2. Stitch Therapy Support Group – This initiative targets breast cancer patients or survivors of all ages for networking and fellowship. 3. Healing Seated Yoga - This initiative targets cancer patients and their caregivers of all ages that want to refresh their minds and bodies with the exercise of yoga. 4. What's Cooking – This initiative targets cancer survivors and caregivers of all ages who want to cook meals specific to their special dietary needs. 5. Tai Chi for Better Balance – This initiative targets cancer patients and their caregivers of all ages for networking, fellowship and staying physically active. 6. Cancer Survivor and Caregiver Support Group – This initiative targets cancer patients and their caregivers of all ages for networking and fellowship. 7. Look Good Feel Better – This initiative targets cancer patients of all ages undergoing treatment with how to care for skin and nails, offering tips and sharing information about wigs and head wraps. 8. Head and Neck Cancer Support Group – This initiative targets specifically head and neck cancer patients and their caregivers of all ages for networking and fellowship. 9. Prostate Cancer Support Group – This initiative targets specifically prostate cancer patients and their caregivers of all ages for networking and fellowship. 10. Preventative Cancer Screenings – This initiative targets residents who are in the age range to receive breast, lung, colorectal, liver, cervical and other preventative cancer screenings.

Q121. Enter the estimated number of people this initiative targets.

11,000

Q122. How many people did this initiative reach during the fiscal year?

1. Gentle Exercise Group – 33 patients (See Attachment K) 2. Women Support Women Stitch Therapy Support Group – 29 patients (See Attachment K). 3. Healing Seated Yoga – 134 patients (See Attachment K). 4. What's Cooking – 78 patients (See Attachment K). 5. Tai Chi for Better Balance – 152 patients (See Attachment K). 6. Cancer Survivor and Caregiver Support Group – 138 patients (See Attachment K). 7. Look Good Feel Better – 13 patients (See Attachment K) 8. Head and Neck Cancer Support Group – 7 patients (See Attachment K). 9. Prostate Cancer Support Group – 10 patients (See Attachment K). 10. Preventative Cancer Screenings - 13,980 social media account followers (See Attachment M).

Q123. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [x] Community engagement intervention
- [ ]

Other. Please specify.

Q124. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (●) Yes. Please describe who was involved in this initiative.

  1. Gentle Exercise Group – Peninsula Regional Adult Fitness.
  2. Stitch Therapy Support Group – Women Supporting Women.
  3. Healing Seated Yoga – Volunteer Yoga Instructor.
  4. What's Cooking – Peninsula Regional and patients.
  5. Tai Chi for Better Balance – Volunteer Tai Chi instructor.
  6. Cancer Survivor and Caregiver Support Group – Peninsula Regional and patients.
  7. Look Good Feel Better – Volunteer Cosmetologist.
  8. Head and Neck Cancer Support Group - Peninsula Regional and patients.
  9. Prostate Cancer Support Group - Peninsula Regional and patients.
  10. Preventative Cancer Screenings - Peninsula Regional social media and social media account followers.

- ( ) No.

Q125. Please describe the primary objective of the initiative.

1. Gentle Exercise Group – The primary objective is to improve strength, conditioning and balance for cancer patients and their caregivers. 2. Stitch Therapy Support Group –The primary objective is to network, enjoy fellowship with current or past cancer patients and their caregivers and knit hats, scarfs, etc. for patients. 3. Healing Seated Yoga – The primary objective is to improve mentally and physically through yoga for cancer patients and their caregivers. 4. What's Cooking – The primary objective is to educate cancer patients and their caregivers centered around healthy eating and cooking demonstrations. 5. Tai Chi for Better Balance – The primary objective is to provide Tai Chi to cancer patients and their caregivers to keep them active and support each other. 6. Cancer Survivor and Caregiver Support Group – The primary objective is to network, educate and enjoy fellowship with current or past cancer patients and their caregivers. 7. Look Good Feel Better – The primary objective is to educate cancer patients on caring for skin and nails, offer cosmetics tips and share information about wigs and head wraps to patients. 8. Head and Neck Cancer Support Group - The primary objective is to network, educate and enjoy fellowship with current or past head and neck cancer patients and their caregivers. 9. Prostate Cancer Support Group - The primary objective is to network, educate and enjoy fellowship with current or past prostate cancer patients and their caregivers. 10. Preventative Cancer Screenings – The primary objective is to educate and bring awareness to cancers that can be preventative such as breast, lung, and colorectal, liver and cervical cancers.

Q126. Please describe how the initiative is delivered.

1. Gentle Exercise Group – This initiative is delivered by having small group exercise classes on campus. 2. Stitch Therapy Support Group – This initiative is delivered by having small group sessions on campus. 3. Healing Seated Yoga – This initiative is delivered by having small group yoga sessions on campus. 4. What's Cooking – This initiative is delivered by having small group classes and cooking demonstrations on campus. 5. Tai Chi for Better Balance – This initiative is delivered by having small Tai Chi classes on campus. 6. Cancer Survivor and Caregiver Support Group – This initiative is delivered by having small group sessions on campus. 7. Look Good Feel Better – This initiative is delivered by having a volunteer cosmetologist come to campus and perform a workshop for patients. 8. Head and Neck Cancer Support Group – This initiative is delivered by having small group sessions on campus. 9. Prostate Cancer Support Group - This initiative is delivered by having small group sessions on campus. 10. Preventative Cancer Screenings – This initiative is delivered by posting educational messages and information throughout the year about how to receive preventative screenings on social media platforms.

Q127. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: 1. Gentle Exercise Group – 33 patients (See Attachment K). 2. Women Support Women Stitch Therapy Support Group – 29 patients (See Attachment K). 3. Healing Seated Yoga – 134 patients (See Attachment K). 4. What's Cooking – 78 patients (See Attachment K). 5. Tai Chi for Better Balance – 152 patients (See Attachment K). 6. Cancer Survivor and Caregiver Support Group – 138 patients (See Attachment K). 7. Look Good Feel Better – 13 patients (See Attachment K). 8. Head and Neck Cancer Support Group – 7 patients (See Attachment K). 9. Prostate Cancer Support Group – 10 patients (See Attachment K). 10. Preventative Cancer Screenings – 4 social media posts.
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [ ] Biophysical health indicators

- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [x] Other: 10. Preventative Cancer Screenings – 13,980 social media account followers (See Attachment M).

Q128. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

1. Gentle Exercise Group – This initiative addresses the community health needs of Cancer, Community Unity, Health-Related Quality of Life and Well-Being and Physical Activity. By having this group, patients and their caregivers can participate in physical activity in a group setting. Exercise is proven to have a positive effect on Health-Related Quality of Life and Well-Being and this group also gets multiple cancer patients and their caregivers together in a group setting to provide support and create connections in the community. 2. Stitch Therapy Support Group – This initiative addresses the community health needs of Cancer, Community Unity and Health-Related Quality of Life and Well-Being. The support group offers an opportunity for breast cancer patients and their caregivers to discuss life with breast cancer. The support group also offers a chance for support of fellow breast cancer patients and their caregivers and share their cancer stories that could benefit another cancer patient at the time. By having support, patients have an improved frame of mind and can be better equipped for the challenges that breast cancer provides. 3. Healing Seated Yoga – This initiative addresses the community health needs of Cancer, Community Unity, Health-Related Quality of Life and Well-Being and Physical Activity. By having this group, patients and their caregivers can participate in physical activity in a group setting. Yoga is proven to have a positive effect on Health-Related Quality of Life and Well-Being and this group also gets multiple cancer patients and their caregivers together in a group setting to provide support and create connections in the community. The breathing exercises and stretching also help calm the mind and leave participants feeling more relaxed afterwards. 4. What's Cooking – This initiative addresses the community health needs of Cancer, Community Unity, Nutrition and Weight Status, Health-Related Quality of Life and Well-Being, and Health Literacy. By learning these recipes and attending these cooking demonstrations, patients and their caregivers better understand the best nutrition to maintain a healthy body and weight status. Eating better can be linked to improved Health-Related Quality of Life and Well-Being and for patients that have Cancer, learning about what types of foods are better for handling treatments would be beneficial. These classes are also a valuable resource for Community Unity by having multiple cancer patients and their caregivers together to provide support and create connections through this challenging time. 5. Tai Chi for Better Balance – This initiative addresses the community health needs of Cancer, Community Unity, Health-Related Quality of Life and Well-Being and Physical Activity. By having this group, patients and their caregivers can participate in physical activity in a group setting. Tai Chi is proven to have a positive effect on strength, balance, Health-Related Quality of Life and Well-Being and this group also gets multiple cancer patients and their caregivers together in a group setting to provide support and create connections in the community. 6. Cancer Survivor and Caregiver Support Group – This initiative addresses Cancer, Community Unity and Health-Related Quality of Life and Well-Being. The support group offers an opportunity for cancer patients and their caregivers to discuss life with cancer. The support group also offers a chance for support of fellow cancer patients and their caregivers and share their cancer stories that could benefit another cancer patient at the time. By having support, patients have an improved frame of mind and can be better equipped for the challenges that cancer provides. 7. Look Good Feel Better – This initiative addresses Cancer, Community Unity and Health-Related Quality of Life and Well-Being. The class is led by a volunteer cosmetologist who helps cancer patients learn about skin and hair care. The cosmetologist also has experience teaching cancer patients and their caregivers about wigs and head wraps. 8. Head and Neck Cancer Support Group – This initiative addresses the community health needs of Cancer, Community Unity and Health-Related Quality of Life and Well-Being. This support group brings together head and neck cancer patients and their caregivers to talk about difficulties and build relationships with each. By having support, patients have an improved frame of mind and can be better equipped for the challenges that head and neck cancer provides. 9. Prostate Cancer Support Group - This initiative addresses the community health needs of Cancer, Community Unity and Health-Related Quality of Life and Well-Being. This support group brings together prostate cancer patients and their caregivers to talk about their difficulties and build relationships with each other. By having support, patients have an improved frame of mind and can be better equipped for the challenges that prostate cancer provides. 10. Preventative Cancer Screenings – This initiative addresses the community health needs of Cancer, Health-Related Quality of Life and Well-Being, Educational and Community-Based Programs and Health Literacy. Today, social media platforms reach more people than TV and radio advertisements ever could. The social media posts include information about preventative screenings for specific cancers that residents may want to ask their Primary Care Physician about. Further information can be found on the social media posts about where to get these preventative screenings and the benefits of having these screenings completed. In November, Peninsula Regional posts educational information and screening information about lung cancer. In May, Peninsula Regional posts educational information and screening information about skin cancer. In March, Peninsula Regional posts educational information and screening information about colorectal and liver cancers, and in October, Peninsula Regional posts educational information and screening information about breast cancer.

Q129. Please describe how the outcome(s) of the initiative addresses community health needs.

1. Gentle Exercise Group – This initiative addresses the community health needs of Cancer, Community Unity, Health-Related Quality of Life and Well-Being and Physical Activity. By having this group, patients and their caregivers can participate in physical activity in a group setting. Exercise is proven to have a positive effect on Health-Related Quality of Life and Well-Being and this group also gets multiple cancer patients and their caregivers together in a group setting to provide support and create connections in the community. 2. Stitch Therapy Support Group – This initiative addresses the community health needs of Cancer, Community Unity and Health-Related Quality of Life and Well-Being. The support group offers an opportunity for breast cancer patients and their caregivers to discuss life with breast cancer. The support group also offers a chance for support of fellow breast cancer patients and their caregivers and share their cancer stories that could benefit another cancer patient at the time. By having support, patients have an improved frame of mind and can be better equipped for the challenges that breast cancer provides. 3. Healing Seated Yoga – This initiative addresses the community health needs of Cancer, Community Unity, Health-Related Quality of Life and Well-Being and Physical Activity. By having this group, patients and their caregivers can participate in physical activity in a group setting. Yoga is proven to have a positive effect on Health-Related Quality of Life and Well-Being and this group also gets multiple cancer patients and their caregivers together in a group setting to provide support and create connections in the community. The breathing exercises and stretching also help calm the mind and leave participants feeling more relaxed afterwards. 4. What's Cooking – This initiative addresses the community health needs of Cancer, Community Unity, Nutrition and Weight Status, Health-Related Quality of Life and Well-Being, and Health Literacy. By learning these recipes and attending these cooking demonstrations, patients and their caregivers better understand the best nutrition to maintain a healthy body and weight status. Eating better can be linked to improved Health-Related Quality of Life and Well-Being and for patients that have Cancer, learning about what types of foods are better for handling treatments would be beneficial. These classes are also a valuable resource for Community Unity by having multiple cancer patients and their caregivers together to provide support and create connections through this challenging time. 5. Tai Chi for Better Balance – This initiative addresses the community health needs of Cancer, Community Unity, Health-Related Quality of Life and Well-Being and Physical Activity. By having this group, patients and their caregivers can participate in physical activity in a group setting. Tai Chi is proven to have a positive effect on strength, balance, Health-Related Quality of Life and Well-Being and this group also gets multiple cancer patients and their caregivers together in a group setting to provide support and create connections in the community. 6. Cancer Survivor and Caregiver Support Group – This initiative addresses Cancer, Community Unity and Health-Related Quality of Life and Well-Being. The support group offers an opportunity for cancer patients and their caregivers to discuss life with cancer. The support group also offers a chance for support of fellow cancer patients and their caregivers and share their cancer stories that could benefit another cancer patient at the time. By having support, patients have an improved frame of mind and can be better equipped for the challenges that cancer provides. 7. Look Good Feel Better – This initiative addresses Cancer, Community Unity and Health-Related Quality of Life and Well-Being. The class is led by a volunteer cosmetologist who helps cancer patients learn about skin and hair care. The cosmetologist also has experience teaching cancer patients and their caregivers about wigs and head wraps. 8. Head and Neck Cancer Support Group – This initiative addresses the community health needs of Cancer, Community Unity and Health-Related Quality of Life and Well-Being. This support group brings together head and neck cancer patients and their caregivers to talk about difficulties and build relationships with each. By having support, patients have an improved frame of mind and can be better equipped for the challenges that head and neck cancer provides. 9. Prostate Cancer Support Group - This initiative addresses the community health needs of Cancer, Community Unity and Health-Related Quality of Life and Well-Being. This support group brings together prostate cancer patients and their caregivers to talk about their difficulties and build relationships with each other. By having support, patients have an improved frame of mind and can be better equipped for the challenges that prostate cancer provides. 10. Preventative Cancer Screenings – This initiative addresses the community health needs of Cancer, Health-Related Quality of Life and Well-Being, Educational and Community-Based Programs and Health Literacy. Today, social media platforms reach more people than TV and radio advertisements ever could. The social media posts include information about preventative screenings for specific cancers that residents may want to ask their Primary Care Physician about. Further information can be found on the social media posts about where to get these preventative screenings and the benefits of having these screenings completed. In November, Peninsula Regional posts educational information and screening information about lung cancer. In May, Peninsula Regional posts educational information and screening information about skin cancer. In March, Peninsula Regional posts educational information and screening information about colorectal and liver cancers, and in October, Peninsula Regional posts educational information and screening information about breast cancer.

Q130. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Q131. (Optional) Supplemental information for this initiative.

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17.9MB
application/pdf

Q132. Section IV - CB Initiatives Part 4 - Other Initiative Info

Q133. Additional information about initiatives.

Q134. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

Community Benefit FY 2020 Additional Initiative Information.docx
29KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q135. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q136.

In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Access to Health Services: Outpatient Services, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Dementias, Including Alzheimer's Disease, Diabetes, Educational and Community-Based Programs, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Tobacco Use, Transportation, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Obesity

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q137. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q138. Do any of the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? Specifically, do any activities or initiatives correspond to a SHIP measure within the following categories?

See the SHIP website for more information and a list of the measures:
https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx

	Select Yes or No	
	Yes	No
Healthy Beginnings - includes measures such as babies with low birth weight, early prenatal care, and teen birth rate	( )	(●)
Healthy Living - includes measures such as adolescents who use tobacco products and life expectancy	(●)	( )
Healthy Communities - includes measures such as domestic violence and suicide rate	(●)	( )
Access to Health Care - includes measures such as adolescents who received a wellness checkup in the last year and persons with a usual primary care provider	(●)	( )
Quality Preventive Care - includes measures such as annual season influenza vaccinations and emergency department visit rate due to asthma	(●)	( )

Q139. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q140. Section V - Physician Gaps & Subsidies

Q141. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

- [ ] No gaps
- [x] Primary care

- [x] Mental health
- [ ] Substance abuse/detoxification
- [x] Internal medicine
- [ ] Dermatology
- [ ] Dental
- [ ] Neurosurgery/neurology
- [ ] General surgery
- [ ] Orthopedic specialties
- [x] Obstetrics
- [x] Otolaryngology
- [x] Other. Please specify. Pulmonary, Urology

Q142. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand.

Hospital-Based Physicians	
Non-Resident House Staff and Hospitalists	Included in our submission is a subsidy for our employed hospitalist program. A hospitalist program should be a part of any value driven organization which aids in the transformation of a patient from the hospital to home or other designation and avoiding readmissions. Other benefits include shorter length of stay, improved communication between physician and patient/family and ability of community physicians to stay in their offices to treat the community rather than provide inpatient care in what historically has been a medically underserved population.
Coverage of Emergency Department Call	The subsidy included for this category is net of Trauma reimbursement funds received for general trauma, orthopedic, neurosurgery and anesthesia physician specialties received by the State of Maryland. Peninsula has to provide these specialties to support its Level III trauma designation plus other specialties that are recommended by COMAR regulations.
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	PRMC is committed to being an integrator of health services. As an integrator, we must provide appropriate access to service for the populations we seek to serve across the entire continuum. According to a draft of our most recent medical staff development plan conducted by ECG consultants, they identified a need of thirty-nine plus physicians across various specialties and a succession risk of an additional 71 providers that are 60 or older that practice on our medical staff and in our service area. Subsidies include amounts for Primary Care, Endocrinology, Neurology and Pulmonary/Critical Care. All physician types that typically would not present to our service area which is typically an underserved, rural market.
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	

Q143. (Optional) Is there any other information about physician gaps that you would like to provide?

As part of the medical staff development plan, the succession planning component is becoming a priority as a number of specialty groups average age is 60+. From physician practice employment hybrid models and advanced practice model deployed to succession planning, Peninsula Regional continues to evaluate solutions to the aging physician workforce.

Q144. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Q145. Section VI - Financial Assistance Policy (FAP)

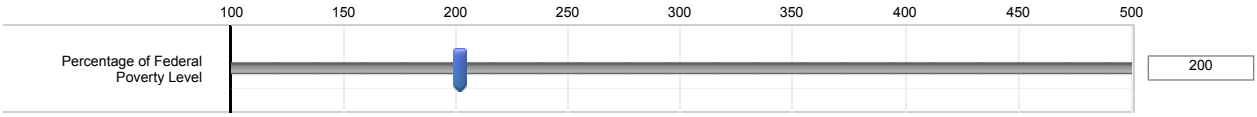
Q146. Upload a copy of your hospital's financial assistance policy.

Financial Assistance - Uncompensated Care - 09-01-20 (English).pdf
4.3MB
application/pdf

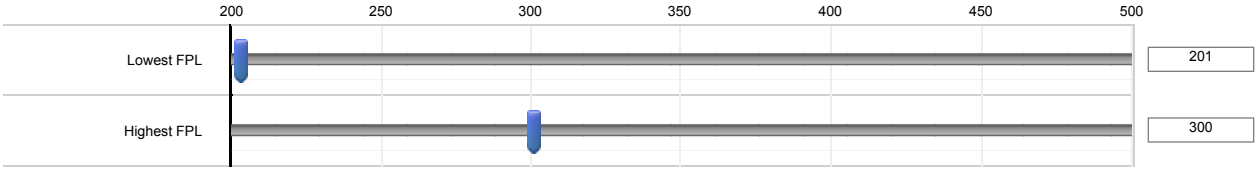
Q147. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

Plain Language Summary - 09-01-20 .pdf
157.6KB
application/pdf

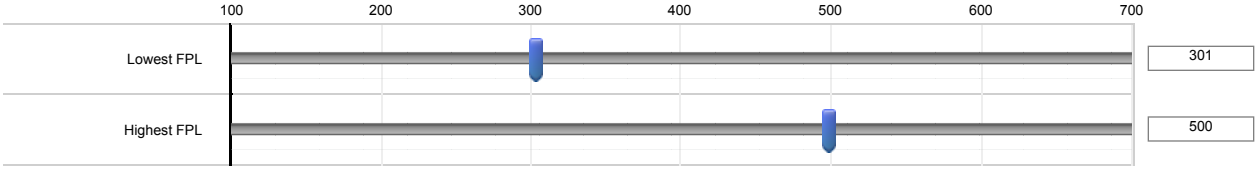
Q148. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL). Please select the percentage of FPL below which your hospital's FAP offers free care.



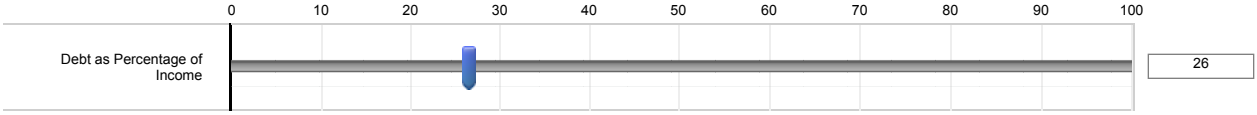
Q149. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.



Q150. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined 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. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q151. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q152. 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: Name change and addition of McCready location

Q153. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

Q154. (Optional) Please attach any files containing further information about your hospital's FAP.

BRO-086-Financial-Assistance-Brochure.pdf
2.4MB
application/pdf

Q155. Summary & Report Submission

Q156.

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: (38.38020324707, -75.634696960449)

Source: GeoIP Estimation

From: Hilltop HCB Help Account
To: rita.mecca@tidalhealth.org; Hilltop HCB Help Account
Subject: FW: HCB Narrative Report Clarification Request - Peninsula
Date: Friday, July 9, 2021 2:37:15 PM
Attachments: Peninsula_Regional_HCBNarrative_FY2020_20210326.pdf

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In order to prepare the statewide community benefit report for FY 2020, we must finalize the narrative responses. Could you please provide the clarifications requested below by Friday, July 16, 2021?

Thank you very much

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Wednesday, May 26, 2021 10:14 AM
To: rita.mecca@peninsula.org
Cc: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: HCB Narrative Report Clarification Request - Peninsula

Thank you for submitting the FY 2020 Hospital Community Benefit Narrative report for the Peninsula Regional Medical Center. In reviewing the narrative, we encountered a few items that require clarification:

- In Question 63 on page 15 of the attached, no selection was made to indicate the involvement of "School – Pharmacy School" and "Consumer/Public Advocacy Organizations" in your hospital's community benefit activities. Additionally, several "Community/Neighborhood Organizations" were identified and their roles were at least partially explained in the "Other" box, but no boxes were selected. Please clarify which answers you intended to select.
- In Question 81 on page 17, where you selected the CHNA-identified needs addressed by the Chronic Disease Management/Community Health initiative, a number of those needs were not selected in Question 56 on page 10. Please confirm whether these should have been selected for question 56:
    - Access to Health Services: ED Wait Times
    - Adolescent Health
    - Children's Health
    - Community Unity
    - Health Communication and Health Information Technology
    - Immunization and Infectious Diseases
    - Respiratory Diseases
    - Telehealth
    - Housing & Homelessness
- Please provide a response for Question 94 on page 23.
- In Question 98 on page 24, where you selected the CHNA-identified needs addressed by the Behavioral Health (Substance Abuse/Behavioral Health) initiative, a number of those needs were not selected in Question 56 on page 10. Please confirm whether these should have been selected for Question 56.
    - Adolescent Health
    - Children's Health
    - Community Unity
    - Telehealth
- Please provide a response for Question 112 on page 28.
- In Question 117 on page 29, where you selected the CHNA-identified needs addressed by the Cancer initiative you selected Community Unity and Telehealth as needs even though they were not selected in Question 56 on page 10 as needs identified in the CHNA. Please confirm whether these should have been selected for Question 56.

- Please provide a response for Question 130 on page 32

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

Additional Resources for Community Benefits

For the Community Benefit Report, Peninsula Regional utilized multiple sources to gather information. The sources we used were Conduent Healthy Communities Institute (HCI), the Maryland Vital Statistics Report for 2018, IntelliMed, ESRI, the Community Health Needs Assessment (CHNA) and Truven Health Analytics.

Conduent Healthy Communities Institute (HCI) is a multi-disciplinary team of public health experts, including healthcare information technology veterans, academicians and former senior government officials, all committed to help health-influencing organizations be successful with their projects. HCI used collaborative approaches to data gathering

Maryland Vital Statistics – The Maryland Department of Health Vital Statistics Administration releases a yearly report to inform the public on Maryland's population, life expectancy, birth rates, infant mortality, the 10 leading causes of death, marriage and divorce rates, etc. The report also breaks down Maryland by regions so that Peninsula Regional can be better informed about the Eastern Shore region numbers when compared to the rest of the state of Maryland.

IntelliMed – IntelliMed is Peninsula Regional's vendor for hospital data sets that are used for analyzing market share, competitor analysis and healthcare market trends. Data can be extracted for multiple variables about patients with no personal information included.

ESRI – ESRI is a geographic information system software that Peninsula Regional uses to visually estimate population size, estimate population density and show the Primary and Secondary Service Areas of Peninsula Regional. The software can be manipulated in various forms to show layers of different data from multiple locations to give the big picture of the markets and populations on the Delmarva Peninsula.

CHNA – The Community Health Needs Assessment (CHNA) is a report collaborated on with Conduent Healthy Communities Institute that analyzes the needs of Worcester, Wicomico and Somerset Counties based on various criteria. The Wicomico County Health Department and the Somerset County Health Department collaborated with Peninsula Regional in the local assessment to determine population health.

Truven Health Analytics – Truven Health Analytics is a software program that Peninsula Regional uses to determine current populations, insurance coverages, healthcare use rates and age breakdowns. Truven can also be used to estimate and compare five and ten year predictions on populations, insurance coverages, and healthcare use rates and age breakdowns.

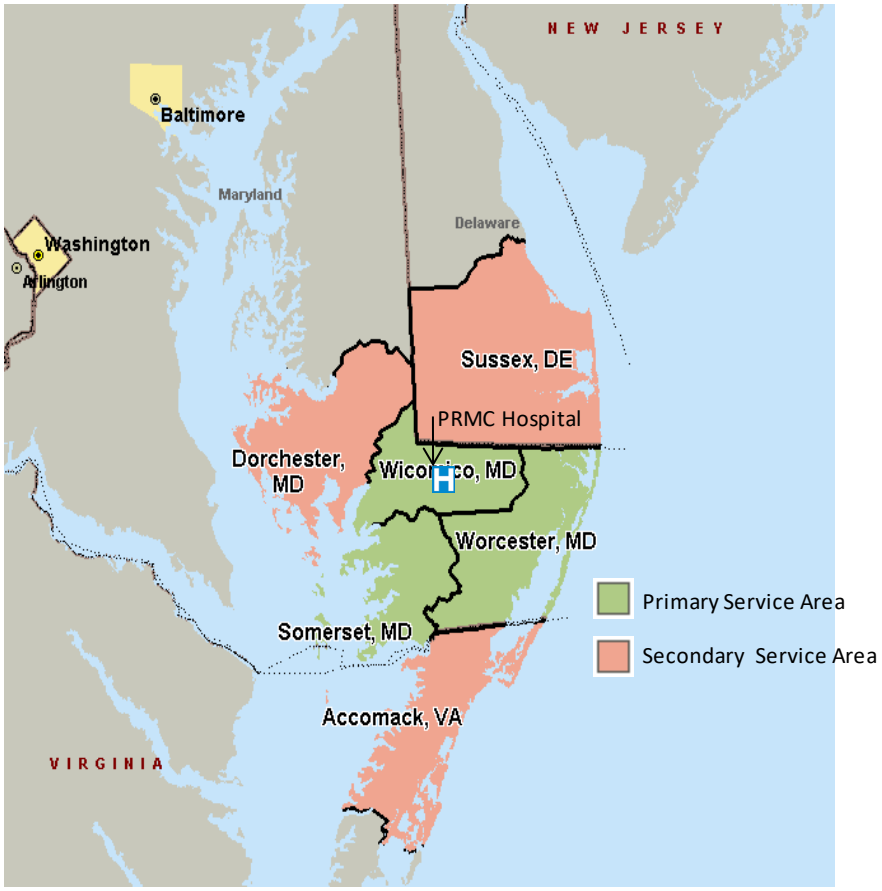
Peninsula Regional Demographics

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

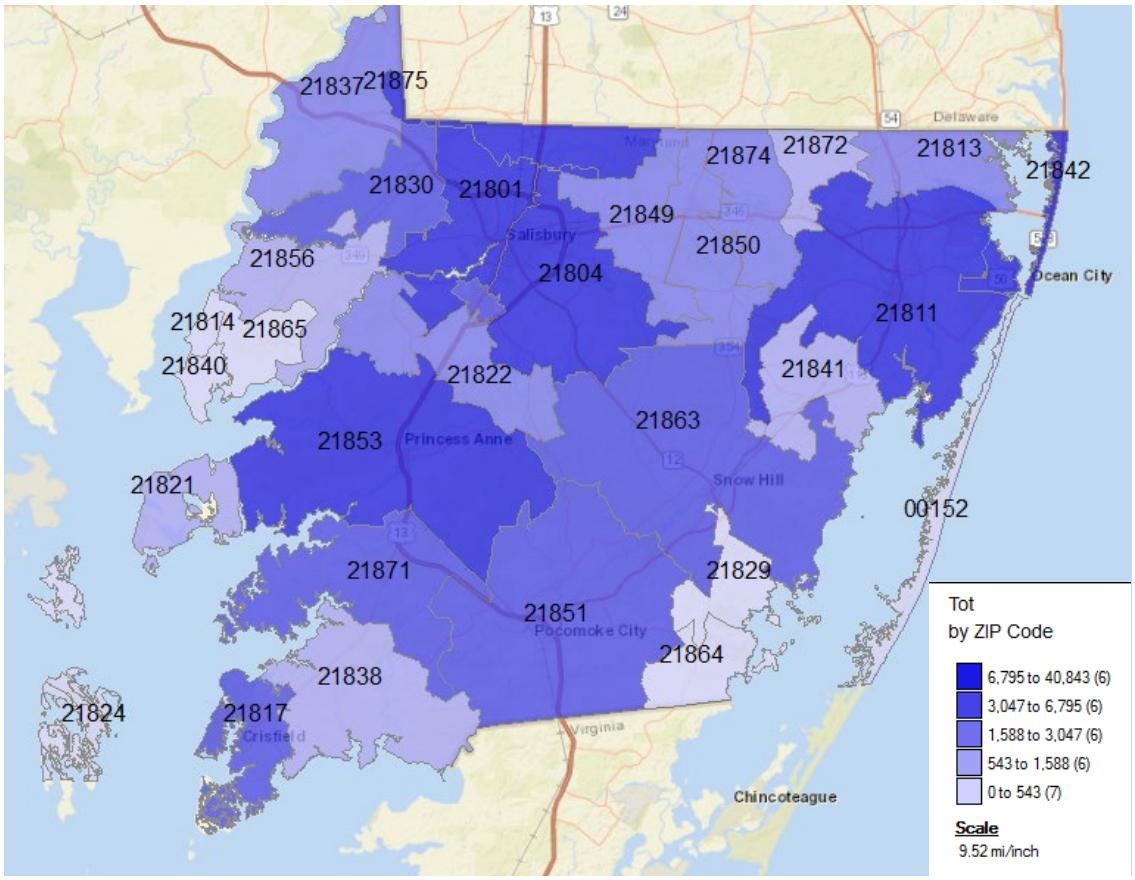
(i) A list of the zip codes included in the organization's CBSA, and

The Community We Serve

Peninsula Regional functions as the primary hospital provider for the rural southernmost three counties of the Eastern Shore of Maryland, which includes Wicomico, Worcester and Somerset Counties (highlighted in green). In FY 2020, approximately 78% of the patients discharged from Peninsula Regional were residents of the primary service area, which has an estimated population of approximately 181,350 in 2019 and is expected to increase to 185,357 in 2024, or by 2.2%. The primary service area population has grown by an estimated 2.3% since 2010.



Peninsula Regional's CBSA consists of those zip codes within our primary service area. Most of the population resides in Wicomico County (105,103) with Salisbury serving as the capital of the Eastern Shore. Salisbury is located on the headwaters of the Wicomico River and it is located at the crossroads of the Bay and the Ocean. The region is unique; the city of Salisbury has similar socio-economic and demographic characteristics of a large city, however, the area surrounding Salisbury is rural and has like-kind characteristics of small-town America. Due to this dichotomy, serving both sometimes presents a challenge in delivering healthcare. The two other counties in Peninsula Regional's CBSA include Worcester County, with a population of 52,030 and Somerset County with a population of 24,217. The map below identifies Peninsula Regional's CBSA by zip codes by population density.



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

The greater *"metropolitan"* Salisbury area (zip codes 21801, 21804) has a higher population density than the surrounding rural areas. This area has a vulnerable population that includes the indigent and a higher Medicaid mix. Moving east towards the beach, located in Worcester County, are several larger towns like Berlin (21811) and Ocean City (21842) which have a high population density. South of Salisbury, located in Somerset County, are the larger towns of Princess Anne (21853) and Crisfield

(21817). Excluding the greater Salisbury area, the landscape and environment is considered rural, made up of small businesses and agriculture.

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

The three counties have a diversified economic base; however, it is predominately made up of small employers (companies with less than 50 employees). Major employers include local hospitals, the poultry industry, local colleges and teaching institutions. The median income of $59,269 in our Community Benefits Service Area is considerably less than Maryland's median income of $87,818. In addition, September 2020 unemployment rates were higher for Maryland's most Eastern Shore counties. The unemployment rate in Maryland was 7.6%, the Nation 7.9% compared to Wicomico 6.4%; Worcester 7.9%; and Somerset 8.0%. Research indicates lower median incomes and higher unemployment rates contribute to a disparity in access to medical care and a prevalence of untreated chronic disease.

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

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

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

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

Peninsula Regional is targeting CBSA zip codes based upon social and economic determinants of health to include the uninsured, indigent population, residents who lack transportation, lack of education and availability of healthy foods. Targeting this by cluster and block groups, we seek to impact the health of these populations by providing primary health services, education, and access to

care. More importantly, we want to foster lasting relationships with the communities we serve. For example, our Wagner Wellness Van travels locally to block groups where there was an identified need for basic health services. It also brings education to local ethnic churches and civic organizations and connects uninsured residents with contacts for Primary Care Providers (PCPs). We also have instilled a program conjointly with the Wicomico County Health Department and the City of Salisbury Emergency Medical Services that provides home visits for individuals who are frequent users of 911 services. This program, named S.W.I.F.T., helps reduce overuse of emergency services and improves access to care for these residents by connecting them with healthcare options provided in a primary or specialty care setting.

Peninsula Regional CBSA

Race/Ethnicity	CBSA Primary Service Area		USA % of Total
White Non-Hispanic	118,578	65.4%	60.0%
Black Non-Hispanic	44,624	24.6%	12.4%
Hispanic	8,546	4.7%	18.4%
Asian & Pacific Islander	4,485	2.5%	5.9%
All Others	5,117	2.8%	3.3%
Total	181,350	100%	100%

Source: Truven Health Analytics 2019

Within our CBSA, Wicomico has the highest Hispanic/Latino population at 5.4%, though all three counties have smaller percentages compared to the state of Maryland. Worcester has the highest percentage of Whites (79.8%), whereas Somerset has the lowest percentage (50.1%). Somerset has the largest proportion of Black/African Americans (41.5%), whereas Worcester has the lowest (12.9%). The other race groups comprise a tiny sliver of the tri-county population in comparison.

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

CBSA Population Age-Cohorts

Age Group	2019 Population	% of Total	USA 2018 % of Total
0-14	29,698	16.4%	18.6%
15-17	6,664	3.7%	3.9%
18-24	22,628	12.5%	9.6%
25-34	22,264	12.3%	13.5%
35-54	39,936	22.0%	25.3%
55-64	24,663	13.6%	12.9%
65+	35,497	19.6%	16.2%
Total	181,350	100.0%	100.0%

CBSA Population Sex

Population	Primary Service Area
Female Population	92,947
Male Population	88,403
Childbearing Age (15-44)	35,343

Source: Truven Health Analytics 2019

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

Wicomico County

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

Worcester County

- African Americans in Worcester County had higher mortality rates than Whites for all-cause mortality and for five of the top six causes of death (heart, cancer stroke, diabetes, kidney disease).

- The greatest mortality ratio disparity for African Americans compared to Whites was for kidney disease, where African Americans have 3.3 times the rate of death compared to Whites.

Somerset County

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

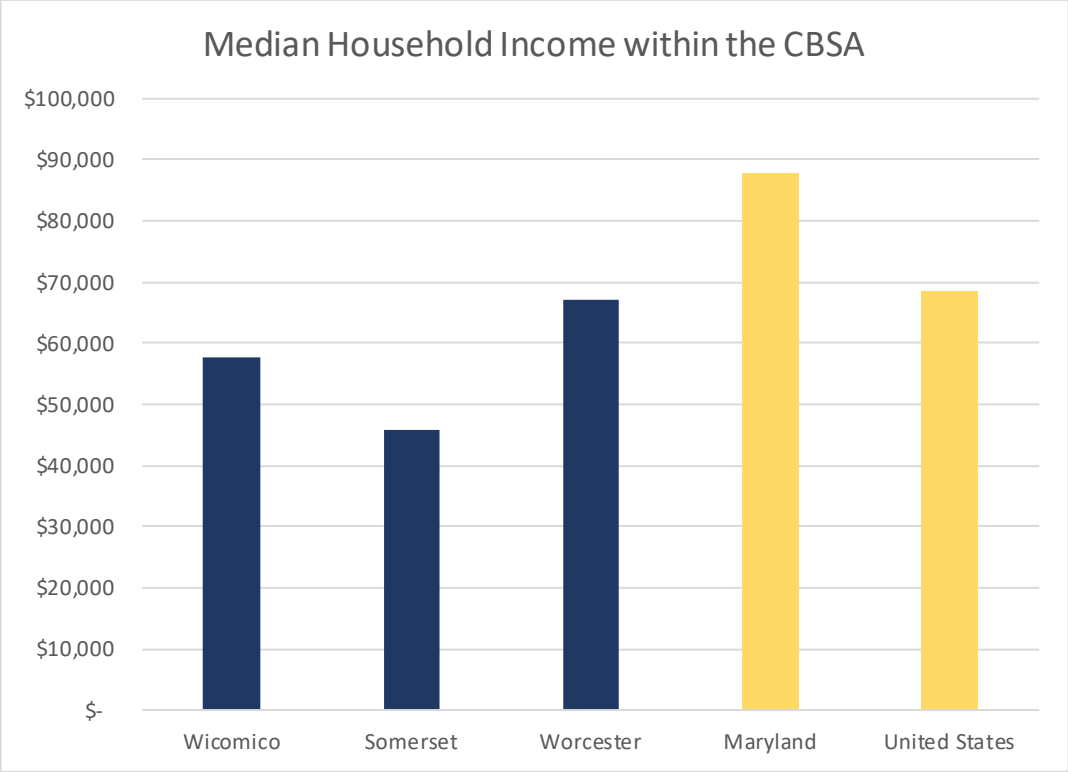
Chronic Disease Management

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

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

Median Household Income within the CBSA

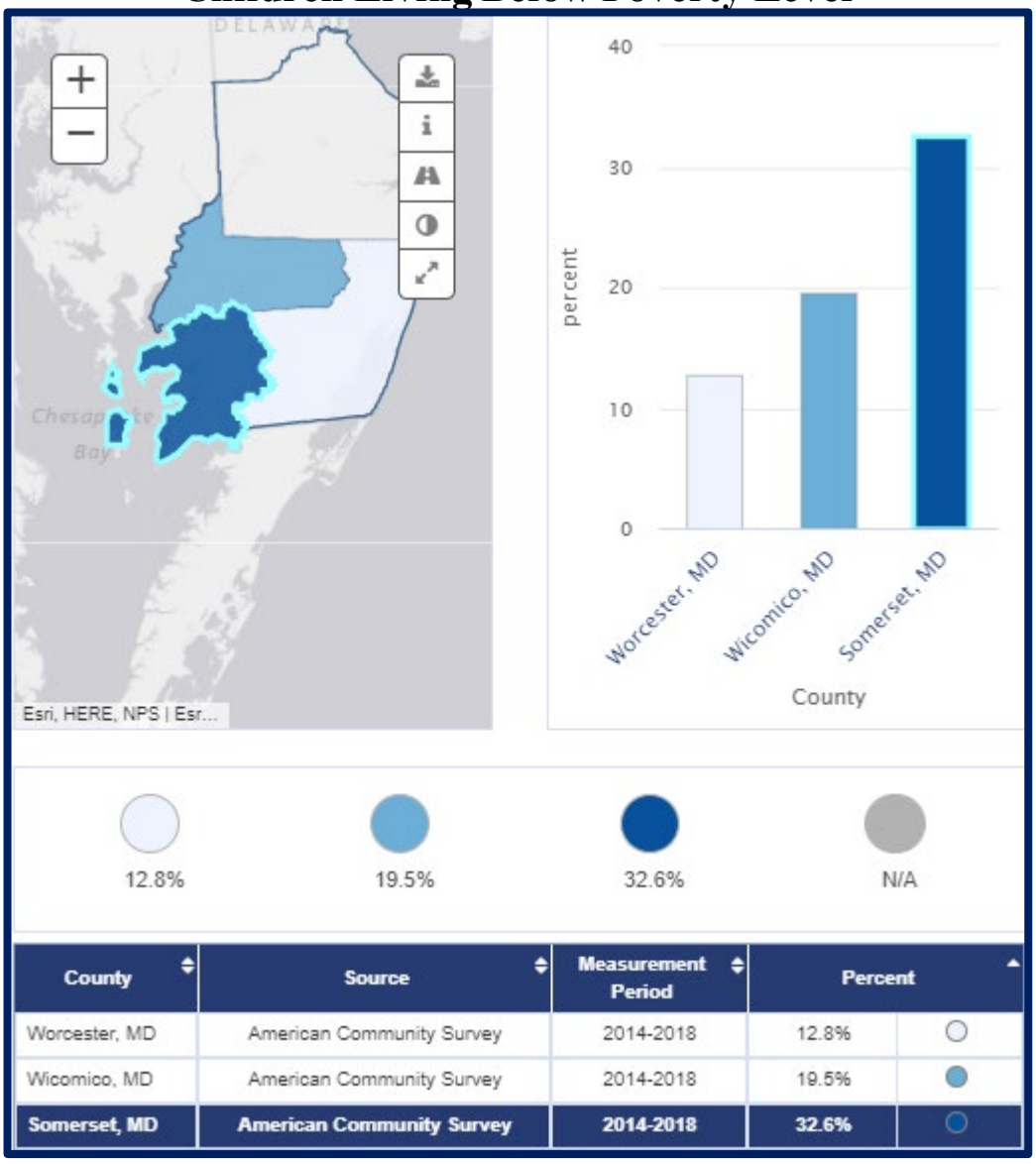
The median household income values in all three counties are lower than that of Maryland. Somerset has the lowest median household income in the tri-county service area with a value of $45,899. Worcester has the highest median household income in the service area at $67,273.
Source: Claritas 2020



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

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

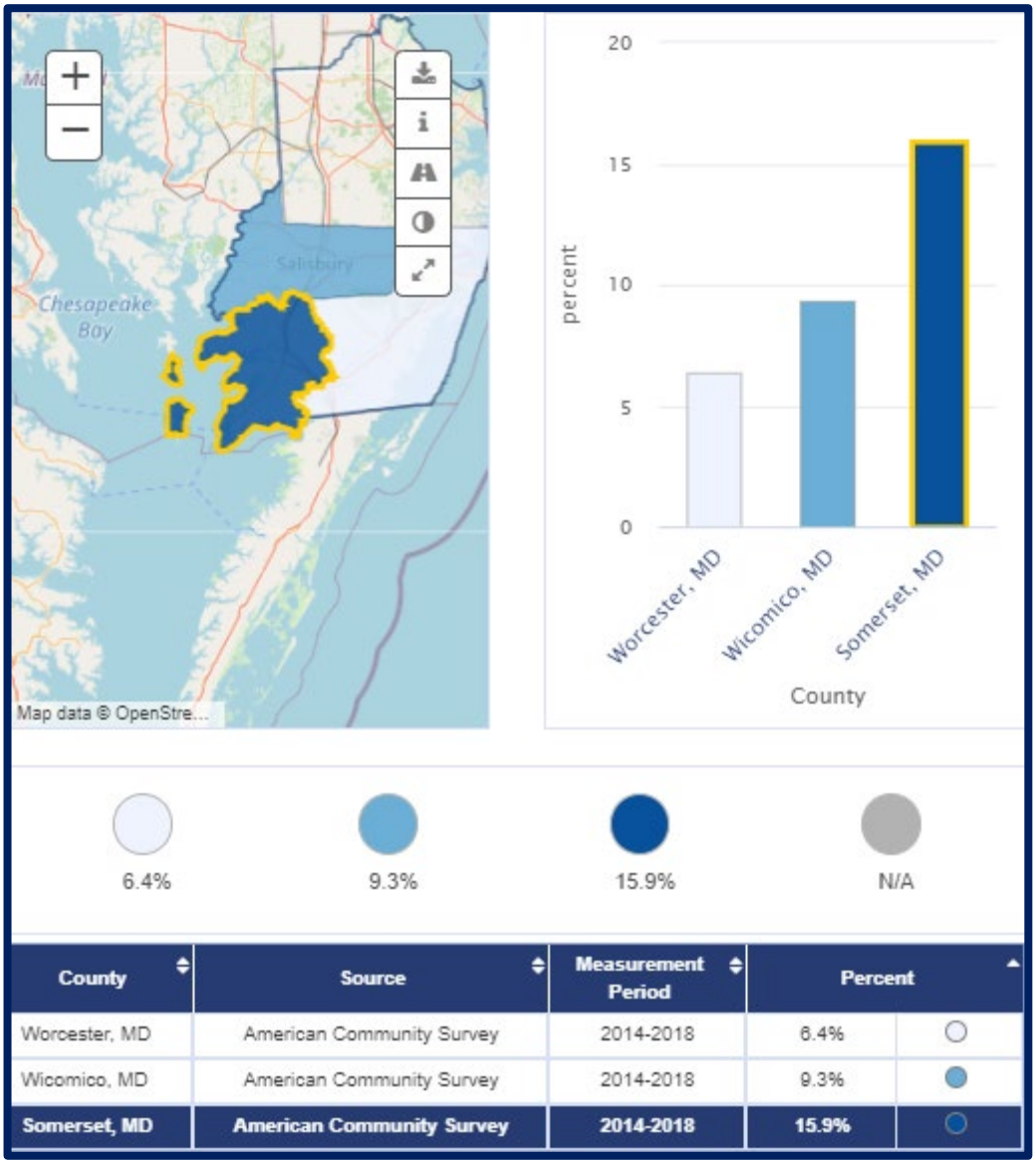
Children Living Below Poverty Level



County	Source	Measurement Period	Percent	
Worcester, MD	American Community Survey	2014-2018	12.8%	
Wicomico, MD	American Community Survey	2014-2018	19.5%	
Somerset, MD	**American Community Survey**	**2014-2018**	**32.6%**	

Source: Healthy Communities Inc. 2020

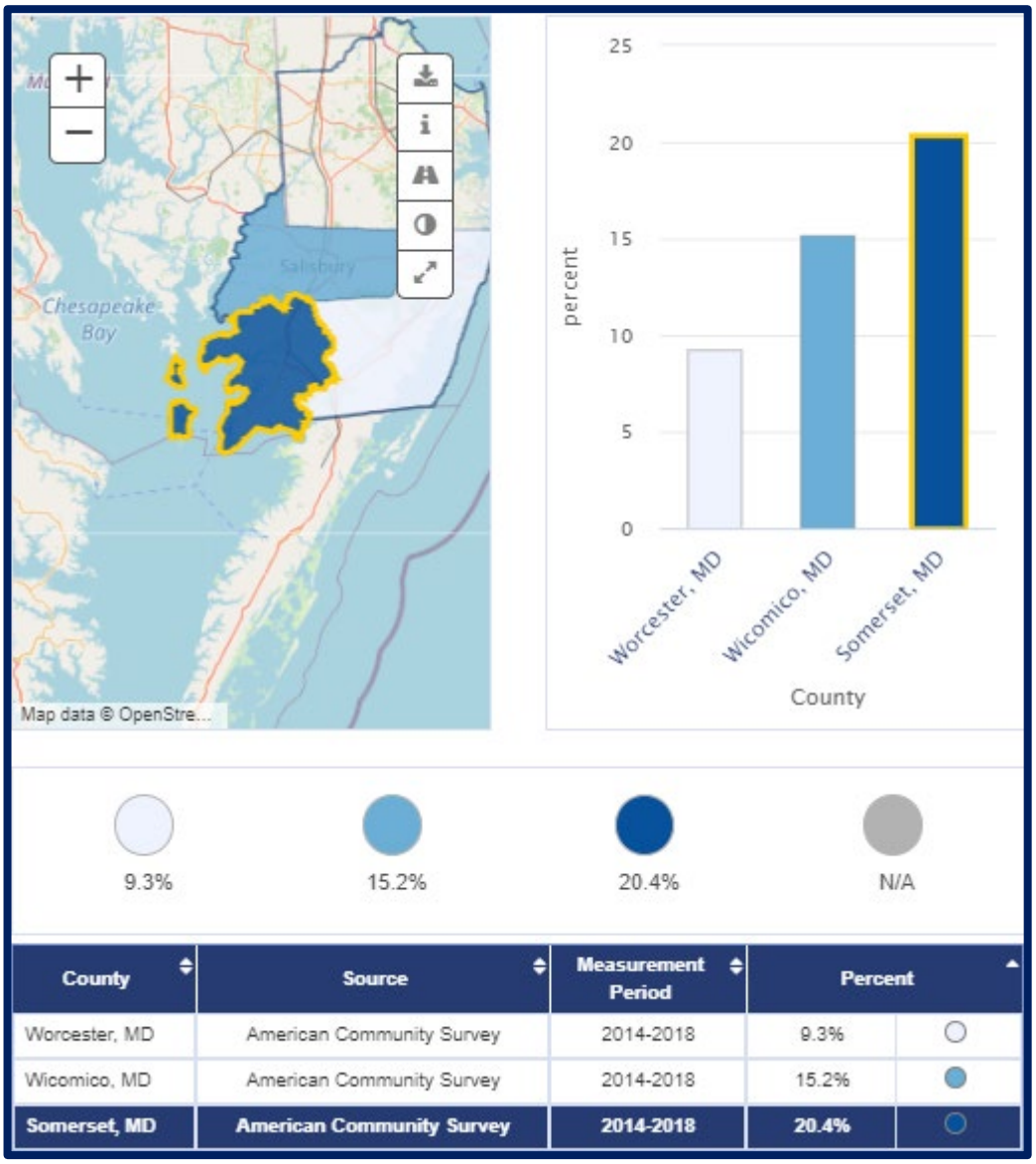
Families Living Below Poverty Level



County	Source	Measurement Period	Percent
Worcester, MD	American Community Survey	2014-2018	6.4%
Wicomico, MD	American Community Survey	2014-2018	9.3%
Somerset, MD	**American Community Survey**	**2014-2018**	**15.9%**

Source: Healthy Communities Inc. 2020

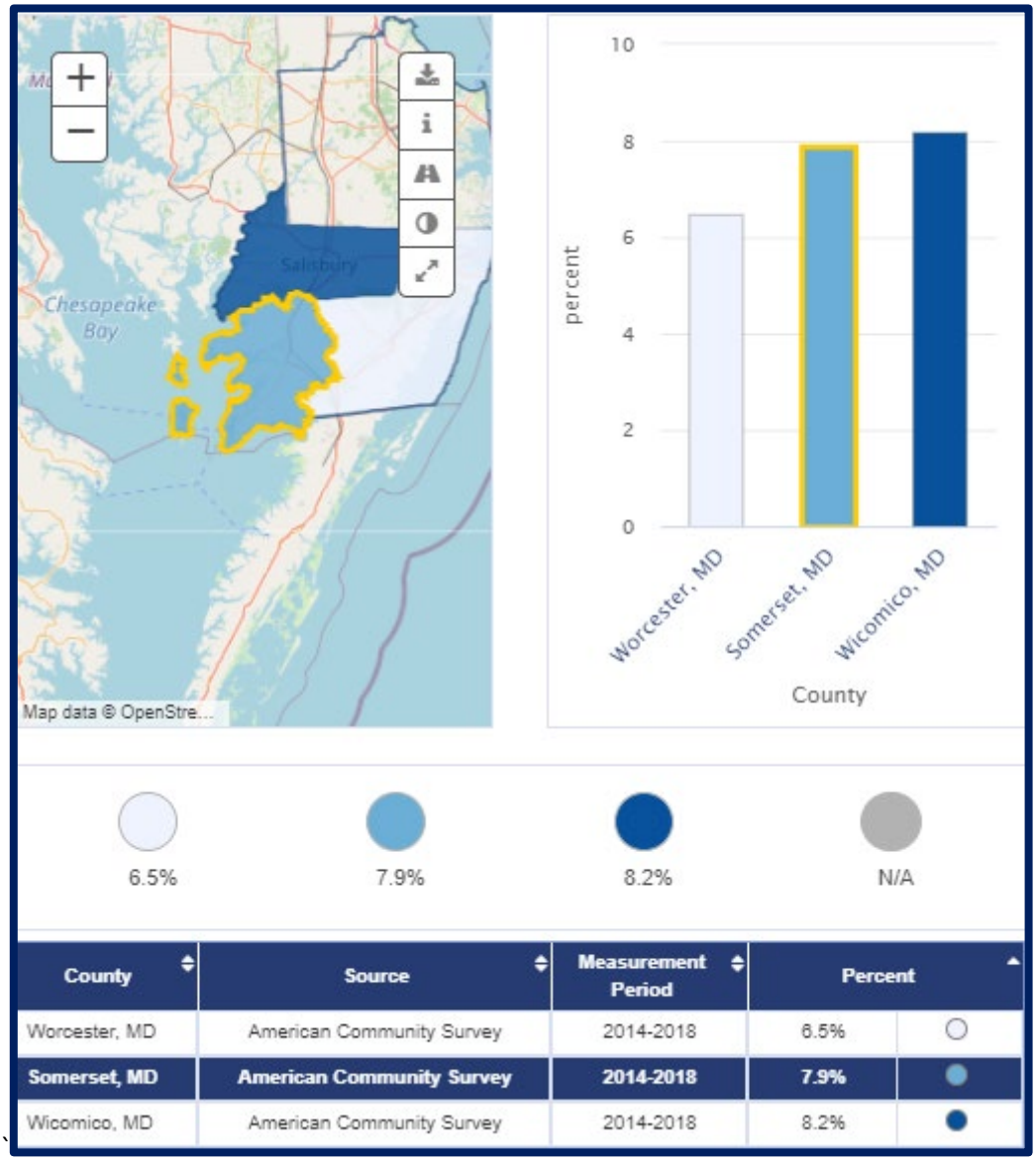
People Below Poverty Level



County	Source	Measurement Period	Percent
Worcester, MD	American Community Survey	2014-2018	9.3%
Wicomico, MD	American Community Survey	2014-2018	15.2%
Somerset, MD	**American Community Survey**	**2014-2018**	**20.4%**

Source: Healthy Communities Inc. 2020

People 65+ Living Below Poverty Level

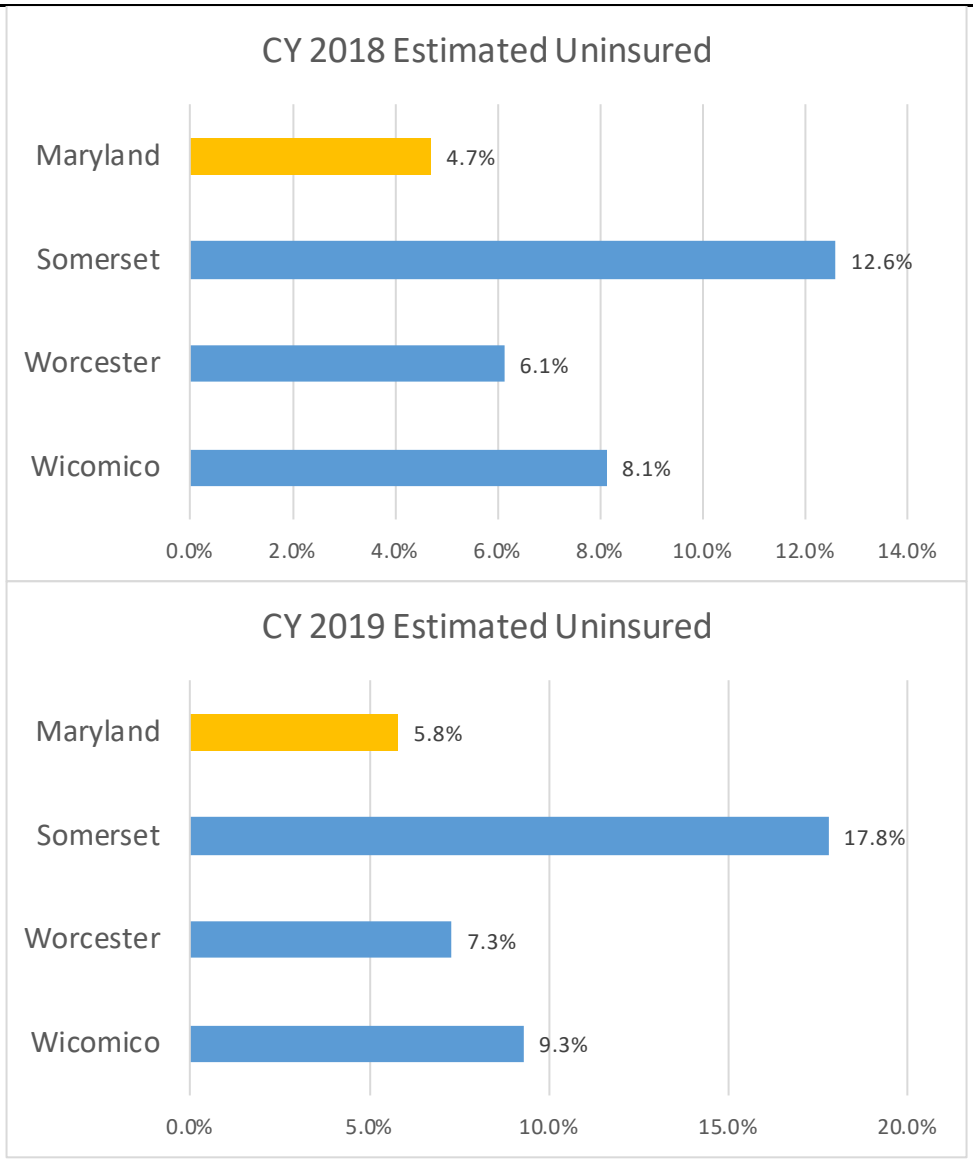


County	Source	Measurement Period	Percent
Worcester, MD	American Community Survey	2014-2018	6.5%
Somerset, MD	**American Community Survey**	**2014-2018**	**7.9%**
Wicomico, MD	American Community Survey	2014-2018	8.2%

Source: Healthy Communities Inc. 2020

For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links:
http://www.census.gov/hhes/www/hlthins/data/acs/aff.html;
http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml

All three counties in Peninsula Regional's CBSA have a greater percentage of its population uninsured. Somerset County is almost three times the number of uninsured residents compared to the state of Maryland.

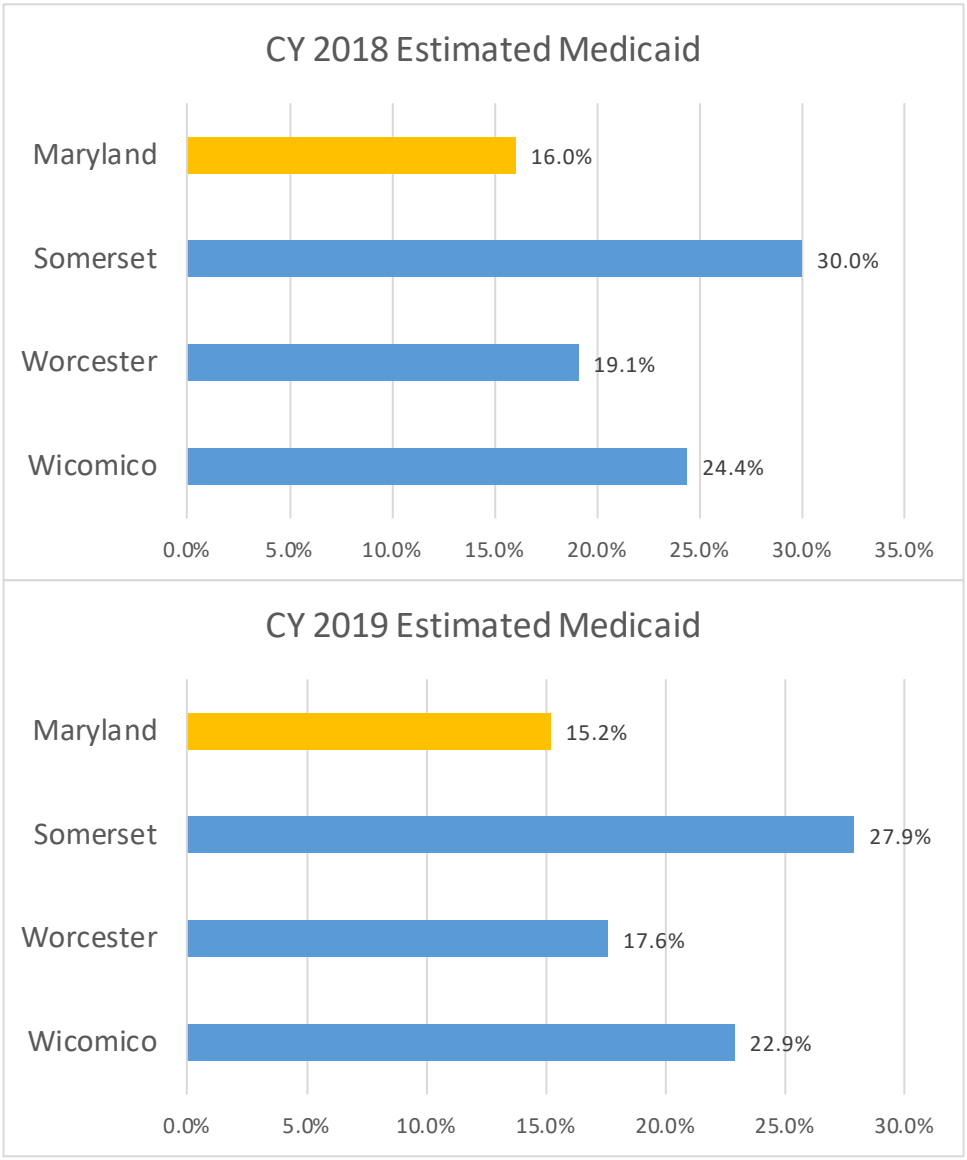


Source: Truven Health Analytics 2018, 2019

Percentage of Medicaid recipients by County within the CBSA.

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

rates, rural economics, and lower educational attainment continue to challenge the access to care and healthy lifestyle changes.



Source: Truven Health Analytics 2018, 2019

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

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

The life expectancy in all three counties is a few years below the Maryland SHIP Target of 79.8 years. Worcester County is very close to meeting the SHIP target of 79.8 years. Somerset is 5 years behind in meeting the Maryland SHIP longevity target. The top leading causes of death in our CBSA area are heart-related and cancer-related diseases, which as a percentage, are higher than other Maryland

counties. Supporting social determinants indicate an underlying lack of healthy lifestyle adoption/education, poverty, and lack of chronic disease management/education.

County	Life Expectancy	Maryland SHIP Target
Wicomico All	76.2	79.8
Black	73.6	79.8
White	77.1	79.8
Worcester All	78.2	79.8
Black	74.1	79.8
White	79.4	79.8
Somerset All	75.2	79.8
Black	75.5	79.8
White	74.3	79.8

Source: Most current available Maryland Vital Statistic Report 2018
Maryland DHMH Vital Statistics Administration (VSA) Annual Report. Date Range 2016-2018

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

Crude Death Rate
The crude death rate for Wicomico County is 1011.7, Worcester County 1252.3, and Somerset County 1090.6, all higher than Maryland at 838.5 deaths/1,000. The large crude death rates reflect multiple factors: specifically, a more aging 65+ population, in addition to healthcare access issues, cultural and lifestyle characteristics not conducive to healthy lifestyles, and lack of education regarding chronic disease management in rural areas.

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

Diseases of the Heart Age-Adjusted Death Rates (2016-2018)
For diseases of the heart, several counties' age-adjusted death rates are much higher than the Maryland average:
Wicomico: 76.7 points higher heart age-adjusted death rate than MD.
Worcester: 38.2 points higher heart age-adjusted death rate than MD.
Somerset: 129.9 points higher heart age-adjusted death rate than MD.

Malignant Neoplasms Age-Adjusted Death Rates (2016-2018)

For malignant neoplasms, all counties' age-adjusted death rates are higher than Maryland.
Wicomico: 47.4 points higher malignant neoplasm age-adjusted death rate than MD.
Worcester: 6.2 points higher malignant neoplasm age-adjusted death rate than MD.
Somerset: 37.3 points higher malignant neoplasm age-adjusted death rate than MD.

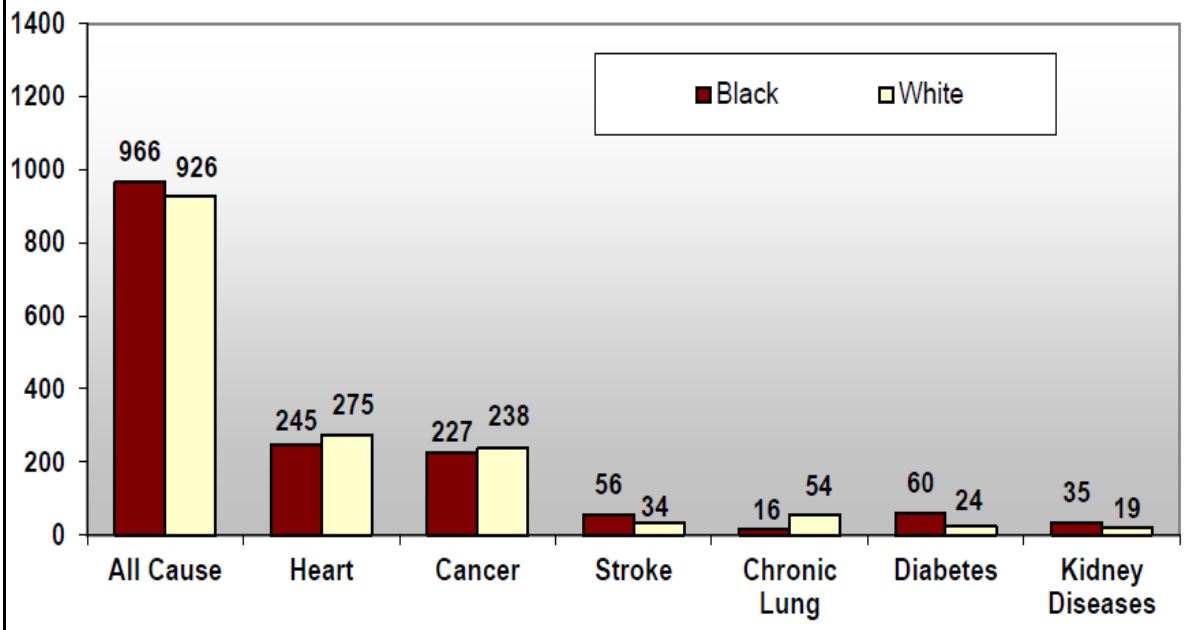
Chronic Lower Respiratory Diseases Age-Adjusted Death Rates (2015-2017)
For chronic lower respiratory diseases, all counties' age-adjusted death rates are both higher and lower than Maryland:
Wicomico: 9 points higher chronic lower respiratory diseases age-adjusted death rate than MD.
Worcester: 2.1 points lower chronic lower respiratory age-adjusted death rate than MD.
Somerset: No percentage*** ***Rates based on <20 events in the numerator are not presented since such rates are subject to instability.

Source: Most current available Maryland Vital Statistics Report 2018

Wicomico County

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

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

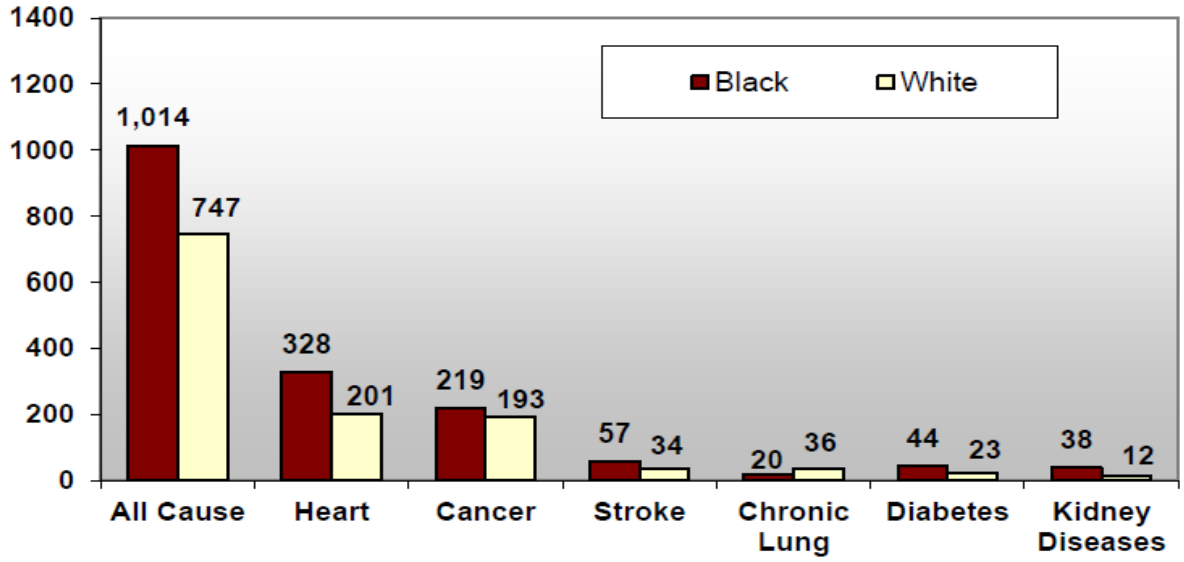


Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

Worcester County

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

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

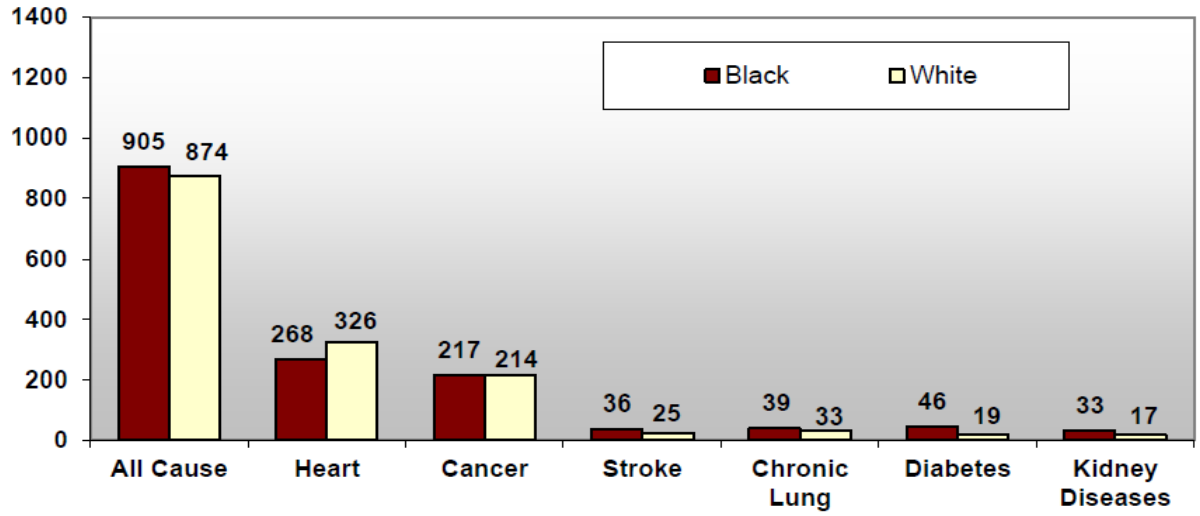


Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

Somerset County

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

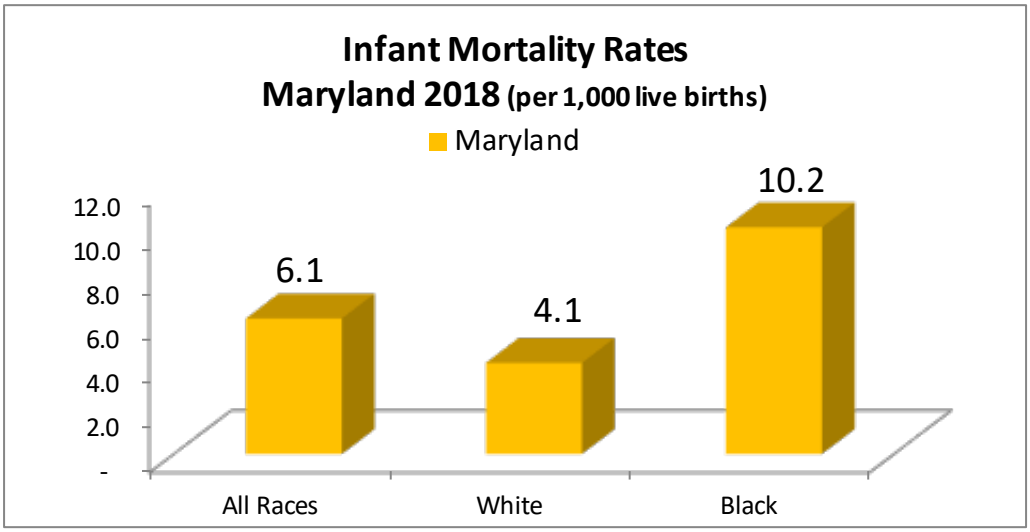
Somerset County Age-Adjusted Morality Rates, Maryland 2005-2009



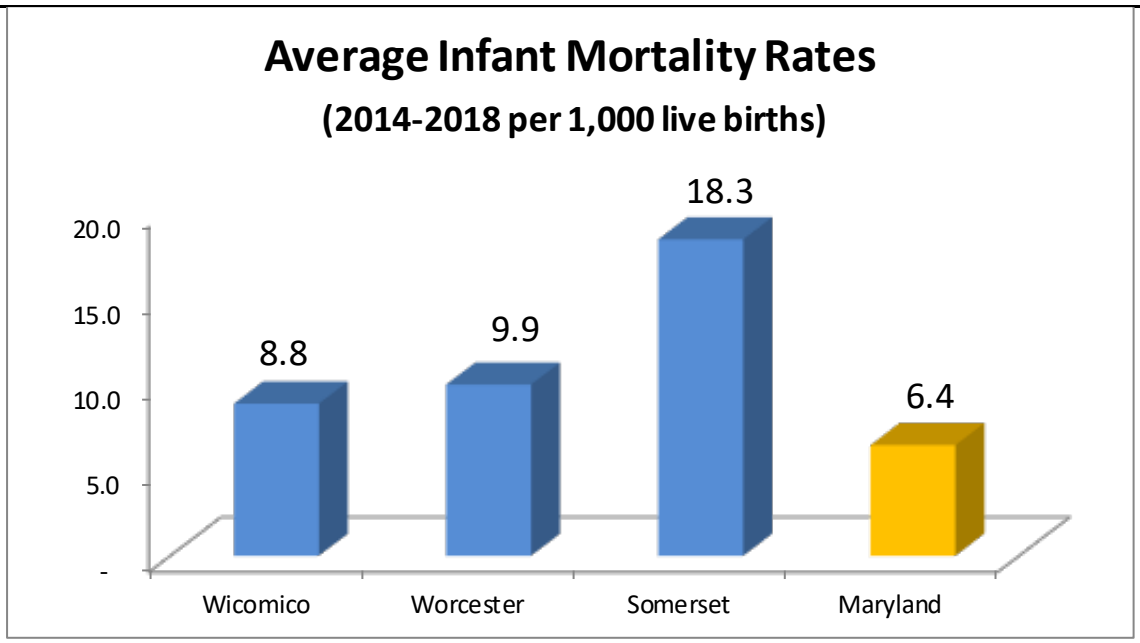
Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

According to the 2018 Maryland Vital Statistics, the average infant mortality rate continues to fall in Maryland over the past decade.

Despite



the statewide decline in infant mortality rate over the past decade, the Lower Eastern Shore's average infant mortality rate continues to be higher than the State of Maryland.

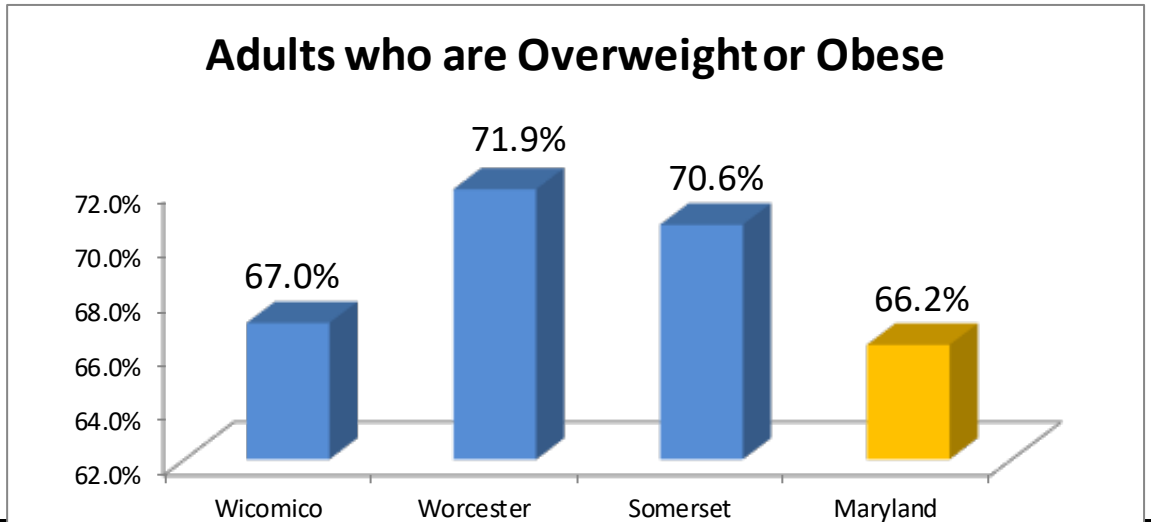


Source: Maryland Vital Statistics Infant Mortality in Maryland, 2018

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

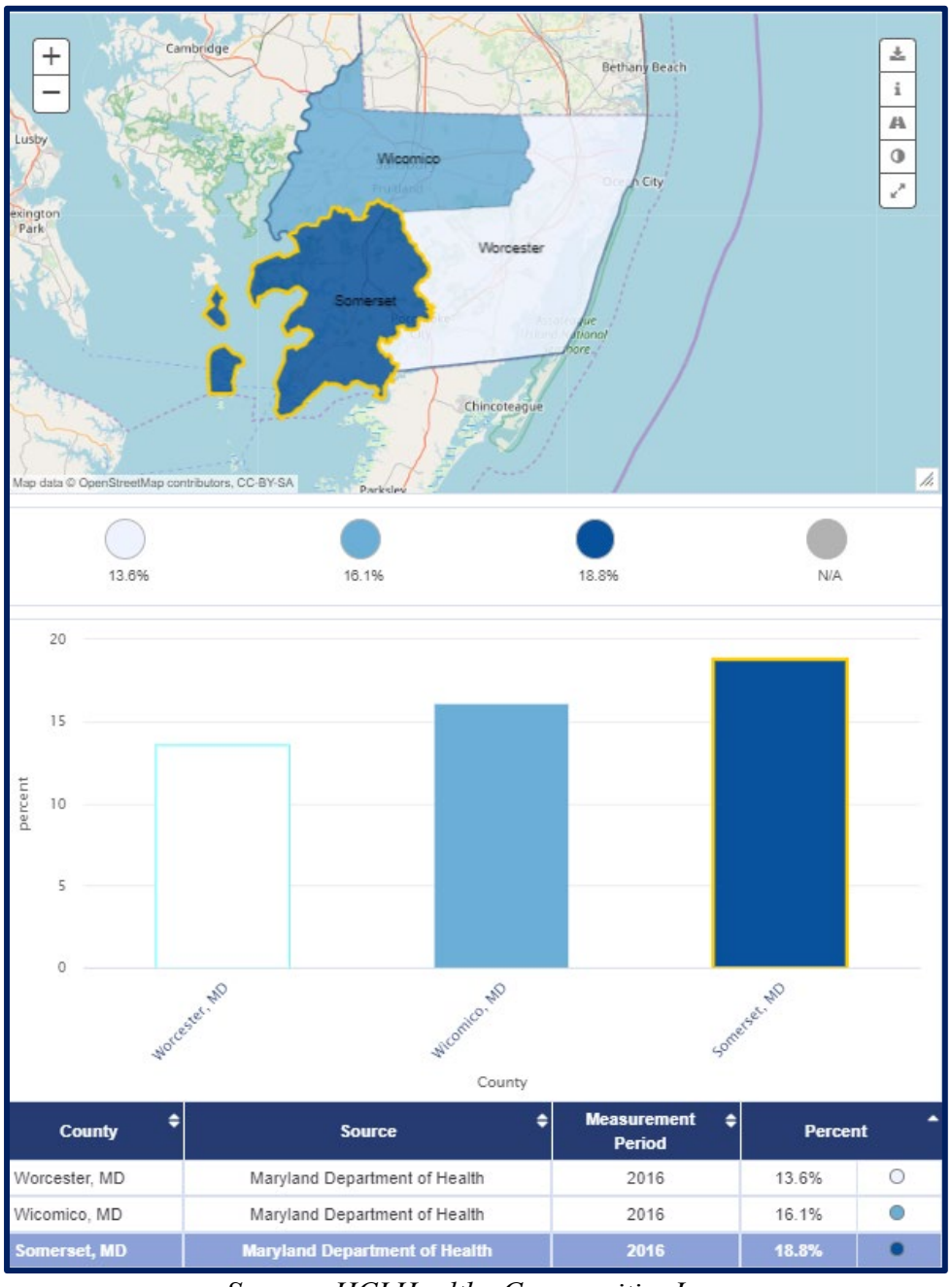
Access to Healthy Food
Healthy Food/Healthy Lifestyle Environmental Factors
Obesity continues to be a health issue in Wicomico, Worcester and Somerset Counties. Somerset County has a high percentage of adolescent obesity: 18.8% compared to the Maryland SHIP 2017 target of 10.7% and the Maryland state value of 12.6%. The tri-county area has a higher percentage of overweight or obese adults than Maryland and is an indicator of general overall health. Additional weight and obesity increase the risk of many diseases and health conditions. These include type 2 diabetes, cancer, hypertension, stroke, liver, gallbladder and respiratory problems, all of which we are experiencing. Being obese also carries significant economic costs due to increased healthcare spending.

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



Source: HCI Healthy Communities Inc. 2020

Adolescent Obesity



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

Source: HCI Healthy Communities Inc.

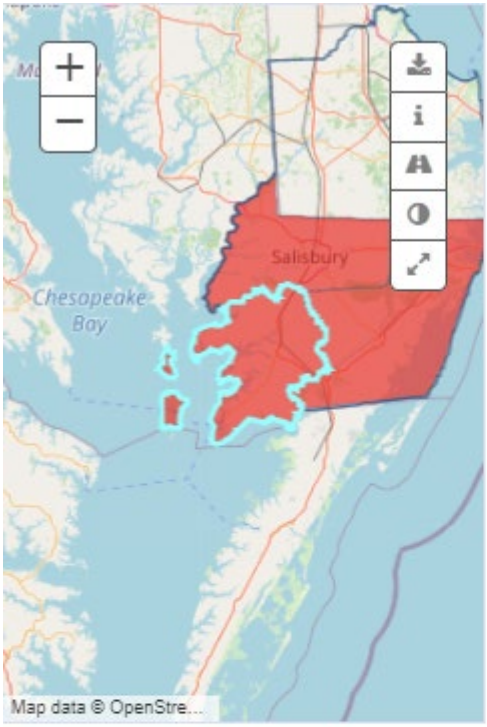
Food Insecurity

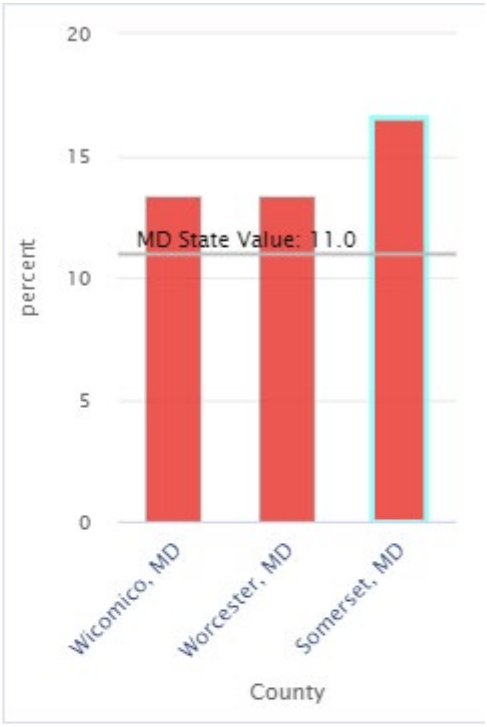
Food insecurity is an economic and social indicator of the health of a community. The U.S. Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways. Poverty and unemployment are frequently predictors of food insecurity in the United States.

Wicomico and Accomack County have negative food insecurity ratings, which are associated with chronic health problems such as diabetes, heart disease, high blood pressure, obesity and depression.

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

Food Insecurity Rate





< 11% = 11% > 11% N/A

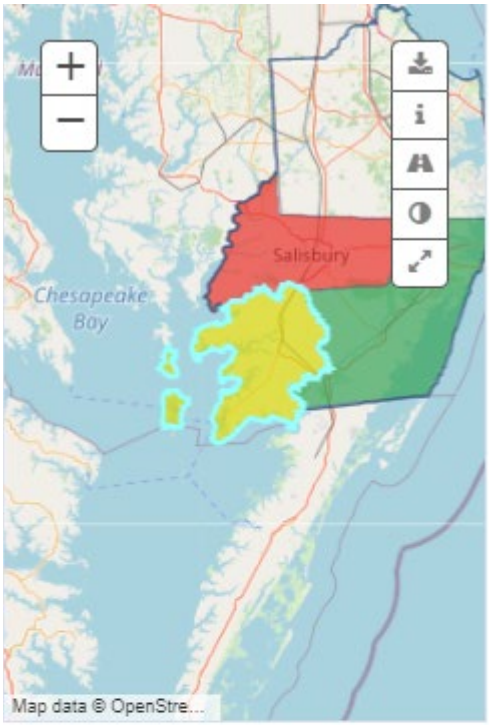
County	Source	Measurement Period	Percent	
Wicomico, MD	Feeding America	2018	13.3%	
Worcester, MD	Feeding America	2018	13.3%	
Somerset, MD	**Feeding America**	**2018**	**16.6%**	

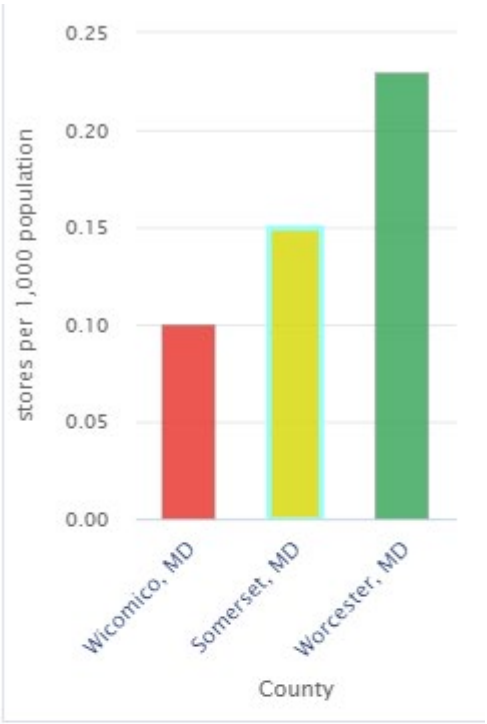
Source: HCI Healthy Communities Inc. 2020

Grocery Store Density

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

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





Worst Quartile
< 0.14

25th to 50th Quartile
0.14 - 0.16

Best 50th Percentile
> 0.16

N/A

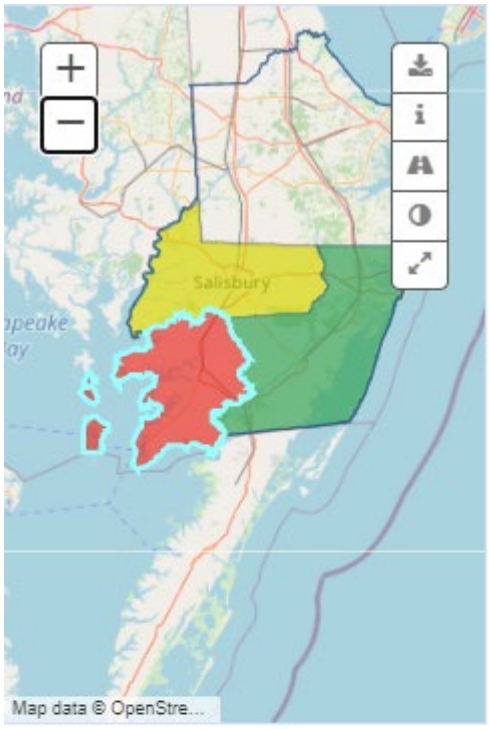
stores per 1,000 population

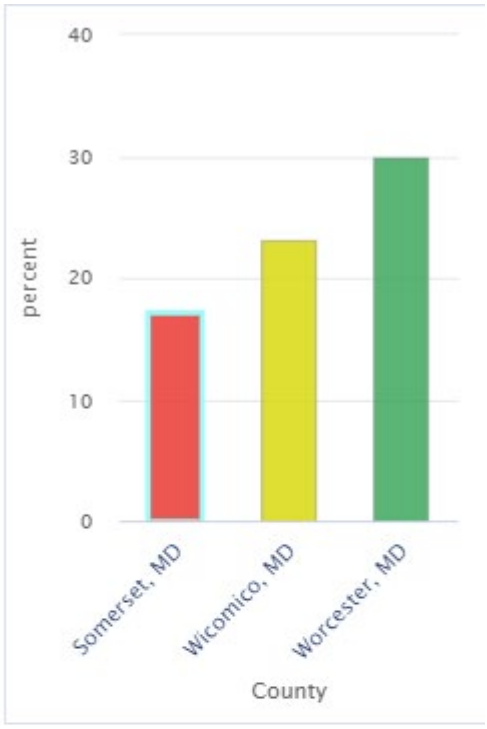
County	Source	Measurement Period	Stores per 1,000 population	
Wicomico, MD	U.S. Department of Agriculture - Food Environment Atlas	2016	0.10	
Somerset, MD	**U.S. Department of Agriculture - Food Environment Atlas**	**2016**	**0.15**	
Worcester, MD	U.S. Department of Agriculture - Food Environment Atlas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

Source: HCI Healthy Communities Inc. 2020

Adult Fruit and Vegetable Consumption

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

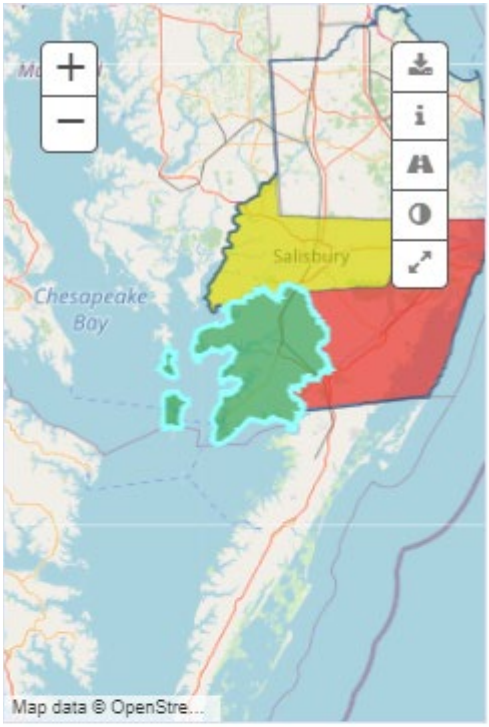


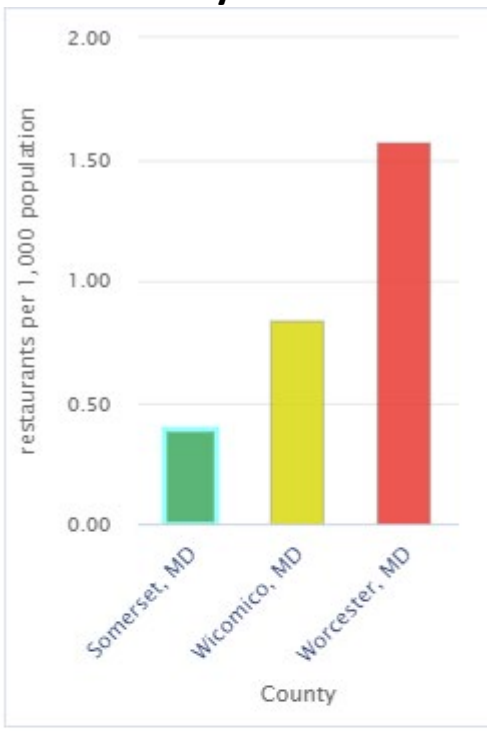


County	Source	Measurement Period	Percent	
Somerset, MD	**Maryland Behavioral Risk Factor Surveillance System**	**2010**	**17.2%**	
Wicomico, MD	Maryland Behavioral Risk Factor Surveillance System	2010	23.1%	
Worcester, MD	Maryland Behavioral Risk Factor Surveillance System	2010	30.0%	

Source: HCI Healthy Communities Inc. 2020

Fast Food Restaurant Density





Best 50th Percentile
< 0.77

50th to 75th Quartile
0.77 - 0.87

Worst 25th Quartile
> 0.87

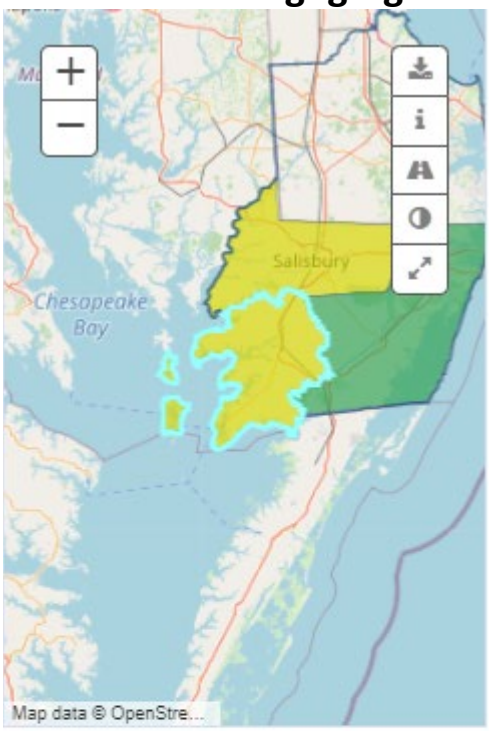
N/A

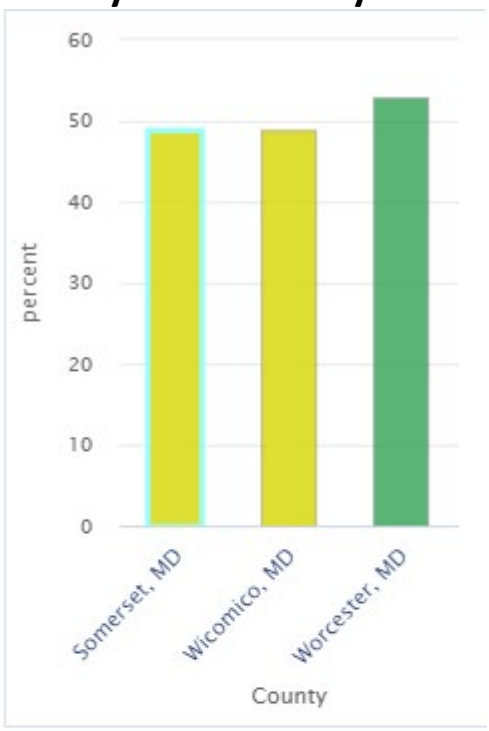
restaurants per 1,000 population

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

Source: HCI Healthy Communities Inc. 2020

Adults Engaging in Regular Physician Activity





County	Source	Measurement Period	Percent	
Somerset, MD	**Maryland Behavioral Risk Factor Surveillance System**	**2017**	**48.8%**	
Wicomico, MD	Maryland Behavioral Risk Factor Surveillance System	2017	49.0%	
Worcester, MD	Maryland Behavioral Risk Factor Surveillance System	2017	53.0%	

Source: HCI Healthy Communities Inc. 2020

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

Transportation Services

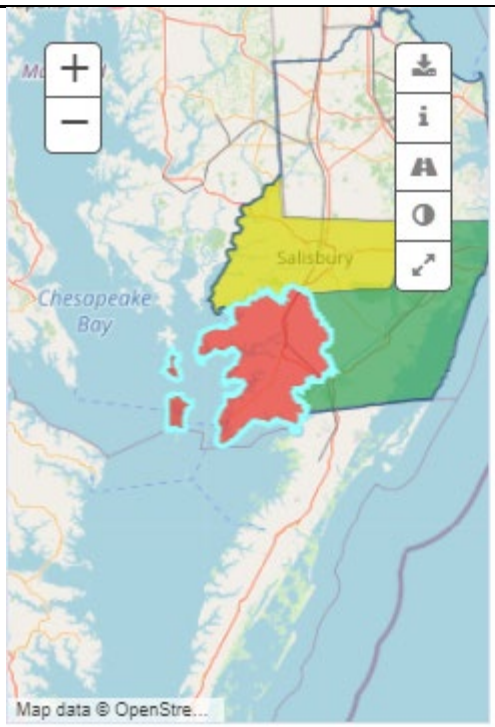
Peninsula Regional does make available transportation services for those in extenuating circumstances. Every effort will be made to assist patients receiving care under a series account like radiation oncology or chemo by utilizing various community resources. When community resources are not available,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

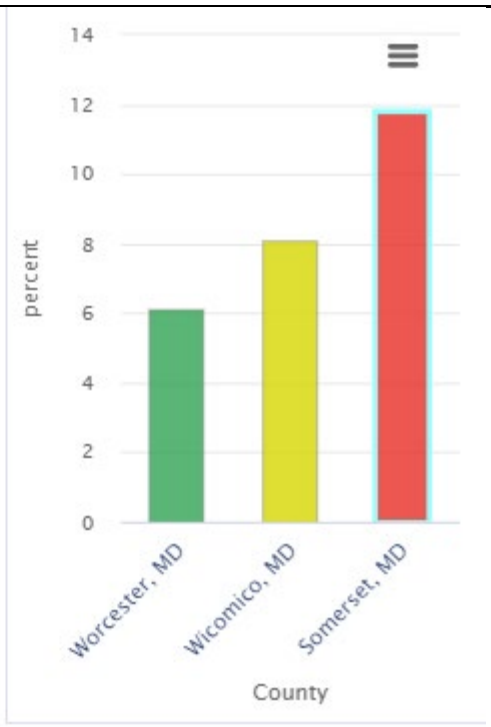
Upon inpatient hospital discharge, the Institution also provides transportation for certain elderly patients who do not drive and/or those who may lack a caregiver. A bus tickets or a taxi fare is provided for those patients who are indigent or may lack a vehicle. Our Patient Care Management Department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

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

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

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





Best 50th Percentile
< 6.2%

50th to 75th Quartile
6.2% - 8.6%

Worst 25th Quartile
> 8.6%

N/A

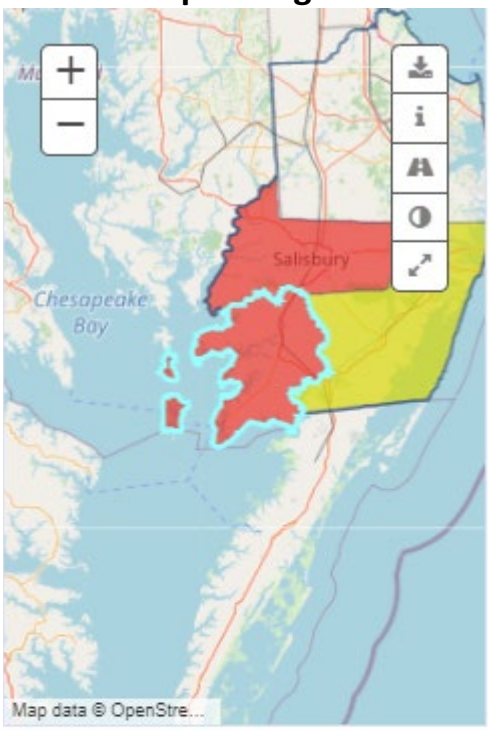
County	Source	Measurement Period	Percent	
Worcester, MD	American Community Survey	2014-2018	6.1%	
Wicomico, MD	American Community Survey	2014-2018	8.1%	
Somerset, MD	**American Community Survey**	**2014-2018**	**11.8%**	

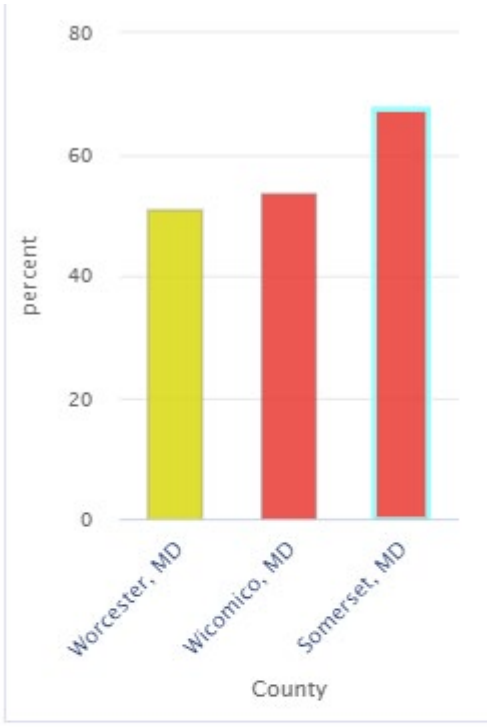
Source: HCI Healthy Communities Inc. 2020

Affordable Housing

Peninsula Regional's CBSA has exceptionally high household rent compared to other Maryland counties. Spending a high percentage of household income on rent can create financial hardship, especially for lower-income renters. Limited income due to high rent makes it difficult to access health care resources. A limited income also limits the ability for families to eat healthy meals that are more expensive than less healthy meals.

Renters Spending 30% or More of Household Income on Rent





Best 50th Percentile
< 50.8%

50th to 75th Quartile
50.8% - 53.3%

Worst 25th Quartile
> 53.3%

N/A

County	Source	Measurement Period	Percent	
Worcester, MD	American Community Survey	2014-2018	51.1%	
Wicomico, MD	American Community Survey	2014-2018	53.7%	
Somerset, MD	**American Community Survey**	**2014-2018**	**67.7%**	

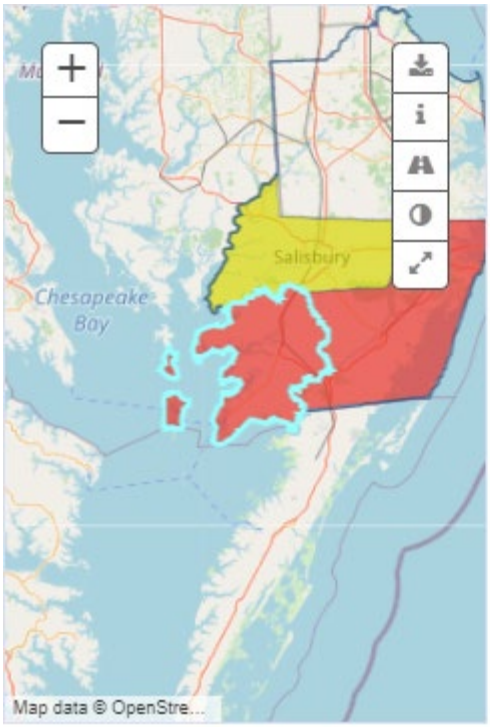
Source: HCI Healthy Communities Inc. 2020

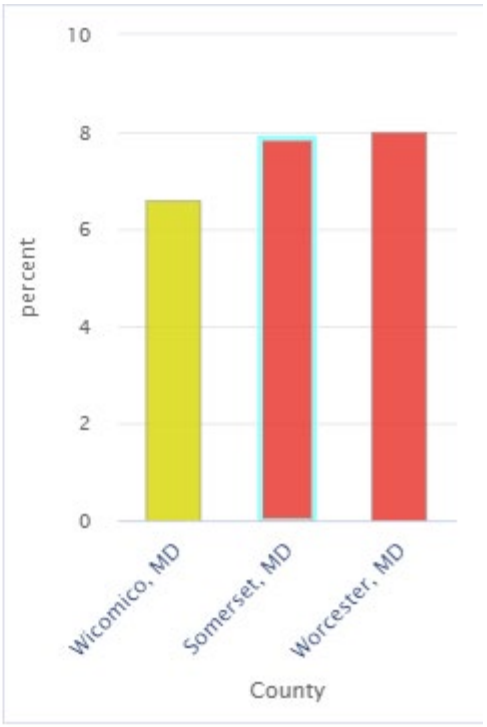
Safe and affordable housing is an important component of healthy communities and based upon the following data both Wicomico and Somerset Counties have widespread housing problems. Residents who do not have a kitchen in their home are more likely to spend on unhealthy convenience foods. Research has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

Unemployment

Compared to the state of Maryland, which has an unemployment rate of 7.2%, the unemployment rate is higher in Worcester and Somerset counties. Unemployment is a key indicator of the health

of the local economy; in addition, high unemployment rates can be related to reduced access to health resources and unhealthier living conditions.





Best 50th Percentile
< 6.3%

50th to 75th Quartile
6.3% - 7.2%

Worst 25th Quartile
> 7.2%

N/A

County	Source	Measurement Period	Percent	
Wicomico, MD	U.S. Bureau of Labor Statistics	August 2020	6.6%	
Somerset, MD	**U.S. Bureau of Labor Statistics**	**August 2020**	**7.9%**	
Worcester, MD	U.S. Bureau of Labor Statistics	August 2020	8.0%	

Source: HCI Healthy Communities Inc. 2020

Sources:
Healthy Communities (HCI) 2020
www.ers.usda.gov/FoodAtlas/
www.shoretransit.org
Truven Health Analytics 2019

Available detail on race, ethnicity, and language within CBSA.
See SHIP County profiles for demographic information of Maryland jurisdictions.
http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx

Within the CBSA, all three counties' average household incomes are considerably less than Maryland's average. In addition, a smaller percentage of the population has a bachelor's degree or above. Wicomico County (13.14%) and Somerset County (18.2%) have a much higher high school drop-out rate than the state of Maryland (10.09%). Research indicates that education level is a social determinant and predictor of a healthy lifestyle and health literacy.
Worcester has the higher percentage of white population at 81.59%, whereas Somerset has the lowest at 52.46%. Somerset has the largest proportion of Black/African Americans at 41.84%, whereas Worcester has the lowest at 12.90%.

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

Demographics	Wicomico County	Worcester County	Somerset County	State of Maryland
Race				
White Non-Hispanic	63.73%	81.59%	52.46%%	**54.12%**
Black Non-Hispanic	27.17%	12.90%	41.84%	**30.22%**
American Indian/Alaskan Native	0.28%	0.34%	0.40%	**0.39%**
Asian	3.29%	1.65%	0.88%	**6.87%**
Native Hawaiian/Pacific Islander	0.06%	0.03%	0.05%	**0.07%**
Some Other Race	2.38%	1.43%	1.61%	**4.76%**
2+ Races	3.10%	2.06%	2.76%	**3.57%**
Median Household Income	$57,660	$67,273	$45,899	**$87,818**
Pop. 25+ Without H.S. Diploma	13.14%	9.94%	18.2%	**10.09%**
Pop. 25+ With Bachelor's Degree or Above+	39.46%	30.04%	14.44%	**39.46%**
Demographics	**Wicomico County**	**Worcester County**	**Somerset County**	**State of Maryland**
English Spoken at Home	88.7%	95.2%	91.0%	**81.6%**
Other than English Spoken at Home	11.3%	4.8%	9.0%	**18.4%**

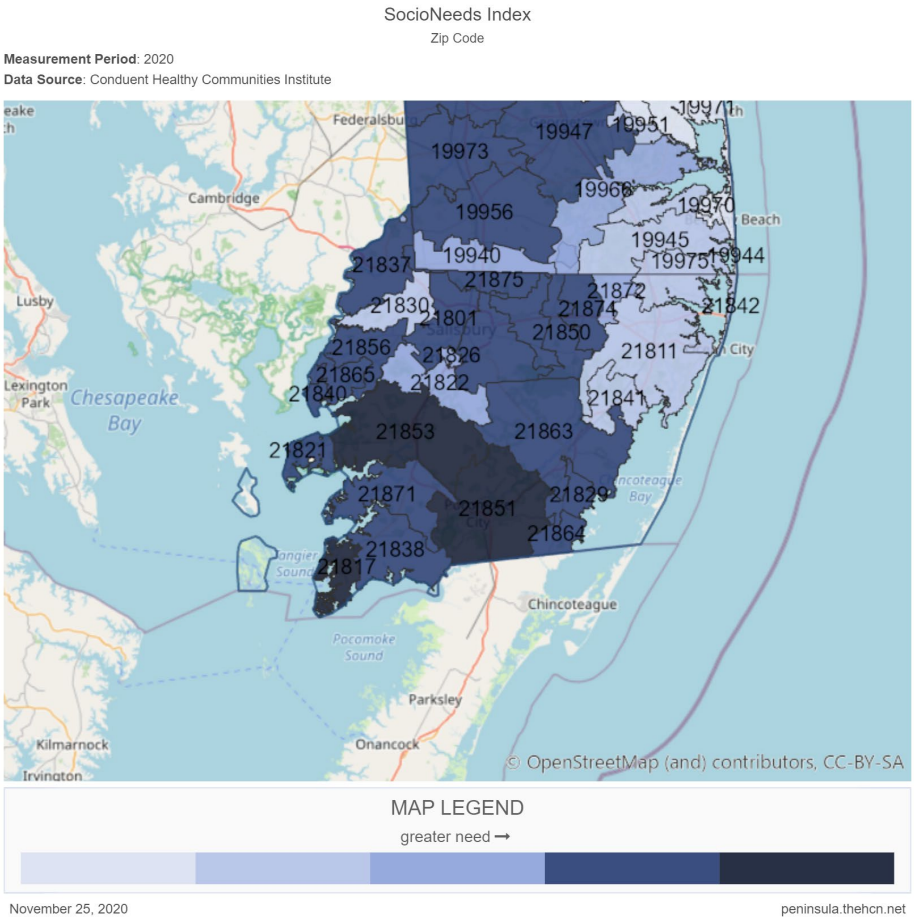
Source: United States Census Bureau American Community Survey 2018, Healthy Communities (HCI) 2020

Other

SocioNeeds Index

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

HCI SocioNeeds Index



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

Social Environment

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

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

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

Economy

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

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

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

Education

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

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

Source: HCI Healthy Communities Inc. 2020

TidalHealth Debuts to Provide Care to Delmarva

In reference to the Community Benefit Report for Peninsula Regional Health System in FY 2020, we wanted to bring attention to the new health system on the Delmarva Peninsula which incorporates Peninsula Regional Health System in Salisbury, MD, Nanticoke Memorial Hospital in Seaford, DE, and McCready Memorial Hospital in Crisfield, MD. The new health system is bringing providers, campuses, pavilions, and hospitals together to better serve the communities and families of Delmarva.

In September of 2020 formerly Peninsula Regional Health System announced its new name: TidalHealth. TidalHealth includes TidalHealth Peninsula Regional, TidalHealth Nanticoke, TidalHealth McCready Pavilion, and an expansive physician network with approximately 250 providers in 22 different specialties have joined forces to offer the best in patient-centered care. The three former entities: Peninsula Regional Health System, Nanticoke Memorial Hospital and McCready Memorial Hospital have joined together with the accompanying hospital physician networks to better serve the Delmarva Peninsula and its expanding population.

As we joined together, three key points became evident about our new health system: quality is our constant, special is our signature and community is our core.
We provide a full range of services, including neurosurgery, cardiothoracic surgery, joint replacement, emergency/trauma care, comprehensive cancer care, women's and children's services, wound care and clinical trials and research as a member of the Johns Hopkins Clinical Research Network.

By combining knowledge and sharing evidence-based protocols, TidalHealth is able to offer the best healthcare on Delmarva. Primary care physicians and specialists are collaborating every day to personalize the patient experience, and new technologies and treatment options continue to define the standard for safer care, faster recoveries and better outcomes.
Through TidalHealth's primary care and specialty care offices across Delmarva, health campuses in Maryland and Delaware, FamilyLabs and pharmacies and our Wagner Wellness Van, we are making it more convenient than ever for patients to get the care they need.

Community Benefit FY 2020

Attachments

Attachment A – HSCRC Transformation Grant

Attachment B – MAC Inc., the Area Agency on Aging Data

Attachment C – Community Wellness Team Data

Attachment D – Smith Island Telemedicine Statistics

Attachment E – Peninsula Regional SWIFT Data

Attachment F – Peninsula Regional Remote Patient Monitoring Data

Attachment G – Nutrition/Diabetes Education and Support Group Information

Attachment H – Peninsula Regional Emergency Department Heroin Overdose Data

Attachment I – Wicomico County Health Department COAT Data

Attachment J – Opioid Intervention Team (OIT) and Somerset County Opioid United Team (SCOUT) Data

Attachment K – Richard A. Henson Cancer Institute Community Benefit Report Tracker Data

Attachment L – Peninsula Regional Prescription Data

Attachment M – TidalHealth Facebook Page Screenshot

Attachment A – HSCRC Transformation Grant

HSCRC Transformation Grant

FY 2020 Report

The Health Services Cost Review Commission (HSCRC) requires the following information for FY 2020 Regional Partnership Transformation Grant Program participants: this Report, the Budget Report, and the Budget Narrative. Whereas the Budget Report distinguishes efforts between each hospital, this Summary Report should consolidate information and describe all hospitals, if more than one, that are in the Regional Partnership.

Regional Partnership Information

Regional Partnership (RP) Name	TidalHealth (formally Peninsula Regional Medical Center)
RP Hospital(s)	• Tidal Health- Peninsula Regional • Atlantic General • McCready Health (until 2/29/2020)
RP Point of Contact	Kathryn Fiddler 100 East Carroll Street Salisbury MD 21801 410-219-4923 Kathryn.fiddler@peninsula.org
RP Interventions in FY 2020	1. Wagner Wellness Van Mobile Outreach & SWIFT (Mobile Integrated Health) 2. Smith Island Telemedicine 3. Care Management and Disease Management Program for Chronic Conditions
Total Budget in FY 2020 *This should equate to total FY 2017 award*	FY 2020 Award: **$ 1,099,679**
Total FTEs in FY 2020	Employed: **30.5** FTEs Peninsula Regional **2.06** FTEs Atlantic General
	Contracted: 0
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	• Wicomico, Somerset and Worcester County Health Departments • Wicomico, Somerset and Worcester County Boards of Education • Wicomico, Somerset and Worcester Community Health Providers • City of Salisbury • Salisbury Fire Department • Salisbury Police Department • United Way of the Lower Eastern Shore • HOPE • HALO • Chesapeake Housing Mission

	• Salisbury Urban Ministries • St. James AME • St. Peter's Lutheran • Resource and Recovery Center • Atlantic Club • Marion Pharmacy • MAC, Inc • National Kidney Foundation • Maryland Food Bank • YMCA

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs):

The Regional Partnership is comprised of TidalHealth(formerly PRMC), Atlantic General Hospital, and McCready Health. The Partnership focused on the three priority program areas that continued to evolve and expand over the course of fiscal 2020. The Community Wellness team (formerly the Wagner Wellness Van team) continued to build on partnerships throughout the community to identify and outreach vulnerable and at-risk populations in Wicomico, Worcester, and Somerset counties. It has become one tool of broader community health and wellness initiatives. In FY20, screening fairs were conducted by the Community Wellness team in all three counties several days each week including; local migrant camps, Haitian community centers, schools, Smith Island, shelters, and churches. Their commitment to and trust from our community, proved to be significant in their COVID-19 response.

The Community Wellness team also supports the Salisbury Wicomico Integrated FirstCare Team (SWIFT) program, a mobile integrated health initiative in partnership with the City of Salisbury, and the Wicomico County Health Department. The program continues to reduce unnecessary use of the 911 EMS system and Emergency Department by addressing the physical and social needs of those who are identified as high utilizers of EMS and/or ED. The program currently serves clients in Wicomico County only, but is aggressively working towards expanding its reach to other areas of the county and beyond.

Both Atlantic General and TidalHealth continue to have dedicated care coordination teams that function both in the ambulatory care and community settings. Over the course of FY20, community-based coordination has evolved as new Medicare and other HSCRC initiatives have been introduced. Care coordination staff embedded within the primary care offices and those working within Transitional Care Services predominantly support care management functions associated with the Maryland Primary Care Program and Episode Care Improvement programs, which focus on the evolving and high-risk Medicare beneficiaries. These functions include transitional care management following an emergency department visit or acute care hospitalization, as well as, longitudinal care management that incorporates chronic disease self-management education, nurse led-advance care planning, and social determinant of health interventions.

MAC, Inc. is a partner providing evidence-based classes in chronic disease management, depression, and fall reduction. The care coordination staff routinely refer patients to MAC, Inc. Hundreds of community members have attended community-based classes in all three counties. TidalHealth Peninsula Regional Clinically Integrated Network has added these classes to their clinical pathways, and

the partnership is the first in the State to pilot work with CRISP to build a referral pathway with patient information and class participation added into Care Alerts. These alerts then highlight any social determinants of health needs. Focused effort on IT and data sharing has been a priority with these programs.

Smith Island telehealth is continually evolving- A health fair was held on the island during the summer of 2019. New PCP appointments were offered to community members with no PCP. Telehealth acute visits continue with an NP at PRMC. Staff continues to screen Island residents and offer support for chronic disease management. There is a full time community health worker on Smith Island who works with community members on chronic disease education, medication management, referrals and follow up post discharge and ED visits.

Intervention Program

Please copy/paste this section for each Intervention/Program that your Partnership maintains, if more than one.

Intervention or Program Name	1. Wagner Wellness Van Mobile Outreach & SWIFT (Mobile Integrated Health)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All three (3): • Peninsula Regional Medical Center • Atlantic General • McCready Health
Brief description of the Intervention *2-3 sentences*	The Wagner Wellness Van, SWIFT and Community Care Coordination works to provide in-home and telephonic care coordination and clinical assessment and treatment for high utilizers of the 911 system or Emergency Departments. Multidisciplinary teams led by a nurse practitioner provide telehealth, and linkage to linkage to outreach services, community programs, primary care services, chronic disease and preventative care to address the physical and psyscho-social needs of our communities.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	• Wicomico, Somerset and Worcester County Health Departments • Wicomico, Somerset and Worcester County Boards of Education • Wicomico, Somerset and Worcester Community Health Providers • City of Salisbury • Salisbury Fire Department • Salisbury Police Department • United Way of the Lower Eastern Shore • HOPE • HALO • Chesapeake Housing Mission • Salisbury Urban Ministries

	• St. James AME • St. Peter's Lutheran • Resource and Recovery Center • Atlantic Club • Marion Pharmacy • MAC, Inc • National Kidney Foundation • Maryland Food Bank • YMCA
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2020: **112** SWIFT Patients **1,097** Community Wellness Patients **3,353** COVID Tests administered
	Denominator of Eligible Patients: **38, 795** Eligible Patients Source: RP Analytic Files FY 2020 : Population
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	SWIFT Pre-Post Analysis attached.
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	In FY20, the Community Wellness outreach team performed outreach services throughout Worcester and Wicomico Counties reaching over 1,000 community members during approximately 40 outreach events. During these events and daily community outreach missions, the team provided flu vaccines, connected patients to primary care providers and provided referrals to various community partners and agencies for housing, faith, utilities, healthcare and many other social determinants of health. SWIFT utilized CRISP to identify vulnerable patient populations and patients that are considered high risk and rising risk. SWIFT is also utilizing the CRISP care alerts for when patients have an ED encounter.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The community wellness team from the Wagner Wellness Van and SWIFT programs were able to work with individuals throughout the region to address social determinants of health that were preventing them from gaining control of

	their health conditions and causing crisis situations and high utilization of the Emergency Department. The team connected residents to various assistance programs ranging from housing, dental, substance abuse treatment and recovery support, food, shelter, utility bill assistance, health care coverage, social services. The team serves as an extension of an integrated and coordinated health care team that works to address all of the needs and issues impacting an individual's health. Once the coronavirus pandemic took hold of the community, the needs of residents changed and the SWIFT and Wagner Wellness Van mobile teams adapted to meet the changing needs of vulnerable and disadvantaged residents most impacted by the pandemic. The staff were critical for mass community-based COVID-19 testing throughout the region. The teams were recruited to participate in a regional, grassroots task force organized to bring together agencies, organizations and services to better meet the needs of vulnerable populations at a time when so many lost their employment, income and access to brick-and-mortar programs. Again, the programs adapted to the needs of the community and provided health services, education and outreach to pop-up resource fairs in the hardest hit communities. This work continues as the pandemic continues to affect communities.
Additional Freeform Narrative Response (Optional)	The community wellness and SWIFT programs temporarily halted their traditional in-home services out of an abundance of caution and the need to focus on COVID-19 response in our community. The community wellness team became the primary staff to work community-based testing sites. However, as tests became more available through local labs, immediate/urgent care facilities, the health department and pharmacies, the team was able to resume in-home visits for referred patients and modify the mobile clinic/outreach model and schedule to better respond to the changing needs in the community. This team has now been part of multiple "One Stop Shop" events providing food, sign up for school, insurance sign up, translation services, disease management and screening, sign up for the 2020 Census, legal air, housing and many other events to improve health equity and access to services.

Intervention or Program Name	2. Smith Island Telemedicine
RP Hospitals Participating in Intervention	• Peninsula Regional Medical Center • McCready Health

Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.	
Brief description of the Intervention *2-3 sentences*	The community members of Smith Island have no direct access to health care. The program provides the residents access, by way of a medical assistant who lives on the island and Telehealth services from a TidalHealth Nurse Practitioner and Physician.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	• Wicomico, Somerset and Worcester County Health Departments • Wicomico, Somerset and Worcester County Boards of Education • Wicomico, Somerset and Worcester Community Health Providers • City of Salisbury • Salisbury Fire Department • Salisbury Police Department • United Way of the Lower Eastern Shore • HOPE • HALO • Chesapeake Housing Mission • Salisbury Urban Ministries • St. James AME • St. Peter's Lutheran • Resource and Recovery Center • Atlantic Club • Marion Pharmacy • MAC, Inc • National Kidney Foundation • Maryland Food Bank • YMCA
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may overstate the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2020: **184**
	Denominator of Eligible Patients: **38, 795** Eligible Patients Source: RP Analytic Files FY 2020 : Population
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	None

Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	In FY20, the Smith Island Community Wellness team was successful in transmitting 46 telehealth visits, providing 18 medication refill prescriptions to patients that could not leave the island due to their declining health, lack of transportation or access, or inclement weather. In addition, the team provided "office visit" access to 32 residents. During these visits, 27 blood pressure screenings were completed and 14 lab draws.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	Telemedicine accessibility improved through the Smith Island initiative as the program installed DSL internet in the Health Clinic, providing a more reliable connection to PRMC's Electronic Medical Record and ability to facilitate the telemedicine visit. In addition to technology improvements, relationships and trust continued to be built among the residents of the island because of the medical assistant residing on the island and making herself available to patients in between scheduled appointments/visits with the nurse practitioner. Many patients have not physically seen a medical provider in years, and this program brought access and improved the health of residents. For example, one patient in her 30s had not left the island for two or three years and had untreated, severe depression. She was also suffering from chronic conditions - obesity and diabetes. Access to telemedicine connected her to psychiatric care and primary care. The local medical assistant was able to build trust with the patient and connect her to mental health and physical health care. Another patient attended the annual health fair and because of the education and screenings, she took the advice of the staff and had a follow-up dermatology appointment in which she discovered that she had melanoma on her back. She would not have known that she needed to see the specialist had she not attended the health fair and spoke with health care practitioners. Other residents participated in additional screenings offered which also led to follow-up visits with specialists.
Additional Freeform Narrative Response (Optional)	Due to COVID19, the partnership was not able to conduct its Annual Health Fair on the island in fiscal 2020. Looking forward, the Smith Island Telehealth program will continue to grow in volume and services offered. As of fall (fiscal 2021) the community health team hosts biweekly clinic days to promote health and nutrition, as well as other

	services offered by the health system, and to build trust and relationships within the community in addition to holding telemedicine appointments. The community health team plans to purchase a lightweight telemedicine kit with secure video conferencing and diagnostic equipment to provide real time clinical data to utilize on Smith Island.

Intervention or Program Name	3. Care Management and Disease Management Program for Chronic Conditions
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	• Peninsula Regional Medical Center • Atlantic General Hospital • McCready Health
Brief description of the Intervention *2-3 sentences*	Deploy and embed care managers in Primary Care Practices, the ED, and Transitional Care to provide evidence-based care management services for evolving and high-risk Medicare beneficiaries. Enroll beneficiaries in chronic disease management programs available through partner programs. Implement disease management protocols and develop patient-centered care plans.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	• Wicomico, Somerset and Worcester County Health Departments • Wicomico, Somerset and Worcester County Boards of Education • Wicomico, Somerset and Worcester Community Health Providers • City of Salisbury • Salisbury Fire Department • Salisbury Police Department • United Way of the Lower Eastern Shore • HOPE • HALO • Salisbury Urban Ministries • Tri-County Mediation • St. James AME • St. Peter's Lutheran • Resource and Recovery Center • Atlantic Club • MAC, Inc • Maryland Food Bank • YMCA
Patients Served	# of Patients Served as of June 30, 2020:

Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files. *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	**4,678** Community Members have had Care Coordination in the last 12 months. **35** Community Members Care Managed in partnership with MAC, Inc. and Atlantic General. **348** Community Members Care Managed in partnership with MAC, Inc and Peninsula Regional (See attached data from MAC, Inc. Evidence Based Classes in FY20). **316** Community Members have had a Community Health Worker
	Denominator of Eligible Patients: **38, 795** Eligible Patients Source: RP Analytic Files FY 2020 : Population
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	Case Managers and Social Workers work in the Emergency Department, 24/7/365, where their primary role is determining admission criteria for hospitalization. They prevent many admissions by providing other levels of care, they work with all populations. Social Workers provide resources to many of our patients whether medication assistance, transportation, referring to financial counselors if no insurance, referring to home health, rehab, hospice, assisted living or nursing homes. ED Case Managers also assist with outpatient appointments, arranging DME, provide education and have end of life discussions with patients/families. The Case Managers utilize CRISP Care Alerts to identify current Care Management resources within the Regional Partnership and the Community. ER Case Managers: • Have the responsibility to maximize the resources of the hospital – help prevent readmissions/PAU • Oversee implementation of established clinical protocols to ensure quality care • Help determine medical necessity for admission to the hospital

	• Here to help, the patient, the families, the nurses, the providers, the hospitalists • During FY20, the ED Case Managers supported 1,359 patients. During FY2020, Atlantic General Hospital reduced ED visits by 25.5%, decreased PAU by 4.1% and lowered our readmission rate to historic low of 7.5%
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The Care Managers are utilizing CRISP ENS alerts for care management coordination and patient identification within all three hospitals in partnership, as well as community providers.The Regional partnership continued its strong collaboration, developing a referral pathway process with MAC, Inc. in Salisbury, MD and the Living Well Center of Excellence for its evidence based programs. Through the partnership, MAC is able to provide countless resources to patients. For example, a patient was primarily eating processed frozen meals and processed convenience foods. As a result of being coached to read labels and guidance on healthy eating and how to plan her meals and snacks Rhetta was able to exceed her weight loss goals. Rhetta has also purchased a used stationary bike and has also reported that due to the increase in physical activity both her pain levels and shortness of breath have decreased. The Regional Partnership and MAC, Inc. are actively working to develop a Social Determinants of Health tracking system to provide both support and visibility to care managers. In addition, the Community Health Workers provided support to over 300 high utilizers from within the ED and in the Community during FY20. As well as, The Community Health Program Social Worker provided support Services to over 600 patients within the Regional Partnership's community. These patients range in risk scores and need, however they typically seem to need the most help. For example, one patient found himself alone and homeless, living behind a gas station. The Community Health Workers, in collaboration with the SWIFT team were able to get him accepted into the local homeless shelter, HALO. Next, they assisted him in getting a new government ID card that had previously been stolen, as well as a new disability card that provided this gentleman an income of 800 dollars per month, for shelter, clothing, toiletries and shoes. The Community Health Workers then helped him apply for food stamps and actively worked with local housing authorities to get this gentleman safe and

	permanent housing. Without the Community Wellness program, the Regional Partnership would not be able to provide this level of support to our community.
Additional Freeform Narrative Response (Optional)	The onset of the COVID19 pandemic prevented many educational programs and community outreach events in the second half of FY 2020, however MAC has recently been approved for a Telehealth Program to reach patients in isolation.

Core Measures

Please fill in this information with the latest available data from the in the CRS Portal Tools for Regional Partnerships. For each measure, specific data sources are suggested for your use– the Executive Dashboard for Regional Partnerships, or the CY 2019 RP Analytic File (please specify which source you are using for each of the outcome measures).

Utilization Measures

Measure in RFP *(Table 1, Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Total Hospital Cost per capita	**Partnership IP Charges per capita** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Charges per Capita, reported as average 12 months of CY 2019 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	**$118** IP Charges per Capita Source: Regional Partnership Executive Dashboard: July 2020
Total Hospital Discharges per capita	**Total Discharges per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Discharges per 1,000, reported as average 12 months of FY 2020 -or- Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	**3** Total Discharges per 1,000 Source: Regional Partnership Executive Dashboard: July 2020

ED Visits per capita	**Ambulatory ED Visits per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Ambulatory ED Visits per 1,000, reported as average 12 months of FY 2020 -or- Analytic File 'ED Visits' over 'Population' (Column H / Column C)	**9** Ambulatory ED Visits per 1,000 Source: Regional Partnership Executive Dashboard: July 2020

Quality Indicator Measures

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Readmissions	**Unadjusted Readmission rate by Hospital** (please be sure to filter to include all hospitals in your RP) Executive Dashboard: '[Partnership] Quality Indicators' – Unadjusted Readmission Rate by Hospital, reported as average 12 months of FY 2020 -or- Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	**9.8 %** Unadjusted Readmission Rate Source Regional Partnership Executive Dashboard: JUNE 2020 , as July's report stated NULL.
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2020	**$3,550,338** PAU Source: Regional Partnership Executive Dashboard: July 2020

	-or- Analytic File: 'TotalPAUCharges' (Column K)	

CRISP Key Indicators (Optional)

These process measures tracked by the CRISP Key Indicators are new, and HSCRC anticipates that these data will become more meaningful in future years.

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Portion of Target Population with Contact from Assigned Care Manager	**Potentially Avoidable Utilization** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' – % of patients with Case Manager (CM) recorded at CRISP, reported as average monthly % for most recent six months of data *May also include Rising Needs Patients, if applicable in Partnership.*	**23.0 %** High Needs **9.7%** Rising Needs Source: Regional Partnership Executive Dashboard: July 2020

Self-Reported Process Measures

Please describe any partnership-level measures that your RP may be tracking but are not currently captured under the Executive Dashboard. Some examples are shared care plans, health risk assessments, patients with care manager who are not recorded in CRISP, etc. By-intervention process measures should be included in 'Intervention Program' section and don't need to be included here.

Return on Investment – (Optional)

Annual Cost per Patient as calculated by

Total Patients Served (all interventions) / Total FY 2020 Expenditures (from FY 2020 budget report)

Impact of COVID-19 on Interventions – (Optional)

Please include information on the impact of COVID-19 on your interventions, if any. Freeform Narrative response, 1-3 paragraphs.

As a result of the COVID19 pandemic, our regional partnership, health systems, and collaborating partners were able to develop unique strategies to meet the ever changing needs of our communities

during this healthcare crisis. As a result of legislative changes with the Federal and State systems, we were able to respond to rapid changes in the delivery of healthcare services. Examples include the expansion of healthcare services to alternative treatment settings, expanded telehealth / virtual care services, screenings and call center support. The pandemic dramatically changed our climate and elicited the creation of innovative Care Management programs.

Both TidalHealth and Atlantic General Hospital (AGH) developed alternative care units within our hospital settings as well as externally in preparation for surge capacity. AGH developed a medical-surgical overflow unit in a local skilled nursing facility (SNF) which required a complete build of infrastructure, EMR, supply management, staffing and care navigation from acute care to SNF. Expansion of services required intense resource management, policy development, and the implementation of regional care management efforts to ensure all healthcare agencies received up to date information on regional resources and bed availability. TidalHealth developed and implemented a region wide call center where healthcare agencies across the tri-county region called each day to report their daily statistics and identification of barriers such as staffing and PPE shortages. TidalHealth handled more than 3,80 calls from April to May. This is a hugely successful program and continues to current day.

Intervention Continuation Summary

TidalHealth Peninsula Regional will continue to support all three areas of focus from this grant. Despite direct ROI, the ability to integrate with the community, build trust and rapport as we work to improve health disparities is critical for this region. All current roles have continued to be supported and are key strategies for our future. We are working as a region with a large Vulnerable Population grass roots group, composed of local, regional and state stakeholders to focus on removing health disparities in the region.

Opportunities to Improve – (Optional)

Acquiring data to sufficiently detail the time and effort of care coordination and outreach remains a challenge. CRISP data is often limited to Medicare claims only which limits ability to measure success in other groups, specifically the Medicaid populations. CRISP data is limited in its ability to show impact to broader populations in the community. There is also limited data in CRISP related to health disparities and vulnerable populations which could have helped inform our teams about areas of focus. More local and census tract data mapped to claims for all payers would be helpful to understand where to focus the community efforts.

Attachment B – MAC Inc., the Area Agency on Aging Data

Chronic Disease Self-Management
July 1, 2019 - June 30, 2020

Number of workshops: 14

Average participants per workshop: 7.5
Number of participants: 105
Participants with attendance data: 101
Completers: 72 of 101 (71%)
Number who are caregivers: 17 of 89 (19%)

Aug 1, 19—MAC Inc
[Control]Sep 17, 19—Eastern Shore Wellness Solutions
[Control]Sep 24, 19—MAC Inc
[Control]Oct 2, 19—Pine Bluff Village Apartments
[Control]Nov 5, 19—Victoria Park at Sassafras Meadows
[Control]Nov 12, 19—The Lodges at Naylor Mill
[Control]Jan 5, 20—Park Seventh Day Adventist Church
[Control]Jan 12, 20—New Life Seventh Day Adventist Church
[Control]Jan 22, 20—Pine Bluff Village Apartments
[Control]Jan 30, 20—Glenburn House - ESWS
[Control]Mar 9, 20—Home TK
[Control]Mar 9, 20—Home TK
[Control]Jun 16, 20—MAC Inc
[Control]Jun 24, 20—MAC Inc

Age	Count	Percent	Bar
0-44	2	2%	
44-49	2	2%	
50-54	6	6%	
55-59	3	3%	
60-64	9	10%	
65-69	15	16%	
70-74	31	33%	
75-79	13	14%	
80-84	6	6%	
85-89	5	5%	
90+	2	2%	
Unknown	11		

Can Manage Condition	Count	Percent	Bar
9	22	47%	

8	9	19%	
10	8	17%	
7	4	9%	
6	3	6%	
4	1	2%	
Unknown	58		

Caregiver	Count	Percent	Bar
No	72	81%	
Yes	17	19%	
Unknown	16		

Chronic Condition	Count	Percent	Bar
Hypertension	59	63%	
Diabetes	51	55%	
Arthritis	41	44%	
Chronic Pain	29	31%	
Lung Disease	24	26%	
Depression or Mental Illness	22	24%	
Cancer	22	24%	
Obesity	19	20%	
Osteoporosis	16	17%	
Heart Disease	16	17%	
Stroke	10	11%	
Kidney Disease	5	5%	
Schizophrenia	3	3%	
Other	8	9%	
Unknown	12		

Completers	Count	Percent	Bar
Yes	72	69%	
No	33	31%	

Condition Count	Count	Percent	Bar
Multiple chronic conditions	78	84%	
One chronic condition	15	16%	
Unknown	12		

Disabilities	Count	Percent	Bar
Diff. walking or climbing stairs	29	28%	
Limited Phy/Men/Emotial	23	22%	
Hearing impaired	18	17%	
Diff. with errands	17	16%	
Diff. dressing	14	13%	
Diff. remembering	13	12%	
Visually impaired	5	5%	

Disability Count	Count	Percent	Bar
No disabilities	45	49%	
Multiple disabilities	31	34%	
One disability	16	17%	
Unknown	13		

Education	Count	Percent	Bar
Some College	34	39%	
Completed High School	23	26%	
Completed College	19	22%	
Some High School	11	13%	
Unknown	18		

Ethnicity/Race	Count	Percent	Bar
Black or African American	48	52%	
White/Caucasian	42	45%	
Hispanic/Latino	2	2%	
American Indian or AK Native	2	2%	
Hawaiian Native or Pacific Islander	1	1%	
Unknown	12		

GDM	Count	Percent	Bar
No	76	72%	

Gender	Count	Percent	Bar
Female	76	74%	

Male	27	26%	
Unknown	2		

Health	Count	Percent	Bar
Good	40	49%	
Fair	21	26%	
Very Good	12	15%	
Excellent	4	5%	
Poor	4	5%	
Unknown	24		

How Did You Hear	Count	Percent	Bar
Not reported	105	100%	

Impacted by COVID-19	Count	Percent	Bar
No	7	54%	
Yes	6	46%	
Unknown	92		

Insurance	Count	Percent	Bar
Medicare Part B ("Regular" Medicare)	75	82%	
Medicaid	20	22%	
BC/BS	17	18%	
United	10	11%	
Veterans Health	7	8%	
AARP	3	3%	
Cigna	2	2%	
Veteran's Health Family Coverage	2	2%	
Aetna	1	1%	
Other	6	7%	
Unknown	13		

Lives Alone	Count	Percent	Bar
No	44	51%	
Yes	43	49%	
Unknown	18		

Number of Sessions Attended	Count	Percent	Bar
1	19	19%	
2	7	7%	
3	3	3%	
4	17	17%	
5	21	21%	
6	34	34%	

Organization	Count	Percent	Bar
MAC Inc	91	87%	
Eastern Shore Wellness Solutions	14	13%	

Participant County	Count	Percent	Bar
Wicomico, MD	83	79%	
Dorchester, MD	14	13%	
Somerset, MD	4	4%	
Worcester, MD	2	2%	
Licking, OH	1	1%	
Suffolk City, VA	1	1%	

Payment Source	Count	Percent	Bar
Not reported	105	100%	

Referred	Count	Percent	Bar
No	71	85%	
Yes	13	15%	
Unknown	21		

Virtual Workshop	Count	Percent	Bar
No	13	100%	
Unknown	92		

Living Well with High Blood Pressure
July 1, 2019 - June 30, 2020

Number of workshops: 5

Average participants per workshop: 9.2
Number of participants: 46
Participants with attendance data: 46
Completers: 46 of 46
Number who are caregivers: 11 of 39 (28%)

[Control]Sep 17, 19—MAC Inc
[Control]Jan 5, 20—New Life Seventh Day Adventist Church
[Control]Jan 5, 20—Park Seventh Day Adventist Church
[Control]Jan 15, 20—Pine Bluff Village Apartments
[Control]Mar 9, 20—MAC Inc

Age	Count	Percent	Bar
0-44	1	2%	
50-54	2	5%	
55-59	1	2%	
60-64	1	2%	
65-69	10	25%	
70-74	12	30%	
75-79	6	15%	
80-84	3	8%	
85-89	4	10%	
Unknown	6		

Caregiver	Count	Percent	Bar
No	28	72%	
Yes	11	28%	
Unknown	7		

Chronic Condition	Count	Percent	Bar

Hypertension	26	72%	
Diabetes	21	58%	
Depression or Mental Illness	11	31%	
Arthritis	10	28%	
Stroke	6	17%	
Heart Disease	5	14%	
Lung Disease	5	14%	
Chronic Pain	5	14%	
Cancer	4	11%	
Osteoporosis	3	8%	
Alzheimer's	2	6%	
Other	5	14%	
Unknown	8		

Completers	Count	Percent	Bar
No	46	100%	

Condition Count	Count	Percent	Bar
Multiple chronic conditions	26	68%	
One chronic condition	10	26%	
No chronic conditions	2	5%	
Unknown	8		

Disabilities	Count	Percent	Bar
Limited Phy/Men/Emotial	11	24%	

Education	Count	Percent	Bar
Completed High School	18	46%	
Some College	13	33%	
Completed College	6	15%	
Some High School	2	5%	
Unknown	7		

Ethnicity/Race	Count	Percent	Bar
White/Caucasian	22	55%	
Black or African American	16	40%	

American Indian or AK Native	3	8%	
Hispanic/Latino	1	2%	
Unknown	6		

GDM	Count	Percent	Bar
No	33	72%	

Gender	Count	Percent	Bar
Female	33	73%	
Male	12	27%	
Unknown	1		

How Did You Hear	Count	Percent	Bar
Not reported	46	100%	

Impacted by COVID-19	Count	Percent	Bar
No	9	100%	
Unknown	37		

Insurance	Count	Percent	Bar
Medicare Part B ("Regular" Medicare)	35	97%	
Medicaid	11	31%	
Unknown	10		

Lives Alone	Count	Percent	Bar
No	23	58%	
Yes	17	42%	
Unknown	6		

Organization	Count	Percent	Bar
MAC Inc	46	100%	

Participant County	Count	Percent	Bar
Wicomico, MD	40	87%	
Somerset, MD	3	7%	
Worcester, MD	2	4%	
Suffolk City, VA	1	2%	

Payment Source	Count	Percent	Bar
Not reported	46	100%	

People in Household	Count	Percent	Bar
1	17	42%	
2	14	35%	
3	5	12%	
4	3	8%	
5	1	2%	
Unknown	6		

Virtual Workshop	Count	Percent	Bar
No	9	100%	
Unknown	37		

Living Well with High Blood Pressure
July 1, 2019 - June 30, 2020

Number of workshops: 5

Average participants per workshop: 9.2
Number of participants: 46
Participants with attendance data: 46
Completers: 46 of 46
Number who are caregivers: 11 of 39 (28%)

[Control]Jan 5, 20—New Life Seventh Day Adventist Church
[Control]Jan 5, 20—Park Seventh Day Adventist Church
[Control]Jan 15, 20—Pine Bluff Village Apartments
[Control]Mar 9, 20—MAC Inc

Age	Count	Percent	Bar
0-44	1	2%	
50-54	2	5%	
55-59	1	2%	
60-64	1	2%	
65-69	10	25%	
70-74	12	30%	
75-79	6	15%	
80-84	3	8%	
85-89	4	10%	
Unknown	6		

Caregiver	Count	Percent	Bar
No	28	72%	
Yes	11	28%	
Unknown	7		

Chronic Condition	Count	Percent	Bar
Hypertension	26	72%	
Diabetes	21	58%	
Depression or Mental Illness	11	31%	
Arthritis	10	28%	
Stroke	6	17%	
Heart Disease	5	14%	
Lung Disease	5	14%	
Chronic Pain	5	14%	
Cancer	4	11%	
Osteoporosis	3	8%	
Alzheimer's	2	6%	
Other	5	14%	
Unknown	8		

Completers	Count	Percent	Bar
No	46	100%	

Condition Count	Count	Percent	Bar
Multiple chronic conditions	26	68%	
One chronic condition	10	26%	
No chronic conditions	2	5%	
Unknown	8		

Disabilities	Count	Percent	Bar
Limited Phy/Men/Emotial	11	24%	

Education	Count	Percent	Bar
Completed High School	18	46%	
Some College	13	33%	
Completed College	6	15%	
Some High School	2	5%	
Unknown	7		

Ethnicity/Race	Count	Percent	Bar
White/Caucasian	22	55%	
Black or African American	16	40%	
American Indian or AK Native	3	8%	
Hispanic/Latino	1	2%	
Unknown	6		

GDM	Count	Percent	Bar
No	33	72%	

Gender	Count	Percent	Bar
Female	33	73%	
Male	12	27%	
Unknown	1		

How Did You Hear	Count	Percent	Bar

Not reported	46	100%	

Impacted by COVID-19	Count	Percent	Bar
No	9	100%	
Unknown	37		

Insurance	Count	Percent	Bar
Medicare Part B ("Regular" Medicare)	35	97%	
Medicaid	11	31%	
Unknown	10		

Lives Alone	Count	Percent	Bar
No	23	58%	
Yes	17	42%	
Unknown	6		

Organization	Count	Percent	Bar
MAC Inc	46	100%	

Participant County	Count	Percent	Bar
Wicomico, MD	40	87%	
Somerset, MD	3	7%	
Worcester, MD	2	4%	
Suffolk City, VA	1	2%	

Payment Source	Count	Percent	Bar
Not reported	46	100%	

People in Household	Count	Percent	Bar

1	17	42%	
2	14	35%	
3	5	12%	
4	3	8%	
5	1	2%	
Unknown	6		

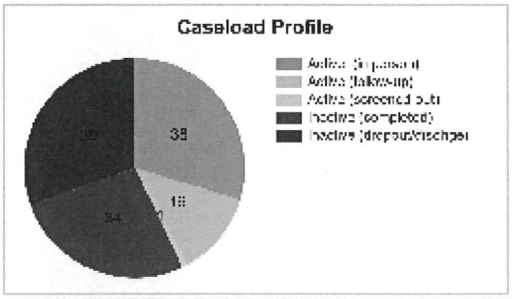
Virtual Workshop	Count	Percent	Bar
No	9	100%	
Unknown	37		

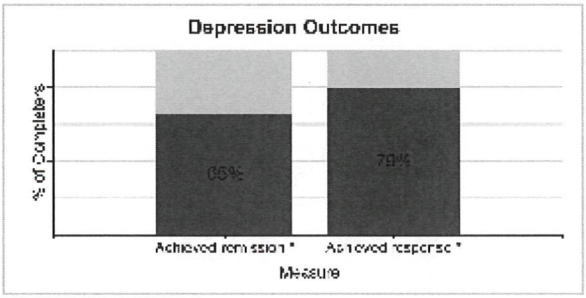
PEARLS Program Overview

MAC, Inc.

For period 7/1/2019 - 6/30/2020

For Counselor: -All Counselors-





Caseload Profile *	128	
Referrals (any status)	0	0%
Not yet screened	*0*	*0%*
Active	55	43%
Having in-person sessions	*38*	*69%*
Completed and having follow-up calls	*17*	*31%*
Screened out but still active	1	1%
Inactive	73	57%
Completed	*34*	*47%*
Screened out in Telephone Screen or at Baseline session	*0*	*0%*
Disenrolled or dropped out or inactivated before screening	*39*	*53%*
New this period	128	100%
Participants with 6 or more sessions to date	49	38%

Outcomes* for participants who completed a final session during this period

	N **	Baseline		Final	
Depression (PHQ9)					
Total Score, mean (SD)	*45*	12.1	(5.8)	3.5	(3.6)
Major or Minor Depression, %		36	80%	8	18%
Achieved Response		-	-	34	79%
Achieved Remission		-	-	28	65%
Self-Rated Health	*34*	19	56%	19	56%
Social Activity	*34*	18	53%	24	71%
Physical Activity					
RAPA meets goal	*21*	1	5%	1	5%
Weekly activity	*21*	13	62%	15	71%
Strength or Flex	*21*	11	52%	7	33%
Pleasant Activity	*30*	27	90%	27	90%

*** Definitions on page 2. **# of completers, active or inactive, who have responses at both baseline and final session**

Attachment C – Community Wellness Team Data

Community Wellness Summary FY 2020

	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020- June 2020
Sick Visits	0	0	0	0	0	0	0	0	**
Screenings	86	100	156	70	98	43	67	77	**
# of outings	15	17	16	11	21	17	21	20	**
Screening events	5	3	5	4	13	3	3	1	**

Outings are 5 days per week, unless we have a down day for maintenance, bad weather, or holiday.

Please note that for March through June, there were no health screenings performed due to COVID-19. Instead, our team performed COVID testing during this time. Please see separate report for those statistics.

Attachment D –
Smith Island
Telemedicine Statistics

SMITH ISLAND TELEMEDICINE FY20 STATISTICS

- Total patients: 184
- Medication refills: 18
- Telehealth visits: 46 (These were with Tammy Walbert, as well as other providers)
- Office: 32 (these are patients that have come into the clinic to see Janet)
- Lab: 14 (patients she has drawn labs for; processed at McCready lab)
- Community BP: 27 (patients she has done BP checks for in her community)

Attachment E – Peninsula Regional SWIFT Data

FY 20 SWIFT Roster

Report Ran: 10/20/2020

CRISP Pre/Post Analysis- Patient Detail
July 1, 2019 through June 30, 2020
n= 42 participants

Visits

Visit Type	Pre	Post	% Reduction	# Reduction
ED	205	102	-50%	103
IP	83	32	-61%	51
OBS > 23	16	6	-63%	10
OP	84	70	-17%	14
Grand Total	388	210	-46%	178

Is PAU	Pre	Post	% Reduction	# Reduction
No	349	195	-44%	154
Yes	39	15	-62%	24
Grand Total	388	210	-46%	178

Is a Readmission Index V	Pre	Post	% Reduction	# Reduction
No	370	206	-44%	164
Yes	18	4	-78%	14
Grand Total	388	210	-46%	178

Is PQI	Pre	Post	% Reduction	# Reduction
No	366	204	-44%	162
Yes	22	6	-73%	16
Grand Total	388	210	-46%	178

Charges

Visit Charges	Pre	Post	% Reduction	$ Reduction
ED	$ 177,265	$ 90,222	-49%	$ 87,043
IP	$ 1,251,624	$ 732,007	-42%	$ 519,617
OBS > 23	$ 86,931	$ 43,016	-51%	$ 43,914
OP	$ 211,326	$ 123,433	-42%	$ 87,893
Grand Total	$ 1,727,146	$ 988,679	-43%	$ 738,467

PAU Charges	Pre	Post	% Reduction	$ Reduction
No	$ 1,230,652	$ 766,401	-38%	$ 464,251
Yes	$ 496,494	$ 222,278	-55%	$ 274,216
Grand Total	$ 1,727,146	$ 988,679	-43%	$ 738,467

Readmission Charges	Pre	Post	% Reduction	$ Reduction
No	$ 1,374,812	$ 931,401	-32%	$ 443,411
Yes	$ 352,334	$ 57,278	-84%	$ 295,056
Grand Total	$ 1,727,146	$ 988,679	-43%	$ 738,467

PQI Charges	Pre	Post	% Reduction	$ Reduction
No	$ 1,484,462	$ 925,249	-38%	$ 559,213
Yes	$ 242,684	$ 63,430	-74%	$ 179,254
Grand Total	$ 1,727,146	$ 988,679	-43%	$ 738,467

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Attachment F – Peninsula Regional Remote Patient Monitoring Data

FY 20 Remote Patient Monitoring Roster

Report Ran: 10/19/2020

CRISP Pre/Post Analysis- Patient Detail
June 1, 2019 through June 30, 2020*
n= 125 patients

CRISP TidalHealth.

Visits

Visit Type	Pre RPM	Post RPM	% Reduction	# Reduction
ED	145	57	-61%	88
IP	207	111	-46%	96
OBS > 23	39	14	-64%	25
OP	383	269	-30%	114
Grand Total	774	451	-42%	323

Charges

Visit Charges	Pre RPM	Post RPM	% Reduction	$ Reduction
ED	$ 171,397	$ 69,658	-59%	$ 101,738
IP	$ 3,522,645	$ 2,713,955	-23%	$ 808,691
OBS > 23	$ 246,294	$ 75,900	-69%	$ 170,394
OP	$ 481,146	$ 514,220	7%	$ (33,074)
Grand Total	$ 4,421,482	$ 3,373,733	-24%	$ 1,047,749

Is PAU	Pre RPM	Post RPM	% Reduction	# Reduction
No	665	384	-42%	281
Yes	109	67	-39%	42
Grand Total	774	451	-42%	323

PAU Charges	Pre RPM	Post RPM	% Reduction	$ Reduction
No	$ 2,937,013	$ 2,093,652	-29%	$ 843,360
Yes	$ 1,484,469	$ 1,280,081	-14%	$ 204,388
Grand Total	$ 4,421,482	$ 3,373,733	-24%	$ 1,047,749

Is a Readmission Index \	Pre RPM	Post RPM	% Reduction	# Reduction
No	739	438	-41%	301
Yes	35	13	-63%	22
Grand Total	774	451	-42%	323

Readmission Charges	Pre RPM	Post RPM	% Reduction	$ Reduction
No	$ 3,847,526	$ 3,149,012	-18%	$ 698,513
Yes	$ 573,956	$ 224,721	-61%	$ 349,235
Grand Total	$ 4,421,482	$ 3,373,733	-24%	$ 1,047,749

Is PQI	Pre RPM	Post RPM	% Reduction	# Reduction
No	697	418	-40%	279
Yes	77	33	-57%	44
Grand Total	774	451	-42%	323

PQI Charges	Pre RPM	Post RPM	% Reduction	$ Reduction
No	$ 3,655,128	$ 2,704,178	-26%	$ 950,950
Yes	$ 766,354	$ 669,556	-13%	$ 96,799
Grand Total	$ 4,421,482	$ 3,373,733	-24%	$ 1,047,749

June 2020 was the go live date of RPM, therefore its included in this fiscal analysis. 13 months total.

The following data analysis consists of 125 patients who received at least 1 day of Remote Patient Monitoring services during the dates of June 2019 through June 2020.

The data analysis shows Maryland hospital utilization and charges for 12 months before and up to 12 months after the Remote Patiet Monitoring enrollment date. Data is analyized at 1,3,6 and 12 month increments.

Case Mix Data is Through: 08/31/2020

ENS Panels Last Upated: 10/08/2020

Data Source:

- Panel Infomration provided to CRISP by ENS.
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals. Individual patients identified using CRISP EID.
- Depending on the number of months selected, some particpants might not be included in the analysis if they do not have data for the entire period before or after the anaylsis.
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 month before Feb 28th is Jan 28th and 1 month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Anaylsis data.

Attachment G – Nutrition/Diabetes Education and Support Group Information

Hours include planning hours, driving time and actual event hours

Presentations and Heath Fairs:
8/25/19 Fresh Start Back To School Event at the Civic Center 7 hours and 50 people attended
9/26/19 Westside Wellness Fair, Sharptown, MD - 10 hours and 30 people attended
9/10/19 Diabetes School Nurses Update at PRMC - 14 hours and 65 attended
10/25/19 Delmarva Life WBOC Interview - 3 hours and ?? TV viewers
12/13/19 Save Our Kids at the Salisbury Moose Lodge - 6 hours and 35 people
1/30/2020 Healthy Eating for Diabetes and Metabolic syndrome at the Wicomico County Library -7 hours and 7 people
8/8/20 Ore Stop Shop by Tri Community Mediation group at Word of Life Haitian Church on Jersey Road in Salisbury - 5 hours and 45 people

Adult Diabetes Support groups: 4 hours each
9/ 9 /19 30 people
10/14/19 25 people
12/9/19 26 people
1/12/20 12 people
2/25/20 25 people
3/9/20 13 people

Diabetes Awareness Event 11/11/19 18 hours and 145 people

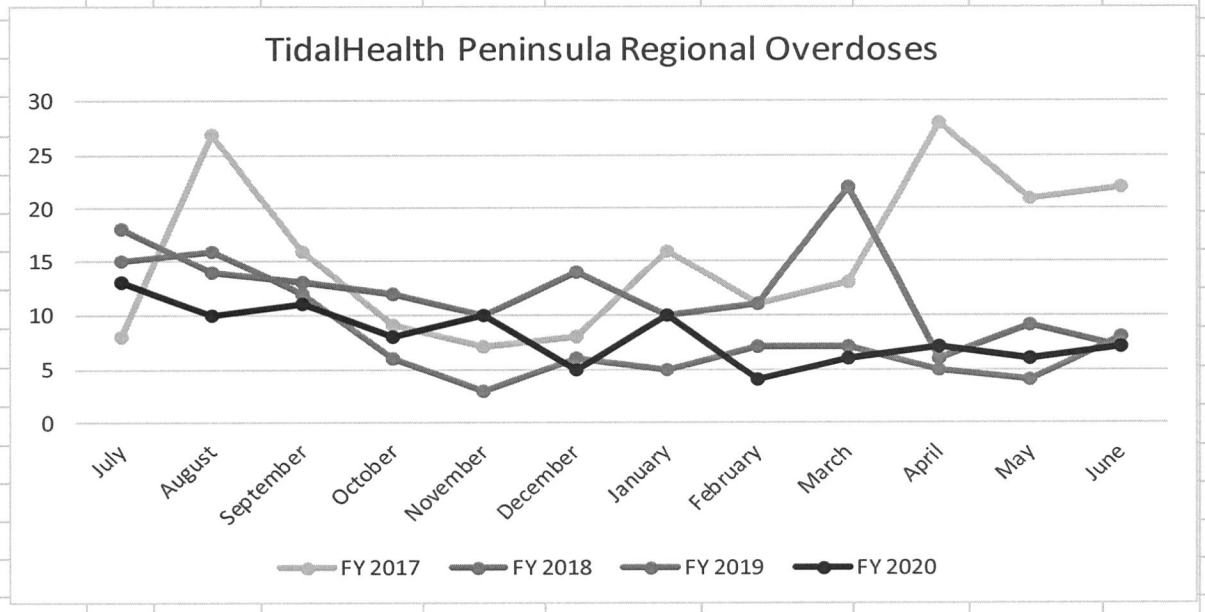
Kids and Teens Diabetes Support Group:
11/5/19 14 hours 16 people
1/21/20 4 hours 6 people

Local Meetings:
Live Healthy Wicomico 3 hours each
9/16/19
11/18/19
3/16/20

Preceptor for UMES Dietetic Internship Program:
20 hours (6 interns) attending meet and greet, journal clubs, case studies. Open house and reviewing competencies

Attachment H – Peninsula Regional Emergency Department Heroin Overdose Data

Fiscal Year	July	August	September	October	November	December	January	February	March	April	May	June	Total
FY 2014	6	2	3	3	8	2	6	6	8	4	4	16	68
FY 2015	6	4	6	11	5	6	15	7	7	1	8	6	82
FY 2016	4	5	15	17	11	4	35	24	44	45	23	18	245
FY 2017	8	27	16	9	7	8	16	11	13	28	21	22	186
FY 2018	18	14	13	12	10	14	10	11	22	6	9	7	146
FY 2019	15	16	12	6	3	6	5	7	7	5	4	8	94
FY 2020	13	10	11	8	10	5	10	4	6	7	6	7	97
FY 2021	11	11											22



Attachment I – Wicomico County Health Department C.O.A.T. Data

COMMUNITY OUTREACH ADDICTIONS TEAM (COAT)
Wicomico County Health Department

FY 2020 COAT Data Evaluation Measures						
	Total # Outreach Services	**Unduplicated # Served***	**# Served Reporting History of Opioid Use***	**# Linked to Treatment***	**6 Month Follow-Up of % Remaining in Recovery****	**# of Navigation Services Provided***
Wicomico County Residents		177 (74%)*	85 (48%)*	94 (53%)*	**	
Non-Wicomico Residents		63 (26%) *	28 (44%)*	25 (40%)*	**	
Total	1,413	240*	113 (47%)*	119 (50%)*	**	260*

* Data for the categories marked, do not include data from July 1, 2019 - December 31, 2019 due to a change in data collection and data operationalization.

**This measure assesses progress of individuals served the prior fiscal year. Data collection began January 2020. Six months of data will be reported in the FY21 report.

NOTES

• Total # of Outreach Services is a total of all phone calls made (whether answered or not), and face-to-face contact (whether home or not).

• Unduplicated # Served from July 1, 2019 - December 31, 2019 used a different method to calculate # served. The # served based on this method is **148** for Wicomico County Residents and **59** for Non Wicomico Residents. Please be cautioned that some of these numbers duplicate the numbers reported above using the revised data collection and data operationalization.

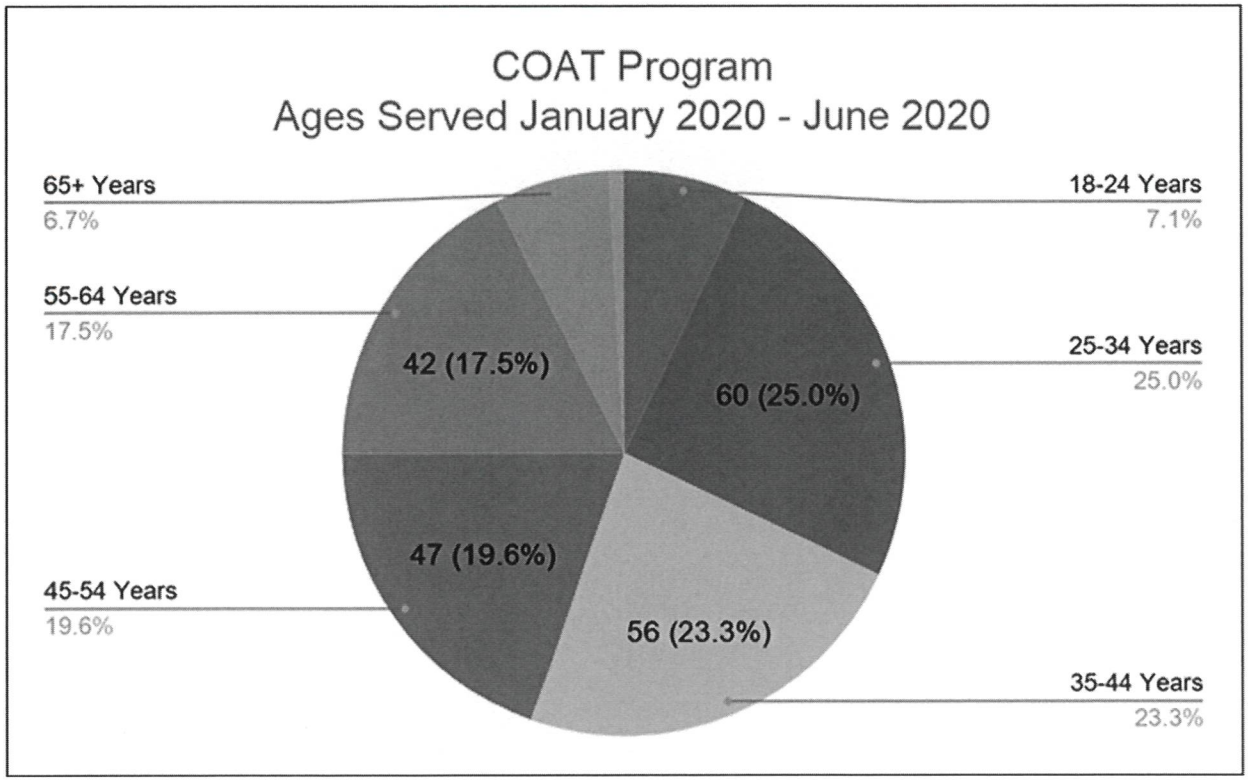
FY2020 COAT Navigation Services*			
Type of Assistance	**# Served by Assistance Type**	**# of Services Provided**	**Average # of Services Per Person**
Insurance Assistance	9	10	1.11
Transportation	54	72	1.33
Food Assistance	0	0	N/A
Housing	19	21	1.11
Financial Assistance	6	6	1.00
Medical Linkage/Referrals	8	11	1.38
Other ***(e.g. Support Meeting Schedule, Resource Information, Treatment Resources, etc.)***	105	140	1.33

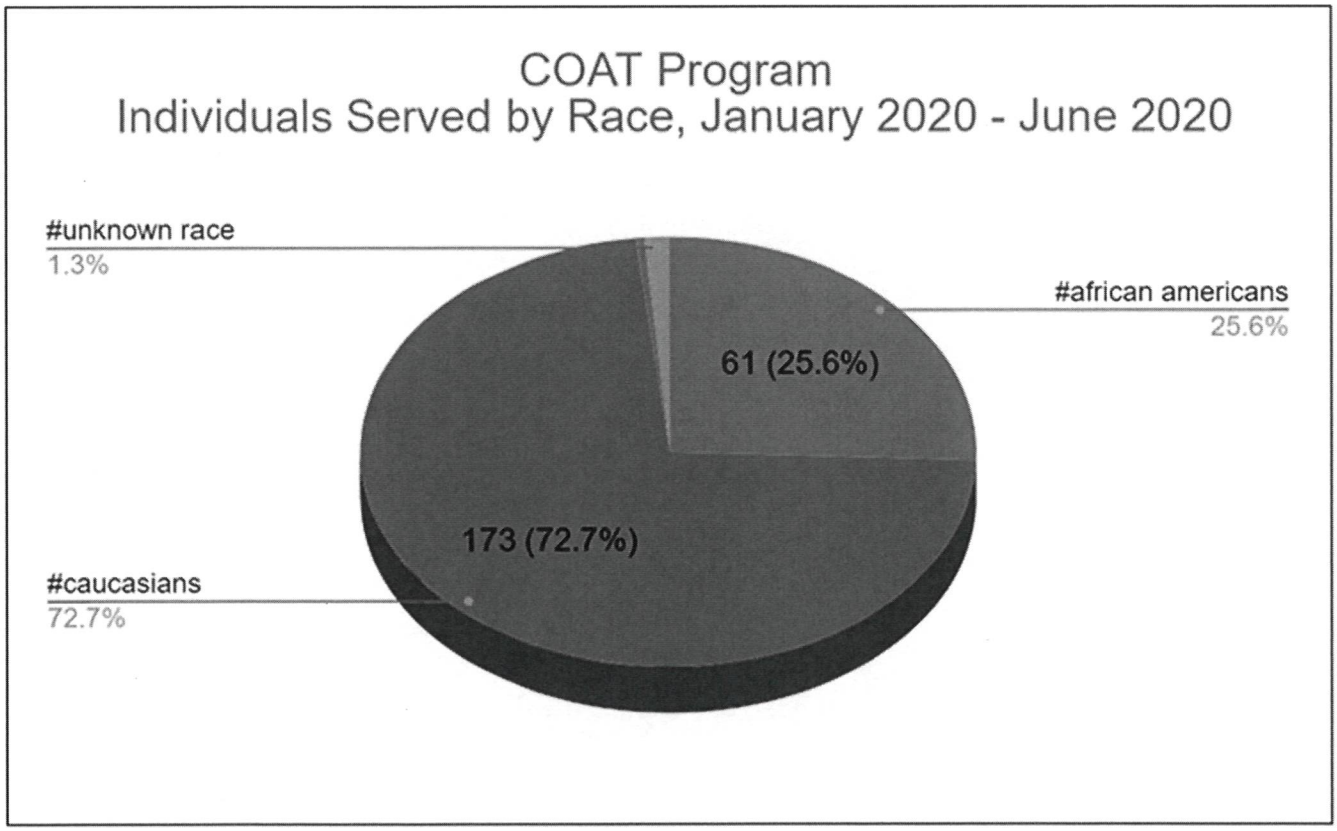
*Data does not include data from July 1, 2019 - December 31, 2019 due to a change in data collection and data operationalization.

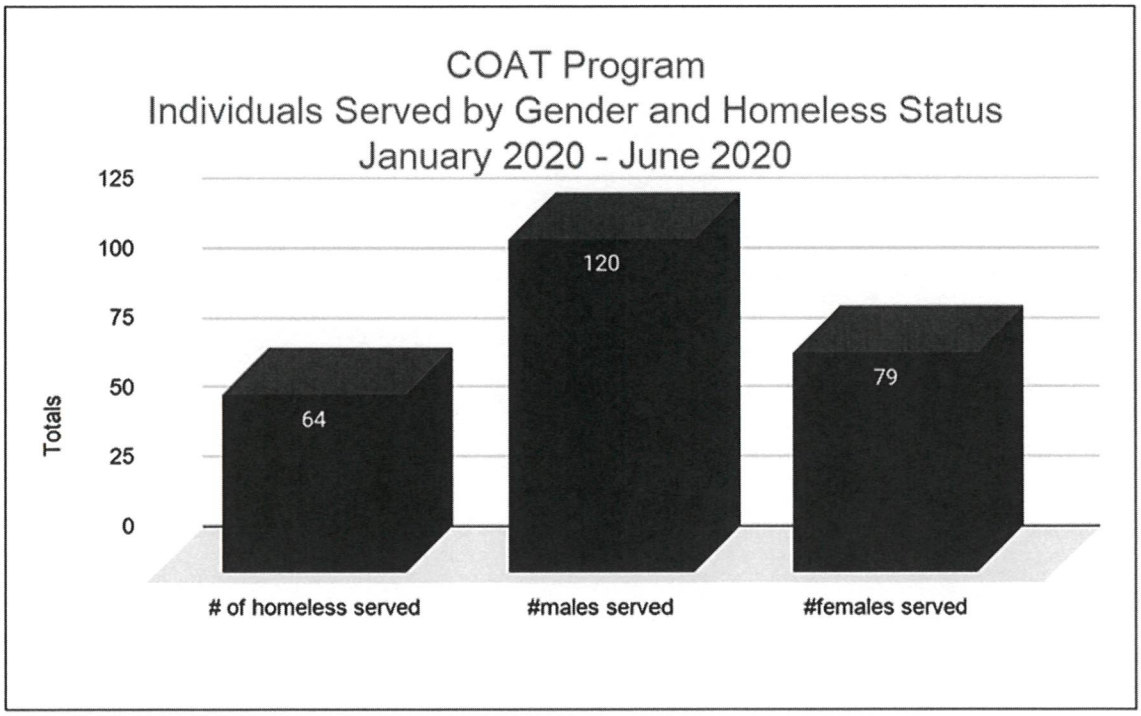
NOTES

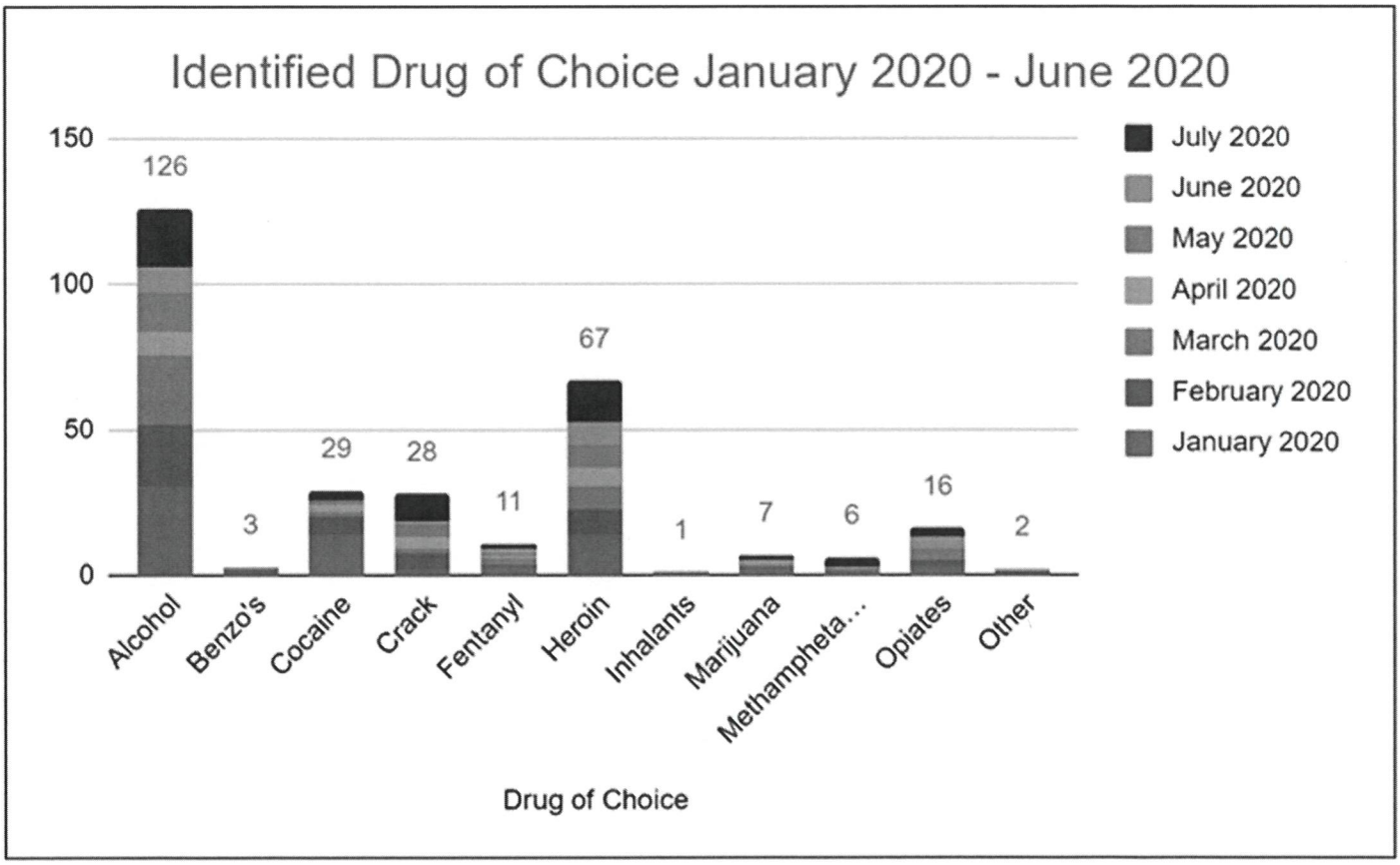
• # Served by Assistance Type is the unduplicated number of individuals receiving the type of service. However, # served may be duplicated across the types of assistance, as an individual may receive more than one type of assistance.

• # of Service Provided is the total # of times staff provided the service, which may include providing individuals with the same type of assistance multiple times.


COAT Program
Ages Served January 2020 - June 2020
65+ Years
6.7%
18-24 Years
7.1%
55-64 Years
17.5%
25-34 Years
25.0%
42 (17.5%)
60 (25.0%)
47 (19.6%)
45-54 Years
19.6%
56 (23.3%)
35-44 Years
23.3%


COAT Program
Individuals Served by Race, January 2020 - June 2020
#unknown race
1.3%
#african americans
25.6%
61 (25.6%)
173 (72.7%)
#caucasians
72.7%


COAT Program
Individuals Served by Gender and Homeless Status
January 2020 - June 2020
Totals
125
100
75
50
25
0
64
120
79
# of homeless served
#males served
#females served


Identified Drug of Choice January 2020 - June 2020
150
100
50
0
126
3
29
28
11
67
1
7
6
16
2
Alcohol
Benzo's
Cocaine
Crack
Fentanyl
Heroin
Inhalants
Marijuana
Methampheta...
Opiates
Other
Drug of Choice
July 2020
June 2020
May 2020
April 2020
March 2020
February 2020
January 2020

Attachment J – Opioid Intervention Team (O.I.T.) and Somerset County Opioid United Team (S.C.O.U.T.) Data

Opioid Teams

Somerset County Health Department & Wicomico County Health Department

FY 2020 Somerset County Opioid United Team (SCOUT) and Wicomico County Opioid Intervention Team (OIT) Data Evaluation Measures		
	Somerset	**Wicomico**
# of Individuals Narcan Trained by SCOUT/OIT	135	184
# of Individuals Exposed to Educational Messaging	4,896	329,034
# of Prescription Drug Deactivation Bags Distributed	100	250
# of Educational/Training Events	13	53
# of SCOUT/OIT Meetings Held	11	26
# of Informational Campaigns	10	4
# of Schools with Go Purple Clubs	0	8
# of School Based Educational Go Purple Events	3	23
# of Emergency Room Opioid Overdoses	12*	119
# of Salisbury Fire Department Overdose Calls	N/A	140
*Number is based on calendar year vs. fiscal year.		

Attachment K – Richard A. Henson Cancer Institute Community Benefit Report Tracker Data

Gentle Exercise Group

Activity Date	Activity ID	Activity Name	Ben Category	Encounters	Screened	Referred	Total Staff	Staff Hours	Cancer	Activity Description
7/11/2019	2527	Gentle Exercise Group-OP2522	A12=Self Help	2	0	0	3	3	TRUE	exercise group for cancer patients who are going through, or have been through cancer treatments to help with strength, flexibility and stamina
7/18/2019	2530	Gentle Exercise Group-OP2530	A10=Community Educati	3	0	0	3	3	TRUE	exercise group in partnership with PRMC Adult Fitness for conditioning and strengthening; reminders to staff/doctors to discuss with pats and refer as appropriate
8/1/2019	2539	Gentle Exercise Group-OP2539	A10=Community Educati	3	0	0	3	3	TRUE	group for strengthening and conditioning in partnership with Adult Fitness; met with several prospective pts to encourage participation.
8/8/2019	2541	Gentle Exercise Group- OP2541	A12=Self Help	4	0	0	3	3	TRUE	exercise class for patients with cancer to keep up stamina , increase strength and balance
8/15/2019	2555	Gentle Exercise Group--OP2551	A10=Community Educati	5	0	0	3	3	TRUE	Exercise group for cancer patients in partnership with Adult Fitness; well received by patients who attend
8/22/2019	2566	Gentle Exercise Group-OP2566	A12=Self Help	1	0	0	3	3	TRUE	Exercise group for cancer patients to build strength, endurance and flexibility. Attendance ebbs and flows especially during the summer. Physicians are increasing there referrals to this group when they see there patients
8/29/2019	2631	Gentle Exercise Group-OP2611	A10=Community Educati	3	0	0	3	3	TRUE	weekly exercise group in partnership with PRMC Adult Fitness; attendance waivers.
9/5/2019	2647	Gentle Exercise-OP2647	A12=Self Help	2	0	0	3	3	TRUE	An exercise class for cancer patients to increase flexibility, strength and stamina.
9/12/2019	2736	Gentle Exercise Group--OP2735	A10=Community Educati	3	0	0	3	3	TRUE	Weekly exercise group in partnership with PRMC Adult Fitness; attendance remains limited.
9/19/2019	2742	Gentle Exercise Group--OP2740	A10=Community Educati	1	0	0	2	2	TRUE	Weekly exercise group in partnership with PRMC Adult Fitness. Attendance is down--regular attendees with variety of appointments. Drs/staff encouraged to refer patients; listed on lobby white board; discussed with new pts.
10/10/2019	2787	Gentle Exercise Group-OP2783	A10=Community Educati	1	0	0	2	2	TRUE	weekly exercise group in partnership with PRMC Adult Fitness; facilitator on vacation this week/attendance low
10/17/2019	2804	Gentle Exercise-OP2791	A10=Community Educati	1	0	0	2	2	TRUE	Weekly exercise group for cancer patients in partnership with PRMC Adult Fitness; attendance has dropped this month (follow up with regular attendees indicate illness/other commitments)
10/24/2019	2805	Gentle Exercise Group-Ocean Pines2805	A10=Community Educati	1	0	0	2	2	TRUE	weekly exercise group for cancer patients in partnership with PRMC Adult Fitness; attendance is down/recruitment efforts ongoing with clinic staff
10/31/2019	2812	Gentle Exercise Group-OP2811	A12=Self Help	1	0	0	3	3	TRUE	Exercise group to benefit cancer patients.
11/7/2019	2820	Gentle Exercise Group-OP2817	A12=Self Help	1	0	0	3	3	TRUE	Weekly exercise group for cancer patients
11/15/2019	2839	Gentle Exercise Group-OP2839	A10=Community Educati	2	0	0	3	3	TRUE	Weekly exercise for cancer patients in partnership with PRMC Adult Fitness; attendance fluctuates due to illness, appointments. continuing efforts for ongoing recrutiment
12/5/2019	2863	Gentle Exercise Group-OP2861	A10=Community Educati	1	0	0	2	2	TRUE	weekly exercise group in partnership with PRMC Adult Fitness; poorly attended past several weeks; pts state holidays and illness have kept them away; have talked with several new pts to encourage them to attend
12/19/2019	2894	Gentle Exercise Group--OP2894	A10=Community Educati	1	0	0	2	2	TRUE	exercise group in partnership with PRMC Adult Fitness; attendance low. Have talked to patients who generally attended in the past--appointments/vacations, etc; recruitment for new patients ongoing
1/2/2020	2895	Gentle Exercise Group-OP2895	A10=Community Educati	2	0	0	2	2	TRUE	Exercise Group in partnership with PRMC Adult Fitness; attendance is variable but those who attend remark positively on the value of the group.
1/9/2020	2898	Gentle Exercise Group-OP2896	A10=Community Educati	3	0	0	2	2	TRUE	weekly exercise group for patients in partnership with PRMC Fitness.
1/16/2020	2906	Gentle Exercise Group-OP2906	A10=Community Educati	3	0	0	2	2	TRUE	Weekly exercise group in partnership with PRMC Adult Fitness; continuing recruitment efforts with doctors and staff.
1/23/2020	2916	Gentle Exercise-OCP2916	A10=Community Educati	1	0	0	2	2	TRUE	Weekly exercise group in partnership with PRMC Adult Fitness; attendance variable; continuing recruitment (appealed to clinical staff)
2/6/2020	2953	Gentle Exercise Group-OCP2949	A10=Community Educati	2	0	0	2	2	TRUE	weekly exercise group; continuing efforts to recruit; group is listed on website and in local papers
2/13/2020	2954	Gentle Exercise Group-OCP2954	A10=Community Educati	1	0	0	2	2	TRUE	weekly exercise group for cancer patients; attendance variable. ongoing efforts to recruit--flyer with pt information; reminders to staff to recommend/refer
2/20/2020	2964	Gentle Exercise Group-OCP2964	A10=Community Educati	1	0	0	2	2	TRUE	Weekly exercise group for patients; attendance is down. Continuing efforts to recruit. Follow up with patients who generally attend reveal they have had conflicts, illness.
2/27/2020	2970	Gentle Exercise Group-OCP2970	A10=Community Educati	1	0	0	2	2	TRUE	Weekly exercise group in partnership with PRMC Fitness. Continuing efforts to promote; encouraged staff to refer pts.
3/5/2020	2982	Gentle Exercise Group-OCP2982	A10=Community Educati	1	0	0	2	2	TRUE	Weekly exercise group in partnership with PRMC Adult Fitness. Attendance is low/different people each week.
				33	0	0	48	48		

WSW Stitch Therapy Support Group

Activity Date	Activity ID	Activity Name	Ben Category	Encounters	Screened	Referred	Total Staff	Staff Hours	Cancer	Activity Description
7/8/2019	2517	WSW Stitch Therapy Group-OP2516	A10=Community Educatic	3	0	0	2	2	TRUE	monthly knitting/crocheting group for networking and fellowship, in partnership with WSW but not limited to patients with breast cancer. Group is small; efforts ongoing for recruitment. Women who attend enjoy it.
8/12/2019	2540	Stitch Therapy-OP2540	A11=Support Group	2	0	0	2	2	TRUE	A group led by WSW facilitator for patients to get together and offer support while learning to knit/crochet. Most of the attendees are breast cancer patients or survivors.
9/9/2019	2679	WSW Stitch Therapy Group-OP2679	A10=Community Educatic	3	0	0	2	2	TRUE	fellowship/social group in partnership with WSW; met with facilitator this month to discuss strategies to recruit new members/may attend support group to share
10/14/2019	2776	WSW Stitch Therapy Group--OP2775	A11=Support Group	5	0	0	1	1	TRUE	networking/support group in partnership with WSW; women in the group knit together while sharing experiences--they also donate completed projects to patients; attendance
11/11/2019	2837	WSW Stitch Therapy Group-OP2822	A11=Support Group	3	0	0	2	2	TRUE	Fellowship of women who have been affected by cancer getting together, knitting, crocheting and sharing. This group also works on hats, scarfs, etc for our patients.
1/13/2020	2899	WSW Breast Cancer Support Group2899	A10=Community Educatic	3	0	0	1	1	TRUE	Yarn group in partnership with WSW; group now open to anyone to encourage interest/participation.
2/10/2020	2937	WSW Stitch Therapy--OCP2933	A10=Community Educatic	4	0	0	1	1	TRUE	networking support group providing fellowship; partnership with WSW.
1/13/2020	2938	WSW Stitch Threapy Group-OCP2938	A10=Community Educatic	2	0	0	1	1	TRUE	knitting/crochet group in partnership with WSW; participants network and provide support to one another. Facilitator contacted with names of 2 possible new members.
3/9/2020	3001	WSW Stitch Therapy Group-OCP3000	A10=Community Educatic	4	0	0	1	1	TRUE	Monthly knitting group for any pt with cancer in partnership with WSW. Pts also network and enjoy fellowship while engaged in activity
				29	0	0	13	13		

Seated Yoga

Activity Date	Activity ID	Activity Name	Ben Category	Encounters	Screened	Referred	Total Staff	Staff Hours	Cancer	Activity Description
7/3/2019	2585	Healing Seated Yoga for Cancer patients and caregivers2585	A12=Self Help	9	0	0	1	0.3	TRUE	Weekly gentle yoga class for cancer patients and their caregivers
7/10/2019	2586	Healing seated yoga for cancer patients and survivors2586	A12=Self Help	8	0	0	1	0.3	TRUE	Weekly seated yoga class for cancer patients and caregivers
7/17/2019	2587	Healing seated yoga for cancer patients and their caregivers2587	A12=Self Help	3	0	0	1	0.3	TRUE	Seated healing yoga class for cancer patients and caregivers
7/24/2019	2588	Healing seated yoga for cancer patients and caregivers2588	A12=Self Help	4	0	0	1	0.3	TRUE	Weekly seated healing yoga class for cancer patients and caregivers
7/31/2019	2589	Seated healing yoga for cancer patients and caregivers2589	A12=Self Help	5	0	0	1	0.3	TRUE	Weekly seated healing yoga class for cancer patients and their caregivers
8/7/2019	2750	Healing Seated Yoga2749	A12=Self Help	3	0	0	1	1	TRUE	Seated yoga class for cancer pts and survivors
8/14/2019	2751	Healing seated yoga2751	A12=Self Help	7	0	0	1	1	TRUE	seated yoga for cancer patients and families
8/21/2019	2752	Healing seated yoga2752	A12=Self Help	8	0	0	1	1	TRUE	seated yoga for cancer patients and caregivers
8/28/2019	2753	healing seated yoga for cancer patients and caregivers2753	A12=Self Help	7	0	0	1	1	TRUE	Seated yoga class for cancer patients and their caregivers
9/4/2019	2791	Seated Healing Yoga2789	A12=Self Help	9	0	0	1	1	TRUE	Seated healing yoga exercise instructed by certified instructor for cancer patients to engage in physical activity
9/11/2019	2792	Seated Healing Yoga2792	A12=Self Help	6	0	0	1	1	TRUE	Seated healing yoga exercise instructed by certified instructor for cancer patients to engage in physical activity
9/18/2019	2793	Seated Healing Yoga2793	A12=Self Help	10	0	0	1	1	TRUE	Seated healing yoga exercise instructed by certified instructor for cancer patients to engage in physical activity
9/25/2019	2794	Seated Healing Yoga2794	A12=Self Help	8	0	0	1	1	TRUE	Seated healing yoga exercise instructed by certified instructor for cancer patients to engage in physical activity
10/2/2019	2841	Seated Healing Yoga 2841	A12=Self Help	8	0	0	1	1	TRUE	A session of healing yoga for patients with cancer and survivors
10/9/2019	2842	Seated Healing Yoga2842	A12=Self Help	11	0	0	1	1	TRUE	A session of healing yoga for patients with cancer and survivors
10/16/2019	2843	Seated Healing Yoga2843	A12=Self Help	4	0	0	1	1	TRUE	A session of healing yoga for patients with cancer and survivors
10/23/2019	2844	Seated Healing Yoga2844	A12=Self Help	7	0	0	1	1	TRUE	A session of healing yoga for patients with cancer and survivors
10/30/2019	2845	Seated Healing Yoga2845	A12=Self Help	6	0	0	1	1	TRUE	A session of healing yoga for patients with cancer and survivors
3/4/2020	3050	Healing Seated Yoga3050	A12=Self Help	10	0	0	1	0.3	TRUE	Weekly seated yoga classes for cancer patients and caregivers
3/4/2020	3051	Healing Seated Yoga3051	A12=Self Help	10	0	0	1	0.3	TRUE	Weekly seated yoga class for cancer survivors and patients
3/11/2020	3052	Healing Seated Yoga3052	A12=Self Help	11	0	0	1	0.3	TRUE	Weekly seated yoga class for cancer survivors and caregivers
5/20/2020	3062	Healing Seated Yoga for Cancer Survivors and Caregivers3062	A12=Self Help	4	0	0	1	4	TRUE	Weekly seated yoga class for cancer survivors and caregivers held via conference call due to Covid 19 restrictions
5/27/2020	3063	Healing Seated Yoga for Cancer Survivors and Caregivers3063	A11=Support Group	5	0	0	1	0.3	TRUE	Weekly seated yoga classes for cancer survivors and caregivers
6/10/2020	3068	Healing Yoga for Cancer Survivors and Caregivers 3068	A12=Self Help	5	0	0	1	0.3	TRUE	Weekly seated yoga classes for cancer survivors and caregivers held via conference call due to Covid 19 Restrictions
6/17/2020	3069	Healing Seated Yoga for Cancer Survivors and Caregivers3069	A12=Self Help	6	0	0	1	0.3	TRUE	Weekly seated yoga classes for cancer survivors and caregivers held via conference call due to Covid 19 restrictions
6/24/2020	3070	Healing Seated Yoga Classes for Cancer Survivors and CAregivers3070	A12=Self Help	6	0	0	1	0.3	TRUE	Weekly seated yoga classes for cancer survivors and caregivers done via Conference call due to Covid 19 restrictions
				134	0	0	18	18.2		

What's Cooking

Activity Date	Activity ID	Activity Name	Ben Category	Encounters	Screened	Referred	Total Staff	Staff Hours	Cancer	Activity Description
8/13/2019	2759	What's Cooking_2759	A10=Community Educatic	8	0	0	1	1	TRUE	Educational class for cancer survivors and caregivers centered on healthy eating and cooking demonstration
9/9/2019	2799	What's Cooking_2799	A12=Self Help	7	0	0	1	1	TRUE	A coking class created for cancer patients to learn how to cook meals specific to their special dietary needs.
9/16/2019	2800	What's cooking_2800	A12=Self Help	7	0	0	1	1	TRUE	A coking class created for cancer patients to learn how to cook meals specific to their special dietary needs.
9/23/2019	2801	What's cooking2801	A12=Self Help	7	0	0	1	1	TRUE	Tai chi is a physical activity class taught by a certified instructor for cancer patients to keep them physically active
9/12/2019	2803	What's cooking_2803	A12=Self Help	8	0	0	1	1	TRUE	A cooking class aimed to teacher cancer patients how to cook specific to their special dietary needs.
10/9/2019	2852	What's cooking_2852	A12=Self Help	11	0	0	1	1	TRUE	A class provided to patient and survivors of cancer where they can learn how to make healthy cancer friendly meals.
12/12/2019	2926	What's cooking_2926	A12=Self Help	10	0	0	1	1	TRUE	A class to educate patients on healthy cooking.
2/13/2020	2995	What's cooking_2995	A12=Self Help	15	0	0	1	2	TRUE	A class for cancer patients and survivors to be educated on healthy cooking recipes.
3/5/2020	3053	Living Well-What's Cooking3053	A10=Community Educatic	12	0	0	1	0.3	TRUE	Monthly healthy cooking demonstrations and tastings for cancer survivorsand caregivers
				85	**0**	**0**	**9**	**9.3**		

X

85
7
78

Tai Chi

Activity Date	Activity ID	Activity Name	Ben Category	Encounters	Screened	Referred	Total Staff	Staff Hours	Cancer	Activity Description
7/1/2019	2596	Tai Chi for Cancer patients and caregivers2596	A12=Self Help	6	0	0	1	0.3	TRUE	Weekly gentle tai chi class for cancer patients and caregivers
7/8/2019	2597	Tai Chi for cancer patients and survivors2597	A12=Self Help	4	0	0	1	0.3	TRUE	Weekly tai chi class for cancer patients and caregivers
7/15/2019	2598	Tai Chi class for cancer patients and their families2598	A12=Self Help	7	0	0	1	0.3	TRUE	Weekly tai chi class for cancer patients and caregivers
7/22/2019	2599	Tai Chi for cancer patients and caregivers2599	A12=Self Help	7	0	0	1	0.3	TRUE	Weekly tai chi classes for cancer patients and caregivers
7/29/2019	2600	Tai Chi for cancer patients and caregivers2600	A12=Self Help	8	0	0	1	0.3	TRUE	Weekly tai chi class for cancer patients and caregivers
8/5/2019	2760	Tai Chi for Better Balance2760	A12=Self Help	4	0	0	1	1	TRUE	Weekly tai chi class for cancer survivors and caregivers
8/12/2019	2761	Tai Chi for Better Balance2761	A12=Self Help	6	0	0	1	1	TRUE	Weekly tai chi class for cancer patients and caregivers
8/19/2019	2762	Tai Chi for Better Balance2762	A12=Self Help	8	0	0	1	1	TRUE	Weekly tai Chi class for cancer survivors and caregivers
8/26/2019	2763	Tai Chi for Better Balance2763	A12=Self Help	8	0	0	1	1	TRUE	weekly tai chi class for cancer patients and caregivers
9/30/2019	2802	Tai Chi for Better Balance2802	A12=Self Help	6	0	0	1	1	TRUE	Tai chi is a physical activity class taught by a certified instructor for cancer patients to keep them physically active.
9/23/2019	2801	Tai Chi for Better Balance2801	A12=Self Help	7	0	0	1	1	TRUE	Tai chi is a physical activity class taught by a certified instructor for cancer patients to keep them physically active
9/16/2019	2800	Tai Chi for Better Balance_2800	A12=Self Help	7	0	0	1	1	TRUE	Tai chi is a physical activity class taught by a certified instructor for cancer patients to keep them physically active
9/9/2019	2799	Tai Chi for Better Balance_2799	A12=Self Help	7	0	0	1	1	TRUE	Tai chi is a physical activity class taught by a certified instructor for cancer patients to keep them physically active
10/7/2019	2853	Tai Chi for Better Balance2853	A12=Self Help	6	0	0	1	1	TRUE	A gentle exercise class where patients and survivors can participate in Tai Chi routines which enhance balance and memory.
10/21/2019	2854	Tai Chi for Better Balance2854	A12=Self Help	7	0	0	1	1	TRUE	A gentle exercise class where patients and survivors can participate in Tai Chi routines which enhance balance and memory
10/28/2019	2855	Tai Chi for Better Balance2855	A12=Self Help	8	0	0	1	1	TRUE	A gentle exercise class where patients and survivors can participate in Tai Chi routines which enhance balance and memory
12/2/2019	2927	Tai Chi for Better Balance2927	A12=Self Help	5	0	0	1	1	TRUE	A CSS activity to provide tai chi exercise routine to patients.
12/9/2019	2928	Tai Chi for Better Balance2928	A12=Self Help	3	0	0	1	1	TRUE	A CSS activity to provide tai chi exercise routine to patients.
12/16/2019	2929	Tai Chi for Better Balance2929	A12=Self Help	3	0	0	1	1	TRUE	A CSS activity to provide tai chi exercise routine to patients.
12/30/2019	2930	Tai Chi for Better Balance2930	A12=Self Help	2	0	0	1	1	TRUE	A CSS activity to provide tai chi exercise routine to patients.
3/2/2020	3054	Tai Chi Classes for Cancer Survivors and Caregivers3054	A12=Self Help	13	0	0	1	0.3	TRUE	Weekly tai chi classes for cancer survivors and caregivers
3/9/2020	3055	Tai Chi Classes for Cancer Survivors and Caregivers3055	A12=Self Help	13	0	0	1	0.3	TRUE	Weekly tai chi classes for cancer survivors and caregivers
				145	**0**	**0**	**22**	**17.1**		

145
7
152

Cancer Survivor / Caregiver Support Group

Activity Date	Activity ID	Activity Name	Ben Category	Encounters	Screened	Referred	Total Staff	Staff Hours	Cancer	Activity Description
7/2/2019	2591	Survivor and caregiver group for cancer patients and their families2591	A11=Support Group	3	0	0	1	2.5	TRUE	Weekly support group for cancer patients and their caregivers
7/9/2019	2592	Support group for cancer patients and caregivers2592	A11=Support Group	3	0	0	1	0.3	TRUE	Weekly support group for cancer patients and caregivers
7/23/2019	2594	Survivor and Caregiver Support Group2594	A11=Support Group	3	0	0	1	0.3	TRUE	Weekly support group for cancer patients and their families
7/30/2019	2595	Survivor and Caregiver Support Group2595	A11=Support Group	1	0	0	1	3	TRUE	Weekly monthly support group for cancer patients and caregivers
8/27/2019	2605	Patient_ Survivor_ Caregiver Support Group -OP2594	A11=Support Group	7	0	0	2	3	TRUE	This is a support group where attendees can share their experiences with other who have been affected by cancer.
9/17/2019	2738	Patient_ Survivor_ Caregiver Support Group2738	A11=Support Group	1	0	0	2	2	TRUE	general support group; attendance fluctuates. efforts ongoing to recruit new members.
8/6/2019	2754	Survivor_Caregiver Group2754	A11=Support Group	3	0	0	1	1	TRUE	Weekly support group for cancer patients and caregivers
8/13/2019	2755	Survivor_Caregiver Suport Group2755	A11=Support Group	2	0	0	1	1	TRUE	weekly support group for cancer patients and caregivers
8/20/2019	2756	Survivor_Caregiver group2756	A11=Support Group	3	0	0	1	1	TRUE	weekly support group for cancer patients and caregivers
8/27/2019	2757	Survivor and Caregiver Support Group2757	A11=Support Group	2	0	0	1	1	TRUE	Weekly support group for cancer patients and caregivers
10/15/2019	2777	Patient_ Survivor_ Caregiver Support Group2777	A11=Support Group	4	0	0	1	1.5	TRUE	general support group; attendance variable
9/3/2019	2795	Survivor_Caregiver Support Group2795	A11=Support Group	1	0	0	1	2	TRUE	A group aimed to provide a supportive environment for survivors and caregivers.
9/10/2019	2796	Surivor Caregiver Support Group	A11=Support Group	2	0	0	1	2	TRUE	A group aimed to provide a supportive environment for survivors and caregivers.
9/10/2019	2796	Survivor_Caregiver Support Group2796	A11=Support Group	2	0	0	1	2	TRUE	A group aimed to provide a supportive environment for survivors and caregivers.
9/17/2019	2797	Survivor_Caregiver Support Group2797	A11=Support Group	3	0	0	1	2	TRUE	A group aimed to provide a supportive environment for survivors and caregivers.
9/24/2019	2798	Survivor_Caregiver Support Group2798	A11=Support Group	0	0	0	1	2	TRUE	A group aimed to provide a supportive environment for survivors and caregivers.
10/1/2019	2847	Survivor_Caregiver Support Group2847	A11=Support Group	7	0	0	1	1	TRUE	A support group of survivors. patients, and caregivers to support one another with their diagnosis.
10/8/2019	2848	Survivor_Caregiver Support Group2848	A11=Support Group	3	0	0	1	1	TRUE	A support group of survivors. patients, and caregivers to support one another with their diagnosis.
10/15/2019	2849	Survivor_Caregiver Support Group2849	A11=Support Group	3	0	0	1	1	TRUE	A support group of survivors. patients, and caregivers to support one another with their diagnosis.
10/22/2019	2850	Survivor_Caregiver Support Group2850	A11=Support Group	3	0	0	1	1	TRUE	A support group of survivors. patients, and caregivers to support one another with their diagnosis.
10/29/2019	2851	Survivor_Caregiver Support Group2851	A11=Support Group	3	0	0	1	1	TRUE	A support group of survivors. patients, and caregivers to support one another with their diagnosis.
11/19/2019	2857	Patients_ Survivors and Caregivers Support Group-OP2842	A11=Support Group	1	0	0	2	2	TRUE	Support for anyone affected by cancer
12/17/2019	2893	Patient_ SUrvivor_ Caregiver Support Group--OP2892	A11=Support Group	2	0	0	1	2	TRUE	General Monthly Support Group; attendance is variable.
1/21/2020	2911	Patient_ Survivor_ Caregiver Support Group-OCP2910	A11=Support Group	5	0	0	1	2	TRUE	monthly support group; attendance is variable.
12/3/2019	2922	Survivor_Caregiver Support Group2922	A11=Support Group	2	0	0	1	1	TRUE	A group for patients and caregivers to share concerns and experiences.
12/10/2019	2923	Survivor_Caregiver Support Group2923	A11=Support Group	4	0	0	1	1	TRUE	A group for patients and caregivers to share concerns and experiences.
12/17/2019	2924	Survivor_Caregiver Support Group2924	A11=Support Group	3	0	0	1	1	TRUE	A group for patients and caregivers to share concerns and experiences.
1/7/2020	2949	Survivor_Caregiver Support Group2949	A11=Support Group	3	0	0	1	1	TRUE	A support group for patients and caregivers
1/14/2020	2950	Survivor_Caregiver Support Group2950	A11=Support Group	2	0	0	1	1	TRUE	A support group for patients and caregivers
1/20/2020	2951	Survivor_Caregiver Support Group2951	A11=Support Group	2	0	0	1	1	TRUE	A support group for patients and caregivers
1/28/2020	2952	Survivor_Caregiver Support Group2952	A11=Support Group	4	0	0	1	1	TRUE	A support group for patients and caregivers
2/20/2020	2958	Patient_ Survivor_ Caregiver Support Group2955	A11=Support Group	5	0	0	1	2	TRUE	Monthly support group; guest speaker Dr. Mary Beth Dwyer spoke on Acupuncture and Cancer Care. Publicized in Newsletter, White Board, Web site--attendance disappointing, Those who attended found it very worthwhile with positive evaluations
3/3/2020	3047	Survivor_Caregivers Support Group3034	A11=Support Group	5	0	0	1	1	TRUE	Weekly support group for cancer survivors and their caregivers
3/10/2020	3048	Survivor_Caregiver Support Group3048	A11=Support Group	6	0	0	1	1	TRUE	Weekly support group held for cancer survivors and their caregivers
4/15/2020	3056	Cancer Surviivor and Caregivers Support Group3056	A11=Support Group	4	0	0	1	1	TRUE	Weekly support group for cancer survivors and caregivers done via conference due to Covid 19 restrictions
4/22/2020	3057	Cancer Survivor and Caregiver Support Group3057	A11=Support Group	4	0	0	1	0.3	TRUE	Weekly support group for cancer survivors and caregivers done via conference call due to Covid 19 restrictions
4/29/2020	3058	Cancer Survivor and Caregiver Support Group3058	A11=Support Group	3	0	0	1	0.3	TRUE	Weekly support group for cancer survivors and caregivers done via conference call due to Covid 19 restrictions
5/6/2020	3059	Cancer Survivor and Caregiver Support Grop3059	A11=Support Group	2	0	0	1	0.3	TRUE	Weekly support group for cancer patients and caregivers held via conference call due to Covid 19 restrictions
5/13/2020	3060	Cancer Survivior and Caregivers Support Group3060	A11=Support Group	3	0	0	1	0.3	TRUE	Weekly support group for cancer survivors and caregivers via conference call due to Covid 19 restrictions
5/20/2020	3061	Cancer Survivor and Caregiver Support Group3061	A11=Support Group	2	0	0	1	0.3	TRUE	Weekly support group for cancer survivors and caregivers held via conference call due to Covid 19 restrictions
6/3/2020	3064	Cancer Survivor and Caregiver Group3064	A11=Support Group	3	0	0	1	1	TRUE	Weekly support group for cancer survivors and caregivers held via conference call due to Covid 19 restrictions
6/10/2020	3065	Cancer Survivor and Caregivers Support Group 3065	A11=Support Group	4	0	0	1	1	TRUE	Weekly support group for cancer survivors and caregivers held via conference call due to Covid 19 restrictions
6/17/2020	3066	Cancer Survivor and Caregiver Support Group3066	A11=Support Group	4	0	0	1	1	TRUE	Weekly support group for cancer survivors and caregivers held via conference call due to Covid 19 restrictions
6/3/2020	3067	Cancer Survivor and Caregiver Support Group3067	A12=Self Help	6	0	0	1	6	TRUE	Weekly support group for cancer survivors and caregivers held via conference call due to Covid 19 restrictions
				138	0	0	47	60.1		

Look Good, Feel Better

Activity Date	Activity ID	Activity Name	Ben Category	Encounters	Screened	Referred	Total Staff	Staff Hours	Cancer	Activity Description
1/27/2020	2917	Look Good Feel Better-OCP2917	A11=Support Group	7	0	0	1	6	TRUE	2 hour workshop led by volunteer cosmetologist who teaches patients undergoing treatment how to care for skin and nails, offers cosmetics tips and shares info about wigs and head wraps. Patients who attended it gave rave reviews.
2/24/2020	2963	Look Good Feel Better--OCP2962	A10=Community Educati	6	0	0	1	4	TRUE	Monthly workshop for women to learn beauty techniques as well as network/support one another; led by volunteer cosmetologist. Complimentary make up kit provided to each participant. Registrants also received PRMC giveaways: nail file, small first aid kit
				13	0	0	2	10		

Head and Neck Support Group

Activity Date	Activity ID	Activity Name	Ben Category	Encounters	Screened	Referred	Total Staff	Staff Hours	Cancer	Activity Description
2/18/2020	2961	Head and Neck Cancer Support Group2959	A11=Support Group	7	0	0	1	2	TRUE	SW met with group to review support/survivorship services offered through cancer and MAC. Also led group exploring emotional and social issues related to their cancers,
2/18/2020	2999	Head and Neck Cancer Group2999	A11=Support Group	7	0	0	1	1.5	TRUE	Attended support group as guest speaker
				14	0	0	2	3.5		

Prostate Support Group

Activity Date	Activity ID	Activity Name	Ben Category	Encounters	Screened	Referred	Total Staff	Staff Hours	Cancer	Activity Description
8/13/2019	2764	Prostate Cancer Support Group2764	A11=Support Group	4	0	0	1	3	TRUE	Monthly support group for prostate cancer patients and caregivers
3/10/2020	3049	Colorectal_Prostate Support Group3049	A11=Support Group	6	0	0	1	2	TRUE	Quarterly support group for colorectal and prostate cancer survivors
				10	0	0	2	5		

Attachment L – Peninsula Regional Prescription Chart

Analytics Explorer™

Information | Total # of Controlled Substance Prescriptions | ED | AMBULATORY | CANCER CENTER | INPATIENT | Hip, Knee, Colon Procedures & Prescriptions | Hip, Knee, Colon Procedures - Prescription Trends | Hip, Knee, Colon Procedures - Total Dispense Qty

Bookmarks

New bookmark name

- 5 west discharges — NTGROUP\389, 1/28/2020
- 2020 YTD — NTGROUP\P27972, 3/18/2020
- 2019 — NTGROUP\P27972, 3/18/2020
- 2018 — P27972, 9/11/2019
- 2017 — P27972, 9/11/2019
- Reset — P27972, 9/11/2019

Filters

Type to search filters

Opiod Dataset - Sheet1

Discharge/Encounter Date: 1/1/2017 – 10/18/2020

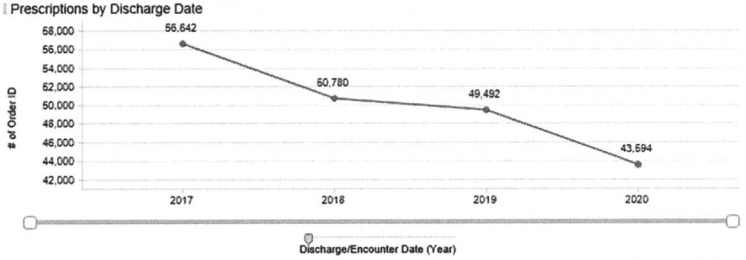
Opioid
- Opiates/Opioid
- Other CS

Opioids and Benzos?
- Opioids and Benzos
- Opioids/Benzos/Other CS

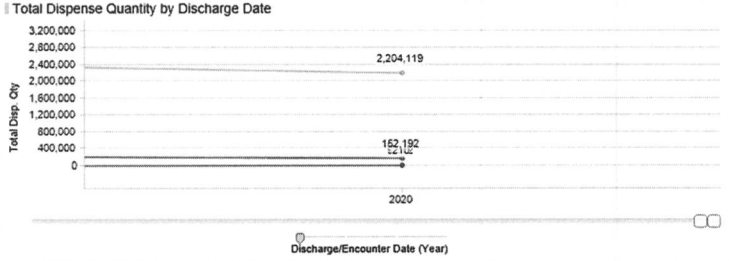
Converted Unit
- Liquids
- Other
- Powder/gel
- Solids

Procedure
- Colon
- Hip

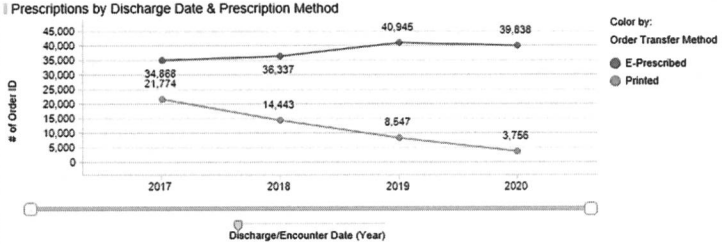
Prescriptions by Discharge Date



Total Dispense Quantity by Discharge Date



Prescriptions by Discharge Date & Prescription Method



Prescriptions by Prescription Method & DEA Class

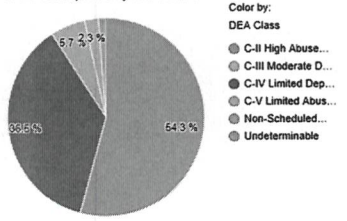
Order Transfer Method

DEA Class	E-Prescribed	Printed	Grand total
C-II High Abuse Potential	80,746	28,046	108,792
C-IV Limited Dependence	57,943	15,248	73,191
C-V Limited Abuse Potential	8,793	2,714	11,507
C-III Moderate Dependence	3,398	1,129	4,527
Non-Scheduled Medication	1,077	1,215	2,292
Undeterminable	31	168	199
Grand total	151,988	48,520	200,508

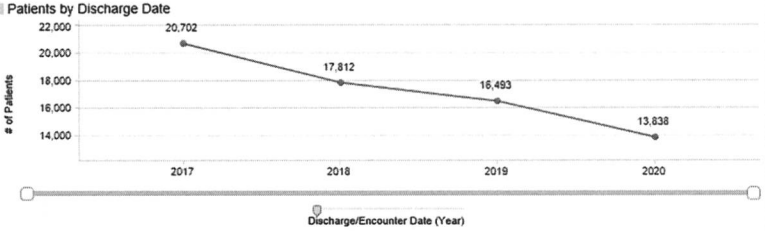
DEA Class

# of Orders

% of Prescriptions by DEA Class



Patients by Discharge Date



Average Dispense Quantity by Unit and DEA Class

DEA Class

Converted Unit	C-II High Abuse Potential	C-III Moderate Dependence	C-IV Limited Dependence	C-V Limited Abuse Potential	Non-Schedul... Medication	Undeterminable	Grand total
Liquids	214.21	43.80	195.59	139.82	-	-	148.79
Solids	54.44	64.29	47.16	84.41	35.37	91.06	52.83
Other		-	52.50	-	-	-	52.50
Powder/gel	11.37	27.12	1.80	-	-	-	14.49

Converted Unit

Avg(DispQty)

Ready

200,570 of 200,570 rows | 0 marked | 44 columns | Opiod Dataset - Sheet1

Attachment M – TidalHealth Facebook Page Screenshot

TidalHealth Facebook Page

Community Benefit FY 2020 Additional Initiative Information

COVID-19 Impact

COVID-19 has altered the lives of hundreds of millions of people around the world. As the coronavirus pandemic became increasingly more widespread throughout the Delmarva Peninsula, Peninsula Regional adapted its approaches to continue to provide as much benefit as possible to the community. Federal and state legislative changes afforded us the opportunity to make rapid changes in the delivery of healthcare services. We transitioned a number of initiatives into aa virtual environment to reach residents in need; at the same time, we shifted the responsibilities of community-based staff to help support COVID-19 specific efforts such as COVID-19 testing for the residents in Somerset, Wicomico and Worcester counties.

As a result of the COVID-19 pandemic, the health system developed unique strategies to meet the ever-changing needs of our communities during this healthcare crisis. Programs moved from face-to-face interactions to a virtual environment using technology such as iPads, cell phones, teleconferencing software and conference calls. Resources had to be reallocated to reflect the most critical needs of the community during COVID-19. Collectively, the employees of the health system, collaborators in the tri-county area, which includes Somerset, Wicomico and Worcester counties, and the residents themselves adapted to the best of their abilities in spite of the obstacles and challenges caused by the pandemic.

Community Wellness

The Community Wellness Team (formerly the Wagner Wellness Van) is the pinnacle of how Peninsula Regional changed its approach to population health management during the pandemic. The health system continues to adapt as the pandemic continues to grip the nation and region. The Community Wellness Team became a primary collaborator with the local health departments in conducting COVID-19 testing. Over the course of the final quarter of FY 2020 (April – June), the Community Wellness Team conducted more than 3,000 COVID-19 tests throughout various locations in the tri-county area. The tests were also primarily for residents who had high levels of needs and/or social determinants of health. The team conducted large scale "mass testing clinics" as well as smaller "pop-up clinics" in local, underserved communities, neighborhoods and churches. The Community Wellness Team went above and beyond the normal functions of their programs in order to provide access to COVID-19 tests to populations that otherwise would not have been tested due to a variety of factors.

The SWIFT initiative also adapted as a result of COVID-19 restrictions. In the initial few weeks of COVID-19 in the area, SWIFT did not make home visits because of the safety concerns of the employees and the residents. As a solution, the SWIFT team regularly called patients to see if they needed any type of assistance such as food, transportation, financial, emotional support, etc. When the weather got warmer in late spring and summer, the SWIFT team resumed in-person meetings outdoors. Unfortunately, due to social distancing requirements, the team was unable to evaluate a subset of patients and redirected them to alternative avenues of assistance. It became increasingly more challenging to provide the typical services and resources of the SWIFT program; for instance, our ability to help with applications related to social security cards, IDs, food stamps, licenses, etc., was delayed because government buildings were closed. SWIFT also had difficulty getting patients in for doctor's appointments because many offices were only doing telehealth appointments, and these patients

required face to face intervention. The employees assigned to the SWIFT team took COVID-19 precautions when helping residents in the community and still managed to persevere and connect people with local resources.

MAC, Inc., the Area Agency on Aging, had to transition from in-person classes to virtual meetings using smart phones, iPads, laptops, etc. to provide important educational information to its participants. The organization also used this equipment to reach senior citizens who were left isolated because of the COVID-19 pandemic. Some of these senior citizens were in crisis and having the ability to reach these residents, speak to them and reassure them that everything was going to be okay had a positive mental impact.

Smith Island telemedicine program was temporarily impacted by COVID-19. The annual health fair was cancelled. Heading into FY 2021, there are biweekly in-person clinic days to promote health and nutrition among other services along with telemedicine visits.

Care Management and Disease Management Program for Chronic Conditions was affected by COVID-19 because of limited access of the team to people in need. The embedded care managers in doctor's offices were not able to see patients during the initial COVID-19 outbreak because of the lockdowns ordered by the governor in order to implement social distancing. Throughout the health system, many patients were not attending their appointments because of COVID-19 and the fear of catching the disease and spreading it to friends and/or family.

Educational programs and community outreach events were paused because of the social distancing measures and limits on gatherings.

Support Groups and Educational Classes – A wide range of support groups and educational classes were initially paused because of the COVID-19 pandemic. With expanded options and resources, the multiple Diabetes and Cancer support groups moved to a virtual environment. Educational classes have moved to a virtual environment as well to limit the face-to-face interaction and follow COVID-19 precautions outlined by the CDC. The Adult Diabetes Support Group and the Kids and Teens Diabetes Support Group have also been impacted by COVID-19. These groups have moved to a virtual environment using web-based meeting tools and presentation slide software to still make an impact with their participants.

Behavioral Health

Behavioral Health is a vital component of community safety. With stay-at-home orders and residents not being able to work or afford necessities, mental health issues came to the forefront as a national public health priority during the pandemic. The health system and its partners worked together to curb the negative mental health/substance abuse impacts that were amplified by the COVID-19 pandemic.

The COAT team altered their service methods by contacting patients by phone after discharge from the Emergency Department instead of being stationed in the ED of the hospital. The COAT team still managed to reach patients and guide them to treatment or navigation services within the community.

The opioid teams in Wicomico and Somerset Counties had meetings virtually through conference calls or conference video calls to continue the work of educating the community on

substance abuse awareness. Work is still being done to have the Opioid Awareness Campaigns in the local community and Narcan trainings still took place.

The PEARLS program through MAC, Inc. The Agency on Aging moved their program to a virtual format. Counselors called participants of the program to check in with them. Because of the increased dangers of COVID-19 among the senior population, many older residents faced prolonged periods of social isolation for fear of contracting COVID-19 and possibly needing to be hospitalized.

Cancer

The multiple cancer initiatives throughout the health system were challenged with the arrival of COVID-19. All of these initiatives were held in group formats, whether it was a support group, a cooking class, or an exercise class. These programs are essential to treatment and mental/physical well-being for current patients, past patients and their caregivers. The cancer team at the health system created unique ways to engage patients by transitioning to a virtual format with the help of technology like iPads, laptops, cell phones and conference call capabilities.

The volunteers, instructors and employees went above and beyond to make sure these programs and groups were able to still be completed during this COVID-19 timeframe. The patients and their caregivers have positively benefitted from these programs and the programs will continue to be delivered in a virtual format until it is possible to meet again in person.

Community Benefit Narratives

Chronic Disease Self-Management/Community Wellness Team

MAC, Inc. Chronic Disease Programs

MAC, Inc. The Area Agency on Aging offers a plethora of services to help more active seniors live their lives to the fullest. The collaboration between Peninsula Regional and MAC, Inc., has been in place for several years. MAC, Inc., offers a variety of classes, events, activities, and meals for the senior populations of the area. The programs that are run by MAC that are related to chronic diseases and quality of life include Chronic Disease Self-Management, Stepping on Falls Prevention and Living Well with High Blood Pressure.

In the Chronic Disease Self-Management program, participants are taught about learning to cope with the fatigue, frustration and pain that accompany chronic disease, and exercises for improving strength and endurance, all which have been shown to improve health and decrease the number of hospital stays.

The Stepping on Falls prevention program focuses on how strength and balancing exercises, medication management, home safety, footwear, vision, and mobility are key factors when trying to prevent falls. Other educational pieces to preventing falls include being aware of surroundings, weather, and transitioning from well-lit areas to completely dark areas. The Living Well with High Blood Pressure program teaches participants how to cope with High Blood Pressure and educate about how nutrition and exercise and improve high blood pressure.

Other programs that MAC Inc., offers include Chronic Pain Self-Management, Diabetes Prevention, Diabetes Self-Management and Walking with Ease. These programs have a similar format to the Chronic Disease Self-Management Program and for most participants in MAC, Inc., programs, they are enrolled in multiple programs.

A substantial number of participants in these programs have comorbidities such as Diabetes, Chronic Pain, Heart Disease, Stroke, Hypertension, etc. The evidence-based programs offered by MAC, Inc. Are essential to improving the health of the communities we serve and are a good first step in helping people become more educated about their health. This collaboration between MAC Inc., The

Area Agency on Aging and Peninsula Regional is a community benefit that has multiple touch points that effects the overall health of our senior and older adult community in the Tri-County area.

Community Wellness Team

The Community Wellness Program utilizes a mobile clinic to build on partnerships throughout the community to identify and outreach to vulnerable and at-risk populations in Wicomico, Worcester, and Somerset counties. Screening events were conducted by the wellness team in all three counties, several days a week including at local migrant camps, Haitian community centers, schools, Smith Island, shelters, and churches. The strong commitment to and trust built by the team proved significant in TidalHealth ability to provide community-based education, information, and testing in response to the COVID-19 pandemic.

In FY20, the Community Wellness outreach team performed outreach services throughout Worcester and Wicomico Counties reaching over 1,000 community members during approximately 40 outreach events. During these events and daily community outreach missions, the team provided flu vaccines, connected patients to primary care providers and provided referrals to various community partners and agencies for housing, faith, utilities, healthcare, and many other social determinants of health.

Once the coronavirus pandemic took hold of the community, the needs of residents changed, and the SWIFT and Community Wellness mobile teams adapted to meet the changing needs of vulnerable and disadvantaged residents most impacted by the pandemic. The staff were critical for mass community-based COVID-19 testing throughout the region. The teams were recruited to participate in a regional, grassroots task force organized to bring together agencies, organizations, and services to better meet the needs of vulnerable populations at a time when so many lost their employment, income, and access to brick-and-mortar programs. Again, the programs adapted to the needs of the community and provided health services, education, and outreach to pop-up resource fairs in the hardest hit communities. This work continues as the pandemic continues to affect communities.

Smith Island Telehealth

TidalHealth supports telehealth to the approximately 300 residents of the remote Smith Island in Somerset County. Without this partnership, Smith Island would have no direct access to health care. An annual health fair provides a full spectrum of screenings and health education to the residents. New primary care provider appointments are offered to community members without a PCP. Telehealth acute visits occur through a nurse practitioner at TidalHealth. A medical assistant resides on the island to provide ongoing support for chronic disease prevention and management, medication management, referrals and follow-up post discharge and ED visits.

In fiscal 2020, the Smith Island Community Wellness team was successful in transmitting 46 telehealth visits, providing 18 medication refill prescriptions to patients that could not leave the island due to their declining health, lack of transportation or access, or inclement weather. In addition, the team provided office visit access to 32 residents. During these visits, 27 blood pressure screenings were completed and 14 lab draws.

SWIFT

SWIFT is a mobile integrated health initiative in partnership with the City of Salisbury and the Wicomico County Health Department. The program reduces unnecessary use of the 911 EMS system and health system emergency department by addressing physical and social needs of those identified as high utilizers of EMS and/or the ED. An interdisciplinary team including a nurse practitioner, registered nurse, paramedic, community health worker and social worker work together to address underlying conditions or social determinants of health contributing to excessive calls to 911 and visits to the ED. The team connects the program participants to primary care, behavioral health, chronic disease prevention and management, medication management, and social determinants of health needs such as

housing, transportation, food, utility assistance and other services. The program saves lives by taking a team approach to support participants in achieving their own goals for better quality of life. The team builds trust with participants over time by showing up, meeting them where they are, and helping them get the support they need to stay well.

Care Management and Disease Management Program for Chronic Conditions

The Care Management and Disease Management Program for Chronic Conditions is a program designed to help Medicare patients enroll in care management programs and improve their overall health. The Care Managers are embedded into Primary Care offices in the local community and try to enroll Medicare patients into community programs associated with reducing chronic diseases and improving the overall health of the patient. Care Managers also try to establish a positive relationship with the patient, building trust and creating a connection that the patient can rely on for any healthcare or social needs.

Remote Patient Monitoring

The Remote Patient Monitoring Program at TidalHealth is geared towards helping Medicare patients with chronic conditions like COPD, CHF, or Respiratory Failure adhere to protocols, medications, and medical instructions. Equipment is rented to the patient free of charge after discharge from the hospital for 60 days. During the 60-day period, healthcare workers help to educate the patient on monitoring their vitals, medications, etc. To reduce readmission rates to the hospital and increase patient/caregiver engagement. After the 60-day period, patients are encouraged to purchase their own monitoring equipment which then can be used in the future for self-monitoring.

Behavioral Health (Substance Abuse/Mental Health)

COAT

The COAT program stands for Community Outreach Addictions Team. This program is geared towards helping people who have entered the Emergency Department for substance abuse issues, behavioral health or socialization issues, high utilization of the ED due to drugs or alcohol, and/or social determinants of health associated with these themes. The COAT Team consists of people who had a history of substance abuse and are on call for the ED to be a navigator for these patients while they are being treated in the ED for the substance. The navigators are there for support and to also provide information about resources to substance abuse counseling, community resources, or social resources that the patient may need. The COAT Team helps people from any area that come to the ED, but the program is mostly helping people from Somerset, Worcester, or Wicomico counties. The COAT Team also tries to maintain contact with the patient post-ED visit to keep the lines of communication open in case the patient needs any other sort of counseling or help with their current social determinants of health.

Opioid Intervention Team and Somerset County Opioid United Team (OIT and SCOUT)

The Opioid Intervention Team and Somerset County Opioid United Team are programs that target the populations of Wicomico and Somerset Counties who are struggling with addiction and their families and friends. The teams consist of several community partners and stakeholders that bring awareness of the harms of opioid and other substances that effect not only the user, but also effects the family and friends of these users. Educational seminars are conducted at local schools and clubs are formed at these schools to help bring education to other students about the dangers of substance abuse and the toll it takes on family and friends. There is also a substantial awareness campaign during Opioid Awareness Month in Somerset and Wicomico Counties. The teams meet with local businesses and local government to set up opioid awareness campaigns that provide education to residents. Secure prescription drug drop boxes are located around Wicomico and Somerset counties as well as at TidalHealth Peninsula Regional, to have residents safely dispose of their unwanted or expired opioids and limit the inappropriate use of these drugs in the community. The teams also educate and

train community members on how to properly administer Narcan, the medicine used to treat someone with an overdose. The overarching strategy of these teams is to combat the current opioid epidemic effecting the local community and get the community engaged in helping reduce opioid use by increasing awareness.

PEARLS

PEARLS stands for Programs to Encourage Active and Rewarding Lives. This program, run by MAC Inc., the Agency on Aging, was created to help residents age 60 and over combat depression from loss or feelings of isolation. The program provides one-on-one counseling sessions to participants who may feel depressed, frustrated, restless, or anxious from due to events in their life. As one ages, there are losses such as loss of health, loved ones, and/or independence. A grieving widow who lost their spouse of forty years may feel depressed and lonely now that their partner is gone. Another older gentleman may feel frustration at not being able to be as independent as he once was at a younger age. PEARLS helps counsel the patient and provide guidance on how to manage their feelings. Especially with the COVID-19 epidemic, many older residents in the Tri-County area are feeling lonely, due to the restrictions on nursing homes and families not being able to get together with older family members. COVID-19 effects older populations worse than younger people, and by advisement of healthcare officials, many families are having to keep their distance. With help from MAC, Inc., these older adults can talk to a counselor and improve their quality of life.

ADMINISTRATIVE POLICY MANUAL

Subject: Financial Assistance / Uncompensated Care

Effective Date:	August 1981
Approved by:	President/CEO and Senior Vice President of Finance/CFO
Responsible Parties:	Senior Executive Director of Patient Financial Services
Revised Date:	12/86, 6/88, 3/90, 3/91, 7/93, 7/94, 8/98, 12/05, 8/08, 5/10, 10/10, 12/14, 7/16, 11/16, 7/17, 7/18, 7/19, 7/20, 9/20
Reviewed Date:	8/83, 12/85, 2/88, 6/92, 8/95, 7/96, 9/97, 6/00, 6/01, 10/02, 10/04, 12/11, 12/12, 12/13
Key Words:	Financial Assistance, Federal Poverty Guidelines, Charity Care, Uncompensated

POLICY

TidalHealth will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their medical bill. For purposes of this policy, TidalHealth shall include TidalHealth Peninsula Regional, TidalHealth McCready Pavilion, TidalHealth Primary Care, and TidalHealth Specialty Care. A patient's payment shall not exceed the amount generally billed (AGB). All hospital regulated services (which includes emergency and medically necessary care) will be charged consistently as established by the Health Services Cost Review Commission (HSCRC) which equates to the amounts generally billed (AGB) method. All patients seen by a TidalHealth Primary Care or Specialty Care provider or in an unregulated area will be charged the fee schedule plus the standard mark-up. The AGB for TidalHealth Primary Care or Specialty Care and other services not regulated by the HSCRC equates to the Medicare fee-for-service amount under the prospective method. A 50% discount will be applied to all self-pay unregulated services and patients seen by a TidalHealth Primary Care or Specialty Care provider. The 50% discount reduces the patient responsibility to the AGB. If the patient qualifies for financial assistance, this 50% discount will be granted prior to the application of the financial assistance write-off.

TidalHealth may use outsource vendors to provide patient collection and/or pre-collection services. Vendors act in accordance with TidalHealth policies and wherever policy notates employee, financial services department, or other such wording – vendor and/or vendor employees are included without such notation.

Definitions:

a. Elective Care: Care that can be postponed without harm to the patient or that is not medically necessary. An appropriate clinical or physician representative will be contacted for consultation in determining the patient status.
b. Medical Necessity: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.

c. Immediate Family: A family unit is defined to include all individuals taken as exemptions on the income tax return for the individual completing the application, whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not been filed, then income from all members living in the household will be considered.
d. Liquid Assets: Cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc. The availability of liquid assets plus annual income may be considered in relation to the current poverty guidelines published in the Federal Register.
e. Medical Debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs for medical costs billed by TidalHealth.
f. Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

TidalHealth will provide free medically necessary care to patients with family income at or below 200% of the federal poverty level. Patients qualifying for financial assistance based on income at or below 200% of the federal poverty level have no cost for their care and therefore pay less than AGB.

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

TidalHealth will provide reduced-cost medically necessary care to low-income patients with family income between 301% and 500% of the Federal poverty level who have a medical hardship as defined by Maryland Law. Medical hardship is medical debt, incurred by a family over a 12 month period that exceeds 25% of the family income.

Other healthcare fees and professional fees that are not provided by TidalHealth are not included in this policy. Pre-planned service may only be considered for financial assistance when the service is medically necessary. As an example, cosmetic surgery is excluded. Inpatient, outpatient, emergency services, and services rendered by TidalHealth are eligible.

TidalHealth's financial assistance is provided only to bills related to services provided at TidalHealth or at a TidalHealth site including services provided by physicians employed by TidalHealth. To determine if your physician's services are covered by the TidalHealth financial assistance program, please see the roster of providers that deliver emergency and other medically necessary care, indicating which providers are covered under the policy and which are not. The list of providers is updated quarterly and available on the TidalHealth website. If you prefer, you may contact any financial counselor or patient accounting representative by calling (410) 912-4974, or in person at TidalHealth Peninsula Regional.

PROCEDURE

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

a. Available free of charge and upon request by calling (410) 543-7436 or (877) 729-7762.
b. Are located in the registration areas.
c. Downloaded from the TidalHealth website:
https://www.tidalhealth.org/patientforms
https://www.tidalhealth.org/patientbills
d. The plain language summary is inserted in the Admission packet and with all patient statements.
e. Through signs posted in the main registration areas.
f. Annual notification in the local newspaper.
g. The application is available in English and Spanish. No other language constitutes a group that is 5% or more, or more than 1,000 residents (whichever is less) of the population in our primary service area (Worcester, Wicomico and Somerset Counties) based on U.S. Census data.
h. For patients who have difficulty in filling out an application, the information can be taken orally by calling (410) 912-6957 or in person at the Financial Counselor's Office located in the Frank B. Hanna Outpatient Center.

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

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

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

c. Preliminary eligibility will be made within 2 business days based upon receipt of sufficient information to determine probable eligibility. A letter will be mailed to patients notifying them of their eligibility status. Following preliminary approval, patients must submit a completed application and any supporting documentation requested (if not done previously). Upon final approval, a financial assistance discount will be applied to the patient's responsibility.

d. Patients who are beneficiaries/recipients of certain means-tested social services programs are deemed to have presumptive eligibility at 100% and are FA eligible without the completion of an application or submission of supporting documentation. It is the responsibility of the patient to notify TidalHealth that they are in a means-tested program. This information may also be obtained from an outsourced vendor or other means available to TidalHealth.

e. A patient that has qualified for Maryland Medical Assistance is deemed to automatically qualify for Financial Assistance (FA) at 100%. The amount due from a patient on these accounts may be written off to FA with verification of Medicaid eligibility. Standard documentation requirements are waived.

f. TidalHealth may automatically approve Financial Assistance for accounts ready to be sent to a collection agency that are identified as Poverty based on the propensity to pay score.

g. If the application is ineligible, normal dunning processes will resume, which includes notifying the agency if applicable to proceed with ECA efforts. A copy of TidalHealth's Collections Policy may be obtained by calling (410) 543-7436 or (877) 729-7762 and is available on the website listed above.

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

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

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

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

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

k. If TidalHealth has reason to believe the information is unreliable or incorrect, or obtained under duress, or through the use of coercive practices, FA may be denied.

l. We do not request or provide waivers, written or oral, expressing patient does not wish to apply for assistance.

Collection Coordinator

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

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

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

d. TidalHealth will communicate with the patient using the method preferred by the patient including electronic communications, telephone or mail.

Steven Leonard
President/CEO

Bruce Ritchie
Senior Vice President of Finance/CFO

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

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

Eligibility Determination Process

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

How to Apply

- Applications can be taken orally by calling (410) 912-6957 between 8:00 a.m. and 5:00 p.m., Monday through Friday
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:00 a.m. and 4:00 p.m., Monday through Friday
- Mailing a request for an application to TidalHealth Peninsula Regional, PO Box 2498, Salisbury, MD 21802-2498

- On the internet at:
  https://www.tidalhealth.org/patientforms
  https://www.tidalhealth.org/patientbills
- Applications are available in English and in Spanish

Qualifications

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

- An independent third party to verify your household income (one of the following)
  a. Recent pay stub showing current and year-to-date earnings
  b. Most recent tax return showing your Adjusted Gross Income or W-2 form
  c. Written documentation of Social Security benefits, SSI disability, VA benefits, etc.
  d. If no income, a letter from an independent source such as a clergy or neighbor verifying no income
- Completed application

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

Need Assistance?

If, at any time, you have questions about obtaining financial assistance, your medical bill, your rights and obligations with regard to the bill, or applying for the Medical Assistance Program, please contact TidalHealth Peninsula Regional's Financial Services Department at (410) 912-6957 or (877) 729-7762. You can obtain a copy of the TidalHealth Financial Assistance Policy at www.tidalhealth.org/financialassistance.

Medical Assistance Program

To find out if you are eligible for Maryland Medical Assistance or other public assistance, please apply at your local Department of Social Services (DSS) office, or you may visit mmcp.dhmh.maryland.gov for information about the various Medicaid programs available. You may apply online for Maryland Medicaid at marylandhealthconnection.gov. If you are applying for assistance for a child or are pregnant, you may apply for the Maryland Children's Health Program (MCHP). If you are only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your local Department of Social Services (DSS) for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. Delaware residents may obtain information online at dhss.delaware.gov or apply online at assist.dhss.delaware.gov. Virginia residents may obtain information at dmas.Virginia.gov. To receive an application, call your local DSS office or the Area Agency on Aging, (AAA). For more information, you may call the Department of Health and Mental Hygiene's Recipient Relations Hotline at 1 (800) 492-5231 or (410) 767-5800.

Patients' Rights and Obligations

Rights:

- Prompt notification of their preliminary eligibility determination for financial assistance.
- Guidance from TidalHealth on how to apply for financial assistance and other programs which may help them with the payment of their medical bill.
- Receipt of financial assistance for all services not payable by another program that meet the qualifications of TidalHealth's Financial Assistance Policy.
- TidalHealth will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their medical bill.

Obligations:

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

Cómo hacer la solicitud

- Llame al (410) 912-6957 o (877) 729-7762 entre las 8:00 a.m. y las 5:00 p.m., de lunes a viernes
- Acuda en persona a la oficina del consejero financiero (Localizado en el vestibulo Frank B. Hanna del Centro de attencion de Pacientes Externos) entre las 8:00 a.m. y las 4:00 p.m., de lunes a viernes
- A través de Internet, visite www.tidalhealth.org. Haga clic en Patients & Visitors (Pacientes y vistantes), luego en Patient Financial Services (Servicios financieros para pacientes) y después en Billing Information (Información de facturación)

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How to Apply

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Obligations:

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TidalHealth Peninsula Regional

100 East Carroll Street
Salisbury, MD 21801
410-546-6400
mytidalhealth.org

BRO-086 (8/20)

TidalHealth™

TidalHealth Peninsula Regional

Need Financial Assistance with Your Medical Bills?

Financial Assistance Policy

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Eligibility Determination Process

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