*Q1.*
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

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

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

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

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

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

| | Is this information correct? Yes | No | If no, please provide the correct information here: |
|---|---|---|---|
| The proper name of your hospital is: UM Shore Regional Health | ◉ | ○ | |
| Your hospital's ID is: Dorchester - 210010, Chestertown - 210030, Easton - 210037 | ◉ | ○ | |
| Your hospital is part of the hospital system called University of Maryland Medical System | ◉ | ○ | |
| The primary Narrative contact at your hospital is Kimberly Davidson and Donna Jacobs | ○ | ◉ | Kathleen Mcgrath kfmcgrath@umm.edu |
| The primary Narrative contact email address at your hospital is kimberly.davidson@umm.edu; djacobs@umm.edu | ○ | ◉ | Kathleen Mcgrath kfmcgrath@umm.edu |
| The primary Financial contact at your hospital is UNKNOWN | ○ | ◉ | D'Acunzi, Anna adacunzi@umm.edu |
| The primary Financial email at your hospital is ACUNNINGHAM@UMM.EDU | ○ | ◉ | D'Acunzi, Anna adacunzi@umm.edu |

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

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

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

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

http://www.countyhealthrankings.org

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

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

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

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

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

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

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

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

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

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

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

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

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

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

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

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

*Q34.* How did your hospital identify its CBSA?

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

Zipcodes checked reflects 60%of admissions for SRH

- [x] Other. Please describe.

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

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

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

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

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

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

- (●) Yes
- ( ) No

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

*This question was not displayed to the respondent.*

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

05/22/2019

*Q41.* Please provide a link to your hospital's most recently completed CHNA.

https://www.umms.org/shore/-/media/files/um-shore/community/srh-chna-2019-board-approved52219.pdf

*Q42.* Please upload your hospital's most recently completed CHNA.

SRH CHNA 2019. Board Approved.5.22.19.pdf
3.4MB
application/pdf

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

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

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

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

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

*Q45.* Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

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

| | Activities | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | N/A - Person or Organization was not Involved | N/A - Position or Department does not exist | Selecting health needs that will be targeted | Selecting the initiatives that will be supported | Determining how to evaluate the impact of initiatives | Providing funding for CB activities | Allocating budgets for individual 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) | ☐ | ☐ | ☑ | ☑ | ☑ | ☐ | ☑ | ☐ | ☐ | ☐ | |

| | 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: |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Senior Executives (CEO, CFO, VP, etc.) (system level) | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | ☐ | ☐ | ☐ | ☐ | |
| | N/A - Person or Organization was not Involved | N/A - Position or Department does not exist | Selecting health needs that will be targeted | Selecting the initiatives that will be supported | Determining how to evaluate the impact of initiatives | Providing funding for CB activities | Allocating budgets for individual 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 (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: |
| Board of Directors or Board Committee (system level) | ☑ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | N/A - Person or Organization was not Involved | N/A - Position or Department does not exist | Selecting health needs that will be targeted | Selecting the initiatives that will be supported | Determining how to evaluate the impact of initiatives | Providing funding for CB activities | Allocating budgets for individual 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) | ☐ | ☐ | ☑ | ☑ | ☑ | ☐ | ☐ | ☑ | ☑ | ☐ | |
| | 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 | ☐ | ☐ | ☑ | ☑ | ☑ | ☐ | ☐ | ☑ | ☑ | ☐ | |
| Hospital Advisory Board | ☐ | ☑ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Other (specify) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

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

*This question was not displayed to the respondent.*

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

Refer to the FY 2021 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is optional for FY 2021, but will be mandatory for FY 2022.

*This question was not displayed to the respondent.*

## Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

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

- (●) Yes
- ( ) No

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

5/22/2019

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

https://www.umms.org/shore/-/media/files/um-shore/community/srh-chip-2019-board-approved52219.pdf

Q222. Please upload your hospital's CHNA implementation strategy.

UM SRH CHIP 2020-2022.pdf
228.8KB
application/pdf

Q53. 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.*

*Q54.* Please select the CHNA Priority Area Categories most relevant to your most recent CHNA. The list of categories is based on the Healthy People 2030 objectives available here. This list is not exhaustive. Please select "other" and describe any CHNA Priority Area Categories that are not captured by this list. Select all that apply even if a need was not addressed by a reported initiative.

- [ ] Health Conditions - Addiction
- [ ] Health Conditions - Arthritis
- [ ] Health Conditions - Blood Disorders
- [x] Health Conditions - Cancer
- [ ] Health Conditions - Chronic Kidney Disease
- [ ] Health Conditions - Chronic Pain
- [ ] Health Conditions - Dementias
- [x] Health Conditions - Diabetes
- [ ] Health Conditions - Foodborne Illness
- [ ] Health Conditions - Health Care-Associated Infections
- [ ] Health Conditions - Heart Disease and Stroke
- [ ] Health Conditions - Infectious Disease
- [ ] Health Conditions - Mental Health and Mental Disorders
- [ ] Health Conditions - Oral Conditions
- [ ] Health Conditions - Osteoporosis
- [ ] Health Conditions - Overweight and Obesity
- [ ] Health Conditions - Pregnancy and Childbirth
- [ ] Health Conditions - Respiratory Disease
- [ ] Health Conditions - Sensory or Communication Disorders
- [ ] Health Conditions - Sexually Transmitted Infections
- [ ] Health Behaviors - Child and Adolescent Development
- [x] Health Behaviors - Drug and Alcohol Use
- [ ] Health Behaviors - Emergency Preparedness
- [ ] Health Behaviors - Family Planning
- [x] Health Behaviors - Health Communication
- [ ] Health Behaviors - Injury Prevention
- [ ] Health Behaviors - Nutrition and Healthy Eating
- [ ] Health Behaviors - Physical Activity
- [ ] Health Behaviors - Preventive Care
- [ ] Health Behaviors - Safe Food Handling
- [ ] Health Behaviors - Sleep
- [ ] Health Behaviors - Tobacco Use
- [ ] Health Behaviors - Vaccination
- [ ] Health Behaviors - Violence Prevention
- [ ] Populations - Adolescents
- [ ] Populations - Children
- [ ] Populations - Infants
- [ ] Populations – LGBT
- [ ] Populations - Men
- [ ] Populations - Older Adults
- [ ] Populations - Parents or Caregivers
- [ ] Populations - People with Disabilities
- [ ] Populations - Women
- [ ] Populations - Workforce
- [ ] Settings and Systems - Community
- [ ] Settings and Systems - Environmental Health
- [ ] Settings and Systems - Global Health
- [ ] Settings and Systems - Health Care
- [ ] Settings and Systems - Health Insurance
- [ ] Settings and Systems - Health IT
- [ ] Settings and Systems - Health Policy
- [ ] Settings and Systems - Hospital and Emergency Services
- [ ] Settings and Systems - Housing and Homes
- [ ] Settings and Systems - Public Health Infrastructure
- [ ] Settings and Systems - Schools
- [ ] Settings and Systems - Transportation
- [ ] Settings and Systems - Workplace
- [ ] Social Determinants of Health - Economic Stability
- [ ] Social Determinants of Health - Education Access and Quality
- [x] Social Determinants of Health - Health Care Access and Quality
- [ ] Social Determinants of Health - Neighborhood and Built Environment
- [ ] Social Determinants of Health - Social and Community Context
- [ ] Other (specify)

*Q56.* (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Access to health care is the number one need identified in the CHNA for five Mid-Shore counties. Noted workforce shortages exist for most specialists and particularly in obstetric and emergency care, mental and behavioral health providers, as well as staff to support them. Lack of emergency and non-emergency transportation services also impacted the accessibility of health care services, while workforce recruitment and retention challenges impact quality care. See response to Q 244 for additional information regarding access to care.

*Q57.* (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

## *Q58.* Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

*Q59.* Please use the questions below to provide details regarding the initiatives to address the CHNA Priority Area Categories selected in the previous question.

For those hospitals completing the ***optional*** CHNA financial reporting in FY 2021, please ensure that these tie directly to line item initiatives in the financial reporting template.

For those hospitals **not** completing the ***optional*** CHNA financial template, please provide this information for as many initiatives as you deem feasible.

***Please note that hospitals will be required to report on each CHNA-related initiative in FY 2022.***

*Q163.* Please describe the initiative(s) addressing Health Conditions - Addiction.

*This question was not displayed to the respondent.*

*Q182.* Please describe the initiative(s) addressing Health Conditions - Arthritis.

*This question was not displayed to the respondent.*

*Q183.* Please describe the initiative(s) addressing Health Conditions - Blood Disorders.

*This question was not displayed to the respondent.*

*Q184.* Please describe the initiative(s) addressing Health Conditions - Cancer.

| | Health Conditions - Cancer Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | Shore Regional Health Wellness for Women Outreach and Wellness for Women Screening | Wellness for Women Outreach 1. Increase the number of women surviving breast cancer by diagnosing them at an earlier stage through education and promotion of preventative measures and early detection. 2. Diagnose African American and Hispanic women at earlier stages of breast cancer, equivalent to Caucasian women. 3. Educate women in breast self-examination. Screenings: The program serves as a point of access into care for age and risk specific mammography screening ,clinical breast exam, and genetic testing for breast cancer Offers no cost mammograms to eligible women: those under the age of 40 and over 65 who have no insurance and Latina women of all ages who will be screened annually thereafter. Those women needing further diagnostic tests or who need treatment for breast cancer are enrolled in the State of Maryland Diagnosis and Treatment Program through the case manager. | • Events were halted this fiscal year due to COVID, thus the number of lives touch was significantly lower at 700+. However, despite the restrictions strong efforts were made to continue to educate the public in all five counties via telephone and by sending materials to organizations through mail. Our Wellness for Women program saw a slight influx in patients from last year at 157. Tumor Registry calendar year 2020 135 diagnosed with Breast Ca in 5 Counties (Stage 0-4) Stages at Diagnosis Caroline County • 24 diagnosed; 21 Caucasian and 3 AA • 1 at Stage 3 ; Caucasian • 1 Stage 4; Caucasian Dorchester County • 32 diagnosed; 21 Caucasian and 10 AA, 1 Other • 2 at Stage 3; 1 Caucasian and 1 AA • 1 Stage 4; Caucasian Kent County • 20 diagnosed; 20 Caucasian • 2 at Stage 3; Caucasian Queen Anne • 19 diagnosed; 18 Caucasian, 1 Other • 1 at Stage 3; 1 Caucasian Talbot County • 40 diagnosed; 33 Caucasian and 5 AA, 2 Other • 4 at Stage 3; Caucasian | Number of screenings and case management: 700+ lives touched |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q185.* Please describe the initiative(s) addressing Health Conditions - Chronic Kidney Disease.

*This question was not displayed to the respondent.*

*Q186.* Please describe the initiative(s) addressing Health Conditions - Chronic Pain.

*This question was not displayed to the respondent.*

*Q187.* Please describe the initiative(s) addressing Health Conditions - Dementias.

*This question was not displayed to the respondent.*

*Q188.* Please describe the initiative(s) addressing Health Conditions - Diabetes.

| | Health Conditions - Diabetes Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | EDUCATION AND SUPPORT FOR PATIENTS WITH DIABETES | Reduce prevalence of diabetes in the population of the midshore. Diabetes: Data on a history of diagnosed diabetes in Maryland shows Non-Hispanic Blacks (NHB) have an average of 1.5 times higher prevalence as compared to Non-Hispanic Whites (NHW) when adjusted for age. This disparity comparing NonHispanic Blacks to Non-Hispanic Whites is higher in some Eastern Maryland counties for example in Talbot County, where it is about 5 times higher. The prevalence of diabetes is about 23% in NHB compared to 6% for NHW in Talbot County (compared to 13% and 8% in NHB and NHW respectively in Maryland). There are several reasons for the high diabetes prevalence rates in rural jurisdictions such as a lack of access to services to prevent or manage their diabetes, barriers to adequate physical activity and healthy eating, lack of access to health care, including shortages of physicians and providers and limited access to transportation to travel to appointments with primary or specialty care providers | (1) Weekly Diabetes Self-Management Classes Offered in Chestertown and Easton, this program provides medical information and strategies enabling patients to manage their diabetes for optimal wellness (2) Individualized Instruction and Support Services Our staff provides individual instruction and support for patients on the topics listed below, both in-person and via telemedicine (phone call or video conference). Topics include: carb counting; medical nutrition therapy, providing an individualized comprehensive nutrition plan; glucose meters, injectable medications, continuous glucose monitoring (CGM) and insulin pump management; and gestational diabetes – care during pregnancy and what to expect afterward (3) Diabetes Support Groups Due to the COVID-19 pandemic, diabetes support is now offered on a group basis via video conference on the 4th Tuesday of each month (login time is 5 p.m.). Open to family members, caregivers and patients, these meetings feature informative presentations by diabetes experts as well as fellowship and support for persons affected by diabetes. | The number of people served by the initiative: 550+ lives touched |
| Initiative B | | | | |

| | | | | |
|---|---|---|---|---|
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q189.* Please describe the initiative(s) addressing Health Conditions - Foodborne Illness.

*This question was not displayed to the respondent.*

*Q190.* Please describe the initiative(s) addressing Health Conditions - Health Care-Associated Infections.

*This question was not displayed to the respondent.*

*Q191.* Please describe the initiative(s) addressing Health Conditions - Heart Disease and Stroke.

*This question was not displayed to the respondent.*

*Q192.* Please describe the initiative(s) addressing Health Conditions - Infectious Disease.

*This question was not displayed to the respondent.*

*Q193.* Please describe the initiative(s) addressing Health Conditions - Mental Health and Mental Disorders.

*This question was not displayed to the respondent.*

*Q194.* Please describe the initiative(s) addressing Health Conditions - Oral Conditions.

*This question was not displayed to the respondent.*

*Q195.* Please describe the initiative(s) addressing Health Conditions - Osteoporosis.

*This question was not displayed to the respondent.*

*Q196.* Please describe the initiative(s) addressing Health Conditions - Overweight and Obesity.

*This question was not displayed to the respondent.*

*Q197.* Please describe the initiative(s) addressing Health Conditions - Pregnancy and Childbirth.

*This question was not displayed to the respondent.*

*Q198.* Please describe the initiative(s) addressing Health Conditions - Respiratory Disease.

*This question was not displayed to the respondent.*

*Q199.* Please describe the initiative(s) addressing Health Conditions - Sensory or Communication Disorders.

*This question was not displayed to the respondent.*

*Q200.* Please describe the initiative(s) addressing Health Conditions - Sexually Transmitted Infections.

*This question was not displayed to the respondent.*

*Q201.* Please describe the initiative(s) addressing Health Behaviors - Child and Adolescent Development.

*This question was not displayed to the respondent.*

*Q202.* Please describe the initiative(s) addressing Health Behaviors - Drug and Alcohol Use.

| | Health Behaviors - Drug and Alcohol Use Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |

| | | | | |
|---|---|---|---|---|
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q203.* Please describe the initiative(s) addressing Health Behaviors - Emergency Preparedness.

*This question was not displayed to the respondent.*

*Q204.* Please describe the initiative(s) addressing Health Behaviors - Family Planning.

*This question was not displayed to the respondent.*

*Q205.* Please describe the initiative(s) addressing Health Behaviors - Health Communication.

| | Health Behaviors - Health Communication Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q206.* Please describe the initiative(s) addressing Health Behaviors - Injury Prevention.

*This question was not displayed to the respondent.*

*Q207.* Please describe the initiative(s) addressing Health Behaviors - Nutrition and Healthy Eating.

*This question was not displayed to the respondent.*

*Q208.* Please describe the initiative(s) addressing Health Behaviors - Physical Activity.

*This question was not displayed to the respondent.*

*Q209.* Please describe the initiative(s) addressing Health Behaviors - Preventive Care.

*This question was not displayed to the respondent.*

*Q210.* Please describe the initiative(s) addressing Health Behaviors - Safe Food Handling.

*This question was not displayed to the respondent.*

*Q211.* Please describe the initiative(s) addressing Health Behaviors - Sleep.

*This question was not displayed to the respondent.*

*Q212.* Please describe the initiative(s) addressing Health Behaviors - Tobacco Use.

*This question was not displayed to the respondent.*

*Q213.* Please describe the initiative(s) addressing Health Behaviors - Vaccination.

*This question was not displayed to the respondent.*

*Q214.* Please describe the initiative(s) addressing Health Behaviors - Violence Prevention.

*This question was not displayed to the respondent.*

*Q215.* Please describe the initiative(s) addressing Populations - Adolescents.

*This question was not displayed to the respondent.*

*Q216.* Please describe the initiative(s) addressing Populations - Children.

*This question was not displayed to the respondent.*

*Q217.* Please describe the initiative(s) addressing Populations - Infants.

*This question was not displayed to the respondent.*

*Q218.* Please describe the initiative(s) addressing Populations - LGBT.

*This question was not displayed to the respondent.*

*Q219.* Please describe the initiative(s) addressing Populations - Men.

*This question was not displayed to the respondent.*

*Q220.* Please describe the initiative(s) addressing Populations - Older Adults.

*This question was not displayed to the respondent.*

*Q221.* Please describe the initiative(s) addressing Populations - Parents or Caregivers.

*This question was not displayed to the respondent.*

*Q222.* Please describe the initiative(s) addressing Populations - People with Disabilities.

*This question was not displayed to the respondent.*

*Q223.* Please describe the initiative(s) addressing Populations - Women.

*This question was not displayed to the respondent.*

*Q224.* Please describe the initiative(s) addressing Populations - Workforce.

*This question was not displayed to the respondent.*

*Q225.* Please describe the initiative(s) addressing Settings and Systems - Community.

*This question was not displayed to the respondent.*

*Q226.* Please describe the initiative(s) addressing Settings and Systems - Environmental Health.

*This question was not displayed to the respondent.*

*Q227.* Please describe the initiative(s) addressing Settings and Systems - Global Health.

*This question was not displayed to the respondent.*

*Q228.* Please describe the initiative(s) addressing Settings and Systems - Health Care.

*This question was not displayed to the respondent.*

*Q229.* Please describe the initiative(s) addressing Settings and Systems - Health Insurance.

*This question was not displayed to the respondent.*

*Q230.* Please describe the initiative(s) addressing Settings and Systems - Health IT.

*This question was not displayed to the respondent.*

*Q231.* Please describe the initiative(s) addressing Settings and Systems - Health Policy.

*This question was not displayed to the respondent.*

*Q232.* Please describe the initiative(s) addressing Settings and Systems - Hospital and Emergency Services.

*This question was not displayed to the respondent.*

*Q233.* Please describe the initiative(s) addressing Settings and Systems - Housing and Homes.

*This question was not displayed to the respondent.*

*Q234.* Please describe the initiative(s) addressing Settings and Systems - Public Health Infrastructure.

*This question was not displayed to the respondent.*

*Q235.* Please describe the initiative(s) addressing Settings and Systems - Schools.

*This question was not displayed to the respondent.*

*Q236.* Please describe the initiative(s) addressing Settings and Systems - Transportation.

*This question was not displayed to the respondent.*

*Q237.* Please describe the initiative(s) addressing Settings and Systems - Workplace.

*This question was not displayed to the respondent.*

*Q238.* Please describe the initiative(s) addressing Social Determinants of Health - Economic Stability.

*This question was not displayed to the respondent.*

*Q239.* Please describe the initiative(s) addressing Social Determinants of Health - Education Access and Quality.

*This question was not displayed to the respondent.*

*Q240.* Please describe the initiative(s) addressing Social Determinants of Health - Health Care Access and Quality.

| | Social Determinants of Health - Health Care Access and Quality Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | Community Care Coordination- | To provide patients with chronic disease and barriers to care, coordination of community services for support, education, and referral to social services to maintain health. | Improved access to care and care coordination were identified in the 2019 CHNA. This program addresses these needs through navigators who refer patients at discharge from the in-patient setting to community based programs who can address health needs and social determinants of health. Patients are followed through an out-patient care coordination process to address medical and non-medical needs. UM SRH implemented a follow up system for all discharged patients and has expanded services to the community to determine if additional health services are required to address medical and non-medical needs (e.g., appointment setting, obtaining medications, understanding care instructions. UM SRH also pays for medical transportation and some medications for patients with medical and financial needs | The number of people served: Served over 1200 patients, reduction in readmissions, improved access to outpatient services through follow-up and referral to community resources |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q241.* Please describe the initiative(s) addressing Social Determinants of Health - Neighborhood and Built Environment.

*This question was not displayed to the respondent.*

*Q242.* Please describe the initiative(s) addressing Social Determinants of Health - Social and Community Context.

*This question was not displayed to the respondent.*

*Q243.* Please describe the initiative(s) addressing other priorities.

*This question was not displayed to the respondent.*

*Q130.* Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

*Q131.*

In your most recently completed CHNA, the following community health needs were identified:
**Health Conditions - Cancer, Health Conditions - Diabetes, Health Behaviors - Drug and Alcohol Use, Health Behaviors - Health Communication, Social Determinants of Health - Health Care Access and Quality**
**Other:**

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.*

*Q132.* Why were these needs unaddressed?

*This question was not displayed to the respondent.*

*Q244.* Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

HEALTH DISPARITIES Overall, the five counties of the Mid-Shore, (Caroline, Dorchester, Kent, Queen Anne's, Talbot) face significant health disparities that accentuate the need for access to quality health care. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities. Within the Mid-Shore the economic condition varies significantly. County Health Rankings reveals large disparities between counties for health outcomes and the social factors that impact health, such as poverty. The impact of these challenges are compounded by the barriers already present, such as limited public transportation options and fewer choices to acquire healthy food. COUNTY HEALTH RANKINGS - Robert Wood Johnson Foundation Health Outcomes for 2021 Caroline:19, Dorchester:23, Kent:16, Queen Anne's:9, Talbot:5 (Ranking is based on 24 counties including Baltimore City) in health outcomes that indicate the overall health of the county) Social & Economic Factors: Caroline:18, Dorchester:22, Kent:16, Queen Anne's:6, Talbot:11 (Ranking based 24 counties including Baltimore City) on Social and economic factors, such as income, education, employment, community safety, and social support that can significantly affect how well and how long we live) Food Insecure: Caroline 12.1%, Dorchester 15.8%, Kent 11.5%, Queen Anne's 7.5%, Talbot10.5% Children in Poverty: Caroline 20%, Dorchester 27%, Kent 19%, QA 9%, Talbot 15% (Source: URL: http://www.mdfoodsystemmap.org) Pre-COVID Additional challenges for the Mid-Shore include limited access to affordable high speed broadband services, a shortage of affordable housing, an inadequate supply of skilled workers, and low per capita income. SRH addressing inequities, disparities Because local action is essential to address health inequities and public health progress, UM Shore Regional Health works in partnership with public sector agencies, health care providers and community-based partners. Through a variety of community building activities, UM Shore Regional Health promotes health equity in the community it serves. These activities include: active engagement and collaboration with local Health Departments, Mid Shore Behavioral Health, Opioid Task Force, Chambers of Commerce, and organizations that work to improve the quality of life for the residents of the Mid-Shore. UM SRH provides on-going services that are fundamental to addressing the identified community health needs that demonstrate the extent to which our commitment to serve our community is integrated into our care delivery model. UM SRH Community Health and Outreach initiatives addressing health disparities and inequities include: • Facilitate listening sessions and Town Hall meetings to understand needs of the community • Health Literacy series- monthly presentation on a specific health topic. Our clinical experts take questions from families using the Ask Me 3® approach to better understand health conditions such as diabetes, asthma and cancer and what is needed to stay healthy. • Food Insecurity - partnership with Maryland Food Bank of the Eastern Shore, including food drives and distribution to local food pantries. • Screenings and Support Group-offered in all five counties. Health and Education Events include: (1) High blood pressure and heart disease; (2) Diabetes; (3) Cancer; (4) Stroke; (5) Hospice services and palliative care; (6) Obesity, exercise and nutrition We have a strong focus on treating patients with chronic conditions. UM Shore Regional Health works to coordinate care, ensure smooth transitions and promote disease self-management strategies at every step of a patient's journey – whether at home, in the community, or within our hospital. We operate specialized clinics to enable access to routine outpatient care. Our transitional care services help patients newly diagnosed or those that have had a recent hospitalization transition safely back to the community. Transitional nurse navigators provide patients with disease education and self-management strategies, connect them to primary care providers and specialists, and help them overcome any barriers to making follow up appointments. An urgent care center to address off hours visits and low acuity emergencies is also available. Resources are embedded throughout the hospital and in the community so that every patient receives the same high level of care coordination. Care managers are embedded within our emergency department and hospital, and provide in-home visits as needed. Community health workers reach out to patients who are identified as being high risk for readmission or in need of critical resources. Close relationships are maintained with skilled nursing facilities and home health agencies so that transfers from the hospital to these facilities are smooth, and the highest quality of care is constantly delivered. Strong relationships exist with local emergency medical service (EMS) providers through our mobile integrated health program, which delivers effective and efficient care to patients outside of the hospital. Nurses and community health workers function outside traditional emergency response roles, with a focus on maintaining individuals' health at their homes while also providing convenient access to care in the community. Additional care partners include primary care providers, specialists, local department of health, office on aging and other community based partners. We are proud to serve our community and appreciate our partners who allow us to fulfill our mission. We will always do what is right for the patient, no matter where they are in their health journey, and will always strive to have our patients receive care in the community they reside. As a part of the University of Maryland Medical System (UMMS) we are shaping a new paradigm in care delivery to address health care equity in a rural setting that we believe will be the future standard of care.

*Q245.* If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [ ] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [x] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe) _____

*Q129.* If you wish, you may upload a document describing your community benefit initiatives in more detail.

## *Q60.* Section III - CB Administration

*Q61.* Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

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

*Q246.* Please describe the third party audit process used.

UMMS engages a third party consultant to review the narrative.

*Q62.* Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

*Q63.* Please describe the community benefit narrative audit process.

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

*Q64.* Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (●) Yes
- ( ) No

*Q65.* Please explain:

*This question was not displayed to the respondent.*

*Q66.* Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

*Q67.* Please explain:

*This question was not displayed to the respondent.*

*Q68.* Does your hospital include community benefit planning and investments in its internal strategic plan?

- (●) Yes
- ( ) No

*Q69.* Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

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

*Q70.* If available, please provide a link to your hospital's strategic plan.

*Q133.* Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents
- [x] Opioid Use Disorder - Improve overdose mortality
- [ ] Maternal and Child Health - Reduce severe maternal morbidity rate
- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

*Q134.* (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

## *Q135.* Section IV - Physician Gaps & Subsidies

*Q223.* Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ○ No
- ◉ Yes

*Q218.* As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

| | Is there a gap resulting in a subsidy? | | What type of subsidy? |
|---|---|---|---|
| | Yes | No | |
| Allergy & Immunology | ○ | ◉ | |
| Anesthesiology | ◉ | ○ | Physician recruitment to meet community need |
| Cardiology | ◉ | ○ | Physician recruitment to meet community need |
| Dermatology | ○ | ◉ | |
| Emergency Medicine | ◉ | ○ | Coverage of emergency department call |
| Endocrinology, Diabetes & Metabolism | ◉ | ○ | Physician recruitment to meet community need |
| Family Practice/General Practice | ◉ | ○ | Physician recruitment to meet community need |
| Geriatrics | ○ | ◉ | |
| Internal Medicine | ○ | ◉ | |
| Medical Genetics | ○ | ◉ | |
| Neurological Surgery | ○ | ◉ | |
| Neurology | ◉ | ○ | Physician recruitment to meet community need |
| Obstetrics & Gynecology | ◉ | ○ | Physician recruitment to meet community need |
| Oncology-Cancer | ◉ | ○ | Physician recruitment to meet community need |
| Ophthamology | ○ | ◉ | |
| Orthopedics | ○ | ◉ | |
| Ololaryngology | ◉ | ○ | Physician recruitment to meet community need |
| Pathology | ○ | ◉ | |
| Pediatrics | ◉ | ○ | Physician recruitment to meet community need |
| Physical Medicine & Rehabilitation | ○ | ◉ | |
| Plastic Surgery | ○ | ◉ | |

| | | | |
|---|---|---|---|
| Preventive Medicine | ○ | ◉ | |
| Psychiatry | ◉ | ○ | Physician recruitment to meet community need |
| Radiology | ○ | ◉ | |
| Surgery | ◉ | ○ | Physician recruitment to meet community need |
| Urology | ◉ | ○ | Physician recruitment to meet community need |
| Other. (Describe) Digestive Health, Pulmonary Care, Acute Rehab, Wound Care, Palliative | ◉ | ○ | Physician recruitment to meet community need |

*Q219.* Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

As part of our ongoing strategic planning process and Community Health Implementation Plan (CHIP), UM SRH regularly evaluates the supply/demand and need for additional physicians and succession planning. In 2020, a consultant group was engaged to create a Medical Staff Development Plan; identifying gaps in physicians and physician specialties for our service area. The plan is based on service area profiles, access, medical market profiles, physician interviews, and community needs assessment. UM SRH developed a detailed recruitment/retention and succession action plan. The plan has identified the following needs and is actively engaged in recruitment and retention efforts for the following specialties; Neurology, Otolaryngology, Primary Care, Psychiatry, Rheumatology, General Surgery, Endocrinology, Medical oncology, Urology, Gastroenterology, Cardiology, Pulmonology & OBGYN.

*Q139.* Please attach any files containing further information and data justifying physician subsidies your hospital.

## *Q140.* Section VI - Financial Assistance Policy (FAP)

*Q141.* Upload a copy of your hospital's financial assistance policy.

Financial Assistance Policy - Final 10.23.20.docx
196.2KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

*Q220.* Provide the link to your hospital's financial assistance policy.

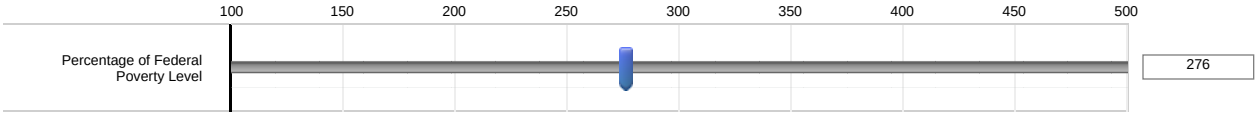
https://www.umms.org/shore/patients-visitors/for-patients/financial-assistance

*Q147.* 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:

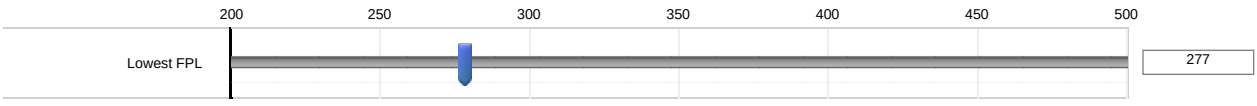
*Q143.* Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



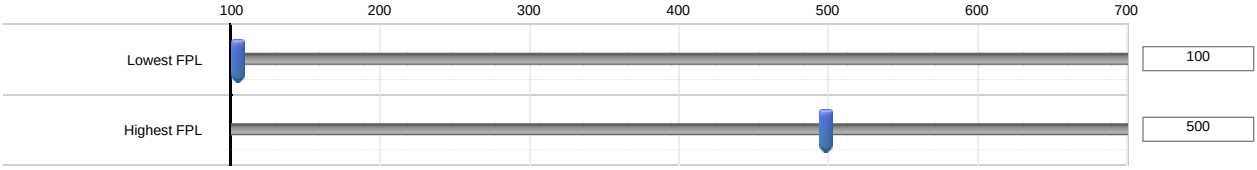

*Q144.* Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

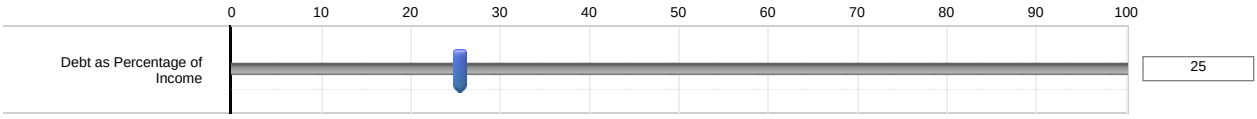



*Q145.* Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

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




*Q146.* Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.




*Q221.* Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding tax able year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [x] Local property tax (real and personal)
- [ ] Other (Describe)

## *Q150.* Summary & Report Submission

*Q151.*

### 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:** (39.264495849609, -76.622398376465)

**Source:** GeoIP Estimation

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

**University of Maryland Shore Medical Center at Chestertown**
**University of Maryland Shore Medical Center at Dorchester**
**University of Maryland Shore Medical Center at Easton**

# Community Health Needs Assessment & Implementation Plan

FY2020-FY2022

**Approved by: Shore Regional Health Board of Directors**
**5/22/2019**

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## Executive Summary

### Overview

University of Maryland Shore Regional Health (UM SRH) is a regional, nonprofit, medical delivery care network serving the Mid-Shore region, which includes Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. In addition to its three hospitals — University of Maryland Shore Medical Center at Chestertown (SMC at Chestertown), the University of Maryland Shore Medical Center at Dorchester (SMC at Dorchester), and the University of Maryland Shore Medical Center at Easton (SMC at Easton) — Shore Regional Health's diverse health care network includes: UM Shore Emergency Center at Queenstown; UM Shore Medical Pavilions at Chestertown, Easton, Denton, Dorchester and Queenstown; the Regional Cancer Center; the Clark Comprehensive Breast Center; UM Shore Home Care; UM Chester River Home Care; a broad array of outpatient diagnostic, surgery and rehabilitation centers; and medical practices under the umbrella of University of Maryland Shore Medical Group.

As the regional health care network serving Caroline, Dorchester, Kent, Queen Anne's and Talbot counties on Maryland's Eastern Shore, University of Maryland Shore Regional Health (UM SRH) provides inpatient and outpatient health care services for residents in this predominantly rural, 2,000 square mile region. With more than 2,500 employees, board members and volunteers, and a medical staff that includes 359 credentialed medical staff members, UM SRH works with various community partners to provide quality health care and to fulfill the organization's mission of Creating Healthier Communities Together.

In FY2018, UM SRH provided care for 11,560 inpatient admissions, 8,873 outpatient surgical cases, and 71,481 emergency department visits. UM SRH is licensed for 194 acute care beds. Beyond Shore Regional Health Medical Center facilities in FY2018, UM SRH provided over 18,000 hours of community health services through education and outreach programs, screenings, support groups, and other initiatives that meet community health care needs. In addition, UM SRH

provides a community outreach section on the UM SRH public web site to announce upcoming community health events and activities in addition to posting the triennial Community Health Needs Assessment (CHNA).
/www.umms.org/shore/-/media/files/um-shore/community/community-health-needs-

**Our Mission and Vision**

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

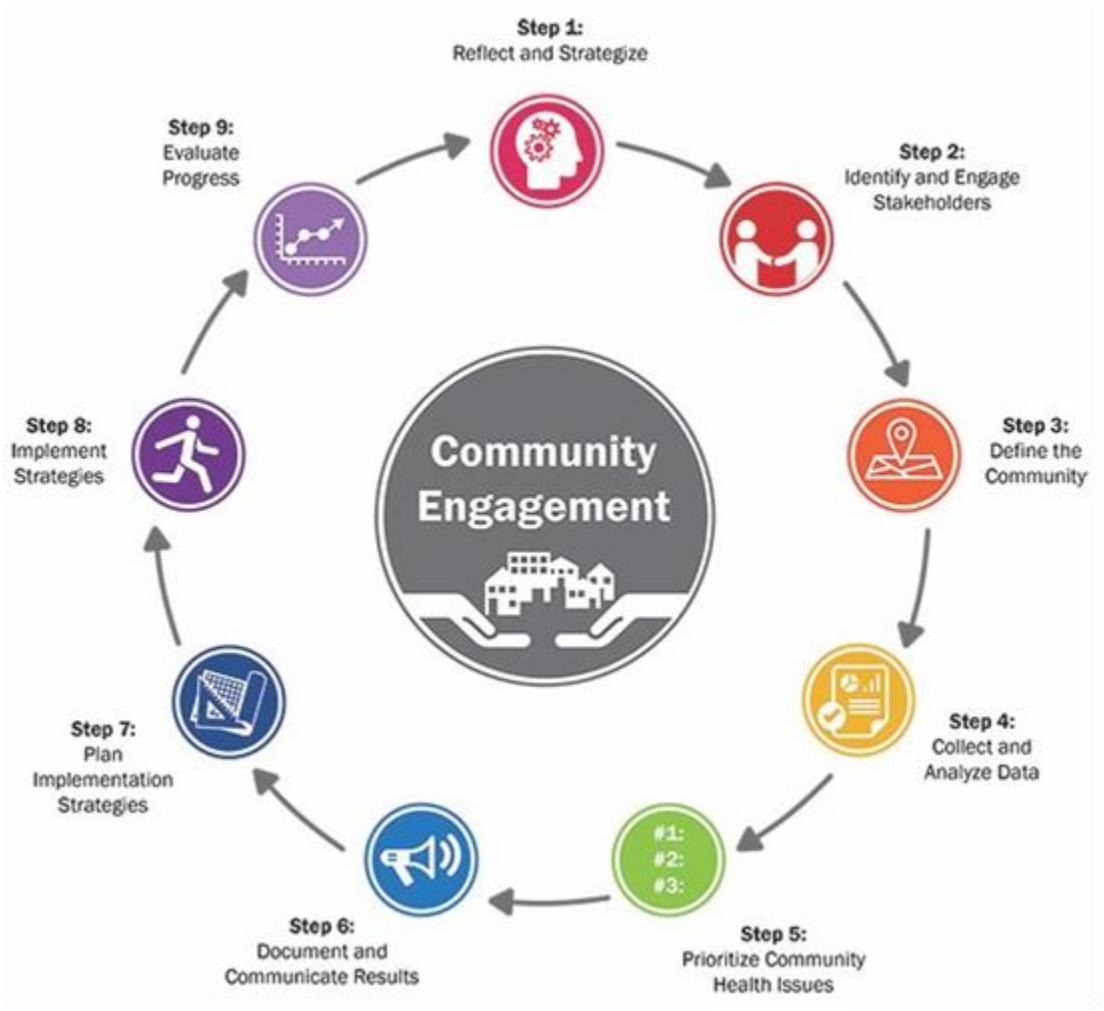
The Strategic Plan supports our **Mission**, **Creating Healthier Communities Together**, and our **Vision**, to be the **region's leader in patient centered health care**. Our goal is to provide quality health care services that are comprehensive, accessible, and convenient, and that address the needs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

## Process

### I. Establishing the Assessment and Infrastructure

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

## Figure 1 - ACHI 9-Step Community Health Assessment Process




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

## Figure 2 – 5-Step Assessment & Engagement Model


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

## II. Defining the Purpose and Scope

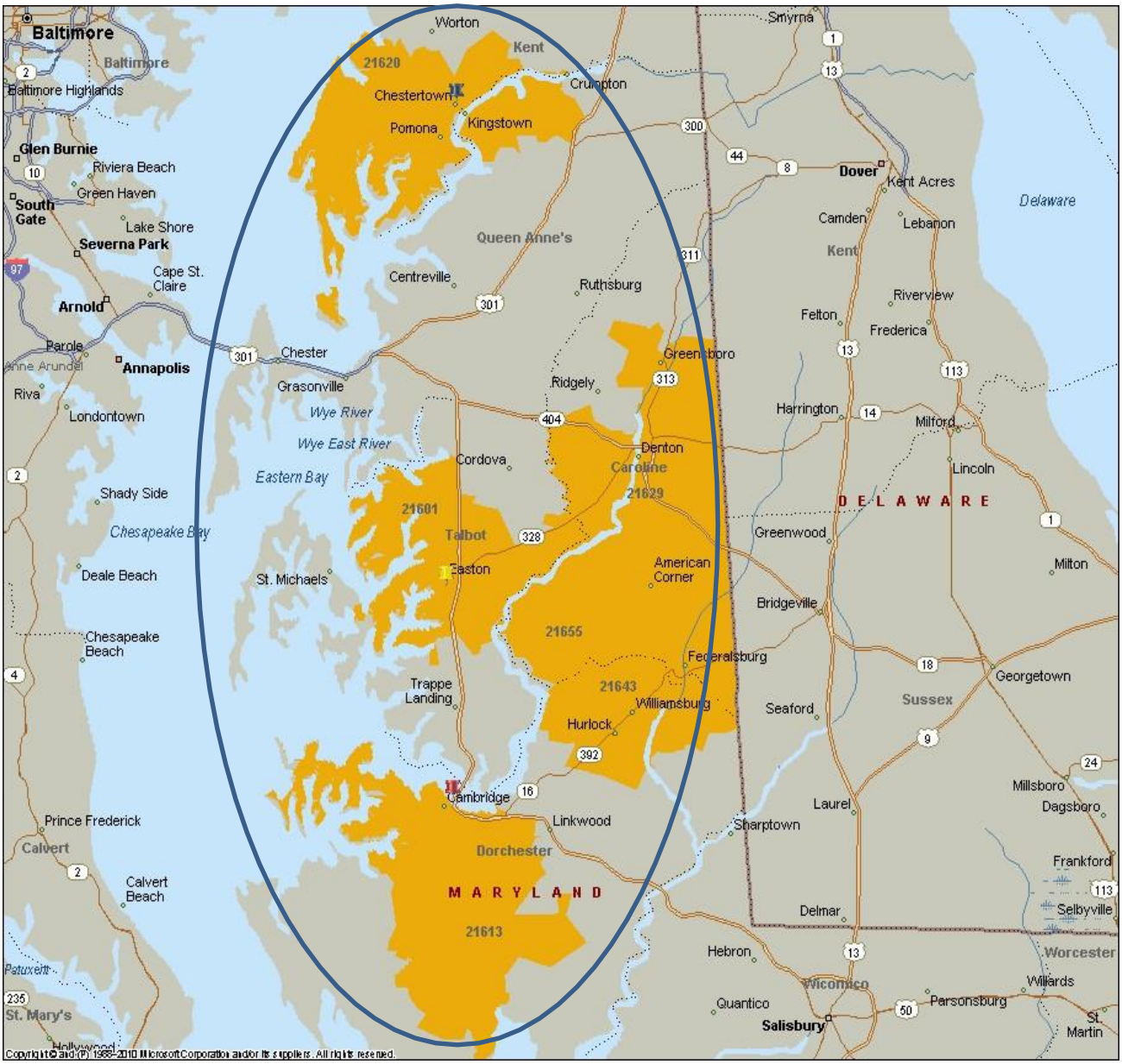
### Primary Community Benefit Service Area

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

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

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

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




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

## Zip Codes included in CBSA

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

## III. Collecting and Analyzing Data

Using the above framework (Figures 1 & 2), data was collected from multiple sources, groups, and individuals and integrated into a comprehensive document which was utilized at the planning session of the Community Health Planning Council held on April 2, 2019 During that strategic planning session, priorities were identified using the collected data and an adapted version of a widely used and referenced quantitative tool (The Hanlon method) to rank the health-related needs based on four selected and weighted criteria:

- Importance to our community- 40% weight
- Capacity to address the need - 25% weight
- Alignment with organizational and statewide goals- 25% weight
- Strength of existing intervention/collaborations- 10% weight

The identified priorities were then validated by UM SRH Strategic Planning Committee meeting on April 17, 2019.

UM SRH used primary and secondary sources of data as well as quantitative and qualitative data and consulted with numerous individuals and organizations during the CHNA, including community leaders, community partners, the University of Maryland Medical System Community Health Improvement Committee, the general public, local health experts, and the Health Officers representing the five counties of the Mid-Shore.

Additionally, UM SRH reviewed the data and findings of two recent and comprehensive studies focused on rural health care delivery and rural health care needs of the Mid-Shore.

- **Maryland Mid-Shore Rural Health Study,** November 2017

  Purpose:

  To help better meet health care needs in the Mid-Shore region and provide recommendations that could be applied to other Maryland rural areas, the

Maryland Health Care Commission (MHCC) and the Department of Health established a workgroup on rural health care delivery to oversee a study, hold public hearings and recommend policy options.

The report's recommendations for restructuring and enhancing the health care delivery system on the Mid-Shore were based on:

- focus groups with residents;
- interviews with community leaders;
- analyses of claims and primary care physician workforce data;
- review of literature and national models; and
- input from the Workgroup, and its advisory groups and public hearings.

"Health Matters: Navigating an Enhanced Rural Health Model for Maryland, Lessons Learned from the Mid-Shore Counties" is the executive summary and report detailing the findings of the group's studies. The data and recommendations from the Mid-Shore Rural Health Study were utilized to inform the Shore Regional Health Strategic Planning Committee and Community Health Planning Council in the development of implementation strategies to improve the access and delivery of health services in the region.

- **Maryland Rural Health Plan**, October 2018

Purpose:

The updated Maryland Rural Health plan is a comprehensive examination of the rural health care needs of Maryland conducted by the Maryland Rural Health Association. The 2018 Maryland Rural Health Plan examined existing county health plans and Community Health Needs Assessments (CHNA), the Maryland State Health Improvement Process (SHIP) data, results from a state appointed study on Maryland's Eastern Shore. Data was aggregated by topic and themes identified from multiple data sources emerged as key priorities.

Findings were collated for the state, with county profiles highlighting their specific results. The Maryland Rural Health Plan documents the health needs for the Mid-Shore as well as serves as a roadmap to develop actionable and practical strategies.

https://mdruralhealthplan.org/

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

## A) Community Perspective

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

### Methods

The survey was distributed in FY2019 using the following methods:

- The link for the online survey was circulated to over 78,000 households within the CBSA via a community health newsletter ***Maryland Health Matters***
- Online survey posted to UM SRH website
- Health fairs and events in neighborhoods within UM SRH's CBSA

The data from the two Rural Health Studies was also examined and considered:

Focus group findings from:

- Maryland Rural Health Plan, October 2018
- Maryland Mid-Shore Rural Health Study, November 2017

### Results

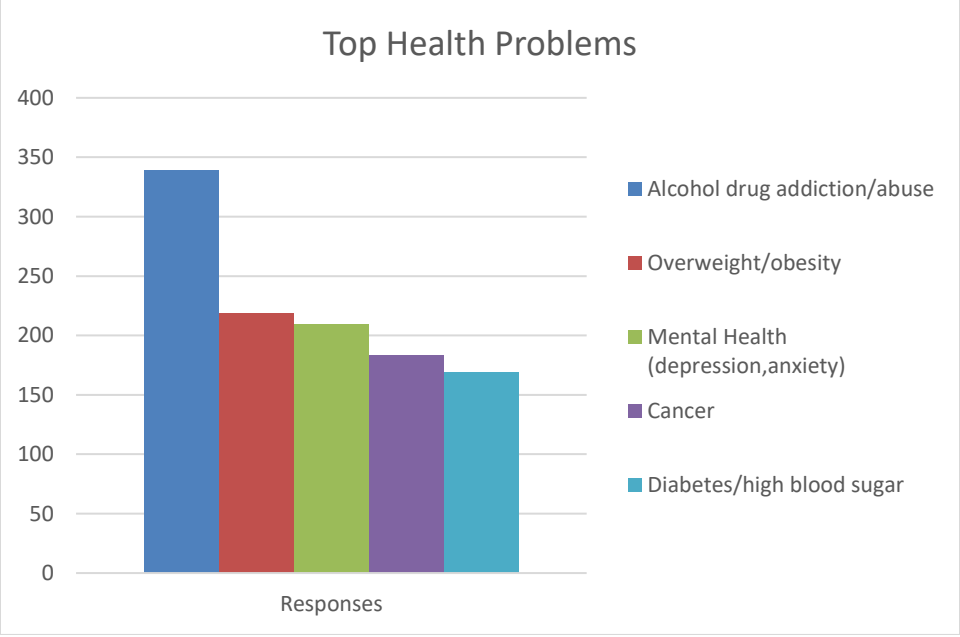
- Top 5 Health Concerns from survey (See Chart 1 below)
    1. Alcohol drug addiction/abuse
    2. Overweight/obesity

3. Mental Health (depression, anxiety)
4. Cancer
5. Diabetes/high blood sugar

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

**Chart 1 - Community's Top Health Concerns**

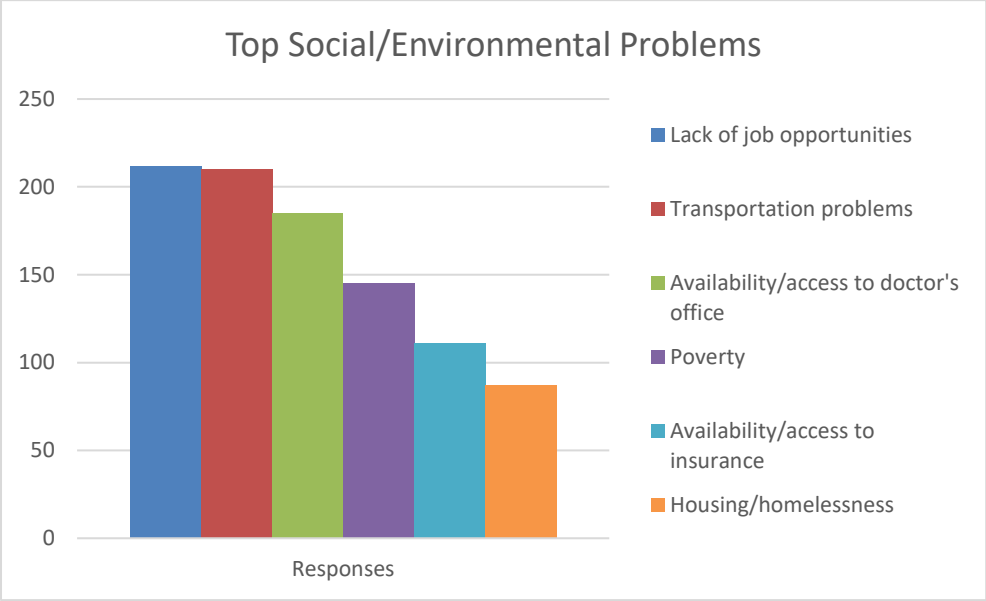
**Question:** What are the three most important health problems that affect the health of your community?




THE SAMPLE SIZE WAS 506 MID-SHORE RESIDENTS FROM THE IDENTIFIED CBSA.

## Chart 2 - Community's Top Health Concerns

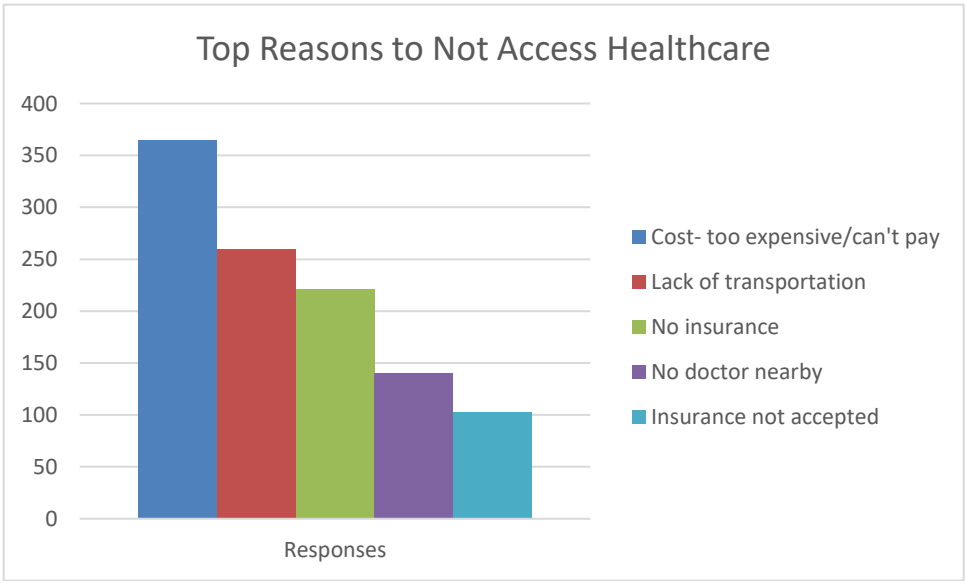
**Question:** What are the three most important social/environmental problems that affect the health of your community?




THE SAMPLE SIZE WAS 507 MID-SHORE RESIDENTS FROM THE IDENTIFIED CBSA

## Chart 3 – Community's Top Barriers to Healthcare

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




THE SAMPLE SIZE WAS 504 MID-SHORE RESIDENTS FROM THE IDENTIFIED CBSA

- **Focus group findings from the Maryland Mid-Shore Rural Health Study:**

  Technical Report 1- Residents' View

  As part of the Maryland Mid-Shore Rural Health Study, the University Of Maryland School Of Public Health, in partnership with the Walsh Center for Rural Analysis at NORC at the University of Chicago, conducted five focus groups — one in each county of the Mid-Shore. Residents shared their perceived ideas of the strengths and weaknesses of the current healthcare delivery system. Generally speaking, residents in the Mid-Shore region recognize that healthcare systems need to accommodate culturally diverse populations and the growing number of vulnerable residents, including elders with chronic health conditions. The residents also feel that in order to improve the healthcare delivery system, recommendations must address social determinants of health. Residents support an integrated care delivery system across a continuum of care with services as close to home as possible.

  Top concerns identified by the Rural Health Study focus groups:

  - Health insurance and costs: cost and coverage difficulties
  - Specialty care lacking or far away
  - Mental, behavioral and substance use care: access and affordability
  - Need for care coordination, case management and patient navigation

- **Focus group findings from the Maryland Rural Health Plan**

  Top 5 barriers to accessing care:

  - Transportation
  - Health Insurance
  - Overbooked providers
  - Hours of Service
  - Lack of care coordination

  Gaps in service:

  - Lack of specialists and oral health services
  - Lack of behavioral health providers

## B) Health Experts

### Methods

- Reviewed and included National Prevention Strategy Priorities, Maryland State Health Improvement Plan (SHIP) indicators, findings from the Maryland Mid-Shore Rural Health Study and Maryland Rural Health Plan, Robert Wood Johnson County Rankings and Roadmaps, and Hospital Inpatient Readmissions and High Utilizer data.
- Healthcare providers' perspective was obtained through a survey distributed to the medical staff of UM SRH. The survey queried providers of care to identify the community's top health concerns and top barriers in accessing health care.

### Results

- National Prevention Strategy – 7 Priority Areas
    - Tobacco Free Living
    - Preventing Drug Abuse and Excessive Alcohol Use
    - Healthy Eating
    - Active Living
    - Injury and Violence Free Living
    - Reproductive and Sexual Health
    - Mental and Emotional Well Being
- SHIP: 39 Objectives in 5 Focus Areas for the State (Figure 4), includes targets for Caroline, Dorchester, Kent, Queen Anne's, Talbot counties:
  - While progress has been made since 2016 - each county's progress varies widely on meeting the identified targets at the state level. Wide disparities exist within the CBSA territory. (See Appendix 2 for SHIP data by county)

  Results for Mid-Shore SHIP Measures:
    - Caroline County has met 14 of 39 SHIP goals
    - Dorchester County has met 7 of 39 SHIP goals
    - Kent County has met 12 of 39 SHIP goals
    - Queen Anne's has met 18 of 39 SHIP goals
    - Talbot County has met 18 of 39 SHIP goals

  Goals not met for the following areas for at least 4 of the 5 counties of the Mid-shore:
    - Life expectancy
    - Cancer mortality rate
    - Adults who currently smoke
    - Obesity -Adolescents who have obesity/Adults who are overweight or obese

- Emergency Department visit rates due to:
  - *Diabetes*
  - *Hypertension*
  - *Mental Health Conditions*
  - *Asthma*
  - *Addictions Related Conditions*

■ Analysis of provider surveys revealed the same top health concerns and top health barriers with little deviation from the community (consumer survey) and overall DHMH State Health Improvement Process.

■ **Maryland Rural Health Plan:**

Feedback from health care professionals for the Mid-Shore:
Top 5 barriers to accessing care:

- Transportation
- Stigma and culture
- Insurance coverage and affordability
- Awareness of services
- Health literacy and health insurance literacy

Gaps in service:

- Lack of specialists and oral health services
- Lack of stable funding

**C) Community Leaders**

**Methods**

■ A series of structured interviews/focus groups were conducted to obtain input from those with knowledge of specific communities, focus areas or disease states (January – February 2019)

**Results**

- Top Health Priorities and Concerns:

  **Access to care:**

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

  **Sustainable funding:**

  - Caught in transition between payment for value versus payment for volume (GBR versus fee-for-service)
  - Shift in health departments from direct service delivery to programs with limited capacity to bill for services

- **Maryland Mid-Shore Rural Health Study:**

  <u>Technical Report 1- Community Leaders' Perspectives</u>

  Community leaders reported challenges/concerns about:

  - Hospital care availability
  - Lack of primary care providers and specialists
  - Limited public and medical transportation
  - Needs of vulnerable populations.

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

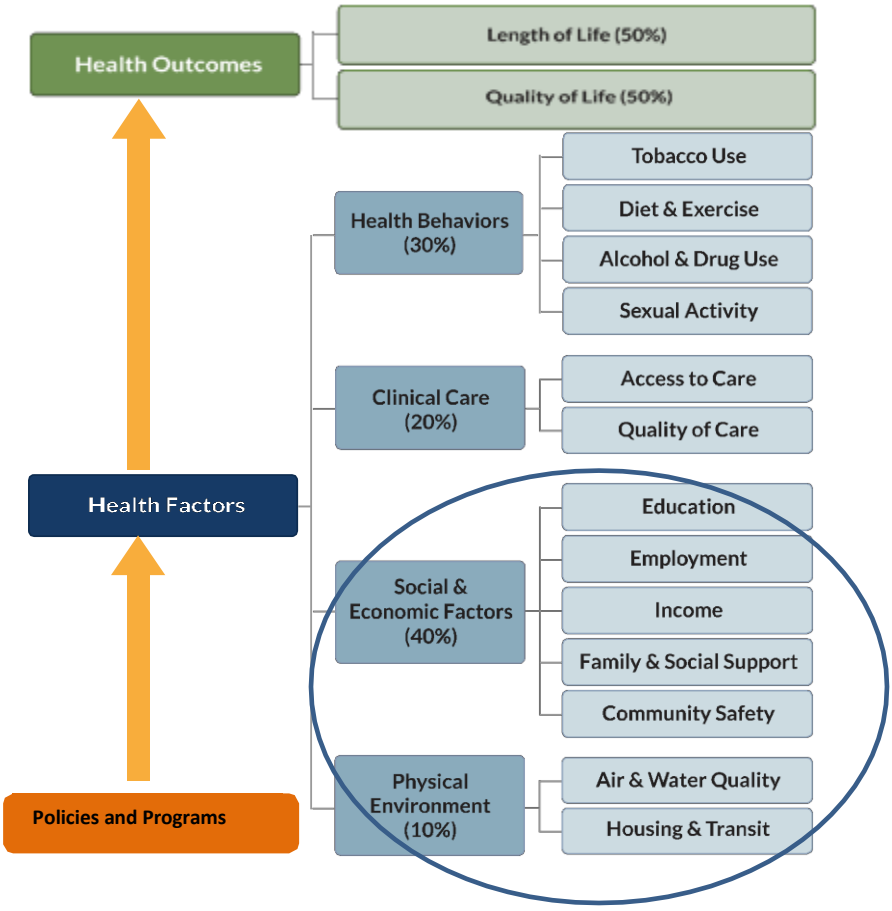
**D) Social Determinants of Health**

**(SDoH) Methods**

- Reviewed SHIP data from Maryland Health Department's MDH data (Appendix 2)
- Reviewed data from Robert Wood Johnson Foundation, County Health Rankings & Roadmaps. (See Appendix 3)

## Results

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




- Top SDoHs impacting health on the Mid-Shore as reported in the Robert Wood Johnson County Health Rankings & Roadmaps 2018 report are:
  - Low Education Attainment (Dorchester and Caroline)
  - High Poverty Rate (Dorchester 15.4%, Caroline 16.5%, Kent (13.2%)
  - Children in Poverty (Dorchester 29%, Caroline 22%, Kent, 20%)
  - High Unemployment Rate (Dorchester 5.7%)
  - Severe Housing Problems (Caroline 19%, Dorchester 19%)

**Local Health Context**

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

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

**E) Health Statistics/Indicators**

**Methods**

Review annually and for this triennial survey the following:

- **Local data sources:**
  - MDH SHIP data
  - Maryland Chart book of Minority Health and Minority Health Disparities Data

- **National trends and data:**
  - Healthy People 2020
  - Robert Wood Johnson County Health Rankings
  - Centers for Disease Control reports/updates

**Results**

- Robert Wood Johnson County Health Data

County Rankings: position out of 23 counties plus Baltimore City

| | Caroline | Dorchester | Kent | Queen Anne's | Talbot |
|---|---|---|---|---|---|
| **Health Outcomes** | **22** | **21** | **16** | **9** | **10** |
| **Length of Life** | **23** | **19** | **14** | **11** | **9** |
| **Clinical Care** | **24** | **23** | **19** | **10** | **4** |
| **Social & Economic Factors** | **19** | **22** | **13** | **6** | **11** |
| **Physical Environment** | **19** | **15** | **10** | **4** | **2** |

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

Health Behaviors

- Adult smoking
- Adult Obesity

Clinical Care

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

- Outcomes Summary for CBSA territory

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

1. Heart Disease
2. Cancer
3. Stroke

## IV. Selecting Priorities

Analysis of all quantitative and qualitative data described in the above section identified these top five areas of need within the Mid-Shore Counties. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths

and mission. These priorities were identified and approved by the Community Health Planning Council (See Appendix 6) and validated with the UM SRH Strategic Planning Committee.

- **Results**: Prioritization- with one being the greatest need:
  1. Access to Care
  2. Preventable ER visits
  3. Chronic disease management
  4. Mental Health/substance abuse
  5. Cancer

## V. Documenting and Communicating Results

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

## VI. Planning for Action and Monitoring Progress

### A) Priorities & Implementation Planning

Based on the above assessment, findings, and priorities, the Community Health Planning Council developed the Community Health Implementation Plan (CHIP), made publicly available June 2019. This plan is a living document that provides concrete actionable strategies for addressing the health needs of the Mid-Shore. UM SRH will track and evaluate progress towards achieving long-term outcome objectives measured through Maryland's Department of Health (MDH) SHIP metrics. Short-term programmatic objectives, including process and outcome metrics will be measured annually by UM SRH for each priority area through the related

programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

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

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

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

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

## B) Unmet Community Needs

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

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# Community Health Implementation Plan, FY2020-FY2022

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

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

Based on qualitative and quantitative data collected and analyzed during the CHNA process, UM SRH's Implementation Plan remains committed to the goals and strategies identified in the 2016 CNHA. Although some of the focus areas have changed in their order of priority per community feedback, the overall needs remain the same as reported in the 2016 CHNA.

**Health Priorities FY2020-2022**

The top five priorities:

1. Access to care
2. Preventable ER visits
3. Chronic Disease management
4. Mental health/substance abuse
5. Cancer

Overarching theme for addressing health priorities:

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

UM SRH is engaged in numerous programs addressing the identified needs of the Mid-Shore. The UM SRH hospitals — SMC at Chestertown, SMC at Dorchester, and SMC at Easton work to

strategically allocate scarce resources to best serve the communities, increase trust and build stronger community partnerships.

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

| HEALTH NEED 1: ACCESS TO CARE | | | |
|---|---|---|---|
| **Goal** | **Strategies** | **Metrics/What are we measuring** | **Potential Partnering/External Organizations** |
| Goal: Improve access to care for medically underserved and vulnerable groups of all ages and populations | **Strategy 1**: Increase capacity by addressing the recruitment, retention, accessibility, competency of providers | • Medical Staff assessment-identify shortages<br>• Provide/fund physician subsidies to meet identified community needs<br>• Establish physician/resident training programs | • University of Maryland School of Medicine and UMMC<br>• Eastern Shore Area Health Education Center (AHEC) |
| | **Strategy 2:** Enhance and Expand Telemedicine Opportunities | • Increase total consults<br>• Identify and implement new consult services: Dermatology and Child/Adolescent Psychiatry currently under negotiation | University of Maryland Medical Center, University of Maryland Faculty Physicians, (FPI) University of Maryland School of Medicine (SOM) |
| | **Strategy 3:** Reduce transportation barriers and enhance awareness of available services | • Number of transportation vouchers<br>• Resource information distribution<br>• Participate Mid-Shore Rural Health Collaborative Transportation Workgroup | • Delmarva Community Transit (DCT) and Queen Anne's County Ride cover Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties<br>• Rural Health Collaborative |
| | **Strategy 4**: Connect uninsured to private insurance, Medicaid, or other available coverage | • Number of insured residents | • Maryland Health Exchange |

ACTIVITIES/INITIATIVE:

**Recruit** additional health care providers and specialists to the region. Provide subsidies to increase the availability of health care providers in order to best meet identified patient and community needs related to the availability of health care services.

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

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

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

| **HEALTH NEED 2: Preventable ER Visits** | | | |
|---|---|---|---|
| **Goal** | **Strategies** | **Metrics/What are we measuring** | **Potential Partnering/External Organizations** |
| Goal: Help patients obtain "The Right Care, at the Right Place, at the Right Time" | **Strategy 1**: Provide community health education to improve understanding of appropriate use of primary care, urgent care, and emergency department in terms of medical capability and patient needs | • Decrease in unnecessary emergency department visits<br>• Increase health in literacy | • Payers<br>• Community media outlets |
| | **Strategy 2:** Improve care coordination, info sharing protocols to achieve safer, more effective care | • Protocols developed<br>• Chronic disease management | • Community providers<br>• five county health departments<br>• social services<br>• EMS agencies<br>• Aging agencies |

ACTIVITIES/INITIATIVES:

**Educational topics include**:

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

**Rural Health Collaborative:** UM SRH participates as a member on the Integrating Clinical and Social Support Services Workgroup. This workgroup supports the Rural Health Collaborative in determining actions that can be taken within the five Mid-Shore counties and throughout the Mid-Shore region to better integrate clinical and social support services. The Workgroup is charged with:

- Articulating the overarching problem to be addressed
- Identifying the current status of clinical and social support services and the resources supporting those services (including the components being added by the Maryland Total Cost of Care Waiver beginning January 2019)
- Determining the optimal availability and integration of clinical and social support services
- Deciding what is feasible to achieve by 2023 to better integrate clinical and social support services and steps to take to do so
- Recommending actions for improving integration of clinical and social support services to the Care Transformation Organizations and/or the Care Managers assigned to Primary Care Providers.

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

| | | | |
|---|---|---|---|
| | **Strategy 3:** Provide specialized health information, "physician to physician" education regarding diabetes treatment and management. | • Number of provider outreach education sessions for primary care offices and medical staff | • Community providers |

ACTIVITIES/INITIATIVES EXAMPLES:

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

**Engage targeted communities on healthy lifestyles**: Through sponsorship or provision of:
- Community-wide education
- Store Tours
- Community Screenings & Referrals (Blood pressure, BMI/Weights, & Cholesterol)
- Exercise Demonstrations

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

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

| **HEALTH NEED 4: BEHAVIORAL HEALTH** | | | |
|---|---|---|---|
| **Goal** | **Strategies** | **Metrics/What are we measuring** | **Potential Partnering/External Organizations** |
| Goal: Improve access and integration/ coordination of mental health and substance abuse services | **Strategy 1**: Provide individual, group, medication assisted treatment, and other mental health services, including prevention and support services | • Decrease re-hospitalization<br>• Number of patients who accept treatment following an overdose<br>• Number of adults who utilize services<br>• Increase family and patient understanding of mental health treatments. | • Eastern Shore Crisis Response<br>• Queen Anne's, Talbot, and Dorchester County Health Departments<br>• Shore Medical Group Bridge Clinic |

| | | | |
|---|---|---|---|
| | **Strategy 2:** Expand program(s) to support ED patients waiting for outpatient mental health and/or substance use disorder treatment | • Number of patients served by the Bridge Clinic<br>• Number of follow-up phone calls and outreach to patients who have experienced an overdose | • Corsica River Mental Health Center<br>• Community Behavioral Health<br>• Marshy Hope Mental Health |
| | **Strategy 3:** Improve care coordination for mental health and substance abuse co-occurring conditions through facilitation of direct hand-offs to the next level of care | • Number of patients referred between systems<br>• Improve access by providing education regarding available resources and services | • Mid-Shore Behavioral Health System<br>• Eastern Shore Crisis Response<br>• Physician practices<br>• Local Health Depts. |

ACTIVITIES/INITIATIVES EXAMPLES:

**Behavioral Health Bridge Clinic.** The Bridge Clinic serves patients discharged from the behavioral health inpatient unit who are unable to access psychiatric care from community due to shortage of psychiatric providers.

Continue to provide: (1) medication administration assistance to complement counseling services currently being offered and to assist post discharge overdose patients; (2) injection support/education clinic to promote use of long acting psychotropic medications

**The Bridge Clinics family group meeting**. Community supporters of patients and in particular patients' family members receive education and support regarding mental health and treatment strategies. Assist families in maintaining positive support for their loved ones.

**Education**: To improve access to mental health care, programs are offered on a quarterly basis to the community providing up to date information on available mental health resources and services.

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

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

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

ACTIVITIES/INITIATIVES:

**WELLNESS FOR WOMEN ACCESS TO CARE PROGRAM**

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

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

**LUNG CANCER EARLY SCREENING PROGRAM**

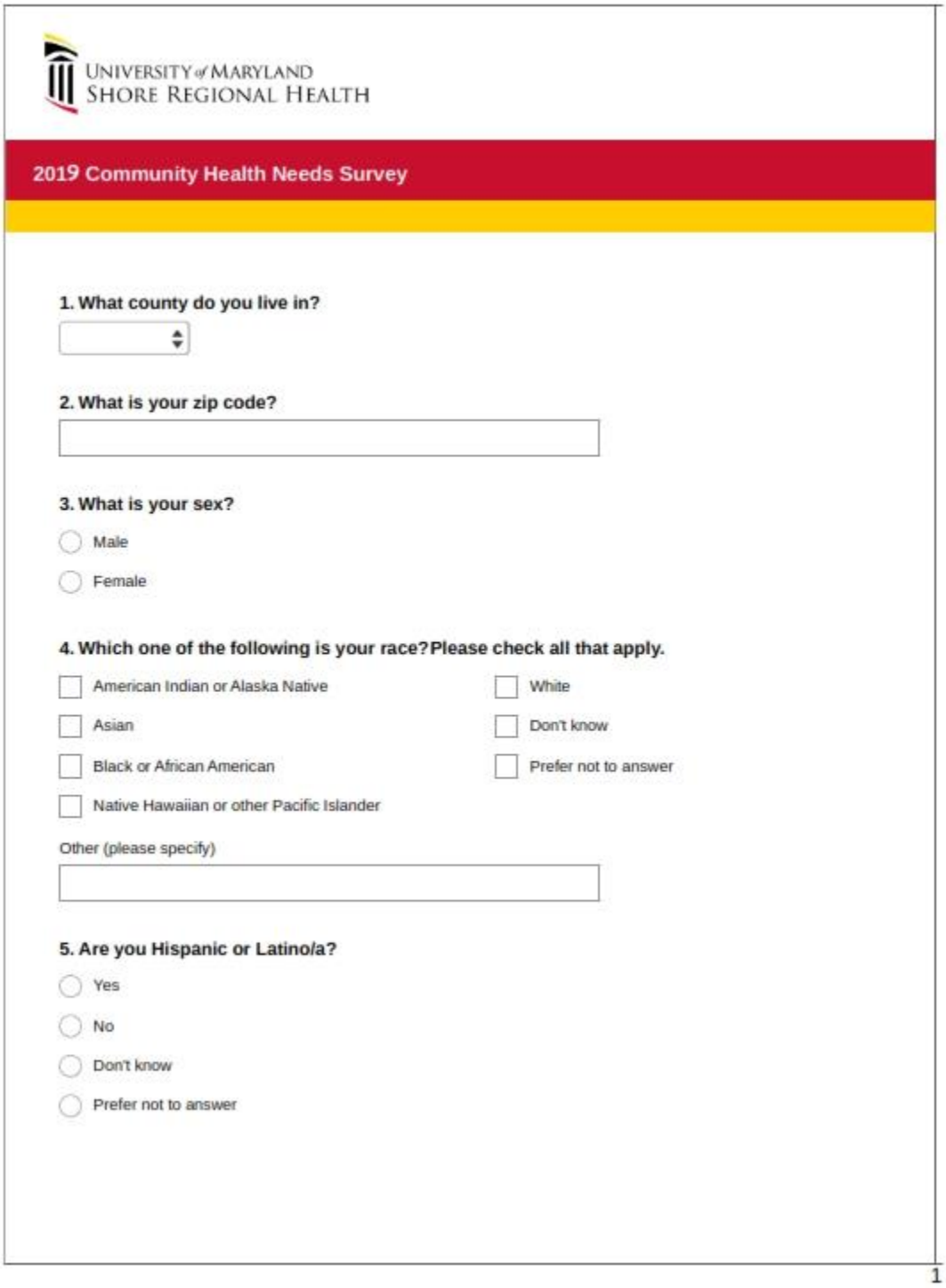
The low dose computed tomography (LDCT) screening program promotes earlier detection of lung cancer. Eligible patients are the high-risk groups which include those who have smoked a pack of

cigarettes daily for two or three decades, who are currently smokers, or those who quit smoking less than 15 years ago to have them screening for lung cancer. Earlier detection promotes better treatment and survival rates.

**ANNUAL PROSTATE SCREENING**

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

## Appendix 1 – Community Survey



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2019 Community Health Needs Survey

**1. What county do you live in?**

**2. What is your zip code?**

**3. What is your sex?**

- Male
- Female

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

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

Other (please specify)

**5. Are you Hispanic or Latino/a?**

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

1

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

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

Days

_____

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

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

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

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

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

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

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

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

Name

Email Address

Phone Number

3

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

### Caroline County Comments

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

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

- Don't know
- More outreach needs to be done for the community. I work for the Medicaid Department at the
- County Health Department and a lot of the community do not know that we are available to help them sign up for health insurance.
- Mobile health unit, outpt clinics, with scheduled transportation
- TRANSPORTATION TO HEALTH CARE FROM A PATIENT S HOME. SECONDARY INSURANCE FOR MEDICARE WITH PRE EXISTING HEALTH PROBLEMS.
- More Primary Care practices. Let's look in to Holistic & Naturopathic. So many issues that could be corrected by holistic health means- improved mental health, obesity etc.
- CLINICS AT THE HEALTH DEPT
- More availability of providers & not being put on a waiting list. More flexible transportation Understanding of conditions/diagnosis
- Need Behavioral Health services

## Dorchester County Comments

- Increase transportation options, more physicians
- More resources for Diabetes/ High Blood Pressure patients. Increased accessibility to informational and exercise programs.
- I would talk with Church leaders to have an exercise or activity program. Go walking with your neighbor. Be aware of the health content of products "Read everything"
- The suggestion I have is better transportation, have several different times throughout the day that a medical bus can be taken to doctor offices with different pick up and drop off areas where patient can get bus from and bus should make stops to all medical doctors in Cambridge.
- More accessible health care and more providers. New construction for medical offices.
- More options to eat healthy at reasonable cost
- More job opportunities. Increased community services.
- Promote more of what we have to offer now.
- To move forward with the Shore Health new building and access to doctors in one area
- More availability to teledoctors or satellite clinics. Health Dept. to expand services to assist the public in guiding people to needed services and offer classes/education (cpr, nutrition, stds, family planning, etc.). Additional staff & area to expand clinic so more people can be seen.
- Our community needs more specialist in the area. To go to a specialist, we need to travel to other counties and transportation is an issue for many residents.
- Not Sure

- Make insurance affordable, especially for seniors.
- Improve transportation to include weekend transportation
- At this time, I think it would be important to have more access to a physicians in the local community.
- 1) I don't know if this is still a problem, but 3.5 years ago, there was no availability of in-home speech and occupational therapy services that accepted United Healthcare insurance; my husband could only get in-home physical therapy and skilled nursing services even though he had a great need for continuation of OT and speech therapy services that he had been receiving while in-patient. 2) Shore Rehab only offers 40 minute therapy sessions while other PT providers in the area offer 1 hour sessions. Since our insurance covers the 1 hour sessions, but is limited to number of days of therapy, it is more beneficial for a patient to seek PT services elsewhere, even though the staff is great at Shore Rehab.
- Shore home health care need to more helpful
- A community pool in northern co
- No idea- awareness campaigns for eating healthy, no smoking, it's just a very poor place in general with many homeless who probably prefer not to be seen or participate in any programs. Education and employment opportunities and/or a willingness to work at jobs migrant workers previously held, who are now prohibited from entering the US to fill. It's a generational thing around here, sadly.
- More and better jobs. More and better education. More and better access to health care.
- Stop all the drug use
- Affordable health insurance, medical provider in Hurlock, safe place for senior citizens to walk.
- Do not get rid of facilities Many citizens live 45-60 minutes away from Cambridge and adding a 20 minutes' drive to Easton or 40 minutes' drive to Salisbury would jeopardize their health care
- There is a group of ladies that go with people to the doctors and help them learn about their health and they use to be ABC but I am not sur if the name now because it changed to Eastern Shore something, but their program is really helpful because me and my mom were able to work with them and now my mom is off of her High Blood Pressure Meds and I have lost 34 pounds through their program.
- Establish high performance heath call center for system to include all physician medical groups - including independent groups.
- Collaborate with EMS services to include screening & preventive services and establish referral process to outpatient services such as CP Rehab & Diabetes Center.
- Increase access to community education and health screening & preventative services.
- Creative solutions like mobile healthcare
- Need physicians in local doctor offices, vs. Nurse practitioners.
- We desperately need more facilities to help those with mental illness and addiction.
- Higher wages for techs to get a better pool of people to apply
- Effective ways of fighting disparities in people of color, which is another way of saying color discrimination in health care

- Affordable public transportation other than MA, due to the fact that it's an all-day process and becomes difficult with parents that have other children and lack of support.
- Transportation available to & from doctor's office to be made more convenient & available at very low cost or free.
- Stricter alcohol & tobacco sales (check ID on everyone).
- People need to start helping themselves also
- Educate the people here to care about their health and increase nutritional classes
- I think that healthcare should be free for all.
- More specialists having hours in Dorchester County; more flexible public transportation
- More farmer's markets and more availability to them in season. Obesity from poor eating choices is a huge issue but I honestly don't know how to address it; it is now a generational issue.
- Safer places to walk without having to run from dogs. Having access to the Cambridge Bridge. More sidewalks on side streets to give neighborhoods access to walking.
- I think if we make patients medication more affordable and physicians are able to spend more time with their patients we would have less readmissions and less patients going to the Emergency Room instead going to PCP.
- Partner with pharmacies more
- Correct items listed above (survey questions)
- Education
- Have more minority and culturally competent professionals and staff. Individuals with compassion and empathy and are willing to learn and understand the culture of those in this community.
- Not sure at the moment
- More support groups and seminars to the general public with information on fighting poverty
- I find that a lot of people that live in Hurlock do not have transportation... So having monthly farmer markets or resource health fairs would be nice. Also the teenage population middle and high school do not have anything recreational to do that would improve their health and keep them out of trouble.
- Awareness of ACES - Adverse Childhood Experiences and their impact on health; tougher child welfare laws so children are truly protected; more mental health services available in schools; trauma informed schools
- Access to Free or Reduced cost Mental Health
- More Prevention for Children (mentors, character counts)
- Anonymous Mental Health
- Free or Reduce Health Care Clinic
- Better programs to address obesity.

- More access to mental health programs.
- Develop a health food store that has lower costs (Similar to Superfresh or Whole Foods), allow individuals who have Medicare and Medicaid to use their health insurance benefits towards the cost of healthy foods to improve their health, increase door to door transportation for individuals who have disabilities or limited mobility; give health-related business incentives and tax deductions for moving to Dorchester County, improve the communication with County and the City of Cambridge to help senior citizens and individuals who have disabilities navigate necessary services within the community; and give employers incentives for becoming disability friendly.
- Mobile screening trailers, education in schools and health fairs
- MORE DRUG ADDICTION RESOURCES AND EDUCATION
- Medical uber
- More diabetes education during the day. Some people can't drive at night
- Make hours more convenient. People that work cannot take off 8-4:30. Need later hours 2-3 days a week. This goes for doctors and physical therapy. Maybe until 6-6:30.
- Provide additional services to small business owners, provide programs and services to those middle income bracket families not just those in poverty, better school system discipline to not tolerate disruptions to other students.
- Educate /motivate people to get jobs as opposed to trying to work the system to stay at home and live off the government and hand-outs. Understand there are people in need, but many who just prefer not to work.
- Education, Healthy Lifestyles that are affordable.
- Need more primary care options
- It is estimated that in the next 20-30 years the number of people with Alzheimer's disease and related Dementias will triple. Our community will be significantly impacted by this because of a vast percentage of our population being 65+. More work needs to be done to educate the community about cognitive impairments and how to care for those suffering from them.
- Help people with no insurance and help to get healthy food cost down
- Universal healthcare

## Kent County Comments

- Keep our regional hospital
- That Chestertown have a hospital serving the needs of the community and county. You are NOT providing adequate health care to Kent County!!!
- Keep the hospital open!
- More comprehensive services at the local hospital like 25/7 emergency cardiac care. Closer access to trauma services, transportation, better access to GOOD specialists.

- Keep the hospital open as full care facility.
- Give more educational programs at a time and location that people can attend
- If going to make current hospital an emergency room only then have Dr who look like Dr. Not sloppily dressed and appears to be dirty like the one who treated my brother in law last month.
- Free day care.
- This is a fairly affluent community, obesity a problem in some areas. Information is not readily accessible
- more doctors
- Keep the hospital open and viable. Make access to specialists possible to people who do not have transportation to urban areas and teaching hospitals.
- Better education and communication
- More health expos, and doctors' seminars on public health issues.
- Mental health awareness, pediatric specialist for mental health
- Adult fitness facility.
- Stop the downgrading of the hospital in Chestertown. Only a glorified emergency room and not much else (too few inpatient beds and backup services for them and the ER) are not acceptable, with the situation downright dangerous. For the first time in my 65+ years I have no primary-care provider as there are only waiting lists for the creditable ones (internists esp.). Traveling 35 miles or so for one is not realistic.
- Retain inpatient and outpatient care at the hospital and open an urgent care clinic
- We need more doctors in and nearer to Kent County.
- Keep our hospital. Many seniors move here because of availability of community hospital. They bring $s and intellect via volunteering and participation.
- Clearly you have skewed these questions to reach a foregone conclusion. The real problem in County revolves around the downgrading of our hospital from an excellent facility to one to be avoided. Patients did not used to be shipped to Baltimore to get basic services, now they are. Patients did not used to travel to Middletown, De to see a doctor, now it is commonplace. Patients did not travel to Christiana Hospital for care except in special circumstances, now they must just to get basic hospital services.
- A viable hospital that plays an integral role in the community's health.
- Keep hospital in Chestertown.
- Keep our Hospital providing quality inpatient care. Encourage new Primary Care Physicians to come to town.
- Prioritize prevention through the Health Departments.
- Maryland state support of the hospital in Chestertown to ensure it will always provide inpatient care, including ICU; increased telemedicine (nephrology, behavioral, neurology, gerontology); 24/7 on-call cardiology, general surgery, orthopedic surgery; 911 responders to evaluate medical, mental, dietary,

housing, transportation & other needs of frequent Emergency Dept. patients & hospital inpatients; increased availability inpatient addiction services.

- Reinstate pediatrics at the hospital in Chestertown. More PCPs in/near County. More mental health providers, including prescribers in/near County.
- more doctors
- Provide financial incentives for medical professionals to locate to rural areas to county. There is currently a lack of general practitioners as well as specialists. Wait times are often very long. The local hospital is a must. We need a place to get prolia for our aging population. The UMMCG offices in Chestertown and Denton and Centreville should be able to provide this service in their office. My mother fell and broke her hip because she hasn't been able to get her shot in over a year due to constraints in transportation to Easton to get it. This is ridiculous
- We need more primary care doctors that are accepting new patients. So many of the established practices aren't available to new residents or those who've changed insurance, etc.
- We need an urgent care facility
- Urgent care center, open to those with or without insurance with same care quality to both.
- Consider a partnership of care with the Elkton Hospital. In addition, satellite offices for routine care and surgical follow ups, at minimum 2 times a week. A few young mothers would like to see a certified mid-wife clinic for pre-natal care. Note: there is no pediatric emergency care in Chestertown.
- More accessible mental health nearby and need for walk in clinic to handle non-emergent health situations
- More job opportunities as well as safe things for kids to do when not in school
- Encourage healthier eating and weight management. Obesity a huge issue.
- There needs to be an urgent care nearby. I have to drive an hour with sick kids when they wake up sick or get sick on the weekend.
- Chestertown needs to retain in-patient beds and bring more doctors to the area
- Keep our hospital open, and run it as a full hospital not like an ER! ! !
- Stop prohibiting reasonable growth of the economy with new jobs - jobs here mean money stays here which means people can afford to pay for doctors. Also great for mental health.
- Keep access to specialists/hospital/ER in Chestertown Increase availability of primary care in Chestertown
- Urgent Care in Chestertown
- Revitalize Chester River Hospital. Clean it up and paint it. Recruit more specialists.
- Please keep our hospital open. We desperately need a hospital here.
- Walk in Clinics

- Unsure, only have been here less than two years. However, my health declined after we moved and I was fortunate to have the hospital here where I received a timely diagnosis of acute PE and DVT that likely saved my life.
- Please have more specialists come to Chestertown from Easton! Indoor walking area and/or place to exercise as not everyone can afford Aquafit.
- Identify people who are not getting health promotion and illness care and the reasons. Public education through the school system, community center, health fairs, other public gatherings. Blood pressure screenings. Home monitoring of patients with chronic disease, free transportation to doctors, clinics, etc.
- Keep the Chestertown hospital open for inpatient care.
- Get people to move, more than just to the next meal
- Education 2.) Gov't assisted healthcare or discounted healthcare services to those who qualify 3.) Health Club Membership supplied by business, education circulated to employees, incentives to practice good health, nutrition & exercise
- More and better employment affording better access to health care.
- Recruit more doctors to the area.
- More doctors or nurse practitioners throughout the counties.
- Keep Chestertown inpatient hospital open permanently
- Need more primary care providers.
- need more PCP's accepting new patients, need reliable public transportation, increase ways for people to get more exercise...better walkability
- SRH put more money into recruiting physicians
- Shore Regional Health is destroying our hospital, bit by bit. Rather than assigning doctors and services to the County area, it is systematically moving these to Easton. This in turn destroys our community and our future economic development. This is the big problem!
- Put the hospital back as a full service acute hospital with inpt beds and an icu
- Better access to mental health services
- Keep the hospital open and provide universal healthcare
- Keep the Chestertown hospital open as a real hospital, not just as a glorified emergency room. Attract general practice and specialty doctors to the community. I no longer have a doctor because mine opted recently for a VIP practice that costs a ridiculous amount annually on top of what I already pay for insurance. Other doctors aren't taking new patients.
- More public education, more preventive medicine, more specialists in town.
- Improve interaction with the black community. Bring businesses in that will increase job opportunities.
- There needs to be more health education during school for kids as after school for the parents. Health starts at home and if parents are not educated, that means their children are not and then unhealthy habits continue to form.

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

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

## Talbot County Comments

- Have professional doctors address problems just as well as they do in the big cities.
- Need a paramedic on the ambulance crew in Oxford, MD
- none
- Have affordable healthcare options available for everyone. Healthcare is very expensive for most people.
- one of the problems in addition to those checked off above has to do with attitude and compliance on the part of the community members - see so much of noncompliance
- Transportation and awareness of how to access it.
- Improved access to affordable housing and healthy food. Equitable health practices would be a good start to address racial inequities and discrepancies.
- Give us more doctors, not just PA's who are here only temporarily.  I have had 2 in the last 6 months and Mother has had 2 also.  The reason we left our primary doctors in the first place was because we went with your Health Advantage Plan. Which did us a lot of good since you dropped the plan anyway leaving us hanging and stuck with Medicare only.
- Improved transportation
- Need more GP's
- Aggressive programs focused on people under the age of 30 in terms of healthy lifestyle, diets, and habits.
- With the exception of the poor and impoverished, I believe most people in County manage to receive health care though there seem to be very few doctors accepting patients, particularly those with Medicare.

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

## Queen Anne's County Comments

- more LOCAL doctors in 21620 Not an hour away
- Make Chestertown Hospital a true center for treatment of all medical problems of the community from prenatal to geriatrics.
- Offer more clinics at the Health Dept. (i.e. Diabetes management/ education, weight management/ access to weight loss programs at low to no cost). Also, increase funding for senior services.
- Access to maternity care. Access to specialists. Inpatient hospital beds. With a college, a senior community, and minority population, serious consideration for all aspects of health care.
- rural health clinics that could do routine healthcare, education of public on value of midwife/douma as
- alternative to hospital delivery

- An independent urgent care center would be life changing
- Need to recruit more primary care physicians to the area & promote health care programs. More Health fairs should be scheduled
- need urgent care
- Keep Chestertown Hospital
- Open the Chestertown hospital
- More health fairs. More Doctors with practices here on Kent Island
- Seeking better health and wellness planning.
- Have a hospital that is functioning as it used to. My 1 depression day was due to none responsiveness of
- Community scheduling. Also was unable to talk to an operator at hospital as machine had a message no one called back from either place although I left my name and phone number as directed.
- Bring health care down make it affordable I don't mean that stupid Obama plan either that was highway robbery. Talk about being stabbed in the back that was a criminal act. Can afford insurance and then got fined anyway. So then my children went without insurance and paid the fine because that was cheaper.
- No ideas
- Walk, socialize
- Lower cost of in-hospital care (i.e. $2,000 for "OR “expense alone for routine colonoscopy is far too high.
- Better water drainage
- More free health assessments given through schools or churches in area.
- Keep the Chester River Hospital open as a functioning hospital. ..not just an Emergency Hospital....more specialists, neurologists, cardiologists, surgeons.
- Safer sidewalks for outdoor walking, a health food store, and organized walking groups. Place to walk indoors would be wonderful.
- Don't have any right now
- Keep the hospital in Chestertown
- Public transportation
- More quality physicians.
- More affordable public health insurance. More access to mental health services on the Eastern Shore.
- Need a walk in after hour walk in clinic.
- Keep doctors… need geriatricians, cardiologists, primary care providers
- Please hire doctors for our hospital in Kent Co. You are closing a vital need for us.
- Develop easier access to food pantries that have fresh foods and heart healthy options.

- Develop transportation specifically for health care related visits.
- Better transportation for those who need public transportation.
- Mental health events for stress and anxiety.
- Stress and anxiety free zones/socials
- Affordable health care
- Increase availability of PCP in QAC
- More doctors accepting Priority Partners and Maryland Smile.
- Make sure the local hospital is not closed.
- Lower Rx costs. Transparent and published fee schedules to allow comparative shopping.
- Better transportation for people to get to/from dr appts. 2. Expansion of the cardiopulmonary rehab program at hospital
- Add community health clinics in the local health department. There are few local physicians and even fewer specialty care providers in County.
- More mental health service providers that accept patients with and without insurance, using sliding scale where necessary More awareness raising (advertising, awareness days, open houses, community events) re mental health services Chesapeake College is good location, larger venues in designated zip codes. Awareness raising campaigns of the value of exercise wherever and however you can find it - walking, dog walking, parking further away, reduced screen time exchanged for movement, convey the idea that you don't have to join a club or pay a fee to get movement in your day, raise awareness of improving nutrition - more home cooked food, what is a good grocery list, how to keep costs down when grocery shopping,
- Continued efforts to meet people on their 'turf'. Bi lingual contact needs to be improved
- Clinics or options that are on a sliding fee scale for those with little income and poor or no insurance.
- I know that there is a focus on affordable housing, but the continued development of high density housing without any supporting infrastructure is a serious issue effecting all aspects of life.
- none
- Access to high quality healthcare. Drs, specialist, etc have no reason to move to this area.
- Invest in the local hospital so that people in outlying areas have reasonable access. Bring obstetrics back to Chestertown. Refer people who call looking for healthcare to doctors closest to their zip codes. Give signing bonuses to new doctors to practice in outlying areas to make care as easily available as AAMC does, so our patients stay within the system. I hear ALOT of complaints about our ER staff, the rudeness, lack of caring, long waits(which I know are unavoidable at times), but I think we should do more to improve our ER situation and we should have care available for pediatric patients, as I hear a lot of complaints and now hear everyone say "I'll just take them to AAMC", they feel the kids are disregarded and not properly cared for, so I think we should think about a neonatologist on staff, or a small pediatric ER.

- In general, I think we now have the technological ability to do doctor's visits for simple ailments through phone or Internet. This should be both cheaper in the long term, and result in more care, where I might ordinarily wait till offices open back up, or not go at all. For us, living on Kent Island, we are close enough to major hospitals to have our more serious medical needs cared for.
- There seems to be plenty of doctors' offices in the area. Insurance, or lack thereof, has been a limiting factor for myself and my family in the past.
- Bring back services that aren't currently available at the local hospital (Chestertown).
- More activities for children and families to engage in positive, quality time together!

## Appendix 2: State Health Improvement Process (SHIP) Measures

# Maryland State Health Improvement Proces

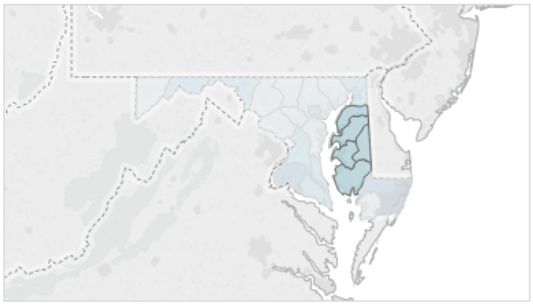
Network of Care

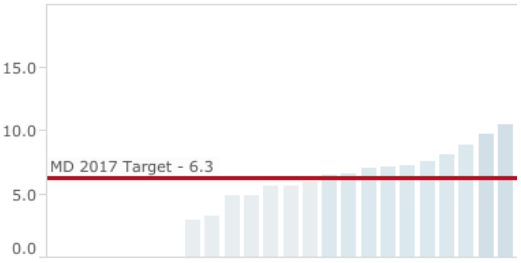
**Focus Area**
Healthy Beginnings

**Indicator**
Infant Death Rate

If charts and map are not present, select an Indicator for the current Focus Area selection. Select a jurisdiction in the map, table or bar chart to see the performance of that jurisdiction in the large chart area. Use the Ctrl key to select multiple jurisdictio..

**Jurisdiction Value**
2.9 — 19.0






Jurisdictions (hover for details)

| Jurisdictions | |
|---|---|
| Maryland | 6.5 |
| Allegany | 8.1 |
| Anne Arundel | 5.6 |
| Baltimore City | 8.8 |
| Baltimore Cou.. | 5.9 |
| Calvert | 6.6 |
| Caroline | |
| Carroll | 2.9 |
| Cecil | 7.2 |
| Charles | 10.5 |
| Dorchester | |
| Frederick | 3.2 |
| Garrett | |
| Harford | 4.8 |
| Howard | 4.8 |
| Kent | |
| Montgomery | 5.6 |
| Prince Georges | 7.6 |
| Queen Annes | |
| Saint Marys | 7.0 |
| Somerset | |
| Talbot | |
| Washington | 7.1 |
| Wicomico | 9.7 |
| Worcester | 19.0 |

This indicator shows the infant mortality rate per 1,000 live births. Infant mortality has long been considered the most sensitive indicator of the overall health of a population. While there have been several decades of improvement in infant mortality, Maryland's rate remains higher than the national average. Source: Maryland Department of Health and Mental Hygiene. Date Range: 2016

In the chart below, Change is from previous reporting period. Blue bar shows the jurisdiction value and red line shows the MD

| Focus Area | Indicator | Jurisdictions | Value | Change | Goal me.. |
|---|---|---|---|---|---|
| **Healthy Beginnings** | Infant Death Rate | Caroline | Null | Null | N/A |
| | | Dorchester | Null | Null | N/A |
| | | Kent | Null | Null | N/A |
| | | Queen Annes | Null | Null | N/A |
| | | Talbot | Null | -18.6 | Yes |
| | Babies with Low Birth Weight | Caroline | 6.2 | -2.5 | Yes |
| | | Dorchester | 9.7 | -1.6 | No |
| | | Kent | 8.1 | -2.7 | No |
| | | Queen Annes | 7.6 | 0.9 | Yes |
| | | Talbot | 7.6 | 3.3 | Yes |
| | Sudden Unexpected Infant Death Rate (SUIDs) | Caroline | Null | Null | N/A |
| | | Dorchester | Null | Null | N/A |
| | | Kent | Null | Null | N/A |
| | | Queen Annes | Null | Null | N/A |
| | | Talbot | Null | Null | N/A |
| | Teen Birth Rate | Caroline | 21.2 | -5.8 | No |
| | | Dorchester | 27.4 | -23.3 | No |
| | | Kent | 6.9 | -11.3 | Yes |
| | | Queen Annes | 14.8 | 8.0 | Yes |
| | | Talbot | 22.9 | 7.5 | No |
| | Early Prenatal Care | Caroline | 72.6 | -4.1 | Yes |
| | | Dorchester | 76.7 | -1.4 | Yes |
| | | Kent | 72.9 | -9.0 | Yes |
| | | Queen Annes | 75.5 | 0.2 | Yes |
| | | Talbot | 74.6 | -1.7 | Yes |
| | Students Entering Kindergarten Ready To Learn | Caroline | 48.0 | -5.0 | N/A |
| | | Dorchester | 28.0 | -9.0 | N/A |
| | | Kent | 54.0 | -9.0 | N/A |
| | | Queen Annes | 48.0 | -3.0 | N/A |
| | | Talbot | 38.0 | -6.0 | N/A |
| | High School Graduation Rate | Caroline | 89.0 | 0.3 | No |
| | | Dorchester | 86.5 | 0.3 | No |
| | | Kent | 88.6 | -2.2 | No |
| | | Queen Annes | 95.0 | 0.1 | Yes |
| | | Talbot | 85.5 | -7.8 | No |

# Maryland State Health Improvement Proces

Network of Care

**Focus Area**
Healthy Beginnings

**Indicator**
Infant Death Rate

If charts and map are not present, select an Indicator for the current Focus Area selection. Select a jurisdiction in the map, table or bar chart to see the performance of that jurisdiction in the large chart area. Use the Ctrl key to select multiple jurisdictio..

**Jurisdiction Value**
2.9 — 19.0

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| Baltimore Cou.. | 5.9 |
| Calvert | 6.6 |
| Caroline | |
| Carroll | 2.9 |
| Cecil | 7.2 |
| Charles | 10.5 |
| Dorchester | |
| Frederick | 3.2 |
| Garrett | |
| Harford | 4.8 |
| Howard | 4.8 |
| Kent | |
| Montgomery | 5.6 |
| Prince Georges | 7.6 |
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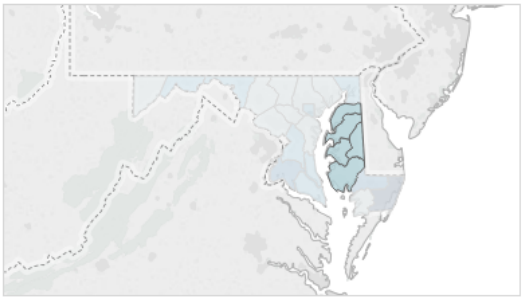

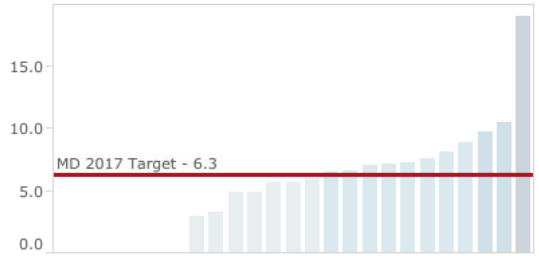


Jurisdictions (hover for details)

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| Focus Area | Indicator | Jurisdictions | Value | Change | Goal me.. |
|---|---|---|---|---|---|
| **Healthy Beginnings** | Children Receiving Blood Lead Screening | Caroline | 70.7 | 1.2 | Yes |
| | | Dorchester | 61.4 | 1.7 | No |
| | | Kent | 50.9 | -4.0 | No |
| | | Queen Annes | 61.4 | 5.2 | No |
| | | Talbot | 73.4 | 3.1 | Yes |
| **Healthy Living** | Adults Who Currently Smoke | Caroline | 27.9 | 4.4 | No |
| | | Dorchester | 25.7 | 5.9 | No |
| | | Kent | 18.0 | Null | No |
| | | Queen Annes | 16.5 | -0.7 | No |
| | | Talbot | 13.6 | Null | Yes |
| | Adolescents Who Use Tobacco Products | Caroline | 19.5 | -6.6 | No |
| | | Dorchester | 25.8 | 0.9 | No |
| | | Kent | 20.4 | -2.5 | No |
| | | Queen Annes | 20.7 | -3.6 | No |
| | | Talbot | 16.7 | -4.9 | No |
| | HIV Incidence Rate | Caroline | 7.3 | -3.8 | Yes |
| | | Dorchester | 36.7 | 0.0 | No |
| | | Kent | 5.7 | 0.0 | Yes |
| | | Queen Annes | 4.8 | 2.4 | Yes |
| | | Talbot | 3.1 | -9.2 | Yes |
| | Chlamydia Infection Rate | Caroline | 360.1 | 30.6 | Yes |
| | | Dorchester | 561.7 | -240.2 | No |
| | | Kent | 326.2 | 138.2 | Yes |
| | | Queen Annes | 293.8 | 45.7 | Yes |
| | | Talbot | 319.3 | 33.8 | Yes |
| | Life Expectancy | Caroline | 76.1 | 0.0 | No |
| | | Dorchester | 76.8 | -0.8 | No |
| | | Kent | 79.6 | 0.1 | No |
| | | Queen Annes | 79.4 | -0.2 | No |
| | | Talbot | 81.1 | 0.3 | Yes |
| | Increase Physical Activity | Caroline | 51.8 | 12.8 | Yes |
| | | Dorchester | 38.7 | 6.7 | No |
| | | Kent | 49.7 | 8.3 | No |
| | | Queen Annes | 51.2 | 1.5 | Yes |
| | | Talbot | 53.4 | 4.4 | Yes |

This indicator shows the infant mortality rate per 1,000 live births. Infant mortality has long been considered the most sensitive indicator of the overall health of a population. While there have been several decades of improvement in infant mortality, Maryland's rate remains higher than the national average. Source: Maryland Department of Health and Mental Hygiene. Date Range: 2016

# Maryland State Health Improvement Proces

Network of Care

**Focus Area**
Healthy Beginnings

**Indicator**
Infant Death Rate

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| Howard | 4.8 |
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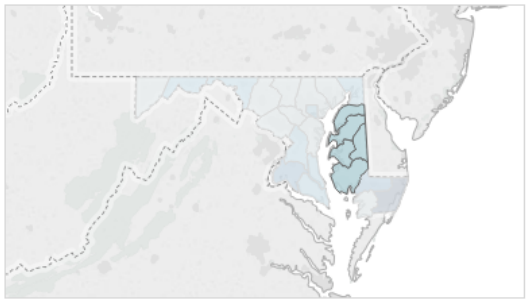
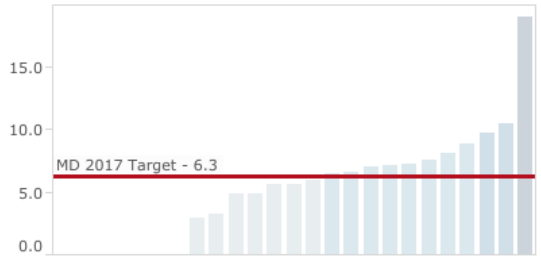





Jurisdictions (hover for details)

In the chart below, Change is from previous reporting period. Blue bar shows the jurisdiction value and red line shows the MD ..

| Focus Area | Indicator | Jurisdictions | Value | Change | Goal me.. |
|---|---|---|---|---|---|
| **Healthy Living** | Adolescents Who Have Obesity | Caroline | 16.0 | 2.1 | No |
| | | Dorchester | 18.6 | 1.4 | No |
| | | Kent | 14.4 | 1.6 | No |
| | | Queen Annes | 11.1 | -0.6 | No |
| | | Talbot | 12.0 | 1.7 | No |
| | Adults Who Are Not Overweight Or Obese | Caroline | 26.0 | 4.8 | No |
| | | Dorchester | 28.6 | 3.0 | No |
| | | Kent | 39.9 | 12.7 | Yes |
| | | Queen Annes | 34.1 | 1.2 | No |
| | | Talbot | 32.5 | -8.3 | No |
| **Healthy Co mmunities** | Child Maltreatment Rate | Caroline | 13.5 | 0.3 | N/A |
| | | Dorchester | 17.2 | 1.2 | N/A |
| | | Kent | 8.0 | -1.7 | N/A |
| | | Queen Annes | 3.0 | 0.1 | N/A |
| | | Talbot | 4.3 | -1.9 | N/A |
| | Suicide Rate | Caroline | Null | Null | N/A |
| | | Dorchester | Null | Null | N/A |
| | | Kent | Null | Null | N/A |
| | | Queen Annes | Null | Null | N/A |
| | | Talbot | Null | Null | N/A |
| | Domestic Violence | Caroline | 350.1 | -31.0 | Yes |
| | | Dorchester | 632.4 | 43.0 | No |
| | | Kent | 268.6 | -74.5 | Yes |
| | | Queen Annes | 329.0 | 19.6 | Yes |
| | | Talbot | 136.8 | -78.4 | Yes |
| | Children With Elevated Blood Lead Levels | Caroline | 0.3 | -0.3 | Yes |
| | | Dorchester | 0.3 | 0.1 | Yes |
| | | Kent | Null | Null | N/A |
| | | Queen Annes | 0.3 | Null | Yes |
| | | Talbot | 0.3 | 0.1 | Yes |
| | Fall-Related Death Rate | Caroline | Null | Null | N/A |
| | | Dorchester | Null | Null | N/A |
| | | Kent | Null | Null | N/A |
| | | Queen Annes | Null | Null | N/A |
| | | Talbot | Null | Null | N/A |

# Maryland State Health Improvement Proces

Network of Care

**Focus Area**
Healthy Beginnings

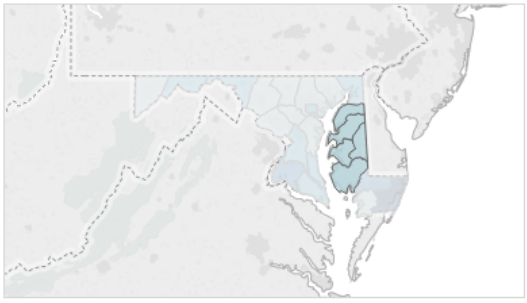
**Indicator**
Infant Death Rate

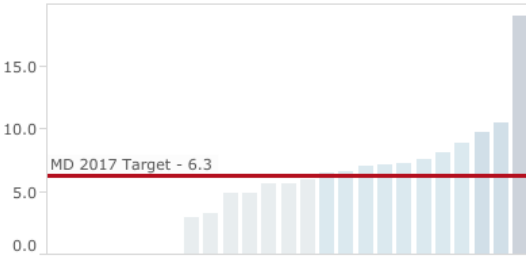
If charts and map are not present, select an Indicator for the current Focus Area selection. Select a jurisdiction in the map, table or bar chart to see the performance of that jurisdiction in the large chart area. Use the Ctrl key to select multiple jurisdictio..

**Jurisdiction Value**
2.9 — 19.0

| Jurisdictions | |
|---|---|
| Maryland | 6.5 |
| Allegany | 8.1 |
| Anne Arundel | 5.6 |
| Baltimore City | 8.8 |
| Baltimore Cou.. | 5.9 |
| Calvert | 6.6 |
| Caroline | |
| Carroll | 2.9 |
| Cecil | 7.2 |
| Charles | 10.5 |
| Dorchester | |
| Frederick | 3.2 |
| Garrett | |
| Harford | 4.8 |
| Howard | 4.8 |
| Kent | |
| Montgomery | 5.6 |
| Prince Georges | 7.6 |
| Queen Annes | |
| Saint Marys | 7.0 |
| Somerset | |
| Talbot | |
| Washington | 7.1 |
| Wicomico | 9.7 |
| Worcester | 19.0 |

This indicator shows the infant mortality rate per 1,000 live births. Infant mortality has long been considered the most sensitive indicator of the overall health of a population. While there have been several decades of improvement in infant mortality, Maryland's rate remains higher than the national average. Source: Maryland Department of Health and Mental Hygiene. Date Range: 2016






Jurisdictions (hover for details)

In the chart below, Change is from previous reporting period. Blue bar shows the jurisdiction value and red line shows the MD ..

| Focus Area | Indicator | Jurisdictions | Value | Change | Goal me.. |
|---|---|---|---|---|---|
| **Healthy Co mmunities** | Pedestrian Injury Rate On Public Roads | Caroline | Null | Null | N/A |
| | | Dorchester | Null | Null | N/A |
| | | Kent | Null | Null | N/A |
| | | Queen Annes | Null | Null | N/A |
| | | Talbot | Null | Null | N/A |
| | Affordable Housing | Caroline | 79.0 | 2.0 | Yes |
| | | Dorchester | 64.8 | -1.6 | Yes |
| | | Kent | 56.5 | 5.6 | Yes |
| | | Queen Annes | 38.2 | 5.6 | No |
| | | Talbot | 38.9 | -0.6 | No |
| **Access to Health Care** | Adolescents Who Received A Wellness Checkup In The Last Year | Caroline | 63.5 | -0.9 | Yes |
| | | Dorchester | 59.1 | -3.6 | Yes |
| | | Kent | 48.4 | -1.7 | No |
| | | Queen Annes | 51.5 | -0.7 | No |
| | | Talbot | 61.8 | -1.4 | Yes |
| | Children Receiving Dental Care In The Last Year | Caroline | 68.9 | -3.2 | Yes |
| | | Dorchester | 66.3 | -2.4 | Yes |
| | | Kent | 72.1 | 0.2 | Yes |
| | | Queen Annes | 68.4 | -1.5 | Yes |
| | | Talbot | 72.1 | -1.1 | Yes |
| | Persons With A Usual Primary Care Provider | Caroline | 88.8 | 6.0 | Yes |
| | | Dorchester | 83.6 | -5.4 | No |
| | | Kent | 94.2 | -1.3 | Yes |
| | | Queen Annes | 89.6 | 1.0 | Yes |
| | | Talbot | 85.5 | -8.6 | Yes |
| | Uninsured ED Visits | Caroline | 7.1 | 0.3 | Yes |
| | | Dorchester | 6.1 | -0.7 | Yes |
| | | Kent | 4.0 | -0.7 | Yes |
| | | Queen Annes | 5.8 | 0.7 | Yes |
| | | Talbot | 6.6 | 0.0 | Yes |
| **Quality Preventive Care** | Emergency Department Visit Rate Due to Diabetes | Caroline | 244.2 | 33.3 | No |
| | | Dorchester | 455.4 | 86.4 | No |
| | | Kent | 209.4 | -140.9 | No |
| | | Queen Annes | 154.2 | 28.4 | Yes |
| | | Talbot | 276.4 | 52.1 | No |

# Maryland State Health Improvement Proces

Network of Care

**Focus Area**
Healthy Beginnings

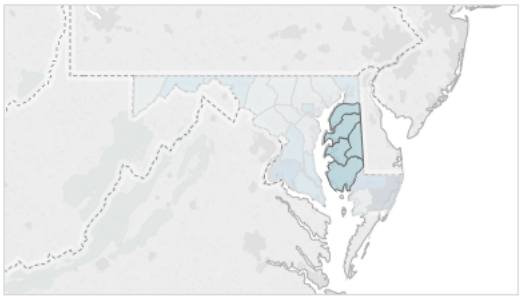
**Indicator**
Infant Death Rate

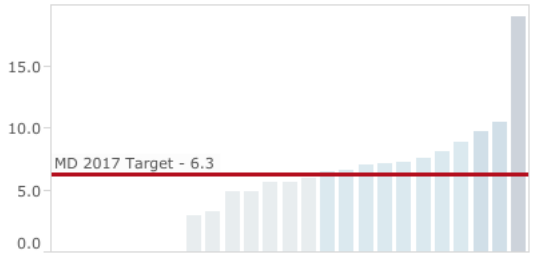
If charts and map are not present, select an Indicator for the current Focus Area selection. Select a jurisdiction in the map, table or bar chart to see the performance of that jurisdiction in the large chart area. Use the Ctrl key to select multiple jurisdictio..

**Jurisdiction Value**
2.9 — 19.0

| Jurisdictions | |
|---|---|
| Maryland | 6.5 |
| Allegany | 8.1 |
| Anne Arundel | 5.6 |
| Baltimore City | 8.8 |
| Baltimore Cou.. | 5.9 |
| Calvert | 6.6 |
| Caroline | |
| Carroll | 2.9 |
| Cecil | 7.2 |
| Charles | 10.5 |
| Dorchester | |
| Frederick | 3.2 |
| Garrett | |
| Harford | 4.8 |
| Howard | 4.8 |
| Kent | |
| Montgomery | 5.6 |
| Prince Georges | 7.6 |
| Queen Annes | |
| Saint Marys | 7.0 |
| Somerset | |
| Talbot | |
| Washington | 7.1 |
| Wicomico | 9.7 |
| Worcester | 19.0 |

This indicator shows the infant mortality rate per 1,000 live births. Infant mortality has long been considered the most sensitive indicator of the overall health of a population. While there have been several decades of improvement in infant mortality, Maryland's rate remains higher than the national average. Source: Maryland Department of Health and Mental Hygiene. Date Range: 2016

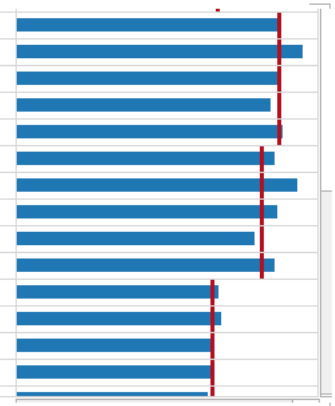





Jurisdictions (hover for details)

In the chart below, Change is from previous reporting period. Blue bar shows the jurisdiction value and red line shows the MD ..

| Focus Area | | | | | |
|---|---|---|---|---|---|
| **Quality Preventive Care** | Emergency Department Visits for Addictions-Related Conditions | Caroline | 1311.1 | 38.5 | Yes |
| | | Dorchester | 3120.7 | 869.5 | No |
| | | Kent | 1538.3 | -3.6 | No |
| | | Queen Annes | 1048.9 | -92.4 | Yes |
| | | Talbot | 1587.6 | 41.5 | No |
| | Emergency Department Visit Rate For Dental Care | Caroline | 1225.2 | 56.1 | No |
| | | Dorchester | 2659.4 | 13.1 | No |
| | | Kent | 1359.6 | -216.1 | No |
| | | Queen Annes | 624.9 | -61.5 | Yes |
| | | Talbot | 1246.3 | 198.0 | No |
| | Cancer Mortality Rate | Caroline | 178.3 | 4.8 | No |
| | | Dorchester | 196.9 | 1.7 | No |
| | | Kent | 147.8 | -1.9 | No |
| | | Queen Annes | 152.4 | -8.0 | No |
| | | Talbot | 127.9 | -15.9 | Yes |



## Appendix 3: Social Determinants of Health

County Health Rankings & Roadmaps

| | Maryland | Caroline (CR), | Dorchester (DO), MD | Kent (KE), MD | Queen Anne's (QA), | Talbot (TA), MD X |
|---|---|---|---|---|---|---|
| **Health Outcomes** | | **22** | **21** | **16** | **9** | **10** |
| **Length of Life** | | **23** | **19** | **14** | **11** | **9** |
| Premature death | 6,500 | 9,500 | 8,000 | 7,000 | 6,700 | 6,200 |
| **Quality of Life** | | **20** | **22** | **19** | **6** | **9** |
| Poor or fair health | 14% | 18% | 18% | 14% | 11% | 12% |
| Poor physical health days | 3.1 | 3.9 | 3.6 | 3.1 | 2.9 | 3.1 |
| Poor mental health days | 3.5 | 4.6 | 4.0 | 3.7 | 3.4 | 3.7 |
| Low birthweight | 9% | 8% | 10% | 11% | 7% | 7% |
| Health Factors | | 21 | 22 | 13 | 6 | 7 |
| **Health Behaviors** | | **22** | **21** | **12** | **7** | **5** |
| Adult smoking | 14% | 21% | 20% | 14% | 14% | 12% |
| Adult obesity** | 29% | 37% | 35% | 30% | 29% | 28% |
| Food environment index** | 9.1 | 8.5 | 7.4 | 8.9 | 9.3 | 8.7 |
| Physical inactivity** | 22% | 29% | 33% | 26% | 23% | 21% |
| Access to exercise opportunities | 93% | 39% | 72% | 61% | 81% | 75% |
| Excessive drinking | 17% | 16% | 15% | 16% | 20% | 18% |
| Alcohol-impaired driving deaths | 30% | 41% | 27% | 60% | 27% | 36% |
| Sexually transmitted infections** | 459.3 | 292.0 | 635.4 | 176.6 | 202.9 | 201.9 |
| Teen births | 21 | 29 | 43 | 12 | 14 | 19 |
| **Clinical Care** | | **24** | **23** | **19** | **10** | **4** |
| Uninsured | 7% | 9% | 9% | 9% | 6% | 8% |
| Primary care physicians | 1,140:1 | 2,710:1 | 2,940:1 | 1,100:1 | 2,720:1 | 1,100:1 |
| Dentists | 1,320:1 | 1,930:1 | 1,790:1 | 2,470:1 | 2,720:1 | 1,240:1 |
| Mental health providers | 460:1 | 2,530:1 | 470:1 | 580:1 | 1,060:1 | 240:1 |
| Preventable hospital stays | 47 | 75 | 81 | 59 | 49 | 49 |
| Diabetes monitoring | 85% | 86% | 85% | 86% | 89% | 89% |
| Mammography screening | 64% | 63% | 69% | 68% | 63% | 75% |
| **Social & Economic Factors** | | **19** | **22** | **13** | **6** | **11** |
| High school graduation** | 87% | 89% | 86% | 93% | 95% | 93% |
| Some college | 69% | 44% | 55% | 59% | 65% | 61% |
| Unemployment | 4.3% | 4.7% | 6.0% | 4.7% | 3.8% | 4.1% |
| Children in poverty | 13% | 22% | 29% | 20% | 9% | 16% |
| Income inequality | 4.6 | 4.2 | 4.7 | 4.7 | 3.7 | 5.0 |
| Children in single-parent | 34% | 39% | 45% | 36% | 24% | 38% |
| Social associations | 8.9 | 11.4 | 11.1 | 14.7 | 8.2 | 13.1 |
| Violent crime** | 465 | 317 | 466 | 314 | 218 | 229 |
| Injury deaths | 64 | 91 | 71 | 88 | 71 | 54 |
| **Physical Environment** | | **19** | **15** | **10** | **4** | **2** |
| Air pollution - particulate matter | 9.5 | 9.1 | 8.8 | 9.5 | 9.4 | 8.9 |
| Drinking water violations | | Yes | Yes | Yes | No | No |
| Severe housing problems | 17% | 19% | 20% | 16% | 14% | 18% |
| Driving alone to work | 74% | 83% | 79% | 68% | 79% | 80% |
| Long commute - driving alone | 49% | 47% | 38% | 34% | 55% | 31% |

## Technical Notes and Glossary of Terms

### What is health equity? What are health disparities? And how do they relate?

**Health equity** means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

**Health disparities** are differences in health or in the key determinants of health such as education, safe housing, and discrimination, which adversely affect marginalized or excluded groups.

Health equity and health disparities are closely related to each other. Health equity is the ethical and human rights principle or value that motivates us to eliminate health disparities. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

*Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? And What Difference Does a Definition Make? Robert Wood Johnson Foundation. May 2017*

### How do we define racial/ethnic groups?

In our analyses by race/ethnicity we define each category as follows:

- Hispanic includes those who identify themselves as Mexican, Puerto Rican, Cuban, Central or South American, other Hispanic, or Hispanic of unknown origin.
- American Indian/Alaskan Native includes people who identify themselves as American Indian or Alaskan Native and do not identify as Hispanic. This group is sometimes referred to as Native American in the report.
- Asian/Pacific Islander includes people who identify themselves as Asian or Pacific Islander and do not identify as Hispanic.
- Black includes people who identify themselves as black/African American and do not identify as Hispanic.
- White includes people who identify themselves as white and do not identify as Hispanic.

All racial/ethnic categories are exclusive so that one person fits into only one category. Our analyses do not include people reporting more than one race, as this category was not measured uniformly across our data sources.

We recognize that "race" is a social category, meaning the way society may identify individuals based on their cultural ancestry, not a way of characterizing individuals based on biology or genetics. A strong and growing body of empirical research provides support for the notion that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

### How did we compare county ranks and racial/ethnic groups for length and quality of life?

Data are from the same data sources and years listed in the table on page 15. The mean and standard deviation for each health outcome measure (premature death, poor or fair health, poor physical health days, poor mental health days, and low birthweight) are calculated for all ranked counties within a state. This mean and standard deviation are then used as the metrics to calculate z-scores, a way to put all measures on the same scale, for values by race/ethnicity within the state. The z-scores are weighted using CHR&R measure weights for health outcomes to calculate a health outcomes z-score for each race/ethnicity. This z-score is then compared to the health outcome z-scores for all ranked counties within a state; the identified-score calculated for the racial/ethnic groups is compared to the quartile cut-off values for counties with states. You can learn more about calculating z-scores on our website under Rankings Methods.

### How did we select evidence-informed approaches?

Evidence-informed approaches included in this report represent those backed by strategies that have demonstrated consistently favorable results in robust studies or reflect recommendations by experts based on early research. To learn more about evidence analysis methods and evidence-informed strategies that can make a difference to improving health and decreasing disparities, visit What Works for Health.

### Technical Notes:

- In this report, we use the terms disparities, differences, and gaps interchangeably.
- We follow basic design principles for cartography in displaying color spectrums with less intensity for lower values and increasing color intensity for higher values. We do not intend to elicit implicit biases that "darker is bad".
- In our graphics of state and U.S. counties we report the median of county values, our preferred measure of central tendency for counties. This value can differ from the state or U.S. overall values.

## 2018 County Health Rankings for Maryland: Measures and National/State Results

| Measure | Description | US | MD | MD Minimum | MD Maximum |
|---|---|---|---|---|---|
| **HEALTH OUTCOMES** | | | | | |
| Premature death | Years of potential life lost before age 75 per 100,000 population | 6,700 | 6,500 | 3,700 | 12,500 |
| Poor or fair health | % of adults reporting fair or poor health | 16% | 14% | 9% | 22% |
| Poor physical health days | Average # of physically unhealthy days reported in past 30 days | 3.7 | 3.1 | 2.4 | 4.5 |
| Poor mental health days | Average # of mentally unhealthy days reported in past 30 days | 3.8 | 3.5 | 2.8 | 4.6 |
| Low birthweight | % of live births with low birthweight (< 2500 grams) | 8% | 9% | 6% | 12% |
| **HEALTH FACTORS** | | | | | |
| **HEALTH BEHAVIORS** | | | | | |
| Adult smoking | % of adults who are current smokers | 17% | 14% | 7% | 21% |
| Adult obesity | % of adults that report a BMI ≥ 30 | 28% | 29% | 21% | 45% |
| Food environment index | Index of factors that contribute to a healthy food environment, (0-10) | 7.7 | 9.1 | 6.1 | 9.5 |
| Physical inactivity | % of adults aged 20 and over reporting no leisure-time physical activity | 23% | 22% | 16% | 33% |
| Access to exercise opportunities | % of population with adequate access to locations for physical activity | 83% | 93% | 39% | 100% |
| Excessive drinking | % of adults reporting binge or heavy drinking | 18% | 17% | 14% | 20% |
| Alcohol-impaired driving deaths | % of driving deaths with alcohol involvement | 29% | 30% | 20% | 60% |
| Sexually transmitted infections | # of newly diagnosed chlamydia cases per 100,000 population | 478.8 | 459.3 | 141.5 | 1,080.3 |
| Teen births | # of births per 1,000 female population ages 15-19 | 27 | 21 | 8 | 44 |
| **CLINICAL CARE** | | | | | |
| Uninsured | % of population under age 65 without health insurance | 11% | 7% | 4% | 11% |
| Primary care physicians | Ratio of population to primary care physicians | 1,320:1 | 1,140:1 | 3,220:1 | 510:1 |
| Dentists | Ratio of population to dentists | 1,480:1 | 1,320:1 | 2,720:1 | 680:1 |
| Mental health providers | Ratio of population to mental health providers | 470:1 | 460:1 | 2,530:1 | 240:1 |
| Preventable hospital stays | # of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees | 49 | 47 | 29 | 81 |
| Diabetes monitoring | % of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring | 85% | 85% | 81% | 90% |
| Mammography screening | % of female Medicare enrollees ages 67-69 that receive mammography screening | 63% | 64% | 59% | 75% |
| **SOCIAL AND ECONOMIC FACTORS** | | | | | |
| High school graduation | % of ninth-grade cohort that graduates in four years | 83% | 87% | 70% | 96% |
| Some college | % of adults ages 25-44 with some post-secondary education | 65% | 69% | 37% | 85% |
| Unemployment | % of population aged 16 and older unemployed but seeking work | 4.9% | 4.3% | 3.2% | 9.0% |
| Children in poverty | % of children under age 18 in poverty | 20% | 13% | 6% | 32% |
| Income inequality | Ratio of household income at the 80th percentile to income at the 20th percentile | 5 | 4.6 | 3.5 | 6.3 |
| Children in single-parent households | % of children that live in a household headed by a single parent | 34% | 34% | 21% | 64% |
| Social associations | # of membership associations per 10,000 population | 9.3 | 8.9 | 5.9 | 18.2 |
| Violent crime | # of reported violent crime offenses per 100,000 population | 380 | 465 | 130 | 1,389 |
| Injury deaths | # of deaths due to injury per 100,000 population | 65 | 64 | 33 | 126 |
| **PHYSICAL ENVIRONMENT** | | | | | |
| Air pollution – particulate matter | Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) | 8.7 | 9.5 | 8.3 | 11.1 |
| Drinking water violations | Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation. | NA | NA | No | Yes |
| Severe housing problems | % of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities | 19% | 17% | 12% | 24% |
| Driving alone to work | % of workforce that drives alone to work | 76% | 74% | 60% | 85% |
| Long commute – driving alone | Among workers who commute in their car alone, % commuting > 30 minutes | 35% | 49% | 19% | 64% |

## 2018 County Health Rankings: Ranked Measure Sources and Years of Data

| | Measure | Source | Years of Data |
|---|---|---|---|
| **HEALTH OUTCOMES** | | | |
| Length of Life | Premature death | National Center for Health Statistics – Mortality files | 2013-2015 |
| Quality of Life | Poor or fair health | Behavioral Risk Factor Surveillance System | 2016 |
| | Poor physical health days | Behavioral Risk Factor Surveillance System | 2016 |
| | Poor mental health days | Behavioral Risk Factor Surveillance System | 2016 |
| | Low birthweight | National Center for Health Statistics – Natality files | 2010-2016 |
| **HEALTH FACTORS** | | | |
| **HEALTH BEHAVIORS** | | | |
| Tobacco Use | Adult smoking | Behavioral Risk Factor Surveillance System | 2016 |
| Diet and Exercise | Adult obesity | CDC Diabetes Interactive Atlas | 2014 |
| | Food environment index | USDA Food Environment Atlas, Map the Meal Gap | 2015 |
| | Physical inactivity | CDC Diabetes Interactive Atlas | 2014 |
| | Access to exercise opportunities | Business Analyst, Delorme map data, ESRI, & US Census Files | 2010 & 2016 |
| Alcohol and Drug Use | Excessive drinking | Behavioral Risk Factor Surveillance System | 2016 |
| | Alcohol-impaired driving deaths | Fatality Analysis Reporting System | 2012-2016 |
| Sexual Activity | Sexually transmitted infections | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention | 2015 |
| | Teen births | National Center for Health Statistics – Natality files | 2010-2016 |
| **CLINICAL CARE** | | | |
| Access to Care | Uninsured | Small Area Health Insurance Estimates | 2015 |
| | Primary care physicians | Area Health Resource File/American Medical Association | 2015 |
| | Dentists | Area Health Resource File/National Provider Identification file | 2016 |
| | Mental health providers | CMS, National Provider Identification file | 2017 |
| Quality of Care | Preventable hospital stays | Dartmouth Atlas of Health Care | 2015 |
| | Diabetes monitoring | Dartmouth Atlas of Health Care | 2014 |
| | Mammography screening | Dartmouth Atlas of Health Care | 2014 |
| **SOCIAL AND ECONOMIC FACTORS** | | | |
| Education | High school graduation | EDFacts | 2014-2015 |
| | Some college | American Community Survey | 2012-2016 |
| Employment | Unemployment | Bureau of Labor Statistics | 2016 |
| Income | Children in poverty | Small Area Income and Poverty Estimates | 2016 |
| | Income inequality | American Community Survey | 2012-2016 |
| Family and Social Support | Children in single-parent households | American Community Survey | 2012-2016 |
| | Social associations | County Business Patterns | 2015 |
| Community Safety | Violent crime | Uniform Crime Reporting – FBI | 2012-2014 |
| | Injury deaths | CDC WONDER mortality data | 2012-2016 |
| **PHYSICAL ENVIRONMENT** | | | |
| Air and Water Quality | Air pollution – particulate matter* | Environmental Public Health Tracking Network | 2012 |
| | Drinking water violations | Safe Drinking Water Information System | 2016 |
| Housing and Transit | Severe housing problems | Comprehensive Housing Affordability Strategy (CHAS) data | 2010-2014 |
| | Driving alone to work | American Community Survey | 2012-2016 |
| | Long commute – driving alone | American Community Survey | 2012-2016 |

*Not available for AK and HI.

## Appendix 4: Community Partner Interviews

UM SRH completed interviews with community partners throughout the region to gain a better understanding of community health needs from the perspective of organizations and agencies that have a deep understanding from their day-to-day interactions with populations in greatest need.

I**nterview questions focused on:**

- Identifying the challenges to improving health and health care for the residents of your community
- Identify opportunities for improving current programs and services, as well as highlight service and program gaps.
- Share ideas for how to improve services and relationships in the community

**HEALTH CONDITIONS**

1. Substance Use disorders and the increasing risk of Hepatitis C and HIV with intravenous injection of illegal drugs
2. Mental health problems and lack of providers, but especially for children
3. The behavioral, physical, economic and social problems resulting from Adverse Childhood Experiences
4. Obesity and its contributions to multiple chronic conditions such as heart disease, hypertension, cardiovascular disease, renal failure
5. Chronic conditions – co-occurring for more complex management problems
6. Aging and its contributions to chronic conditions and decline of cognitive function
7. Increasing incidence of latent and infectious tuberculosis with immigrant population

**LACK of SERVICES THAT IMPACT HEALTH**

1. Lack of early appropriate prevention services; lack of utilization when available by some
2. Lack of primary care providers for basic clinical services (prevention and chronic disease management plus acute care services in timely manner)
3. Lack of primary care providers attention to detecting and early management of behavioral health problems
4. Lack of pediatric attention to detecting and early management of behavioral health and developmental problems
5. Lack of access for young children with co-occurring developmental, behavioral and learning disorders to a comprehensive multidisciplinary team for diagnosis and care plans
6. Lack of behavioral health services for all ages but especially for providers that work with parents and children in order to modify child's behavior
7. Lack of obstetric services and ability to access if uninsured in first trimester
8. Lack of integration and coordination of clinical services; lack of integration and coordination of social services; lack of integration and coordination of clinical with social services
9. Gaps in socio-economic support services that impact health: inability to afford medications or primary care co-pays
10. Lack of transportation for medical appointments

11. Lack of interpreter services at some healthcare sites

**WHAT WE CAN DO ABOUT IT?**

Recurring comments in these conversations included the need to ensure quality of care, build trust with community residents and partners, leverage existing programs, and support innovation.

1. Support Rural Health Collaborative efforts – Social/Clinical Integration of services
2. Support health professions education of local residents ("growing our own")
3. Continue work of the Opioid Taskforce
4. Continue to expand use of telemedicine

| Interviews: Jan.-Feb 2019 | | | | |
|---|---|---|---|---|
| Participants Name | Title | Organization | Email | Phone |
| Mary O'Brien | Program Director | Talbot County Health Dept. | mary.obrien@maryland.gov | 410-819-5656 |
| Fredia Wadley | Health Officer | Talbot County Health Dept. | fredia.wadley@maryland.gov | 410-819-5606 |
| Kate Stinton | AERS and Care Coordinator | Talbot County Health Dept. | kate.stinton@maryland.gov | 410-819-5631 |
| Sarah Cloxtan | TCAP Director | Talbot County Health Dept. | sarah.cloxtone@maryland.gov | 410-8195696 |
| Angela Mercier | Health Education Program Manager | Dorchester County Health Dept. | angela.mercier@maryland.gov | 410-901-8126 |
| Casey Scott | Deputy Health Officer | Dorchester County Health Dept. | casey.scott@maryland.gov | 410-228-3825 |
| Beth Spencer | Social Work Program Administrator | Dorchester County Health Dept. | beth.spenser@maryland.gov | 410-901-8177 |
| Roger Harrell | Health Officer | Dorchester County Health Dept. | roger.harrell@maryland.gov | 410-228-3223 |
| Nicole Riddleberger | WIC Director | Caroline County Health Dept. | Nicole.riddleberger@maryland.gov | 410-479-8091 |
| Linda Adair | Alcohol Specialist | Caroline County Health Dept. | Linda.adair@maryland.gov | 410-479-3800 |
| Kat Varga | Intern | Caroline County Health Dept. | Kiv29@cornell.edu | |
| Leigh Marquess | Director of Wellness | Caroline County Health Dept. | leigh.marquess@maryland.gov | 410-479-8080 |
| Edna Garlic | Director of Medical Adult Daycare | Caroline County Health Dept. | Edna.garlic@maryland.gov | 410-479-8030 |
| Scott Leroy | Health Officer | Caroline County Health Dept. | scott.leroy@maryland.gov | 410-4798030 |
| Jennifer Knapp | Nursing Supervisor Maternal Child Health | Caroline County Health Dept. | Jennifer.knapp@maryland.gov | 410-479-8185 |
| Pam Eberhard | CRUP PP/CD | Caroline County Health Dept. | pam.eberhard@maryland.gov | 410-479-8124 |
| Don Wilson | Director Environmental Health | Caroline County Health Dept. | don.wilson@maryland.gov | 410-479-8049 |
| Joseph Ciotola | Health Officer | Queen Anne's County Health Dept. | jciotola@qac.org | |
| William Webb | Health Officer | | william.webb@maryland.gov | |

| | | | | |
|---|---|---|---|---|
| Susan Johnson | VP of Quality Assurance and Population Health | Choptank Community Health | SMJohnson@choptankhealth.org | |
| Ashyrra Dotson | President & CEO | Eastern Shore Wellness Solutions | adotson@easternshorewellness.org | 410- 221-0795 |
| Katie Dilley | Executive Director | Mid Shore Behavioral Health | kdilley@midshorebehavioralhealth.org | 410-770-4801 |

## Appendix 5: Prioritization Process

### Prioritization Process

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

**Step 1**
Committee members receive initial list of community defined needs
**Step 2**
Members rank community needs individually using set criteria
**Step 3**
Community Health Planning Council engages in a group prioritization activity to select priorities
**Step 4**
Results will be used to prioritize needs that will be the focus of our community health improvement plan

### Prioritization Criteria

**Organizational capacity** – hospital has the capacity to address the issue.
**Alignment with vision/mission** – hospital has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.
**Existing collaboration** – there are established relationships with community partners to address the issue and existing resources are committed to the issue.

| Health Need* (A) | Importance to community* (B) weight 40% | Capacity to address (C) weight 25% | Alignment with vision/mission (D) weight 25% | Existing collaboration/ interventions (E) weight 10% | Final Score (F) Max=100 |
|---|---|---|---|---|---|
| Score each criterion 0 (very low agreement) to 10 (very strong agreement) | | | | | |
| Access to care | 10 | | | | Leave blank-Will be calculated |
| Chronic disease conditions | 9 | | | | |
| Preventable ER visits | 9 | | | | |
| Mental health/ substance abuse | 10 | | | | |
| Care coordination | 8 | | | | |
| Overweight/obesity | 10 | | | | |
| Preventive/wellness programs | 8 | | | | |
| Smoking | 9 | | | | |
| Cancer | 9 | | | | |

*These two columns are populated in accordance with the qualitative analysis findings.

## Appendix 6: Community Health Planning Council

- Patti Willis – Regional Senior Vice President, Strategy and Communications
- Kathleen McGrath – Regional Director of Outreach & Business Development
- William Huffner, MD – Chief Medical Officer
- Walter Atha, MD – Regional Director of Emergency Medicine
- Brian Leutner – Vice President of Clinical and Ambulatory Services
- Diane Murphy, RN – Vice President/Chief Quality Officer
- Timothy Shanahan, DO – Medical Director University of Maryland Shore Medical Group
- Jeanie Scott, – Manager of Oncology Services
- Rita Holley, RN – Director of Shore Home Care
- Kevin Chapple, Pharm.D – .Director of Pharmacy Operations
- Trish Rosenberry, RN, – Director of Clinical & Ambulatory Services
- Jackie Crawford, RN, – Nurse Manager for Shore Behavioral Health Services
- John Mistrangelo, ACSW, LCSW-C – Director, Shore Behavioral Health Services
- Cheryl Ruff – Director of Operations University of Maryland Community Medical Group
- Kathy Elliott, RN – Executive Director, Shore Medical Center Chestertown
- Luanne Satchell, RN – Manager, Women's & Children's Services
- Anna D'Acunzi – Manager, Financial Decision Support
- Trena Williamson– Regional Director, Communications and Marketing
- Nannette Bedell, RN – Director, Population Health
- Teresa Blem – Director, Comprehensive Rehab Care

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UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

# Community Health Implementation Plan, FY2020-FY2022

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

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

Based on qualitative and quantitative data collected and analyzed during the CHNA process, UM SRH's Implementation Plan remains committed to the goals and strategies identified in the 2016 CNHA. Although some of the focus areas have changed in their order of priority per community feedback, the overall needs remain the same as reported in the 2016 CHNA.

**Health Priorities FY2020-2022**

The top five priorities:

1. Access to care
2. Preventable ER visits
3. Chronic Disease management
4. Mental health/substance abuse
5. Cancer

Overarching theme for addressing health priorities:

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

UM SRH is engaged in numerous programs addressing the identified needs of the Mid-Shore. The UM SRH hospitals — SMC at Chestertown, SMC at Dorchester, and SMC at Easton work to

strategically allocate scarce resources to best serve the communities, increase trust and build stronger community partnerships.

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

| HEALTH NEED 1: ACCESS TO CARE | | | |
|---|---|---|---|
| **Goal** | **Strategies** | **Metrics/What are we measuring** | **Potential Partnering/External Organizations** |
| Goal: Improve access to care for medically underserved and vulnerable groups of all ages and populations | **Strategy 1**: Increase capacity by addressing the recruitment, retention, accessibility, competency of providers | • Medical Staff assessment-identify shortages<br>• Provide/fund physician subsidies to meet identified community needs<br>• Establish physician/resident training programs | • University of Maryland School of Medicine and UMMC<br>• Eastern Shore Area Health Education Center (AHEC) |
| | **Strategy 2:** Enhance and Expand Telemedicine Opportunities | • Increase total consults<br>• Identify and implement new consult services: Dermatology and Child/Adolescent Psychiatry currently under negotiation | University of Maryland Medical Center, University of Maryland Faculty Physicians, (FPI) University of Maryland School of Medicine (SOM) |
| | **Strategy 3:** Reduce transportation barriers and enhance awareness of available services | • Number of transportation vouchers<br>• Resource information distribution<br>• Participate Mid-Shore Rural Health Collaborative Transportation Workgroup | • Delmarva Community Transit (DCT) and Queen Anne's County Ride cover Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties<br>• Rural Health Collaborative |
| | **Strategy 4**: Connect uninsured to private insurance, Medicaid, or other available coverage | • Number of insured residents | • Maryland Health Exchange |

ACTIVITIES/INITIATIVE:

**Recruit** additional health care providers and specialists to the region. Provide subsidies to increase the availability of health care providers in order to best meet identified patient and community needs related to the availability of health care services.

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

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

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

| **HEALTH NEED 2: Preventable ER Visits** | | | |
|---|---|---|---|
| **Goal** | **Strategies** | **Metrics/What are we measuring** | **Potential Partnering/External Organizations** |
| Goal: Help patients obtain "The Right Care, at the Right Place, at the Right Time" | **Strategy 1**: Provide community health education to improve understanding of appropriate use of primary care, urgent care, and emergency department in terms of medical capability and patient needs | • Decrease in unnecessary emergency department visits<br>• Increase health in literacy | • Payers<br>• Community media outlets |
| | **Strategy 2:** Improve care coordination, info sharing protocols to achieve safer, more effective care | • Protocols developed<br>• Chronic disease management | • Community providers<br>• five county health departments<br>• social services<br>• EMS agencies<br>• Aging agencies |

ACTIVITIES/INITIATIVES:

**Educational topics include**:

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

**Rural Health Collaborative:** UM SRH participates as a member on the Integrating Clinical and Social Support Services Workgroup. This workgroup supports the Rural Health Collaborative in determining actions that can be taken within the five Mid-Shore counties and throughout the Mid-Shore region to better integrate clinical and social support services. The Workgroup is charged with:

- Articulating the overarching problem to be addressed
- Identifying the current status of clinical and social support services and the resources supporting those services (including the components being added by the Maryland Total Cost of Care Waiver beginning January 2019)
- Determining the optimal availability and integration of clinical and social support services
- Deciding what is feasible to achieve by 2023 to better integrate clinical and social support services and steps to take to do so
- Recommending actions for improving integration of clinical and social support services to the Care Transformation Organizations and/or the Care Managers assigned to Primary Care Providers.

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

| | | | |
|---|---|---|---|
| | **Strategy 3:** Provide specialized health information, "physician to physician" education regarding diabetes treatment and management. | • Number of provider outreach education sessions for primary care offices and medical staff | • Community providers |

ACTIVITIES/INITIATIVES EXAMPLES:

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

**Engage targeted communities on healthy lifestyles**: Through sponsorship or provision of:
- Community-wide education
- Store Tours
- Community Screenings & Referrals (Blood pressure, BMI/Weights, & Cholesterol)
- Exercise Demonstrations

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

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

| **HEALTH NEED 4: BEHAVIORAL HEALTH** | | | |
|---|---|---|---|
| **Goal** | **Strategies** | **Metrics/What are we measuring** | **Potential Partnering/External Organizations** |
| Goal: Improve access and integration/ coordination of mental health and substance abuse services | **Strategy 1**: Provide individual, group, medication assisted treatment, and other mental health services, including prevention and support services | • Decrease re-hospitalization<br>• Number of patients who accept treatment following an overdose<br>• Number of adults who utilize services<br>• Increase family and patient understanding of mental health treatments. | • Eastern Shore Crisis Response<br>• Queen Anne's, Talbot, and Dorchester County Health Departments<br>• Shore Medical Group Bridge Clinic |
| | **Strategy 2:** Expand program(s) to support ED patients waiting for | • Number of patients served by the Bridge Clinic | • Corsica River Mental Health Center |

| | | | |
|---|---|---|---|
| | outpatient mental health and/or substance use disorder treatment | • Number of follow-up phone calls and outreach to patients who have experienced an overdose | • Community Behavioral Health<br>• Marshy Hope Mental Health |
| | **Strategy 3:** Improve care coordination for mental health and substance abuse co-occurring conditions through facilitation of direct hand-offs to the next level of care | • Number of patients referred between systems<br>• Improve access by providing education regarding available resources and services | • Mid-Shore Behavioral Health System<br>• Eastern Shore Crisis Response<br>• Physician practices<br>• Local Health Depts. |

ACTIVITIES/INITIATIVES EXAMPLES:

**Behavioral Health Bridge Clinic.** The Bridge Clinic serves patients discharged from the behavioral health inpatient unit who are unable to access psychiatric care from community due to shortage of psychiatric providers.

Continue to provide: (1) medication administration assistance to complement counseling services currently being offered and to assist post discharge overdose patients; (2) injection support/education clinic to promote use of long acting psychotropic medications

**The Bridge Clinics family group meeting**. Community supporters of patients and in particular patients' family members receive education and support regarding mental health and treatment strategies. Assist families in maintaining positive support for their loved ones.

**Education**: To improve access to mental health care, programs are offered on a quarterly basis to the community providing up to date information on available mental health resources and services.

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

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

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

ACTIVITIES/INITIATIVES:

**WELLNESS FOR WOMEN ACCESS TO CARE PROGRAM**

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

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

**LUNG CANCER EARLY SCREENING PROGRAM**

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

**ANNUAL PROSTATE SCREENING**

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

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

**KEY WORDS: Financial Assistance**

**OBJECTIVE/BACKGROUND:**

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

**APPLICABILITY:**

***PROGRAM ELIGIBILITY***

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

**Specific exclusions to coverage under the Financial Assistance Program:**

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

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

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

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

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

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

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

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

***Presumptive Financial Assistance***

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

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

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

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

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

**POLICY:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**PROCEDURE:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***Financial Hardship***

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

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

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

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

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

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

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

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

***Appeals***

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

**ATTACHMENTS:**

# ATTACHMENT A

## Sliding Scale – Reduced Cost of Care

| 2020 Federal Poverty Limits (FPL) and Maryland Dept of Health & Mental Hygiene (DHMH) Annual Income Eligibility Limit Guidelines | | | UMMS 100% Charity | UMMS 90% Charity | UMMS 80% Charity | UMMS 70% Charity | UMMS 60% Charity | UMMS 50% Charity | UMMS 40% Charity | UMMS 30% Charity | UMMS 20% Charity | UMMS 10% Charity |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Equals Up to 200% of MD DHMH Annual Income limits | Equals Up to 210% of MD DHMH Annual Income limits | Equals Up to 220% of MD DHMH Annual Income limits | Equals Up to 230% of MD DHMH Annual Income limits | Equals Up to 240% of MD DHMH Annual Income limits | Equals Up to 250% of MD DHMH Annual Income limits | Equals Up to 260% of MD DHMH Annual Income limits | Equals Up to 270% of MD DHMH Annual Income limits | Equals Up to 280% of MD DHMH Annual Income limits | Equals Up to 290% of MD DHMH Annual Income limits |
| House-hold (HH) Size | 2020 FPL Annual Income Elig Limits | 2020 MD DHMH Annual Income Elig Limits | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: |
| Size | Up to | Up to | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max |
| 1 | 12,490 | **$17,620** | $35,240 | $37,002 | $38,764 | $40,526 | $42,288 | $44,050 | $45,812 | $47,574 | $49,336 | $52,859 |
| 2 | 16,910 | **$23,797** | $47,594 | $49,974 | $52,353 | $54,733 | $57,113 | $59,493 | $61,872 | $64,252 | $66,632 | $71,390 |
| 3 | 21,330 | **$29,974** | $59,948 | $62,945 | $65,943 | $68,940 | $71,938 | $74,935 | $77,932 | $80,930 | $83,927 | $89,921 |
| 4 | 25,750 | **$36,167** | $72,334 | $75,951 | $79,567 | $83,184 | $86,801 | $90,418 | $94,034 | $97,651 | $101,268 | $108,500 |
| 5 | 30,170 | **$42,344** | $84,688 | $88,922 | $93,157 | $97,391 | $101,626 | $105,860 | $110,094 | $114,329 | $118,563 | $127,031 |
| 6 | 34,590 | **$48,521** | $97,042 | $101,894 | $106,746 | $111,598 | $116,450 | $121,303 | $126,155 | $131,007 | $135,859 | $145,562 |

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

**Effective 7/1/20**

**POLICY OWNER:**

UMMS CBO

**APPROVED:**

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