

SHORE HEALTH SYSTEM FY13 COMMUNITY BENEFIT REPORT

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. For the purposes of this section, “primary services area” means the Maryland postal ZIP code areas from which the first 60 percent of a hospital’s patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Table I

Bed Designation	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:		Percentage of Patients who are Medicaid Recipients, by County:	
Memorial at Easton 112	7,688	21601, 21613, 21629, , 21632, 21655, 21639, 21643	Anne Arundel Medical Center Dorchester General Hospital	CAROLINE	0.6%	CAROLINE	7.9%
				DORCHESTER	0.3%	DORCHESTER	7.4%
				KENT	0.0%	KENT	0.7%
				QUEEN		QUEEN	
				ANNES	0.2%	ANNES	2.2%
				TALBOT	0.6%	TALBOT	6.5%
				TOTAL	1.7%	TOTAL	24.7%
Dorchester General Hospital 41	2,614	21613, 21643, 21631	Memorial Hospital at Easton Peninsula Regional Medical Center	CAROLINE	1.5%	CAROLINE	2.5%
				DORCHESTER	3.6%	DORCHESTER	13.3%
				KENT	0.3%	KENT	0.8%
				QUEEN		QUEEN	
				ANNES	0.5%	ANNES	1.0%
				TALBOT	0.8%	TALBOT	2.2%
				TOTAL	6.8%	TOTAL	19.8%

2. For purposes of reporting on your community benefit activities, please provide the following information:

- a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the

hospital's Community Benefit Service Area – “CBSA”. This service area may differ from your primary service area on page 1. Please describe in detail.) This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

Description of the community Shore Health System serves:

Situated on Maryland's Eastern Shore, Shore Health System's two hospitals, The Memorial Hospital at Easton and Dorchester General Hospital in Cambridge, are not for profit hospitals offering a complete range of inpatient and outpatient services to over 170,000 people throughout the Mid-Shore of Maryland.

Shore Health System's service area is defined as the Maryland counties of Caroline, Dorchester, Talbot (primary service area); Queen Anne's and Kent (secondary service area).

Memorial Hospital at Easton is situated at the center of the mid-shore area and thus serves a large rural geographical area. Dorchester General Hospital is located approximately 18 miles from MHE. MHE is located approximately 44 miles from Chester River Hospital and approximately 42 miles from Anne Arundel Medical Center.

The five counties of the Mid-Shore comprise 20% of the landmass of the State of Maryland and 2% of the population. The population of the five counties is just over 170,000 – 9.62% adults have less than a 9th grade education and another 9.62% have an education at the 9th -12th grade level but do not have a high school diploma.

The entire region has over 4,400 employers with nearly 45,000 workers. Only 50 of those employers employ 100 or more workers. Almost 85% of employers in this rural region are manufacturing firms, which require workers with high-level technology skills as well as low-skilled workers. The service industry is growing rapidly as the local population shifts to include more senior adults who retire to this beautiful area of the State. Although the seafood industry continues to be important to the region it is fast becoming an endangered species.

Memorial Hospital's service area has a higher percentage of population aged 65 and older as compared to Maryland overall. Talbot County has a 23.7 % rate for this age group. This concentration is due mainly to influx of retirees. The Mid Shore Region has 26,203 minority persons, representing 25.3% of the total population.

While steady progress is being made, the Mid-Shore economy still faces a myriad of challenges that include limited access to affordable high speed broadband services,

a shortage of affordable housing, an inadequate supply of skilled workers, low per capita income, and more layoffs in the manufacturing sector.
(Source: *Mid Shore Comprehensive Economic Development Strategy CEDS*)

In terms of healthcare, large disparities exist between Blacks and Whites as reported by the Office of Minority Health and Health Disparities, DHMH. For emergency department (ED) visit rates for diabetes, asthma and hypertension, the Black rates are typically 3- to 5 fold higher than White rates. Adults at healthy weight metric is lower (worse) for Blacks in all three counties where Black data could be reported. Heart disease mortality Black rates are variously higher or lower compared to White rates in individual counties. In Caroline, the Black rate is lower than the White rates not because the Black rate is particularly low, but because the White rate is unusually high. For cancer mortality, Black rates exceed White rates in Dorchester, Kent, Queen Anne’s and Talbot. In Caroline, Black rates are lower, again because of a rather high White rate. The Black rates and White rates are below the State Health Improvement Process (SHIP) goals.

(Source: <http://www.dhmh.maryland.gov/ship>).

County Health Rankings for the Mid-Shore counties also reveal the large disparities between counties for health outcomes in the service area.

County ranking (out of 24 counties including Baltimore City)								
County	Health Outcomes	Mortality	Morbidity	Health Factors	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Queen Anne	4	4	3	8	10	8	7	4
Talbot	6	9	7	4	3	3	11	2
Caroline	23	23	20	21	23	24	19	10
Dorchester	21	22	21	22	21	19	22	7

(Source: <http://www.countyhealthrankings.org>).2013

b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person’s current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, education and environment, having or not having health

insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, ethnicity, and average age)		Total Population	White	Black	Native American	Asian	Hispanic or Latino origin	
	Talbot	37,782	81.4%	12.8%	0.2%	1.2%	5.5%	
	Dorchester	32,618	67.6%	27.7%	0.3%	0.9%	3.5%	
	Caroline	33,066	79.8%	13.9%	0.4%	0.6%	5.5%	
	Queen Anne's	47,793	88.7%	6.9%	0.3%	1.0%	3.0%	
		Median Age	Under 5 Years	Under 18 Years	65 Years and Older	Female	Male	
	Talbot	43.3	4.9%	19.5%	23.7%	52.3%	47.7%	
	Dorchester	40.7	6.2%	21.7%	17.7%	52.3%	47.7%	
	Caroline	37.0	7.0%	25.2%	13.3%	51.2%	48.8%	
	Queen Anne's	38.8	5.7%	23.8%	14.9%	50.3%	49.7%	
	Source: http://dhmh.maryland.gov/ship/ and its County Health Profiles 2012							
	Median Household Income within the CBSA			Median Household Income				
Talbot		\$62,739						
Dorchester		\$46,710						
Caroline		\$59,689						
Queen Anne's		\$83,958						
Source: http://dhmh.maryland.gov/ship/ and its County Health Profiles 2012								
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Talbot	7.7%						
	Dorchester	15.0%						
	Caroline	11.8%						
	Queen Anne's	6.3%						
	Source: http://quickfacts.census.gov/qfd/states/24/24041.html (2007-2011))							

<p>Please estimate the percentage of uninsured people by County within the CBSA</p>	<p>Talbot 10.5% Dorchester 11.87% Caroline 14.58% Queen Anne's 10.3%</p> <p>Source: http://www.seedco.org</p>																																																																						
<p>Percentage of Medicaid recipients by County within the CBSA.</p>	<p>Talbot 12.63% Dorchester 23.30% Caroline 22.17% Queen Anne's 12.08%</p> <p>Source: http://www.chpdm-ehealth.org/mco</p>																																																																						
<p>Life Expectancy by County within the CBSA</p>	<table border="1" data-bbox="527 661 1177 955"> <thead> <tr> <th>Life Expectancy</th> <th>All Races</th> <th>White</th> <th>Black</th> </tr> </thead> <tbody> <tr> <td>Talbot</td> <td>80.5</td> <td>81.2</td> <td>77.1</td> </tr> <tr> <td>Dorchester</td> <td>77.6</td> <td>79.1</td> <td>73.7</td> </tr> <tr> <td>Caroline</td> <td>76.5</td> <td>76.8</td> <td>74.7</td> </tr> <tr> <td>Queen Anne's</td> <td>79.7</td> <td>80.0</td> <td>75.2</td> </tr> </tbody> </table> <p>Source: http://dhmh.maryland.gov</p>								Life Expectancy	All Races	White	Black	Talbot	80.5	81.2	77.1	Dorchester	77.6	79.1	73.7	Caroline	76.5	76.8	74.7	Queen Anne's	79.7	80.0	75.2																																											
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DEATH RATES BY RACE, 2011					
	All Races	White	Black	Asian or Pacific Islander	Hispanic ²
Talbot	1086.1	1118.0	1015.8	**	273.7
Dorchester	1106.0	1163.3	1008.4	**	**
Caroline	942.9	955.3	980.6	**	**
Queen Anne's	800.6	800.3	1077.9	**	**
<p>Source: http://dhhm.maryland.gov/vsa/Documents/11annual.pdf</p> <p>*INCLUDES RACES CATEGORIZED AS 'UNKNOWN' OR 'OTHER'.</p> <p>**RATES BASED ON <5 EVENTS IN THE NUMERATOR ARE NOT PRESENTED SINCE SUCH RATES ARE SUBJECT TO INSTABILITY.</p> <p>***INCLUDES ALL PERSONS OF HISPANIC ORIGIN OF ANY RACE.</p> <p>****PER 100,000 POPULATION.</p>					
Access to healthy food		Limited Access to healthy food	Proportion of county restaurants that are Fast food restaurants		
	Talbot	2%	37%		
	Dorchester	3%	60%		
	Caroline	2%	58%		
	Queen Anne's	3%	45%		
Source: http://www.countyhealthrankings.org					
Quality of housing	County	Housing units	Home Ownership Rate		
	Caroline	13,469	74.2%		
	Dorchester	16,574	69.8%		
	Talbot	19,645	72.6%		
	Queen Anne's	20,303	86.0%		
Source: <i>Housing Characteristics for the Region (2000 Census-State & County Quick facts 2011)</i>					

Primary Service area:

Caroline County. There is a lack of Section 8 Rental Assistance housing in Caroline County. At the present time, only about one-third of the demand has been filled.

Dorchester County. Housing in Dorchester County, even though relatively low-priced, is not necessarily more affordable due to the relatively low income of county residents. Compared to the surrounding counties, the housing stock is older, fewer homes are owner-occupied, more households are low to moderate income, and more housing lacks complete plumbing.

The lack of move-up housing in the County is seen as a deterrent to attracting business. Dorchester County has a relatively weak housing market linked to the weak economy. In addition, the disproportionate amount of the County's elderly population dictates the need for more modest priced homes for the persons in this age category.

County-wide, just over 31.5 percent of housing was renter occupied in 2010 with a renter rate for incorporated towns nearing 50 percent. In 2010, 18.3 percent of the County's housing units were vacant. This is a much higher percentage than for adjoining counties. Problems associated with Dorchester County housing include the following:

- High housing costs compared to income
- Significant number of homes in poor physical condition
- Owner occupancy level for housing units in Cambridge at less than 50 percent
- Market demand for rural subdivisions coupled with disincentives for housing developments in towns are resulting in increasing housing development in the unincorporated area of the County

Talbot County. The housing issues in Talbot County are complex primarily because of the extreme disparity of income levels in the County. Limited entrepreneurial and job opportunities keep the moderate income wage earners from home ownership. Habitat for Humanity and new Easton Town Council initiatives now require developers to address low to moderate income, affordable home ownership opportunities as part of any new housing development strategy. The net effect will not be known for several years. There is no shortage of high end housing

	<p>options. Middle income affordable housing remains a county wide issue.</p> <p>Talbot County had the fourth smallest number of persons per household in the State in 2000 (2.32) however 40% of public housing remains inexplicably vacant. Rental property is exorbitant and often requires unrelated families to share space. Apartments represent 85% of the rental property. Failure of code enforcement allows rentals to remain in a state of disrepair. Much of the substandard housing is in small rural pockets.</p> <p>The Talbot County Housing Roundtable, a coalition of organizations and individuals formed to assess and recommend affordable housing policy for Talbot County, and the local and county councils are exploring avenues to significantly address quality of life issues through better housing options. On the drawing board are zoning and design standards that increase the mix of uses and housing types; mandated moderately priced dwellings as part of all new developments; employer- assisted housing, creation of housing trust funds solely to build affordable homes in low, moderate and middle income brackets and creating nonprofit, semi-public developers and other financiers of affordable housing.</p> <p><i>Source: Mid Shore Comprehensive Economic Development Strategy CEDS Source: http://www.midshore.org/reports/</i></p>
<p>Transportation by County within the CBSA</p>	<p>Transit services in the three county areas are provided under contract by Delmarva Community Transit. Services include medical and senior citizen demand services and fixed route county and regional service. While most of the region is served by the fixed routes, there are gaps in coverage in the less populated areas of the counties. The regional system, Maryland Upper Shore Transit (MUST), provides low cost and seamless service for the general public from Kent Island to Ocean City with convenient free transfer points at key locations on the shore.</p> <p>MUST is a coordinated effort of several Upper Shore agencies and governments to provide a regional transit system for Kent, Queen Anne's, Talbot, Caroline, and Dorchester Counties. Transit services are provided by Queen Anne's County Ride (operated by the county) and Delmarva Community Transit (DCT), a private company under contract to the counties. The system also includes Shore Transit, which provides scheduled routes on the lower shore. The MTA and the Maryland Department of Human Resources have provided funding. Overall management of the</p>

	<p>regional system is the responsibility of the Transportation Advisory Group (TAG). The County Commissioners of the five Upper Shore counties appoint the members of the TAG.</p> <p><i>Source: Mid Shore Comprehensive Economic Development Strategy CEDS (revised March 2012) http://www.midshore.org/reports/</i></p>											
<p>Unemployment Rate by County within the CBSA</p>	<table border="1"> <thead> <tr> <th data-bbox="513 478 779 577">County</th> <th data-bbox="779 478 1050 577">Unemployment Rate June 2013</th> </tr> </thead> <tbody> <tr> <td data-bbox="513 577 779 640">Talbot</td> <td data-bbox="779 577 1050 640">6.4%</td> </tr> <tr> <td data-bbox="513 640 779 703">Dorchester</td> <td data-bbox="779 640 1050 703">9.4%</td> </tr> <tr> <td data-bbox="513 703 779 766">Caroline</td> <td data-bbox="779 703 1050 766">7.7%</td> </tr> <tr> <td data-bbox="513 766 779 831">Queen Anne's</td> <td data-bbox="779 766 1050 831">6.1%</td> </tr> </tbody> </table>	County	Unemployment Rate June 2013	Talbot	6.4%	Dorchester	9.4%	Caroline	7.7%	Queen Anne's	6.1%	
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II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act (“ACA”), hospitals must perform a Community Health Needs Assessment (CHNA) either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and perform an assessment at least every three years. 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, the IRS defines a CHNA as a:

Written document developed for a hospital facility that includes a description of the community served by the hospital facility; the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

The written document (CHNA) must include the following:

A description of the community served by the hospital and how it was determined;

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact the hospital organization’s ability to assess the health needs of the community served by the hospital facility. If a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties;

A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility, including a description of when and how the hospital consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital

organization consulted. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual’s special knowledge or expertise. The report must identify any individual providing input who is a “leader” or “representative” of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and

A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

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

- (1) Maryland Department of Health and Mental Hygiene’s State Health Improvement Process (SHIP)(<http://dhmh.maryland.gov/ship/>);**
- (2) SHIP’s CountyHealth Profiles 2012 (<http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx>);**
- (3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);**
- (4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;**
- (5) Local Health Departments;**
- (6) County Health Rankings (<http://www.countyhealthrankings.org>);**
- (7) Healthy Communities Network (<http://www.healthycommunitiesinstitute.com/index.html>);**
- (8) Health Plan ratings from MHCC (<http://mhcc.maryland.gov/hmo>);**
- (9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);**
- (10) Behavioral Risk Factor Surveillance System (<http://www.cdc.gov/BRFSS>);**
- (11) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;**
- (12) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;**
- (13) Survey of community residents; and**
- (14) Use of data or statistics compiled by county, state, or federal governments.**

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

Shore Health System (SHS) in collaboration with Chester River Hospital System (CRHS) conducted a Community Health Needs Assessment (CHNA) for the five counties of Maryland's Mid-Shore: Talbot, Caroline, Queen Anne's, Dorchester, and Kent. The health needs of our community were identified through a process which included collecting and analyzing primary and secondary data. In particular, the CHNA includes primary data from Talbot, Caroline, Dorchester, Kent, Queen Anne's Health Departments and the community at large. Additionally, Shore Health, is a participating member of the Mid-Shore SHIP coalition, where we are partnering with other community stakeholders invested in improving the community's overall health. Members of the Mid-Shore SHIP coalition include community leaders, county government representatives, local non-profit organizations, local health providers, and members of the business community. Feedback from customers includes data collected from surveys, advisory groups and from our community outreach and education sessions. Secondary data resources referenced to identify community health needs include County Health Rankings (<http://www.countyhealthrankings.org>), Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(<http://dhmh.maryland.gov/ship/>), the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf)

Shore Health participates on the University of Maryland Medical System (UMMS) Community Benefits Workgroup to study demographics, assess community health disparities, inventory resources and establish community benefit goals for both Shore Health System and UMMS.

Shore Health System consulted with community partners and organizations to discuss community needs related to health improvement and access to care. The following list of partner agencies meets on a monthly basis as members of the Mid-Shore SHIP coalition:

- Choptank Community Health Systems
- Caroline County Minority Outreach Technical Assistance
- Talbot County Local Management Board
- Partnership for Drug Free Dorchester
- Caroline County Community Representative
- Eastern Shore Area Health Education Center
- Kent County Minority Outreach Technical Assistance
- YMCA of the Chesapeake
- University of MD Extension
- Kent County Local Management Board
- Kent County Department of Juvenile Services
- Coalition Against Tobacco Use

- Mt. Olive AME Church
- Mid Shore Core Service Agency
- Associated Black Charities
- Queen Anne County Housing and Family Services
- Queen Anne County Health Department
- Dorchester County Health Department
- Talbot County Health Department
- Caroline County Health Department
- Easton Memorial Hospital
- Chester River Hospital
- Mid- Shore Mental Health Systems

Chester River Health and Shore Health hosted a series of community listening forums to gather community input for a regionalization study that explores the benefits of a regional approach to providing health care for Caroline, Dorchester, Kent, Queen Anne's and Talbot counties. In addition, Shore Health meets quarterly with members of the local health departments and community leaders, including:

Choptank Community Health System	Joseph Sheehan
Health Departments	Health Officers
Mid Shore Mental Health Systems	Holly Ireland
Eastern Shore Hospital Center	Randy Bradford

In addition, the following agencies/organizations are referenced in gathering information and data.

- Maryland Department of Health and Mental Hygiene
- Maryland Department of Planning
- Maryland Vital Statistics Administration
- HealthStream, Inc.
- County Health Rankings
- Mid Shore Comprehensive Economic Development Strategy CEDS

Our CHNA identified the following list of priorities for our community:

- Diabetes
- Heart Disease
- Cancer
- Behavioral Health
- Access to Care

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?

Yes
 No

Provide date here. 5/22/2013

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

<http://www.shorehealth.org/pdfs/2013-community-health-action-plan.pdf>

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?

Yes
 No

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

<http://www.shorehealth.org/pdfs/2013-community-health-action-plan.pdf>

See **Appendix 2 in the CHNA** in link provided above

III. COMMUNITY BENEFIT ADMINISTRATION

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

a. Is Community Benefits planning part of your hospital's strategic plan?

Yes
 No

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

i. Senior Leadership

1. CEO
2. CFO
3. Other (please specify)
COO
Board of Directors

ii. Clinical Leadership

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

iii. Community Benefit Department/Team

1. Individual (please specify FTE)
Director, Outreach and Business Development
(1FTE)
2. Committee (please list members)

- Michael Silgen (Chair) - VP, Strategic Planning & Business Development
- Vickey Bramble, Executive Assistant
- Aaron Lefort – Data Analyst, Shore Wellness Partners
- Andrew McCarthy, MD
- Bill Roth - Senior Director, Comprehensive Rehab Care
- Chris Parker - Senior Vice President-Patient Care Services, Chief Nursing Officer
- Chris Mitchell MSN, RN, NEA-BC, Director of Emergency and Outpatient Services
- Chris Pettit – Planning Analyst
- Dale Jafari MSN, CRNP, Breast Center Coordinator
- Iris Lynn Girardo RN,BSN, Readmissions Care Coordinator
- Kathleen McGrath - Director of Strategic Planning & Business Development
- Linda Porter, Patient Access Manager
- Patricia Plaskon - PhD, LCSW-C, OSW-C, Coordinator of Oncology Social Work
- Rita Holley MS, BSN, RN Director of Shore Home Care
- Ruth Ann Jones EdD, MSN, RN, NEA-BC, Director Acute Care
- Sharon Stagg RN, DNP, MPH, FNP-BC, Director of Shore Wellness Partners
- Susan Siford, PharmD, MBA, Director of Pharmacy
- Trish Rosenberry, BSN, RN, Manager of Outpatient Services
- Bee Fish – Director IT, Site Executive
- Deborah Reeder RN, COS-C, Home Health Manager

- Gary Jones, Director, Cardiovascular & Pulmonary Services
- Holly Patronik - Clinical Nutrition Manager
- Jackie Weston, BSN, RN-BC, Nurse Manager for Shore Behavioral Health Services
- Kathy Gootee - Director Clinical Information Management
- Paul Monte, MD
- Terri Ross - Director of Care Coordination

3. ___ Other (please describe)

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

Spreadsheet yes no

Narrative yes no

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

Spreadsheet yes no

Narrative yes no

If you answered no to this question, please explain why.

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

This Information should come from the implementation strategy developed through the CHNA process.

1. Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached examples of how to report.

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

- a. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.

- b. Name of Initiative: insert name of initiative.
 - c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (Use several pages if necessary)
 - d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?
 - e. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.
 - f. How were the outcomes of the initiative evaluated?
 - g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?
 - h. Continuation of Initiative: Will the initiative be continued based on the outcome?
 - i. Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
2. **Were there any primary community health needs that were identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.**

Needs Identified not addressed:

Several additional topic areas were identified by the CHNA Steering Committee including: safe housing, transportation, and substance abuse. The unmet needs not addressed by SHS and CRHS will continue to be addressed by key governmental agencies and existing community-based organizations. While SHS and CRHS will focus the majority of our efforts on the identified priorities outlined in the CHNA Action Plan, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through other health care organizations with our assistance as available.

Initiative 1.

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY13
<p>CHRONIC DISEASE—</p> <p>SHIP OBJECTIVES #27, 28, 17</p> <p>Reduce diabetes - related emergency department visits.</p> <p>Reduce hypertension related - emergency department visits.</p> <p>Reduce emergency department visits from asthma.</p> <p>Reduce complications for conditions such as HF, COPD, CKD and asthma</p>	<p>Shore Wellness Partners (SWP)</p>	<p>Shore Well Partners is a unique program that provides a continuum of care, focusing on preventive care to improve the ability of patients and families to work together to reduce emergency department visits and readmissions. Designed for at-risk families and individuals who do not have sufficient resources and are not eligible for other in-home services. Wellness Partners helps patients with disease management and life skills so that they can continue to live in their own homes. The service is provided by Shore Health System at no charge for those who qualify.</p> <p>Objectives:</p> <ul style="list-style-type: none"> • Managing physical health problems • Connection with other community services • Dietary education • Home safety evaluations • Safe medicine use • Education on specific illness and treatments • Emotional support • Monitoring client progress through home visits or phone calls 	<p>Ongoing; currently in second year</p>	<p>Members of the Shore Wellness Partners team include advanced practice nurses and medical social workers. These specialists work with patients, caregivers, and primary care providers (sometimes care is provided in the patient’s home). Shore Wellness Partners is a partner in the HEZ for Dorchester and Caroline Counties. Detailed information for the HEZ model, Competent Care Connections can be found at: http://dhmh.maryland.gov/healthenterprisezones/SitePages/Updates.aspx</p>	<p>1. # of referrals to service</p> <p>2. # of patients on service with Shore Wellness Partners</p> <p>3. Comparison of ALL CAUSE readmissions for FY13 to FY12</p>	<p>1. Number of referrals = 433</p> <p>2. Number of active patients =213 New patients=93</p> <p>Readmission, ALL CAUSE:</p> <p>Memorial at Easton FY13. decreased by 18.8% , 157 patients</p> <p>Dorchester General FY13. decreased by 9% , 16 patients</p>	<p>Ongoing, multiyear</p> <p>Expansion of SWP as part of the HEZ grant</p>	<p>\$485,341 (includes staff salary and supplies Does not include indirect overhead)</p>

Initiative 2

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY13
CHRONIC DISEASE-- Cardiovascular	Anti-thrombosis Clinic	Provide anticoagulated patients (no charge) with close monitoring, educational resources and dedicated expertise to prevent adverse outcomes, reduction of hospital encounters related to over anticoagulation or under anticoagulation	Multi-year /ongoing	Shore Health Pharmacy Services	# of patients enrolled Average time in therapeutic INR % of patients in therapeutic range	Clinic manages greater than 1,000 patients enrolled 12,187 patient encounters Average time to therapeutic INR is 4.3 days compared to national average of 5.8 days 73% of patients spend greater than 90% of time in therapeutic range (national average, 58%) 1.4% adverse event requiring hospitalization	The initiative is continuing	\$187,054 (includes staff salary and supplies Does not include indirect overhead)
Critical Care Access to emergency medications prevents terminal outcomes for patients	EMS Medication Programs	Shore Regional Health provide emergency management medications to the local Ambulance Services so that Advanced Cardiac Life Support may be initiated in the field	Multi-year /ongoing	Shore Health Pharmacy, EMS	# of patients served.	Early interventions by EMS, served 10,000 persons.	The initiative is continuing	\$79,586

Initiative 3

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY13
<p>CHRONIC DISEASE—CANCER</p> <p>SHIP OBJECTIVE #26 Reduce overall cancer death rate</p>	Shore Regional Breast Outreach	<ol style="list-style-type: none"> 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. Diagnose African American women at earlier stages of breast cancer, equivalent to Caucasian women. Educate Latina women in breast self examination with the assistance of a translator. 	Multi-year /ongoing	Health Departments	<ol style="list-style-type: none"> # of women educated Correlation of tumor registry data with outreach events, screenings 	<p>Increased the community’s awareness of breast cancer prevention, detection and treatments.</p> <p>Served 4,267 person at 30 community events, 7 professional presentations</p> <p>The stage at diagnosis as reported by the Tumor Registry for the Cancer Center indicates women are being diagnosed at early stages of the disease, and that there is no distinction between the ethnic groups in our community</p>	Ongoing	<p>\$25,000</p> <p>(includes staff salary and supplies Does not include indirect overhead)</p>
	Shore Regional Breast Center Wellness for Women Program	<p>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</p> <p>Baseline/Strategies/Outcomes: Offered no cost mammograms to eligible women: those under the age of 40 and over 65who 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 will be enrolled in the State of Maryland Diagnosis and Treatment Program through the case manager.</p>	Multi-year /ongoing	Health Departments	<ol style="list-style-type: none"> Ongoing data collection reported monthly to capture total number seen with breakdown by race. Increase breast screening levels among uninsured and underinsured women. . 	<p>WFW Screenings: 187 patients</p> <ul style="list-style-type: none"> African American new patients, up 10.5% Hispanic new patients, up 34% Caucasian new patients, up 26% <p>Shore Regional Breast Center Case Worker 1,559 patient visits.</p> <ul style="list-style-type: none"> 26 were diagnosed with breast cancer 193 total of patients case managed. 	Ongoing	<p>\$56,000</p> <p>(includes staff salary and supplies Does not include indirect overhead)</p>

	Prostate Cancer Screening	Provide men in the mid shore, the opportunity to obtain a free prostate cancer screening which includes blood test and exam by a competent physician.	Multi-year /ongoing	Shore Comprehensive Urology Talbot County NAACP MOTA	# of screenings and exams provided	Increased awareness and detection of prostate cancer Provided access to screenings to underserved persons of community 85 clients were served. All results are reviewed by the screening physician. Results are mailed to the participant.	ongoing	\$1,400 (includes staff salary and supplies Does not include indirect overhead)
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Initiative 4

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY13
<p>CHRONIC DISEASE SHIP OBJECTIVE # 27</p> <p>Reduce ED visits from diabetes</p> <p>Improve management of diabetes</p> <p>Reduce incidence of diabetes</p>	<p>Diabetes Education Programs</p> <ul style="list-style-type: none"> •Diabetes Update Conversations on Diabetes •Diabetes Support Group • Education on Diabetes for High School Students 	<p>The primary objectives of the Diabetes education programs are:</p> <ul style="list-style-type: none"> • Improve health through better management of diabetes • Increase knowledge of risk factors for diabetes, heart disease and stroke and how to improve health with regular exercise and nutrition • Provide support for diabetes patients and their families 	<p>New program</p>	<p>Grasonville Community Senior Center</p> <p>UM Center for Diabetes and Endocrinology</p> <p>Caroline County Schools</p>	<p># of patient goal plans written.</p> <p># of participants who reach goals</p> <p># of Participants</p> <p>Pre and Post seminar survey</p>	<p>Conversations on Diabetes: 8 Participants attended 2 hour session to increase their knowledge on managing their diabetes. Goals were set and monitored. All participants made progress to meet goals.</p> <p>Diabetes Support Group: 8-10 patients attend monthly Diabetes support group. Attendees and their friends and family meet to discuss diabetes: concerns, problems, and challenges. Facilitator provides health education and accurate information.</p> <p>Education on Diabetes for High School Students: 150 Students attended educational seminars. Quiz given to assess</p>	<p>All the listed initiatives are continuing</p>	<p>\$3,265 (includes staff salary and supplies Does not include indirect overhead)</p>

						awareness of sugar in foods. 95% not aware prior to seminar. Education on reading food labels and making healthy choices provided to attendees.		
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Initiative 5

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY13
Chronic Disease Management: Diabetes and Asthma	Shore Kids Camp	Provide children with learning and networking experience who have diabetes or asthma Prevent hospitalization of children attending the camp	Multi-year /ongoing	American Diabetes Association	Track the attendees for one year after attending camp for hospitalizations due to complications from diabetes or asthma	9 children attended, Only 1 child hospitalized with diabetes complications in following year	Yes, yearly	\$9.600 (includes staff salary and supplies Does not include indirect overhead)

V. PHYSICIANS

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

The SHS Medical Staff by-laws require that physicians provide ten days of Emergency Department call. In areas where there is only one or two sub-specialists for a particular specialty, there will be occasions when certain days are not covered. If a patient presents to the Emergency Department and there is no sub-specialty coverage for that day, the patient is stabilized and then transferred to an appropriate facility for treatment.

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

Physician Subsidies: As a result of the prevailing physician shortage, Shore Health has an insufficient number of specialists on staff. Subsidies for the following specialties are necessary to meet patient demand, including the uninsured and underinsured.

- General Surgery
- Hospitalist
- Chemotherapy
- Psychiatric Services

Stipends to Tidewater Anesthesia and Maryland Emergency Medicine are paid to provide evening, weekend, and holiday call in order to provide emergency Surgical Services 24/7. Consistent with prior years, the report reflects the expense for ER and Anesthesiology physicians, offset by any other.

Physician Recruitment: The Mid-Shore continues to experience a high percentage of physician shortage for specialists. To address the shortage, ongoing recruitment for the following areas occurred for FY13.

- Psychiatric Services
- General Surgery

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):

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

For *example*, state whether the hospital:

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
 - in a culturally sensitive manner,
 - at a reading comprehension level appropriate to the CBSA's population, and
 - in non-English languages that are prevalent in the CBSA.
- posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
- provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
- provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
- includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
- discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

- b. Include a copy of your hospital's FAP (label appendix II).

- c. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).

2. Attach the hospital's mission, vision, and value statement(s) (label appendix IV).

Appendix I

Description of SHS Financial Assistance Policy (FAP):


It is the policy of Shore Health System to work with our patients to identify available resources to pay for their care. All patients presenting as self pay and requesting charity relief from their bill will be screened at all points of entry, for possible coverage through state programs and a probable determination for coverage for either Medical Assistance or Financial Assistance (charity care) from the hospital is **immediately** given to the patient. The process is resource intensive and time consuming for patients and the hospital; however, if patients qualify for one of these programs, then they will have health benefits that they will carry with them beyond their current hospital bills, and allow them to access preventive care services as well. Shore Health System works with a business partner who will work with our patients to assist them with the state assistance programs, which is free to our patients.

If a patient does not qualify for Medicaid or another program, Shore Health System offers our financial assistance program. Shore Health System posts notices of our policy in conspicuous places throughout the hospitals- including the emergency department, has information within our hospital billing brochure, educates all new employees thoroughly on the process during orientation, and does a yearly re-education to all existing staff. All staff have copies of the financial assistance application, both in English and Spanish, to supply to patients who we deem, after screening, to have a need for assistance. Shore Health System has a dedicated Financial Assistance Liaison to work with our patients to assist them with this process and expedite the decision process.

Shore Health notifies patients of availability of financial assistance funds prior to service during our calls to patients, through signage at all of our registration locations, through our patient billing brochure and through our discussions with patients during registration. In addition, the information sheet is mailed to patients with all statements and/or handed to them if needed. Notices are sent regarding our Hill Burton program (services at reduced cost) yearly as well.

- Shore Health prepares its FAP in a culturally sensitive manner, at a reading comprehension level appropriate to the CBSA's population, and in Spanish.
- Shore Health posts its FAP and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
- Shore Health provides a copy of the FAP and financial assistance contact information to patients or their families as part of the intake process;

- Shore Health provides a copy of the FAP and financial assistance contact information to patients with discharge materials.
- A copy of Shore Health's FAP along with financial assistance contact information, is provided in patient bills; and/or
- Shore Health discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.
- An abbreviated statement referencing Shore Health's financial assistance policy, including a phone number to call for more information, is run annually in the local newspaper (*Star Democrat*)

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1.0 POLICY

1.1 This policy applies to Shore Health System (“SHS”). Shore Health System 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 medically necessary care based on their individual financial situation. The hospitals covered by this policy include:

- The Memorial Hospital at Easton
- Dorchester General Hospital

1.2 It is the policy of SHS 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.

1.3 SHS will publish the availability of Financial Assistance on a yearly basis in the local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients on patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided to patients receiving inpatient services with their Summary Bill and made available to all patients upon request.


1.4 Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

1.5 SHS 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 services, applications to the Financial Assistance Program will be completed, received and evaluated retrospectively and will not delay patients from receiving care.


2.0 PROGRAM ELIGIBILITY

2.1 Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, SHS strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further SHS commitment to our mission to provide healthcare to those residing in the neighborhoods surrounding our hospital, SHS reserves the right to grant Financial Assistance without formal application being made by our patients. The zip codes for the SHS primary service area are included in Attachment A. Additionally, patients residing outside of our primary service area may receive Financial Assistance on a one-time basis for a specific episode of care.

2.2 Specific exclusions to coverage under the Financial Assistance program include the following:

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- 2.2.1 Services provided by healthcare providers not affiliated with SHS (e.g., home health services).
- 2.2.2 Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, Workers Compensation or Medicaid), are not eligible for the Financial Assistance Program. 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 considering medical and programmatic implications.
- 2.2.3 Unpaid balances resulting from cosmetic or other non-medically necessary services.
- 2.2.4 Patient convenience items.
- 2.2.5 Patient meals and lodging.
- 2.2.6 Physician charges related to the date of service are excluded from SHS' Financial Assistance Policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.
- 2.3 Patients may become ineligible for Financial Assistance for the following reasons:
 - 2.3.1 Refusal to provide requested documentation or providing incomplete information.
 - 2.3.2 Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid or other insurance programs that deny access to SHS due to insurance plan restrictions/limits.
 - 2.3.3 Failure to pay co-payments as required by the Financial Assistance Program.
 - 2.3.4 Failure to keep current on existing payment arrangements with SHS.
 - 2.3.5 Failure to make appropriate arrangements on past payment obligations owed to SHS (including those patients who were referred to an outside collection agency for a previous debt).
 - 2.3.6 Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.
- 2.4 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.
- 2.5 Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section 3 below). If patient qualifies for COBRA coverage, patient's financial

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ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel 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.

2.6 Coverage amounts will be calculated based upon 200-300% of income as defined by federal poverty guidelines and follows the sliding scale included in Attachment B.

3.0 PRESUMPTIVE FINANCIAL ASSISTANCE

3.1 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 and/or supporting documentation on file. Often there is adequate information provided by the patient or through other sources, which could 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, SHS 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:

- 3.1.1 Active Medical Assistance pharmacy coverage.
- 3.1.2 Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums).
- 3.1.3 Primary Adult Care ("PAC") coverage.
- 3.1.4 Homelessness.
- 3.1.5 Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs.
- 3.1.6 Maryland Public Health System Emergency Petition patients.
- 3.1.7 Participation in Women, Infants and Children Programs ("WIC").
- 3.1.8 Food Stamp eligibility.
- 3.1.9 Eligibility for other state or local assistance programs.
- 3.1.10 Patient is deceased with no known estate.

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3.1.11 Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.

3.2 Patients who present to the Outpatient Emergency Department but are not admitted as inpatients and who reside in the hospitals' primary service area may not need to complete a Financial Assistance Application but may be granted presumptive Financial Assistance based upon the following criteria:

3.2.1 Reside in primary service area (address has been verified).

3.2.2 Lack health insurance coverage.

3.2.3 Not enrolled in Medical Assistance for date of service.

3.2.4 Indicate an inability to pay for their care.

3.2.5 Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

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

3.3.1 Purely elective procedures (e.g., cosmetic procedures) are not covered under the program.

3.3.2 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.

3.3.3 Qualifying Non-U.S. citizens are to be processed for reimbursement through the Federal Program for Undocumented Alien Funding for Emergency Care (a.k.a. Section 1011) prior to financial assistance consideration.


4.0 MEDICAL HARDSHIP

4.1 Patients falling outside of conventional income or Presumptive Financial Assistance criteria are potentially eligible for bill reduction through the Medical Hardship program. Uninsured Medical Hardship criteria is State defined as:

4.1.1 Combined household income less than 500% of federal poverty guidelines.

4.1.2 Having incurred collective family hospital medical debt at SHS exceeding 25% of the combined household income during a 12 month period. The 12 month period begins with the date the Medical Hardship application was submitted.

4.1.3 The medical debt excludes co-payments, co-insurance and deductibles.

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4.2 Patient Balance after Insurance

SHS applies the State established income, medical debt and time frame criteria to patient balance after insurance applications.

4.3 Coverage amounts will be calculated based upon 0 - 500% of income as defined by federal poverty guidelines and follow the sliding scale included in Attachment B.

4.4 If determined eligible, patients and their immediate family are certified for a 12-month period effective with the date on which the reduced cost medically necessary care was initially received.

4.5 Individual patient situation consideration:

4.5.1 SHS reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.

4.5.2 The eligibility duration and discount amount is patient-situation specific.

4.5.3 Patient balance after insurance accounts may be eligible for consideration.

4.5.4 Cases falling into this category require management level review and approval.

4.6 In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance Programs, SHS is to apply the greater of the two discounts.

4.7 Patient is required to notify SHS of their potential eligibility for this component of the Financial Assistance Program.

5.0 ASSET CONSIDERATION


5.1 Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient responsibility without causing undue hardship. Individual patient financial situation such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are reviewed.

5.2 Under current legislation, the following assets are exempt from consideration:

5.2.1 The first \$10,000 of monetary assets for individuals and the first \$25,000 of monetary assets for families.

5.2.2 Up to \$150,000 in primary residence equity.

5.2.3 Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans.

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Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

6.0 APPEALS

- 6.1 Patients whose financial assistance applications are denied have the option to appeal the decision.
- 6.2 Appeals can be initiated verbally or written.
- 6.3 Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
- 6.4 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.
- 6.5 If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
- 6.6 The escalation can progress up to the Chief Financial Officer who will render a final decision.
- 6.7 A letter of final determination will be submitted to each patient who has formally submitted an appeal.

7.0 PATIENT REFUND


- 7.1 Patients applying for Financial Assistance up to 2 years after the service date who have made account payment(s) greater than \$25 are eligible for refund consideration.
- 7.2 Collector notes, and any other relevant information, are deliberated as part of the final refund decision. In general, refunds are issued based on when the patient was determined unable to pay compared to when the payments were made.
- 7.3 Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for refund.

8.0 JUDGEMENTS


If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained or the debt submitted to a credit reporting agency, SHS shall seek to vacate the judgment and/or strike the adverse credit information.

9.0 PROCEDURES

- 9.1 Each Service Access area will designate a trained person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Customer Service, etc.

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- 9.2 Every 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.
- 9.2.1 Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.
- 9.2.2 Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). 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.
- 9.2.3 SHS will not require documentation beyond that necessary to validate the information on the Maryland State Uniform Financial Assistance Application.
- 9.2.4 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.
- 9.2.5 Patients will have thirty (30) days to submit required documentation to be considered for eligibility. If no data is received within 20 days, a reminder letter will be sent notifying that the case will be closed for inactivity and the account referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.
- 9.3 In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:
- 9.3.1 A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable).
- 9.3.2 A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.
- 9.3.3 Proof of Social Security income (if applicable).
- 9.3.4 A Medical Assistance Notice of Determination (if applicable).
- 9.3.5 Proof of U.S. citizenship or lawful permanent residence status (green card).
- 9.3.6 Reasonable proof of other declared expenses.

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- 9.3.7 If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
- 9.4 A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on SHS guidelines. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility. SHS will make a determination of probable eligibility within two business days following a patient's request for charity care services, application for medical assistance, or both.
- 9.4.1 If the patient does qualify for financial clearance, appropriate personnel will notify the treating department who may then schedule the patient for the appropriate service.
- 9.4.2 If the patient does not qualify for financial clearance, appropriate personnel will notify the clinical staff of the determination and the non-emergent/urgent services will not be scheduled. A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.
- 9.5 Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.
- 9.6 The following may result in the reconsideration of Financial Assistance approval:
- 9.6.1 Post-approval discovery of an ability to pay.
- 9.6.2 Changes to the patient's income, assets, expenses or family status which are expected to be communicated to SHS.
- 9.7 SHS will track patients with 6 or 12 month certification periods utilizing either eligibility coverage cards and/or a unique insurance plan code(s). However, it is ultimately the responsibility of the patient or guarantor to advise of their eligibility status for the program at the time of registration or upon receiving a statement.
- 9.8 If patient is determined to be ineligible, 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.

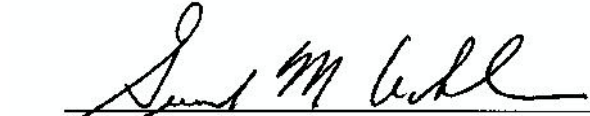


SHORE HEALTH
UNIVERSITY OF MARYLAND
MEDICAL SYSTEM

ADMINISTRATIVE POLICY &
PROCEDURE

FINANCIAL ASSISTANCE


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Gerard M. Walsh, Chief Operating Officer

Effective	10/05
Approved	SHS Board of Directors: 06/22/05
Revised	07/10 (Minor Changes)
Revised	02/11
Approved	SHS Board of Directors: 02/23/11
Revised	08/12 (Minor Changes)
Submitted	Walter Zajac, Sr. Vice President/CFO
	Samuel Harris, Director, Patient Financial Services

ATTACHMENTS:

- Attachment A - Zip Codes for Coverage Areas
- Attachment B - Sliding Scale

 SHORE HEALTH UNIVERSITY OF MARYLAND MEDICAL SYSTEM	ATTACHMENT A TO FINANCIAL ASSISTANCE POLICY	POLICY NO:	LD-34
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ZIP CODES FOR COVERAGE AREAS

The following zip codes represent the coverage areas for the respective Entities:

21601, 21607, 21609, 21610, 21612, 21613, 21617, 21619, 21620, 21620, 21622, 21623, 21624, 21625, 21626, 21627, 21628, 21629, 21631, 21632, 21634, 21635, 21636, 21638, 21639, 21640, 21641, 21643, 21644, 21645, 21647, 21648, 21649, 21650, 21651, 21651, 21652, 21653, 21654, 21655, 21656, 21657, 21657, 21658, 21659, 21660, 21661, 21662, 21663, 21664, 21665, 21666, 21667, 21668, 21669, 21670, 21671, 21672, 21673, 21675, 21676, 21677, 21678, 21679, 21690, 21835, 21869



SHORE HEALTH
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ATTACHMENT B
TO
FINANCIAL ASSISTANCE POLICY

SLIDING SCALE

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		% of Federal Poverty Level Income										
		200%	210%	220%	230%	240%	250%	260%	270%	280-290%	300% - 499%	
		Approved % of Financial Assistance										
Size of Family Unit	FPL Income	100%	90%	80%	70%	60%	50%	40%	30%	20%	25% of Income	
1	\$10,830	\$21,660	\$22,743	\$23,826	\$24,909	\$25,992	\$27,075	\$28,158	\$29,241	\$30,324	\$32,490	\$54,150
2	\$14,570	\$29,140	\$30,597	\$32,054	\$33,511	\$34,968	\$36,425	\$37,882	\$39,339	\$40,796	\$43,710	\$72,850
3	\$18,310	\$36,620	\$38,451	\$40,282	\$42,113	\$43,944	\$45,775	\$47,606	\$49,437	\$51,268	\$54,930	\$91,550
4	\$22,050	\$44,100	\$46,305	\$48,510	\$50,715	\$52,920	\$55,125	\$57,330	\$59,535	\$61,740	\$66,150	\$110,250
5	\$25,790	\$51,580	\$54,159	\$56,738	\$59,317	\$61,896	\$64,475	\$67,054	\$69,633	\$72,212	\$77,370	\$128,950
6	\$29,530	\$59,060	\$62,013	\$64,966	\$67,919	\$70,872	\$73,825	\$76,778	\$79,731	\$82,684	\$88,590	\$147,650
7	\$33,270	\$66,540	\$69,867	\$73,194	\$76,521	\$79,848	\$83,175	\$86,502	\$89,829	\$93,156	\$99,810	\$166,350
8	\$37,010	\$74,020	\$77,721	\$81,422	\$85,123	\$88,824	\$92,525	\$96,226	\$99,927	\$103,628	\$111,030	\$185,050

Patient Income and Eligibility Examples:

Example #1	Example #2	Example #3
<ul style="list-style-type: none"> - Patient earns \$53,000 per year - There are 5 people in the patient's family - The % of potential Financial Assistance coverage would equal 90% (they earn more than \$51,580 but less than \$54,159) 	<ul style="list-style-type: none"> - Patient earns \$37,000 per year - There are 2 people in the patient's family - The % of potential Financial Assistance coverage would equal 40% (they earn more than \$36,425 but less than \$37,882) 	<ul style="list-style-type: none"> - Patient earns \$54,000 per year - There is 1 person in the family - The balance owed is \$20,000 - This patient qualifies for Hardship coverage, owes \$13,500 (25% of \$54,000)

Notes: FPL = Federal Poverty Levels

Effective	02/11
Reviewed	08/12

Appendix III

SHORE HEALTH SYSTEM PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy

Shore Health System is committed to ensuring that uninsured patients within its service area who lack financial resources have access to medically necessary hospital services. If you are unable to pay for medical care, you may qualify for Free or Reduced Cost Medically Necessary Care if you have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability.

Shore Health System meets or exceeds the legal requirements by providing financial assistance to those individuals in households below 200% of the federal poverty level and reduced cost-care up to 300% of the federal poverty level.

Patients' Rights

Shore Health System will work with their uninsured patients to gain an understanding of each patient's financial resources.

- They will provide assistance with enrollment in publicly-funded entitlement programs (e.g. Medicaid) or other considerations of funding that may be available from other charitable organizations.
- If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.
- If you believe you have been wrongly referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

Patients' Obligations

Shore Health System believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

- Cooperate at all times by providing complete and accurate insurance & financial information
- Provide requested data to complete Medicaid applications in a timely manner.
- Maintain compliance with established payment plan terms.
- Notify us immediately at the number listed below of any changes in circumstances.

Contacts:

Call 410-822-1000 x1020 or toll free 1-800-876-5534 with questions concerning:

- Your hospital bill
- Your rights and obligations with regards to your hospital bill
- How to apply for Maryland Medicaid
- How to apply for free or reduced care

For information about Maryland Medical Assistance

Contact your local department of Social Services

1-800-332-6347 TTY 1-800-925-4434

Or visit: www.dhr.state.md.us

Physician charges are not included in hospitals bills and are billed separately by the physician.

HOJA INFORMATIVA PARA LOS PACIENTES DE SHORE HEALTH SYSTEM

POLIZA DEL HOSPITAL PARA AYUDA FINANCIERA:

SHORE HEALTH SYSTEM está avocada para garantizar a los pacientes que residen dentro de su área y que no cuentan con seguro o recursos financieros, acceso a los servicios de atención médica necesarios.

Si Ud. no puede pagar la atención médica, puede aplicar por Atención Médica gratuita o con un costo reducido, en el caso de que no tenga ningún tipo de seguro o recursos para el pago que incluya atención médica, litigio o forma de pago por un tercero.

SHORE HEALTH SYSTEM reúne o excede los requisitos legales para proporcionar ayuda financiera a aquellos individuos con ingresos por debajo del 200% del nivel de pobreza determinado por el Gobierno, así como reducir el pago por atención médica hasta por encima del 300% del nivel de pobreza determinado por el Gobierno.

DERECHOS PARA LOS PACIENTES:

SHORE HEALTH SYSTEM encontrará la forma de llegar a un acuerdo con cada paciente que no cuente con un Seguro, de acuerdo a los ingresos económicos de cada paciente.

- ✚ Asimismo, proporcionará asistencia para afiliación a programas que cuentan con fondos solventados por el Gobierno, tales como Medicaid o afiliación a otras organizaciones que pueden ayudar económicamente.
- ✚ Si Ud. no califica para recibir ayuda Médica o financiera, puede optar por un plan de pagos a largo plazo, para pagar su cuenta del hospital.
- ✚ Si Ud. considera que erróneamente lo han referido a una agencia de recaudación de dinero, tiene el derecho de contactar al hospital para solicitar ayuda. (ver información para contactarse, en la parte inferior de la hoja)

OBLIGACIONES PARA LOS PACIENTES:

SHORE HEALTH SYSTEM considera que sus pacientes tienen responsabilidades con el pago por atención médica recibida. Se espera que los pacientes:

1. Colaboren proporcionando información sobre su compañía aseguradora así como información financiera.
2. Provean la información requerida para llenar las solicitudes de Medicaid en el menor tiempo posible.
3. Cumplan con los términos establecidos para el pago.
4. Nos notifiquen inmediatamente al teléfono indicado en la parte inferior de la hoja sobre algún cambio habido en la información que haya sido proporcionada.

INFORMACION PARA CONTACTARSE:

1. Llame al teléfono 410-822-1000, Anexo 1020 o al teléfono gratuito 1-800-876-5534, en caso de tener preguntas relativas a:
 - ✚ Su cuenta de hospital
 - ✚ Sus derechos y obligaciones con respecto a su cuenta
 - ✚ Cómo aplicar a Medicaid en Maryland
 - ✚ Cómo aplicar para la atención gratuita o con un costo reducido.
2. Para información acerca de la Ayuda Médica en Maryland:
 - ✚ Contacte al Departamento de Servicios Sociales de su Area, llamando al teléfono 1-800-332-6347 TTY 1-800-925-4434
 - ✚ O visite la Página Web: www.dhr.state.md.us

El pago por los servicios del médico no están incluidos en la cuenta del hospital. El médico cobra sus servicios por separado.

Appendix IV

SHORE HEALTH SYSTEM

Vision Statement

Shore Health System will be the provider of “first choice” among patients and physicians of the four Mid-Shore Counties.

Shore Health System’s employees, leadership, and Medical Staff will deliver care through a common culture, adhere to a professional code, and work cohesively as a patient-centered team to ensure the highest favorable outcomes for all the patients we serve.

MISSION STATEMENT

“TO EXCEL IN QUALITY CARE AND PATIENT SATISFACTION”

STRATEGIC PRINCIPLE

“EXCEPTIONAL CARE EVERYDAY”

VALUES STATEMENT

“EVERY INTERACTION WITH ANOTHER IS AN OPPORTUNITY TO CARE”