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 acute care hospitals by the HSCRC. (Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

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:
Adults-275 Newborn-28	Adults-17,558 Newborn-1,905	21804 21801 21853 21811 21851 21875 21826 21817 21842 21863	Atlantic General Hospital McCready Memorial Hospital	Wicomico- 3.24% Worcester- 2.84% Somerset- 2.78% (Based on HSCRC Primary Service Area Report)	Wicomico-16.16% Worcester-15.27% Somerset-17.28% (Based on HSCRC Primary Service Area Report. Includes Medicaid Fee for Service and Medicaid HMO Patients)

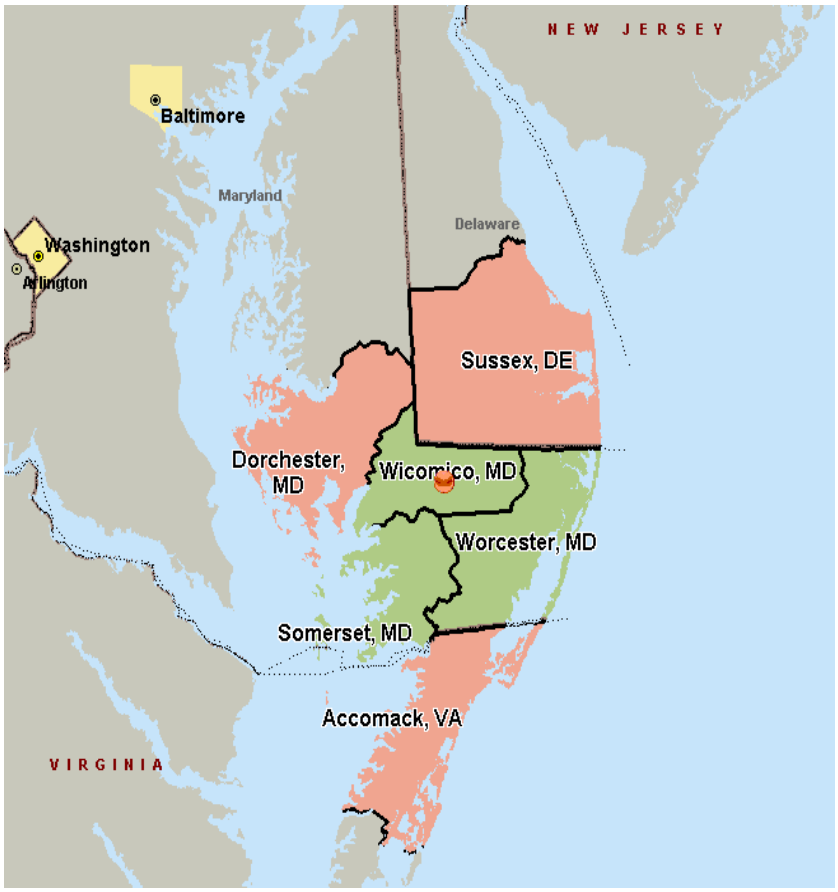
Table II

Community Benefit Service Area (CBSA) Target Population (# of people in target population, by sex, race, ethnicity, and average age)

The Community We Serve

Peninsula Regional Medical Center functions as the primary hospital provider for the rural southernmost three counties of the Eastern Shore of Maryland, which includes Wicomico, Worcester and Somerset. In FY 2015, approximately 77% of the patients discharged from the Medical Center were residents of the primary service area, which had an estimated population of approximately 179,605 in 2015 and is expected to increase to 183,893 in 2020, or by 2.4%. The primary service area population has grown by an estimated 10% since 2000.

The secondary service area, accounting for 20.6% of Peninsula Regional's FY 2015 discharges, consists of the southern portion of Sussex County, Delaware and the northern portion of Accomack County, Virginia and parts of Dorchester County, Maryland. These counties had a population of approximately 285,978 in 2015 and are projected to grow to 301,015 in 2020, a growth rate of 5.3%. The primary and secondary service areas combined accounted for 98% of Peninsula Regional's total patients.



In the past Peninsula Regional's approach to rural population health and community benefits was generalized and consisted of touching our three primary counties: Wicomico, Worcester and Somerset. However, there are examples where Peninsula Regional has participated with our neighbors in Delaware and Virginia on urgent community healthcare needs. Many of the social determinants of rural health in our three county area spill over state lines creating similar issues in our neighboring states and allowing us to work together.

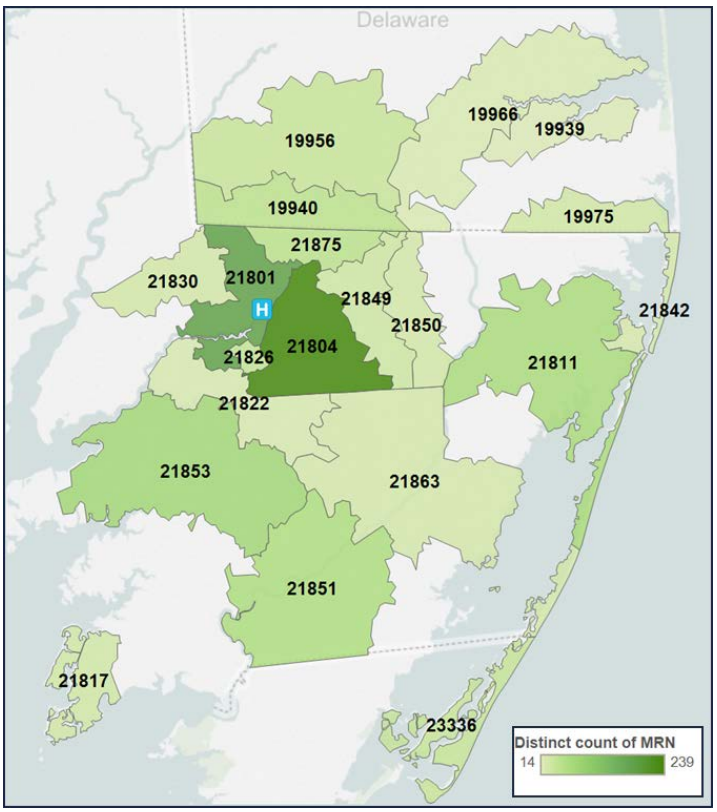
Until now, most of PRMC's initiatives have been "reactive," activated by patients presenting in the emergency room or as inpatients. PRMC now seeks to deploy resources and embed care management functions within primary care practices to address some of the determinants (or root causes) of high utilization. By moving care back out into the community with PCPs and care managers embedded within those PCPs, the right care will delivered, reducing the need for inpatient hospital admissions and readmissions.

Over the next several years, Peninsula Regional will be in a transitional period where specified "Super Utilizers" within our CBSA will be identified, categorized and targeted for population health management.

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

The target population includes patients that have chronic conditions who have demonstrated *to have been high utilizers* at PRMC, or are identified as *being at risk of high utilization* based on his/her chronic conditions and patterns of care.

The following data for FY2015 indicates an “overreliance” by local residents on Peninsula Regional’s emergency room for primary and chronic condition needs. In response, PRMC will be introducing programs, care management and education as part of our transformation plan.



Primary Service Area

Historically Peninsula Regional’s CBSA consisted of those zip codes within our primary service area, Medicaid patients, uninsured and indigent residents. In the future it will continue to consist of the aforementioned, in addition to identifying “Super Utilizers” by zip codes (cluster and block groups) by targeted chronic disease. These targeted “high utilizers” will be identified for proposed interventions, education, follow-up with measurement and outcomes. Based upon a current assessment there are approximately 1,330 residents that meet the criteria of “Super Utilizers” stratified by socio-demographics and chronic disease.

PRMC CBSA

Race/Ethnicity	CBSA Primary Service Area	Secondary Service Area
White Non-Hispanic	120,126 (66.9%)	203,782 (71.3%)
Black Non-Hispanic	42,760 (23.8%)	45,688 (16.0%)
Hispanic	8,394 (4.7%)	26,447 (9.2%)
Asian & Pacific Non-Hisp.	3,916 (2.2%)	3,143 (1.1%)
All Others	4,409 (2.4%)	6,918 (2.4%)
Total	**179,605 (100%)**	**285,978 (100%)**

Source: Truven Health Analytics 2015

Peninsula Regional's primary and secondary service areas combined include over 465,000 people. Additional demographic information indicates the number of elderly (those aged 65+) represent a greater portion of the total population in both Peninsula Regional's primary and secondary areas as compared to the State of Maryland (17.4% and 21.7% respectively vs. 14.2%). The elderly have additional chronic conditions and consume healthcare resources at much higher rates than some of the other age-cohorts.

CBSA Primary Service Area Population Age-Cohorts

Age Group	2015 Population	% of Total	USA 2014 % of Total
0-14	29,434	16.4%	19.1%
15-17	6,573	3.7%	4.0%
18-24	22,077	12.3%	9.9%
25-34	22,222	12.4%	13.3%
35-54	42,772	23.8%	26.3%
55-64	24,502	13.6%	12.7%
65+	32,025	17.8%	14.7%
Total	**179,605**	**100.0%**	**100.0%**

Secondary Service Area Population Age-Cohorts

Age Group	2015 Population	% of Total	USA 2015 % of Total
0-14	49,224	17.2%	19.1%
15-17	9,689	3.4%	4.0%
18-24	21,208	7.4%	9.9%
25-34	30,371	10.6%	13.3%
35-54	66,643	23.3%	26.3%
55-64	43,914	15.4%	12.7%
65+	64,929	22.7%	14.7%
Total	**285,978**	**100.0%**	**100.0%**

Female/Male	Primary Service Area	Secondary Service Area
Total Female Population	91,615	146,986
Total Male Population	87,990	138,998
Child Bearing	34,695	45,117

Source: Truven Health Analytics 2015

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

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

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

Wicomico County

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

Worcester County

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

to Whites.

Somerset County

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

Chronic Disease Management

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

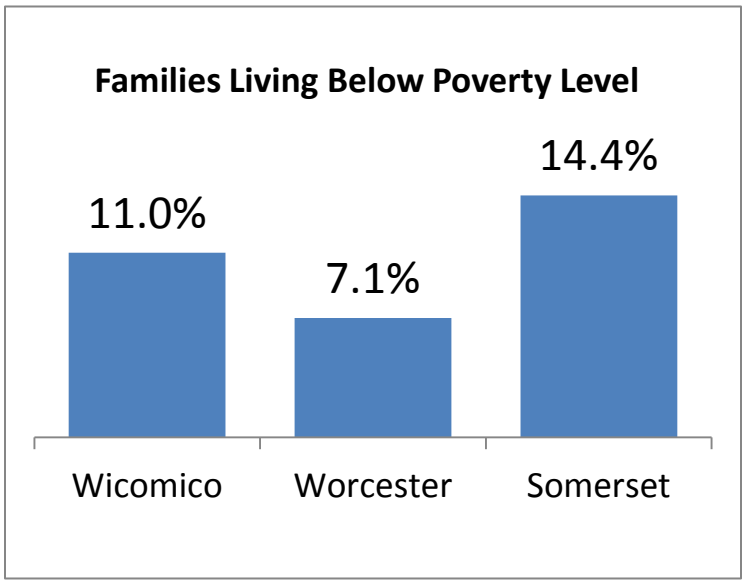
Median Household Income within the CBSA

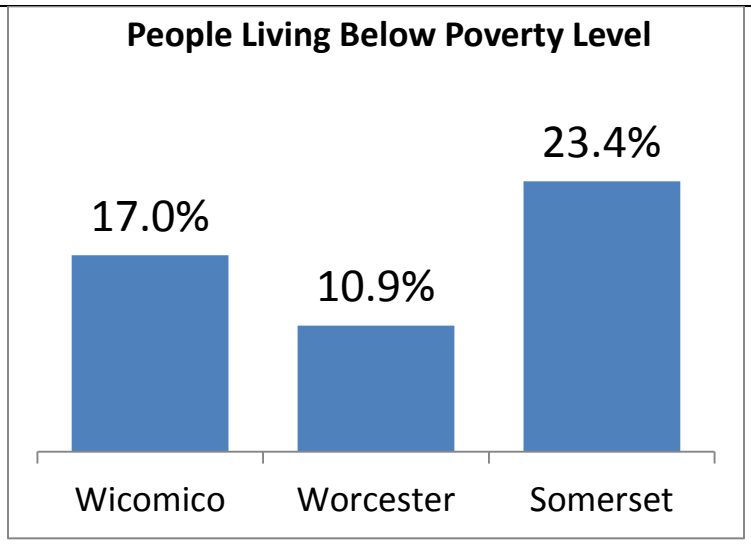
Within Peninsula Regional's CBSA, Wicomico County is 39% less and Somerset County is 46% less than the median income in the state of Maryland. In addition, both counties' median home values are less than the state of Maryland and the Nation.

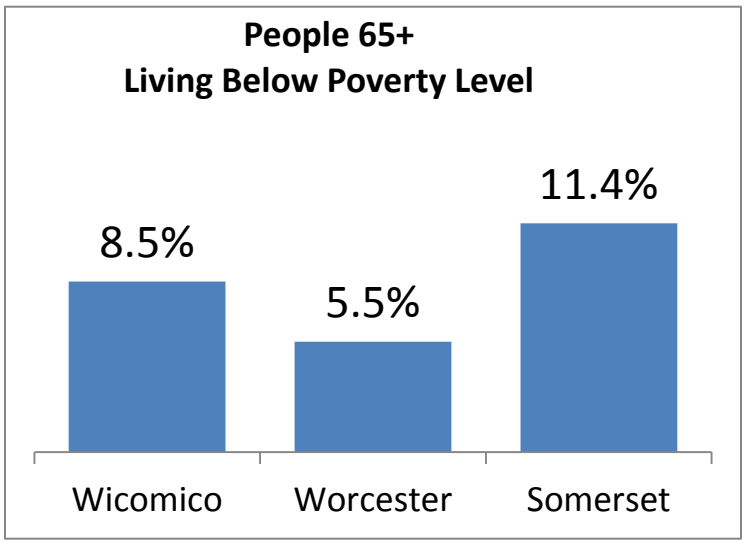
County	Median Income	Median Home Value	
Wicomico	$52,348	$181,301	
Worcester	$62,956	$262,083	
Somerset	$40,146	$162,975	
Maryland	$77,385	$321,511	
Nation	$55,151	$221,079	

Source: Truven Health Analytics 2015

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



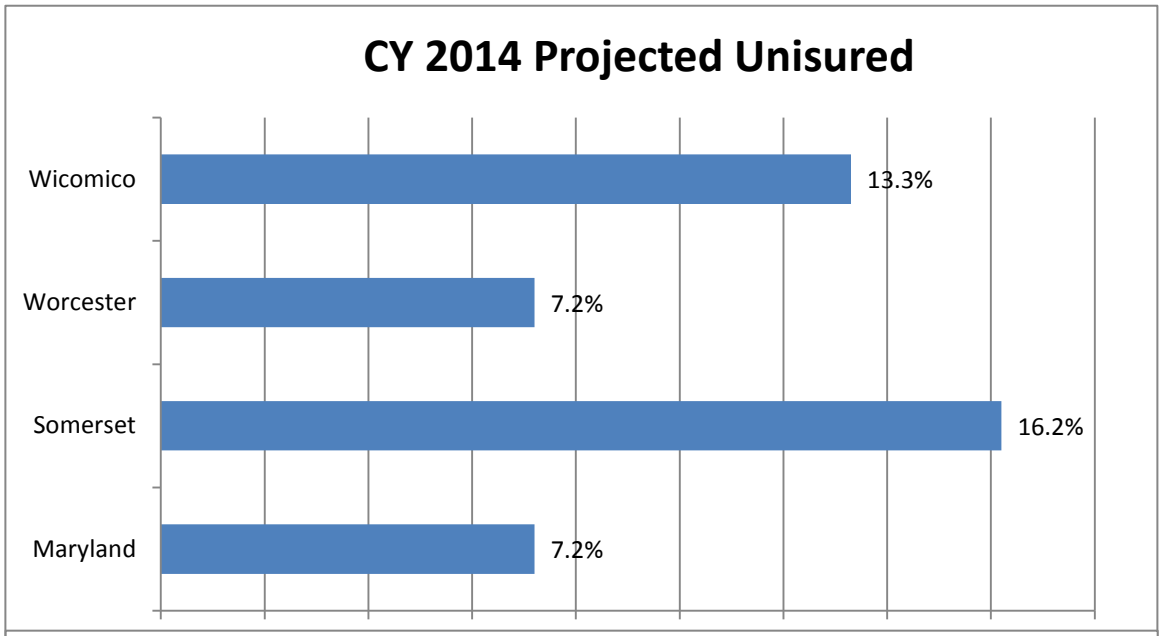


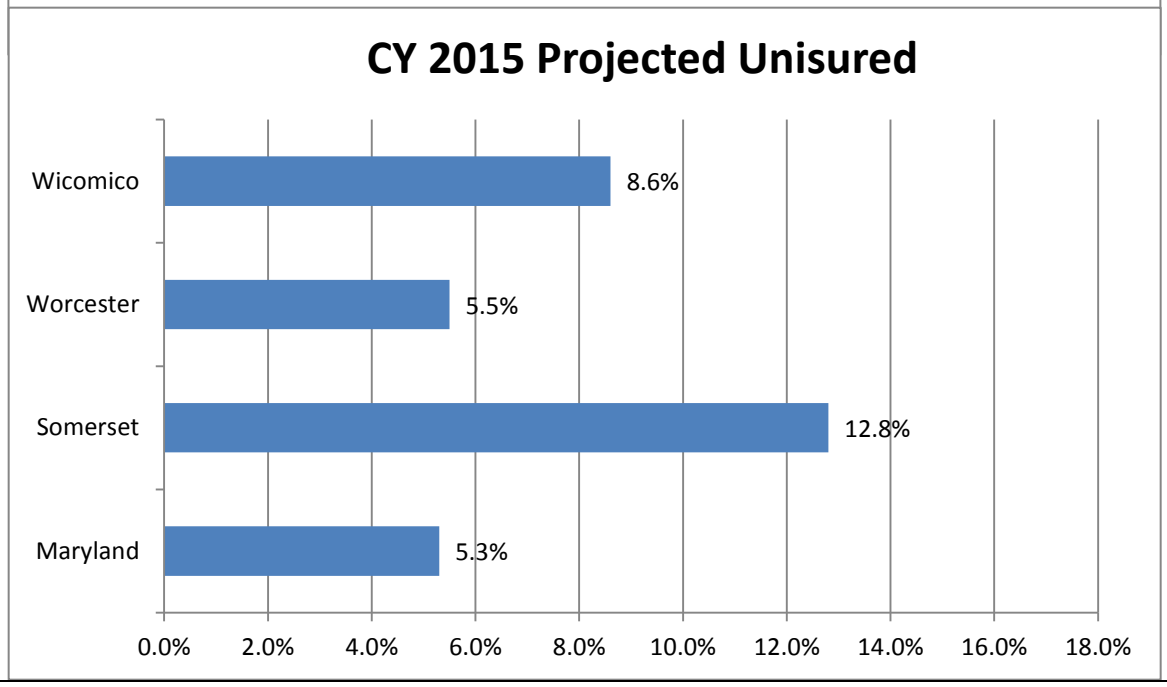


Source: Healthy Communities Inc. 2015

Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links:
http://www.census.gov/hhes/www/hlthins/data/acs/aff.html;
http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml

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

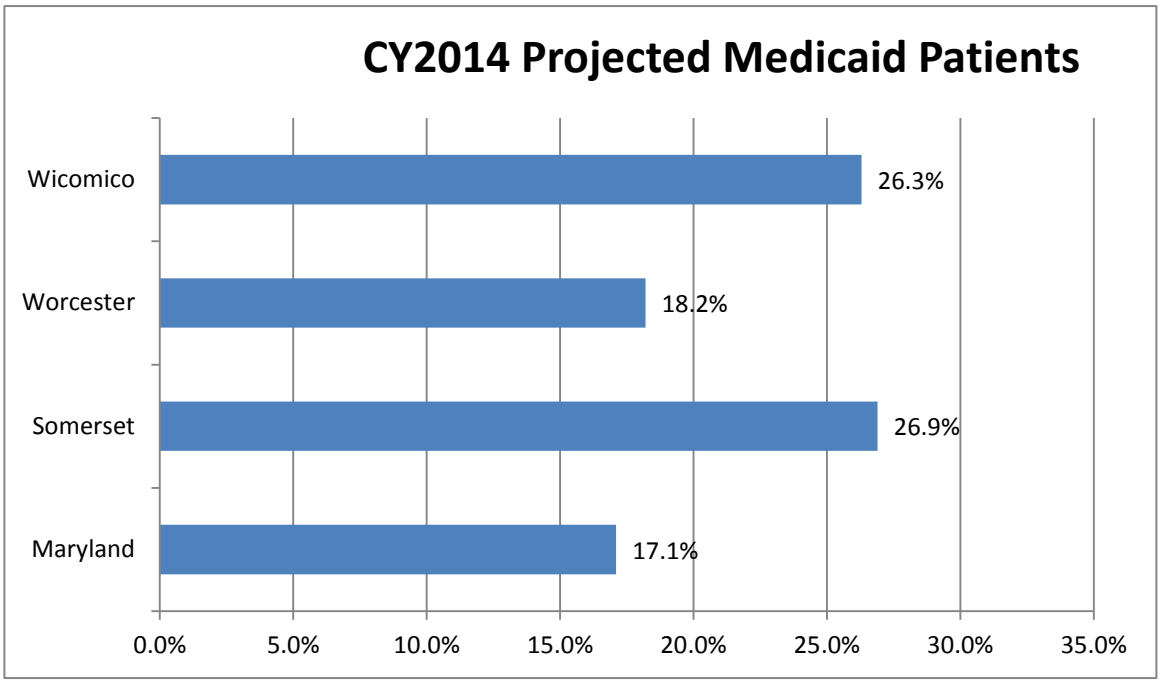


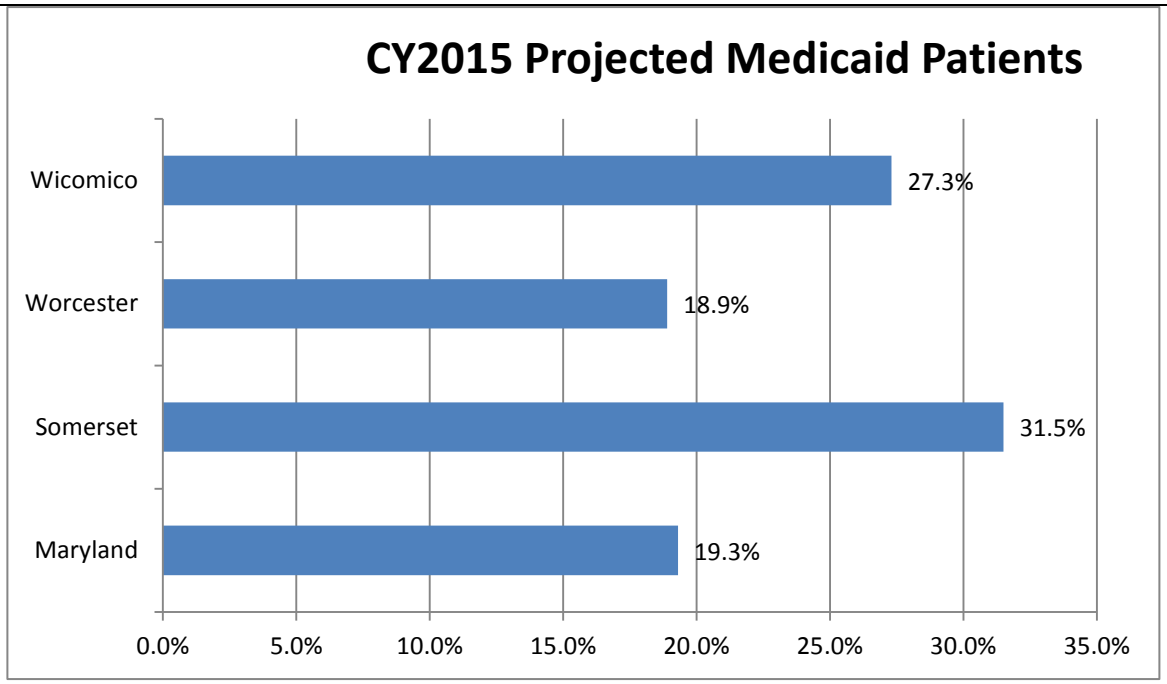


Source: Truven Health Analytics 2014, 2015

Percentage of Medicaid recipients by County within the CBSA.

In comparison to the state of Maryland, Peninsula Regional's CBSA has a greater proportion of Medicaid recipients, specifically Wicomico and Somerset Counties. However, the continued growth of Medicaid recipients within our CBSA continues to reduce the number of uninsured patients. Most importantly, more patients than ever currently have insurance on the Eastern Shore, providing families better access to appropriateness of care. Social determinants such as lower median income, higher unemployment rates, rural economics, and lower educational attainment continue to challenge access to care and healthy lifestyle changes.





Source: Truven Health Analytics 2014, 2015

+ Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).

See SHIP website:

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

County	Life Expectancy	Maryland Ship Target
Wicomico All	77.6	82.5
Black	75.3	82.5
White	78.4	82.5
Worcester All	79.6	82.5
Black	76.3	82.5
White	79.9	82.5
Somerset All	77.2	82.5
Black	77.4	82.5
White	76.3	82.5

Source: Most current available Maryland Vital Statistic Report 2013

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

Crude Death Rate

The crude death rate for Wicomico County is 938.6, Worcester County 1,150.7, and Somerset County 997.2, all higher than Maryland at 766.5 deaths/100,000. The large crude death rates reflect multiple factors specifically a more aging 65+ population in addition to healthcare access issues and lack of chronic disease management in rural areas.

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

Diseases of the Heart Age-Adjusted Death Rates (2011-2013)
For diseases of the heart several counties age-adjusted death rates are much higher than the Maryland average:
Wicomico: 44.4% higher heart age-adjusted death rate than MD.
Worcester: 6.8% higher heart age-adjusted death rate than MD.
Somerset: 67.8% higher heart age-adjusted death rate than MD.

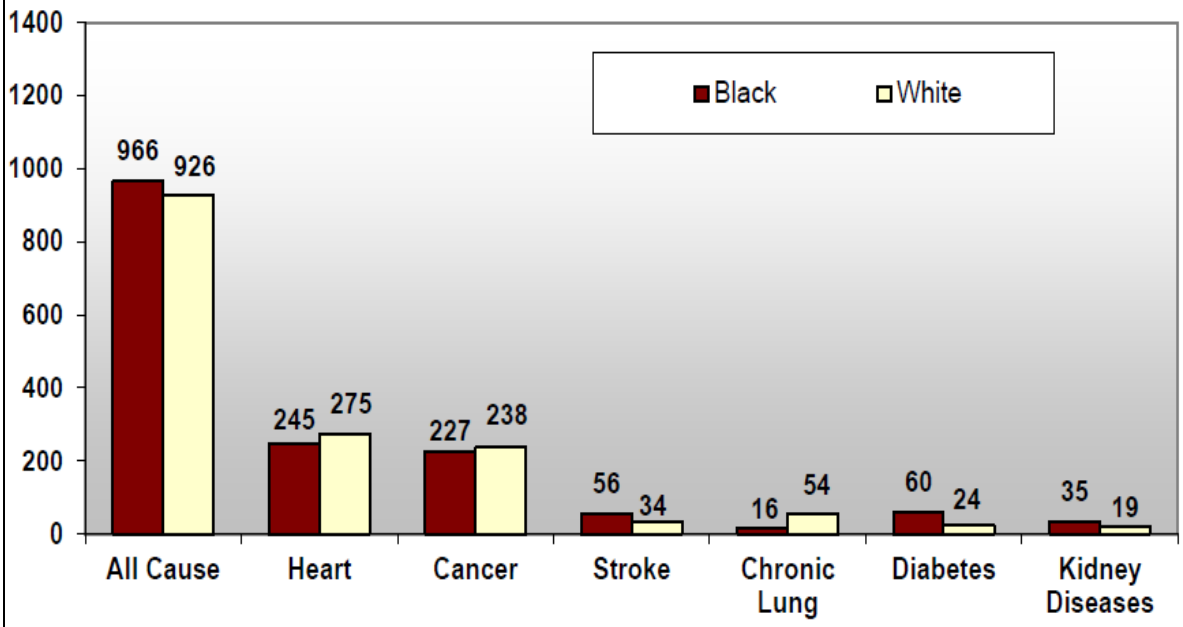
Malignant Neoplasms Age-Adjusted Death Rates (2011-2013)
For malignant neoplasms all counties age-adjusted death rates are higher than Maryland.
Wicomico: 22.4% higher malignant neoplasm age-adjusted death rate than MD.
Worcester: 10.3% higher malignant neoplasm age-adjusted death rate than MD.
Somerset: 30.0% higher malignant neoplasm age-adjusted death rate than MD.

Chronic Lower Respiratory Diseases Age-Adjusted Death Rates (2011-2013)
For chronic lower respiratory diseases all counties age-adjusted death rates are higher than Maryland:
Wicomico: 39.17% higher chronic lower respiratory diseases age-adjusted death rate than MD.
Worcester: 12.5% higher chronic lower respiratory age-adjusted death rate than MD.
Somerset: 50.5% higher chronic lower respiratory age-adjusted death rate than MD.

Source: Most current available Maryland Vital Statistics Report 2013

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

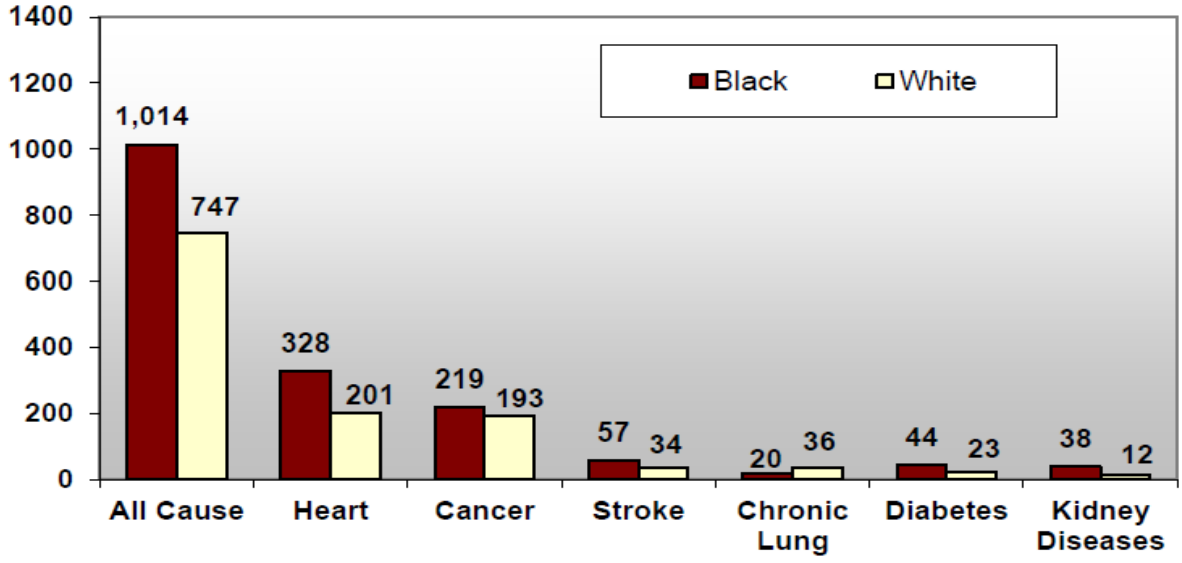
Wicomico County Age-Adjusted Morality Rates, Maryland 2005-2009



Worcester County

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

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

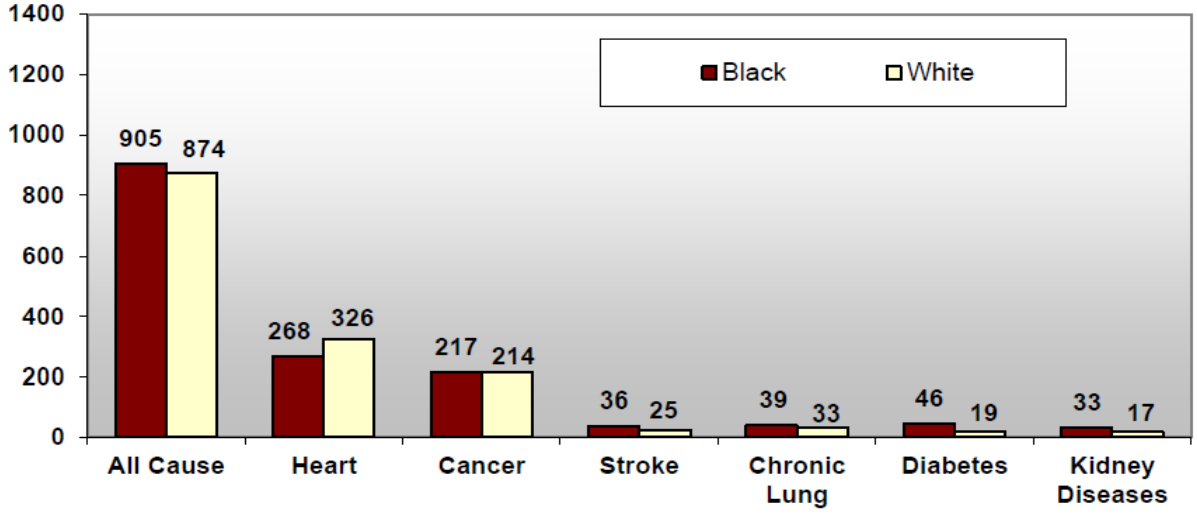


Somerset County

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

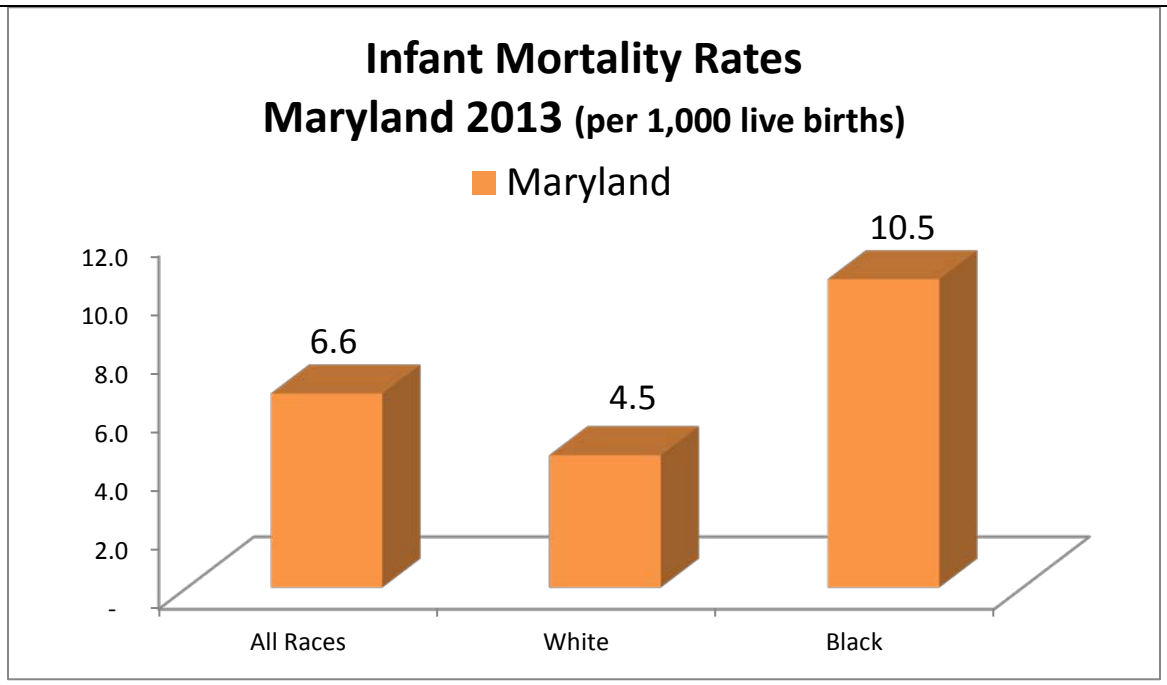
The diabetes mortality rate for Blacks or African Americans was 2.4 times higher than for Whites; and the kidney disease mortality rate was 1.9 times higher for Blacks or African Americans.

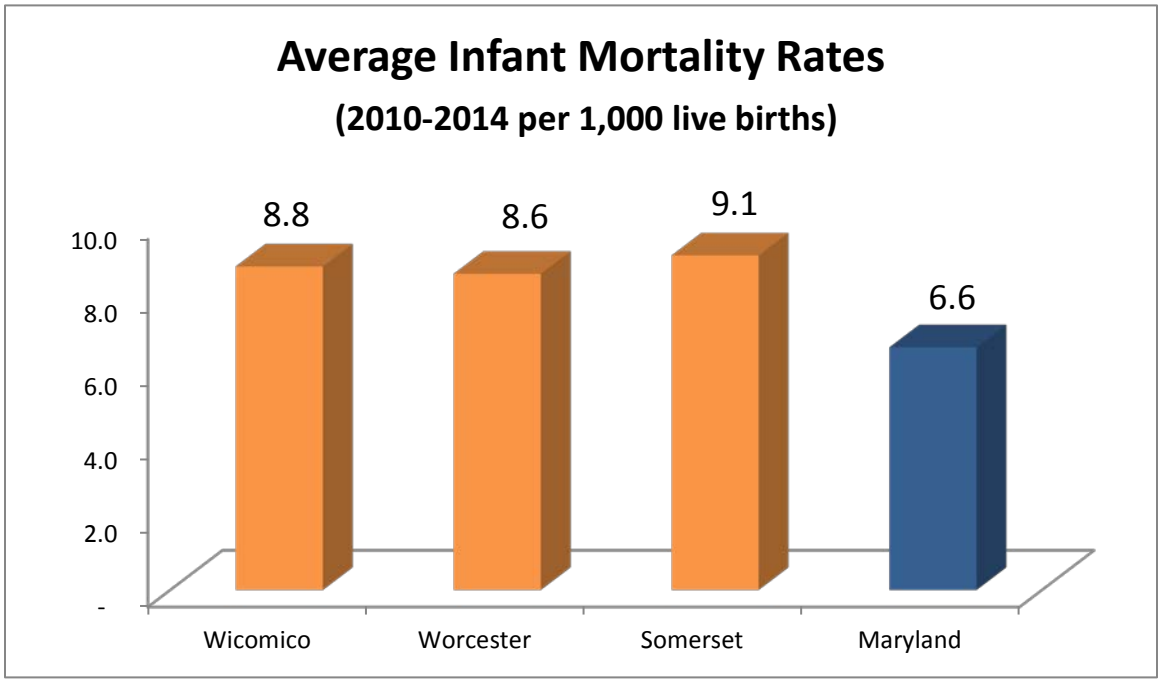
Somerset County Age-Adjusted Morality Rates, Maryland 2005-2009



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

Over the past decade, the average infant mortality rate declined in all regions of the State except in the Eastern Shore area, where the average rate increased by 10% between 2005-2009 and 2010-2014.



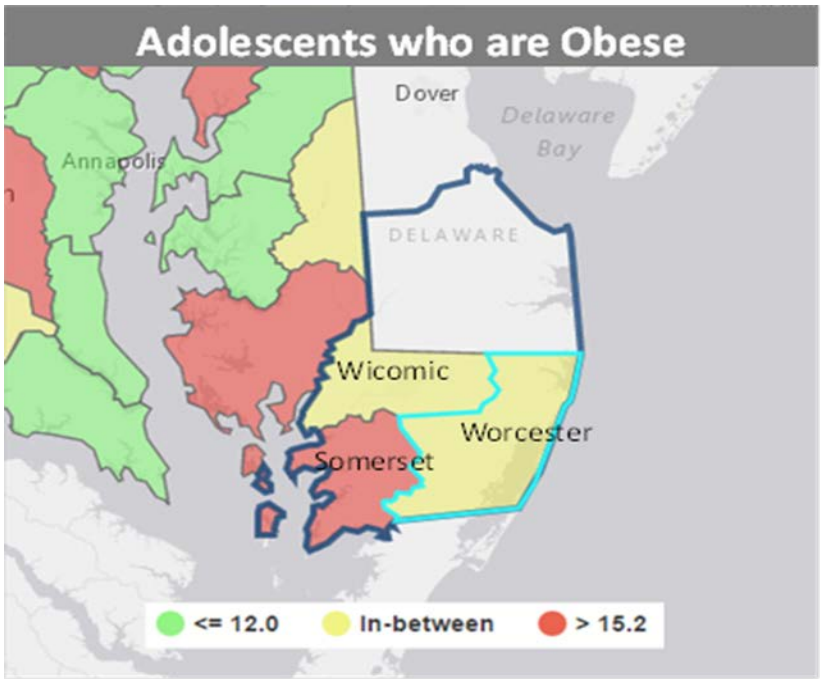


Source: Maryland Department of Health and Mental Hygiene, Infant Mortality in Maryland, 2014

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

Healthy Food / Healthy Lifestyle Environmental Factors
Obesity continues to be a health issue in Wicomico, Worcester and Somerset Counties. The percentage of obese adults is an indicator of overall health and lifestyle of a community. Obesity increases the risk of many diseases and health conditions. These include type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease and respiratory problems. Being obese also carries significant economic costs due to increased healthcare spending.

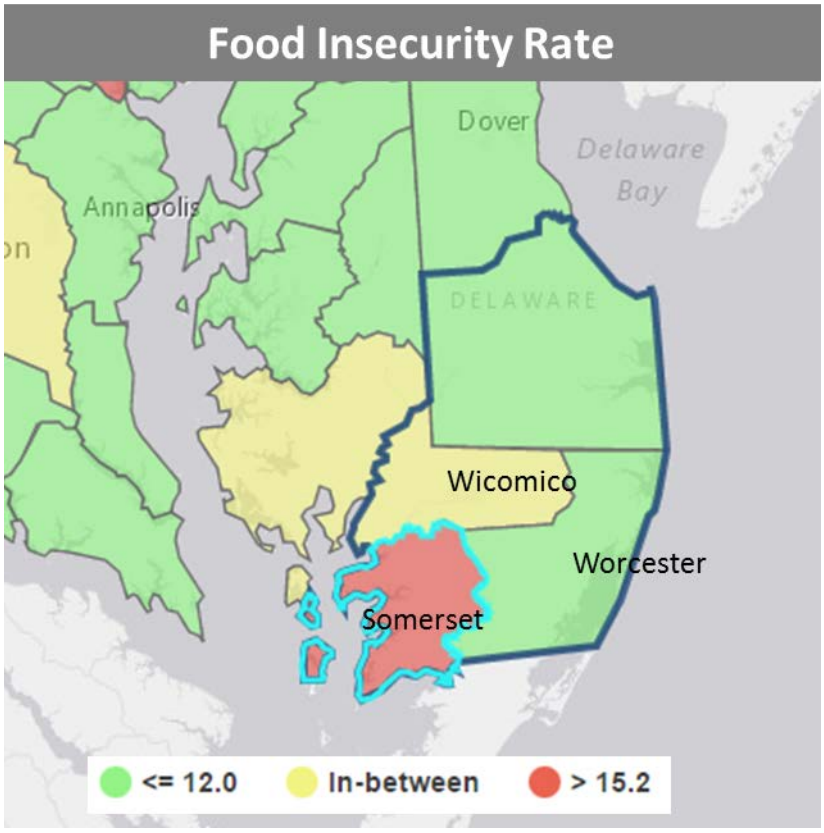
Fast food is often high in fat and calories and lacking in recommended nutrients. Frequent consumption of fast food increases the risk of our population being overweight and obese. Based upon the density of grocery stores per 1,000 population, residents of Wicomico and Somerset County indicate limited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



Source: HCI Healthy Communities Inc.

Food Insecurity

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



Source: HCI Healthy Communities Inc.

Grocery Store Density

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

County: Somerset, MD	17.2	Maryland Behavioral Risk Factor Surveillance System	2010
County: Wicomico, MD	23.1	Maryland Behavioral Risk Factor Surveillance System	2010
County: Worcester, MD	30.0	Maryland Behavioral Risk Factor Surveillance System	2010

Adult Fruit and Vegetable Consumption

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

County: Somerset, MD	0.19	U.S. Department of Agriculture - Food Environment Atlas	2012
County: Wicomico, MD	0.08	U.S. Department of Agriculture - Food Environment Atlas	2012
County: Worcester, MD	0.23	U.S. Department of Agriculture - Food Environment Atlas	2012

Source: HCI Healthy Communities Inc.

Fast Food Restaurant Density

County: Somerset, MD	0.50	U.S. Department of Agriculture - Food Environment Atlas	2012
County: Wicomico, MD	0.89	U.S. Department of Agriculture - Food Environment Atlas	2012
County: Worcester, MD	1.74	U.S. Department of Agriculture - Food Environment Atlas	2012

Adults Engaging in Regular Physician Activity

County: Somerset, MD	42.1	Maryland Behavioral Risk Factor Surveillance System	2013
County: Wicomico, MD	45.6	Maryland Behavioral Risk Factor Surveillance System	2013
County: Worcester, MD	51.9	Maryland Behavioral Risk Factor Surveillance System	2013

Source: HCI Healthy Communities Inc.

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

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

Peninsula Regional launched a new **Live Well Delmarva** website that embodies the spirit of CARE / COACH / CONNECT. Where PRMC will CARE for you, COACH you to wellness and CONNECT you with the right providers. The site provides information on healthy lifestyle choices with local and regional information such as "Farm to Table" in-season fresh fruits and vegetables, including nutritional recipes. The importance of exercise and nutrition is a theme that is woven throughout, with listings of free screenings and events for the community that

include:

- Free Skin Cancer Screenings
- Live Well Health Fest Event (35 Health Screenings, Exercise Demonstrations, and Activities for Kids etc.)
- Free Heart Screenings (Total cholesterol, HDL, risk ratio and glucose; ankle/brachial index; resting 12-lead EKG; pulse oximetry testing; strength and more)
- Babies Health Starts
- Drive-Thru Flu Clinic
- Healthy Tips
- Cancer Survivorship Celebration

The website also addresses regional health issues native to the Eastern Shore. The Eastern Shore is known for its beautiful beaches, water sports, golf and the sun. Links are available directing residents to sites where they can receive material & knowledge on how to protect their family and friends from the damaging effects of the sun, reducing their chances of skin cancer. Another prevalent issue within our CBSA is seasonal allergies which many residents complain of; information is available for residents to take appropriate steps to lessen the effects of allergies.

In FY15 Peninsula Regional has kicked off a **"Live Well"** community campaign that spans several years and will addresses and promote healthy lifestyle choices with a new monthly themes. In addition we have a new website: http://www.peninsula.org/livewell

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

During the campaign, PRMC also offered free promotional items that supported the "Live Well" theme. Items like, jump ropes, hand sanitizers, sun screen, lip balm and others were provided to the community.

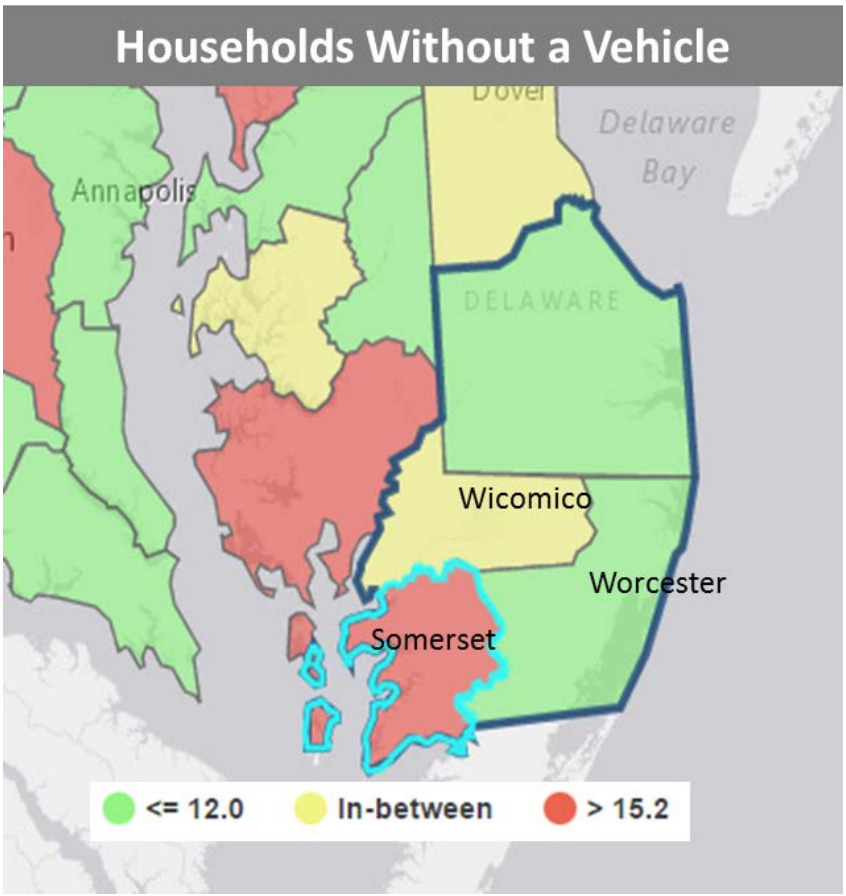
Transportation

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

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

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

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



Source: HCI Healthy Communities Inc.

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

Renters Spending 30% or More of Household Income on Rent

(Average in Maryland is 47.4)

County: Somerset, MD		64.9	American Community Survey	2009-2013
County: Wicomico, MD		56.4	American Community Survey	2009-2013
County: Worcester, MD		55.8	American Community Survey	2009-2013

Safe and affordable housing is an important component of healthy communities and based upon the following data, Peninsula Regional's three counties has scored in the red. (A score below 13.5 is considered good.)

County: Somerset, MD	20.2	County Health Rankings	2007-2011
County: Wicomico, MD	19.4	County Health Rankings	2007-2011
County: Worcester, MD	15.9	County Health Rankings	2007-2011

Unemployment

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

County: Somerset, MD	7.3	U.S. Bureau of Labor Statistics	August 2015
County: Wicomico, MD	5.9	U.S. Bureau of Labor Statistics	August 2015
County: Worcester, MD	6.9	U.S. Bureau of Labor Statistics	August 2015

Sources:
Healthy Communities (HCI)
www.ers.usda.gov/FoodAtlas/
www.shoretransit.org
Truven Health Analytics 2015

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

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

Within our CBSA, all three counties average household incomes are considerably less than Maryland's average. In addition, a smaller percentage of the population has a bachelor's degree or above. Wicomico County (13.92%) and Somerset County (18.9%) have a much higher high school drop-out rate than the state of Maryland (11.1%).

Demographics	Wicomico County	Worcester County	Somerset County	Maryland
Race/Ethnicity				
White Non-Hispanic	64.2%	79.5%	51.2%	52.6%
Black Non-Hispanic	24.7%	13.7%	41.4%	29.0%
Hispanic	5.4%	3.5%	4.2%	9.4%
Asian & Pacific	3.0%	1.3%	.8%	6.2%
All Others	2.67	2.0%	2.4%	2.8%
Average Household Income	$66,795	$83,538	$50,567	$99,758
Pop. 25+ Without H.S. Diploma	13.9%	10.1%	20.9%	11.1%
Pop. 25+ With Bachelor's Degree or Above+	27.7%	26.7%	14.9%	36.8%
English Spoken at Home	94.6%	96.8%	95.5%	
Spanish Spoken at Home	2.2%	1.5%	2.0%	
Other Spoken at Home	3.2%	1.7%	2.5%	

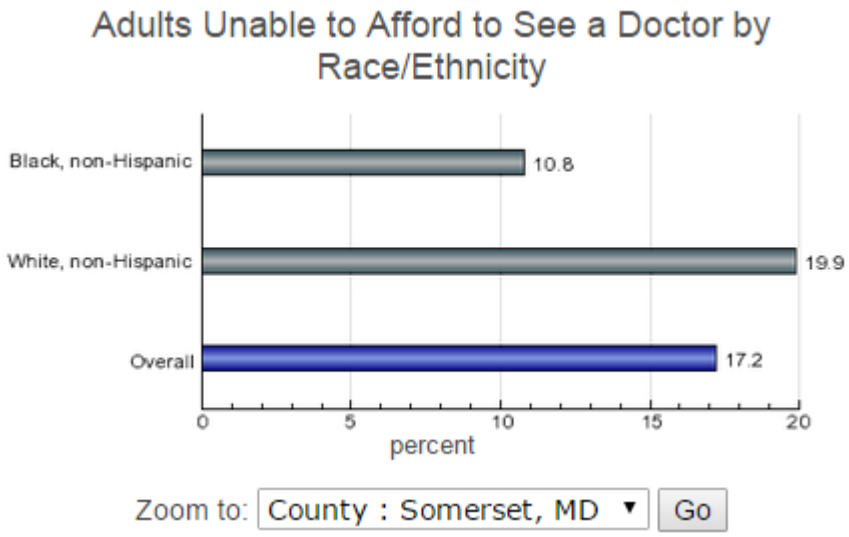
Other

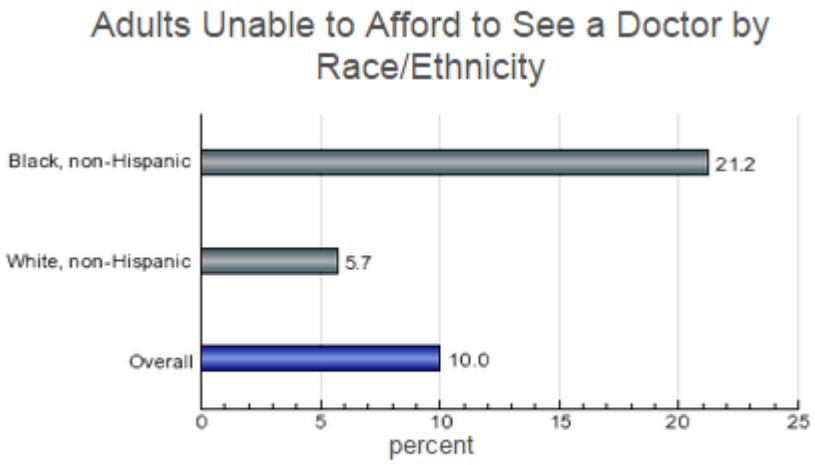
Access to Health Services

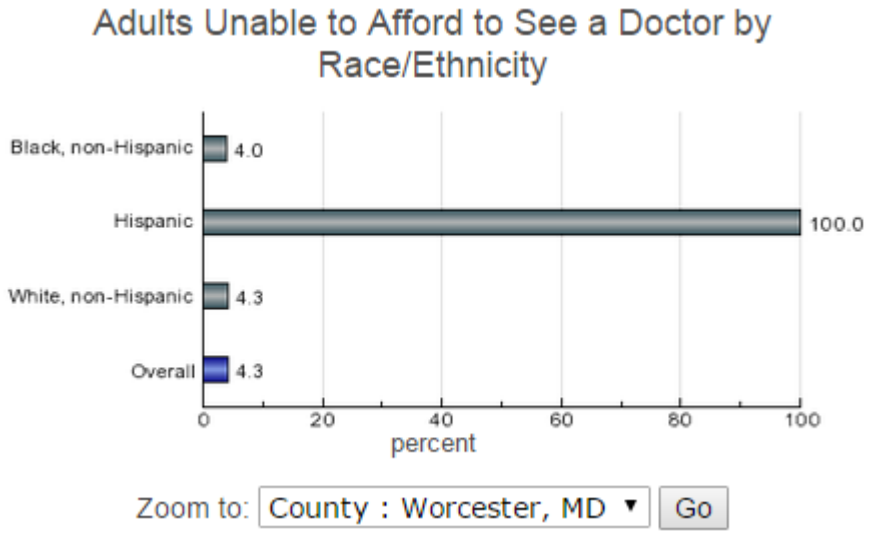
Somerset County is one of the poorest counties in the state of Maryland; hence there is a high rate of adults that are unable to afford to see a physician, as evidenced by the chart below. However, with implementation of the ACA (Accountable Care Act), access to care continues to improve.

Adults Unable to Afford to See a Doctor

County: Somerset, MD	17.2	Maryland Behavioral Risk Factor Surveillance System	2012
County: Wicomico, MD	10.0	Maryland Behavioral Risk Factor Surveillance System	2012
County: Worcester, MD	4.3	Maryland Behavioral Risk Factor Surveillance System	2012







Source: HCI Healthy Communities Inc.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

   _X_ Yes
   ____No

   Provide date here. 06/28 /2013

   If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

   www.peninsula.org at Quick Links, Creating Healthy Communities, 2013 Community Health Needs Assessment.

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

   _X_ Yes 06/28/2013
   ___No

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

   www.peninsula.org at Quick Links, Creating Healthy Communities, 2013 Community Health Needs Assessment.

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital? **(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b,)**

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

_X_ Yes
___No

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

Community Benefits is woven throughout Peninsula Regional's Strategic Plan and is an integral part of each one of our Strategic Tenets which encompasses the following themes: patient centered care, population health management and expanding access through growth of an ambulatory presence. The Strategic Plan is a living document that interfaces with Community Benefit Initiatives, the Strategic Transformation Plan, Local County Health Departments, and dovetails the State Health Improvement Plan (SHIP) goals. In addition, collaboration and partnerships with local civic organizations, faith based institutions and community providers like the YMCA and MAC, etc., are now the norm instead of the exception.

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

Patient Centered Care-Sampling

- Developed a behavioral health "Partial Hospitalization Program" in partnership with Adventist secondary to a community assessment for gaps in service for the region.
- Provision of medication for indigent population to pay for meds to help prevent readmissions and develop a healthier community.
- Palliative care whose focus on patient with complex chronic disease states with specialized care revolving around symptom control, counseling, family support and education/assistance with end of life decision making.
- RN coordinators to improve access to primary care appointments within 72 hours of discharge.
- Additional social worker to connect ED high utilizers with community services, primary care physicians including helping to provide transportation.

Provider Care Teams-Sampling

- Health Coaches at Peninsula Home Care focus on heart failure and chronic kidney disease patients providing assistance with improving compliance with dietary and medication management etc.
- Endocrinology: Implementation of telemedicine/diabetes clinic for pediatric patients with a focus on accurate diagnosis/ treatment using family support and school nurse.
- Continued recruitment of primary care physicians that develop care models targeting high risk patients assigning them to specific care plans and care plan coordinators.

Health Information Systems

Health information technology implemented to support predictive analytic modeling software to determine high risk renal patients and engaging physicians and caregivers in participating in the patient's self-care regimen compliance. Development of processes used to identify high risk patients for care, identification of quality care issues and improvements to prevent complications and readmissions.

Employee Family "Live Well" Campaign

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

A specific module associated with the "Live Well" campaign focuses on employees with diabetes as a diagnosis, the primary objective is to improve diabetes control and reduce A1-C for individuals over time. Employees participating in the program receive a reduction in cost for their health care benefit and receive free testing and medications for their diabetes care.

In addition, PRMC is currently developing a playbook to build ways to engage it's employees and their families in a comprehensive "Live Well" lifestyle.

Population Health

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

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

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

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

In the last several years Peninsula Regional has opened several Health Pavilions within the community, one in Millsboro, Delaware and one in Ocean Pines, Maryland. As part of our plan to expand health services outside the hospital walls and into communities the strategy provides ease of access and promotes continuity of primary and population health services. These health pavilions provide primary care physicians, a pharmacy, rehab, medical imaging, and partnerships that provide specialty services such as cardiology and orthopedics. Each pavilion has an educational room that can be utilized by the public and other community health provider to hold health seminars and educational sessions. PRMC continues to develop its ambulatory care presence in addition to affiliations and partnerships as we review the external environment's socio-demographics, gaps in health services and access needs.

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. X CEO – Dr. Naleppa
2. X CFO – Mr. Ritchie
3. X Other (please specify)
   COO – Ms. Lunsford
   CNO – Ms. Matter
   Vice President – Mr. Leonard
   Vice President – Mr. Feist
   Vice President - Mr. Hall
   Vice President of Population Health- Ms. Poisker
   Chief Medical Officer- Dr. Charles Silvia
   Vice President People- Ms. Scott

Describe the role of Senior Leadership.

Senior leadership is responsible for defining the organization's population health objective and creating the infrastructure that delivers health services to targeted populations. Other roles include creating business cases for population health management initiatives, providing leadership for future health information systems connectivity, targeting high-risk populations for chronic disease management/interventions, identifying service line gaps, building partnerships and collaborations with other health care providers, and setting overall direction and goals. The Senior Leadership appointed Ms. Poisker as an executive dedicated to population health initiatives.

ii. Clinical Leadership

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

Describe the role of Clinical Leadership.

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

iii. Community Benefit Operations

1. _X_ Individual (please specify FTE)
   Rhonda Lasher- Administration & Coordinator of Services
2. _X_ Committee (please list members)
   a. Exercise Physiologist & Nutrition Expert- Caroline Farrell
   b. Communication & Messaging- Gwen Garland
   c. "Live Well" Campaign Administrator- Laren Carmean
   d. Coordinator of Community Benefits – Pattie Serkes
   e. Strategic Guidance and Oversight- Chris Hall
   f. Employee Health- Mitzi Scott
   g. Pediatric Weight Loss & Nutrition- Diane Hitchens

3. _X_ Department (please list staff)
   T**ransitions Services/ Population Health**
   a. Vice President of Population Health Services- Karen Poisker
   b. Director of Population Health Ambulatory Care – Stephanie Elliot
   c. Transitions Coaches- Jennifer Rayne, Lois Morgan, Anna Kirchner, Tammy Kinhart, Barbara Haines, Shelley Flaig
   d. Manager Bariatric, Weight Loss, Nutrition- Christine Carpenter
4. ___ Task Force (please list members)
5. _X_ Other (please describe)
   The following key personnel work in union with both the preceding Community Benefits Committee and the Transitions Services/Population Health Department in their respective expertise.
   a. Clinical Leadership Respiratory Services – Tom Russ
   b. Education Leadership Diabetes/Nutrition- Susan Cottongim
   c. Behavioral Health Leadership – Kim Butler
   d. Obesity and Weight Management- Christine Carpenter

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

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

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

Spreadsheet X yes _____no
Narrative X yes _____no

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

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

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

Spreadsheet X yes _____no
Narrative X yes _____no

If no, please explain why.

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

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

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

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

Peninsula Regional last conducted a CHNA approximately 2 1/2 years ago; since that time significant changes in reimbursement i.e. Global Budgeted Revenue, including State and Federal requirements have driven new community benefit investment. PRMC has made substantial strides in development / implementation of new PRMC population health initiatives and chronic disease management in collaboration with others:

Organization/ Key Partners	Name of Key Collaborator	Title	Collaboration Description
Tri-County Diabetes Alliance	Mimi Dean	Worcester County Dir of Plan & Pop Health	General Diabetes Awareness, Education & Management
Hospitals Atlantic General	Patti Yocubik Colleen	RN/CDE VP	
McCready			
PRMC	Susan Cottingim	Manager Diabetes Ed	
Health Departments			
Somerset County	Craig Stofko Dawn Mills	Health Officer Exec Director Wellness	
Wicomico County	Lori Brewster Jennifer Johnson	Health Officer Chronic Disease	
Worcester County	Deborah Goeller Mimi Dean	Health Officer Dir of Planning Population Health	
TLC	Maureen Sharkey	Community Health	
UMES			

Urban Ministries	Debbie Donaway	Executive Director	
PRMC Parents & Teens Children's National Medical Center	Susan Cottingim Parents & Teens	Manager Diabetes Education	Diabetes Support Group for Teens
PRMC CNMC- Children's National Medical Center YMCA Delmarva PRMC Foundation We Can	Dianne Hitchens Amy Sorg Denise Billing	Executive Director of Women' & Children's Services Wellness Director President Foundation	Pediatric Weight Management Program
PRMC Parents & Children	PRMC Health Day Care Program- Linda Brannock	Director of Child Care	Pediatric Weight Management: PRMC Healthy Day Care Program
Health Fest Expo PRMC James M. Bennett High School	PRMC Health and Wellness Committee Joe Raffa Dr. Cathy Townsend	See Section III. iii. Community Benefit Operations 2. Dean of Students Assistant Superintendent	Obesity-Reduce the Proportion of Children and Adolescents Who are Considered Obese- General Awareness Campaign
University of Maryland MAC- Maintaining Active Citizens	 Peggy Bradford Legh Ann Eagle	 Executive Director Health & Wellness Project Director	Chronic Disease Management Partners

Peninsula Regional Home Care Local Churches New Dimensions Church Crisfield Church of God St. Pauls by the Sea Shelters HOPE inc. HALO Hope and Life Outreach	Nancy Bagwell Jesse Abbott Havey Tyler Alana Tyler Barbara Bassuener Donald O'Grince Donna Clark Celeste Savage	Branch Director Bishop Pastor Pastor Reverend Administration RN Executive Director	
PRMC Adventist Behavioral Health			Partnered with Adventist Health to Provide Behavioral Health Services in the Emergency Department
Lower Shore Health Clinic Go-Getters		 Executive Director	Behavioral Health Services
Atlantic General McCready Health			Provide Access Care to Disparate Communities
Atlantic General McCready Health Emergency Service Associates			ED Care Management for High Utilizers
Salisbury Genesis Aurora Nursing Home Berlin Nursing Home White Oak SNF Harrison House	Rob Stofer	Administrator	Partnering with 7 SNFs for Transitions of Care

Hartley Hall Deers Head Center	Marsha Strauss	CNO	
EMT Services Crisfield Clinic			Partnering with EMT Services and the Crisfield Clinic to provide Care Management and Telemedicine Services to High Utilizes of Smith Island
Independent and Employed Providers within Primary and Secondary Service Areas	To be Determined	To be Determined	PRMC Clinically Integrated Network: Develop Clinical Integration Including Physician Alignment And New Partnerships
Johns Hopkins Clinical Research Network Independent and Employed Providers within Primary and Secondary Service Areas	To be Determined	To be Determined	Cultivate an environment that encourages inquiry and innovation contributing to solutions, improvements and generalizable knowledge that positively impacts our community.

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

_____yes X no

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

___X_ yes _____no

Peninsula Regional has several representatives that attend LHIC.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), 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 example of how to report.

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

a. 1. 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. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.
2. Please indicate whether the need was identified through the most recent CHNA process.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following link: http://www.thecommunityguide.org/)
(Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

c. Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?

d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?

e. 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.

f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.

h. Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.

- What were the measurable results of the initiative?
- For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.

j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:
A. 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.
B. Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

2. Were there any primary community health needs 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.

   In addition to the community health needs identified through the CHNA that we and our partners have agreed to pursue together, there were a number of other health needs which (although important) were not a priority at this time. The health indicators we chose had outcomes measures much worse than the state, the nation and Healthy People 2020 targets. We also felt that working together we could ultimately effect a positive change in our communities as collectively we had the expertise, desire and means to effectuate such a change.

Limited human and financial resources within the health system as well as those of our partners do not allow us to pursue additional interventions. When resources permit, we will aggressively plan for expanding the number of health needs identified in our community health needs assessment.

Alternatively the health indicators we did not select will remain on our "watch list" and will continue to be monitored along with the other indicators. Some of those healthcare concerns on our "watch list" include:

- Heart Disease & Stroke
- Skin Cancer
- Access to Health Care Services
- Mental Health

While we are not able to develop a comprehensive approach to those listed above, we have begun to develop initiatives to address a few of the items in the watch list above. These initiatives can be found in Table III.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

Our analysis takes many of the State's population health initiatives into account. The State Health Improvement Plan provides a framework for our implementation plan. SHIP objective 27- reduce diabetes complications, and SHIP objective 31- reduce the proportion of children and adolescents who are considered obese are examples of several major objectives that Peninsula Regional in partnership with the three local County Health Departments has championed. The Healthiest Maryland Initiative promotes public health actions to expand programs that manage diabetes, prevent heart disease, and educates the public on healthy lifestyles that reduce obesity. As part of our Strategic Transformation Plan Peninsula Regional has committed to these objectives that focus public education on diabetes and other chronic conditions such as congestive heart failure and chronic kidney disease. PRMC has also expanded access to behavioral health addressing the need for much needed mental health and substance abuse in the region. PRMC's overarching goal has been to work with our community partners to improve the overall quality of residents' life in our primary care service area.

FY2015 Diabetes Table III

a. 1. Identified Need 2. Was this identified through the CHNA process?	Reduce Diabetes complications as measured by SHIP 27. Reduce diabetes related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management within the community. *Peninsula Regional conducted a Community Health Needs Assessment Survey (2013). One of the questions asked was, "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was selected as the 2nd highest health concern. The incidence of adults with diabetes is at a higher level for Somerset and Worcester Counties, with most of them in the 65+ age group. For Worcester and Wicomico, diabetes emergency room visits are considerably higher for Blacks than the Statewide Black rates and higher than the White rates in the same county (Minority Health and Health Disparities 2012). Overall, these statistics indicate there is a community wide need for diabetes education and management.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Provide awareness, education & diabetes management to the community.
c. Total Number of People Within the Target Population	Percent of Diabetes: County: Somerset, MD  23.6 County: Worcester, MD  19.2 County: Wicomico, MD  10.0 PRMC serves a rural population in Wicomico, Worcester and Somerset counties that have extremely high prevalence of diabetes. This is our target population. *Source: 2013 Maryland Risk Factor Behavioral Surveillance System.*
d. Total Number of People Reached by the Initiative Within the Target Population	Total Community Benefit diabetes encounters or "touchpoints" in FY2015 was over 1,100.
e. Primary Objective of the Initiative	Continue to create general public awareness around the high prevalence of diabetes in this region. As part of this initiative PRMC has collaborated with our partners to educate the public via various venues: • Diabetes Prevention & Education • Participation in Health Fairs throughout region • Travel to Community Events and Present Healthy Lifestyles • Local Health Department- "Health Events" • Local School Presentations (Grade School, High School, Colleges) • Diabetes Screenings (paper) at civic events • Diabetes support group meetings

f. Single or Multi-Year Initiative –Time Period	This is a multi-year initiative that will continue into the future.	
g. Key Collaborators in Delivery of the Initiative	• Peninsula Regional's Center for Diabetes and Endocrinology • Tri-County Health Departments • Tri-County Diabetes Alliance • Tri-County Healthy Weight Coalitions • Wicomico County Diabetes Planning Committee	
h. Impact/Outcome of Hospital Initiative?	Travel to community events where at-risk populations are present for diabetes screenings and education. **In FY 2015** Total Community Benefit Diabetes Encounters/Touch Points was over 1,100 Health Fairs Attended: 5 Diabetes Encounters: 332 Diabetes Screenings: 171 Meetings with Educators: 4 Attendees: 37 Diabetes Support Group Meetings: 23 Encounters: 324 • Diabetes Support • Insulin Pump Support • Children Support Collaboration & Partnership Meetings & Events: 8+ Local Radio & Talk Show Managing Diabetes: 8	
i. Evaluation of Outcomes:	The outcomes are evaluated individually based upon response rate and participation and by the Community Benefits Task Force.	
j. Continuation of Initiative?	Yes, plan to continue all of these initiatives.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 7,291	B. Direct Offsetting Revenue from Restricted Grants

Initiative 2

a. Identified Need 2. Was this identified through the CHNA process?	Reduce Diabetes complications as measured by SHIP 27. Reduce diabetes related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management within the community. *Peninsula Regional conducted a Community Health Needs Assessment Survey (2013). One of the questions asked was, "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was selected as the 2nd highest health concern. The incidence of adults with diabetes is at a higher level for Somerset and Worcester Counties, with most of them in the 65+ age group. For Worcester and Wicomico, diabetes emergency room visits are considerably higher for Blacks than the Statewide Black rates and higher than the White rates in the same county (Minority Health and Health Disparities 2012). Overall, these statistics indicate there is a community wide need for diabetes education and management.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Provide awareness, education & diabetes management to the community.
c. Total Number of People Within the Target Population	Percent of Diabetes: County: Somerset, MD  23.6 County: Worcester, MD  19.2 County: Wicomico, MD  10.0 PRMC serves a rural population in Wicomico, Worcester and Somerset counties that have extremely high prevalence of diabetes. This is our target population. *Source: 2013 Maryland Risk Factor Behavioral Surveillance System.*
d. Total Number of People Reached by the Initiative Within the Target Population	Total Community Benefit childhood diabetes encounters or "touchpoints" in FY2015 was over 50.
e. Primary Objective of the Initiative	Creation and continuation of a "Diabetes Support Group for Teens and Kids" that meets the medical, educational and social needs of this group.
f. Single or Multi-Year Initiative –Time Period	Multi-Year Initiative.
g. Key Collaborators in Delivery of the Initiative	Peninsula Regional Center for Diabetes and Endocrinology Partnership with parents Tri-County Diabetes Alliance of whom PRMC is a partner; working with local county educators to provide referrals to students in need of diabetes support groups.
h. Impact/Outcome of Hospital Initiative?	Group meetings: 6 *(Group meets every other month)* **Program Overview**

	• Exercise/Sports • Eating/Nutrition • Self-Awareness • Managing your Diabetes • Group Interaction Track # of attendees to the support group: 44 A core children's & teen diabetes group is now established, this group supports, shares and encourages members in controlling their diabetes. Referred children to Peninsula Regional Endocrinology Office as needed.	
i. Evaluation of Outcomes:	Outcomes are evaluated by the help and the education provided to these children in addition to physician referrals.	
j. Continuation of Initiative?	PRMC will continue to promote this initiative through disseminating promotional flyers as pediatric offices in addition to promoting this service to local pediatricians. PRMC will continue to promote this service to local school nurses in an effort to identify children and teens that would benefit from a diabetes support group.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $667	B. Direct Offsetting Revenue from Restricted Grants

Initiative 3

a. Identified Need 2. Was this identified through the CHNA process?	Reduce Diabetes complications as measured by SHIP 27. Reduce diabetes related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management within the community. *Peninsula Regional conducted a Community Health Needs Assessment Survey (2013). One of the questions asked was, "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was selected as the 2nd highest health concern. The incidence of adults with diabetes is at a higher level for Somerset and Worcester Counties, with most of them in the 65+ age group. For Worcester and Wicomico, diabetes emergency room visits are considerably higher for Blacks than the Statewide Black rates and higher than the White rates in the same county (Minority Health and Health Disparities 2012). Overall, these statistics indicate there is a community wide need for diabetes education and management.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Provide awareness, education & diabetes management to the community.
c. Total Number of People Within the Target Population	Percent of Diabetes: County: Somerset, MD  23.6 County: Worcester, MD  19.2 County: Wicomico, MD  10.0 PRMC serves a rural population in Wicomico, Worcester and Somerset counties that have extremely high prevalence of diabetes. This is our target population. *Source: 2013 Maryland Risk Factor Behavioral Surveillance System.*
d. Total Number of People Reached by the Initiative Within the Target Population	The total number of educators reached in FY2015- 37 whom in turn will reach out to the diabetic population in Wicomico, Worcester and Somerset Counties.
e. Primary Objective of the Initiative	"Educating the Educators" Working with multiple educators to promote adolescent & adult diabetes awareness.
f. Single or Multi-Year Initiative –Time Period	Multi-Year Initiative.
g. Key Collaborators in Delivery of the Initiative	Peninsula Regional Center for Diabetes and Endocrinology Wicomico County Diabetes Planning Committee- *(made up of Peninsula Regional, Wicomico County Health Dept., Wicomico County School & the Board of Education - creating awareness and education around childhood diabetes education and availability of resources.)*

	Wor-Wic Community College Salisbury University	
h. Impact/Outcome of Hospital Initiative?	Teach educators to relay & recognize the signs and symptoms of diabetes for early diagnosis and promotion in the schools. Track # of attendees: 37 Track # of joint meetings/groups presented to: 4	
i. Evaluation of Outcomes:	Continuing to engage and collaborate on creating an adolescent diabetes awareness campaign. Review of school menus appropriate for diabetic children. Provision of paper assessment for diabetes.	
j. Continuation of Initiative?	Plan to Continue	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	C. Total Cost of Initiative $926	D. Direct Offsetting Revenue from Restricted Grants

Initiative 4

a. Identified Need 2. Was this identified through the CHNA process?	Reduce Diabetes complications as measured by SHIP 27. Reduce diabetes related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management within the community. *Peninsula Regional conducted a Community Health Needs Assessment Survey (2013). One of the questions asked was, "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was selected as the 2nd highest health concern. The incidence of adults with diabetes is at a higher level for Somerset and Worcester Counties, with most of them in the 65+ age group. For Worcester and Wicomico, diabetes emergency room visits are considerably higher for Blacks than the Statewide Black rates and higher than the White rates in the same county (Minority Health and Health Disparities 2012). Overall, these statistics indicate there is a community wide need for diabetes education and management.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Provide awareness, education & diabetes management to the community.
c. Total Number of People Within the Target Population	Percent of Diabetes:  PRMC serves a rural population in Wicomico, Worcester and Somerset counties that have extremely high prevalence of diabetes. This is our target population. *Source: 2013 Maryland Risk Factor Behavioral Surveillance System.*
d. Total Number of People Reached by the Initiative Within the Target Population	To be determined by the Tri-County Diabetes Alliance Members for FY2015.
e. Primary Objective of the Initiative	Support and partner with the TCDA, (Tri-County Diabetes Alliance) to create awareness, education and management of the diabetes population in the lower three counties.
f. Single or Multi-Year Initiative –Time Period	Multi-Year Initiative
g. Key Collaborators in Delivery of the Initiative	Peninsula Regional Medical Center TCDA Tri-County Diabetes Alliance Tri-County Health Departments (Wicomico, Worcester, Somerset) UMES- University of Maryland Eastern Shore McCready Hospital Atlantic General Hospital

	Three Lower Counties - Salisbury Urban Ministries	
h. Impact/Outcome of Hospital Initiative?	PRMC is a partner in the Tri-County Diabetes Alliance (TCDA). PRMC has sent a total of 150 Diabetes Risk Tests from PRMC for follow-up. Track the number of participants in all collaborative meetings: (10-15) per meeting 10 times per year. TCDA continues to collaborate with the Tri County Health Planning Board to focus on reducing diabetes-related emergency room visits in Wicomico, Worcester, and Somerset. PRMC sends a list of "frequent flier" diabetes patients presenting to our ER (5-10 per quarter) to be case managed and referred for further diabetes education or support group participation.	
i. Evaluation of Outcomes:	Outcomes are evaluated by the Tri-County Diabetes Alliance Members TCDA is following the Healthy People 2020 guidelines for diabetes and will increase the education and identification of those at risk for diabetes.	
j. Continuation of Initiative?	Plan to Continue	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $913	b. Direct Offsetting Revenue from Restricted Grants

New Initiative 5

a. Identified Need 2. Was this identified through the CHNA process?	Reduce Diabetes complications as measured by SHIP 27. Reduce diabetes related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management within the community. *Peninsula Regional conducted a Community Health Needs Assessment Survey (2013). One of the questions asked was, "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was selected as the 2nd highest health concern. The incidence of adults with diabetes is at a higher level for Somerset and Worcester Counties, with most of them in the 65+ age group. For Worcester and Wicomico, diabetes emergency room visits are considerably higher for Blacks than the Statewide Black rates and higher than the White rates in the same county (Minority Health and Health Disparities 2012). Overall, these statistics indicate there is a community wide need for diabetes education and management.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Provide awareness, education & diabetes management to the community. **Disease Self- Management Program** Partnering with MAC (Maintaining Active Citizens) in the state-wide license for chronic disease self-management education.
c. Total Number of People Within the Target Population	Percent of Diabetes: County: Somerset, MD  23.6 County: Worcester, MD  19.2 County: Wicomico, MD  10.0 PRMC serves a rural population in Wicomico, Worcester and Somerset counties that have extremely high prevalence of diabetes. This is our target population. *Source: 2013 Maryland Risk Factor Behavioral Surveillance System.*
d. Total Number of People Reached by the Initiative Within the Target Population	In FY2015, 391 members of the community have been referred for diabetic education and self- management.
e. Primary Objective of the Initiative	The primary objective is to deliver chronic disease self-management services to community residents. The program will promote increased patient competence and coping through treatment plans that include education and referrals to necessary resources. Provide comprehensive assessments and assist the patient utilize the health system appropriately. **Healthy Living with Diabetes.** A diabetes self-management education program at MAC. Healthy Living with Diabetes is a 6-8 week workshop developed at Stanford University, based on self-management.

	CDSMP- Chronic Diabetes Self- Management Program	
f. Single or Multi-Year Initiative –Time Period	Multi-Year Initiative	
g. Key Collaborators in Delivery of the Initiative	MAC's "Center of Excellence" hospital partners include: • Johns Hopkins • Meritus Health • Peninsula Regional	
h. Impact/Outcome of Hospital Initiative?	Referrals to MAC for Chronic Disease Self- Management Program (CDSMP): **From** PRMC Health Fairs: 225 Referrals from Mobile Van: 35 Physicians & Community Health Care Workers: 131 **MAC disease self-management sessions** Number of participants: 85 Number who completed 4 or more sessions: 76% **Ethnicity** Black or African American: 59% White: 40% Other: 1%	
i. Evaluation of Outcomes:	MAC will oversee all the fidelity, data management, and will maintain a database of all chronic disease self-management education trainers and outcomes. To be further developed.	
j. Continuation of Initiative?	Plan to Continue	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $47,162	b. Direct Offsetting Revenue from Restricted Grants

New Initiative 6

a. Identified Need 2. Was this identified through the CHNA process?	Reduce Diabetes complications as measured by SHIP 27. Reduce diabetes related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management within the community. *Peninsula Regional conducted a Community Health Needs Assessment Survey (2013). One of the questions asked was, "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was selected as the 2nd highest health concern. The incidence of adults with diabetes is at a higher level for Somerset and Worcester Counties, with most of them in the 65+ age group. For Worcester and Wicomico, diabetes emergency room visits are considerably higher for Blacks than the Statewide Black rates and higher than the White rates in the same county (Minority Health and Health Disparities 2012). Overall, these statistics indicate there is a community wide need for diabetes education and management.* Yes, this was identified through the CHNA process.
c. Hospital Initiative	Provide awareness, education & diabetes management to the community. Partnering with local Health Departments under the 1422 Grant to prevent obesity and diabetes.
d. Total Number of People Within the Target Population	Percent of Diabetes: County: Somerset, MD  23.6 County: Worcester, MD  19.2 County: Wicomico, MD  10.0 PRMC serves a rural population in Wicomico, Worcester and Somerset counties that have extremely high prevalence of diabetes. This is our target population. *Source: 2013 Maryland Risk Factor Behavioral Surveillance System.*
e. Total Number of People Reached by the Initiative Within the Target Population	Data not yet available, program is in its infancy as infrastructure, processes, material, and organizational structure is being developed.
f. Primary Objective of the Initiative	The primary objective is to expand the Healthiest Maryland initiative through: • Environmental strategies to promote healthy lifestyles. • Strategies to promote build and support lifestyle changes for those at high risk for diabetes. • Health interventions to improve the quality of health care delivery to the highest prediabetes disparities. • Community linkage strategies to support diabetes prevention efforts.
g. Single or Multi-Year Initiative – Time Period	Multi-Year Initiative Beginning in FY 2016
h. Key Collaborators in Delivery of	Somerset County Health Department

the Initiative	Worcester County Health Department Wicomico County Health Department Atlantic General Hospital Peninsula Regional Medical Center Apple Drugs Diabetes and Education Center Tri-County Diabetes Alliance	
i. Impact/Outcome of Hospital Initiative?	**The overall goals of the CDC Chronic Disease Prevention and Health Promotion Grant:** Reduce prevalence of obesity. Reduce rates of death and disability due to diabetes.	
j. Evaluation of Outcomes:	To be determined	
k. Continuation of Initiative?	Plan to Continue	
l. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $0	b. Direct Offsetting Revenue from Restricted Grants:

a. 1. Identified Need 2. Was this identified through the CHNA process?	SHIP 31. Reduce the proportion of children and adolescents who are considered obese. ***Identified Need:*** *The Centers for Disease Control and Prevention states that, sixty-eight percent of all Americans are overweight, and according to the Maryland Behavioral Risk Factor Surveillance System (2010) nearly 2.7 million or about sixty-six percent of all Maryland adults were classified as obese. Obesity has been linked to a number of diseases including diabetes, colorectal cancer, kidney cancer, breast cancer, and many types of cardiovascular disease. Childhood obesity is also on the rise due to the amount of sugary drinks and high energy foods that have become so easily available (CDC, 2013).* *Our Community Healthcare Dashboard indicates that both Somerset and Wicomico counties have higher obesity or overweight adults than most counties in the State of Maryland. Low-income preschoolers in Wicomico County were moderately more obese than other counties in the United States, and Somerset County preschoolers were more obese than other counties across the United States.* *Adults with no college education and with a household income of less than $75,000 were significantly more likely to be obese (Maryland's BRFSS, 2010). The median income of our community benefits service area is considerably less ($41,671 - $56,613) than Maryland's median income of $73,123. In addition, the June 2013 unemployment rate for each one of the counties is; Wicomico 8.1%, Worcester 10.2% and Somerset 9.3% higher than both the state & national averages. Based upon the low density of grocery stores per 1,000 population residents of Wicomico and Somerset have limited access to grocery stores that sell healthy foods. The density of fast food/convenience stores is quite high which contributes to poor eating habits (HCI 2013).* *As obesity rates in American children continue to increase, Type II diabetes, a disease that used to be seen primarily in adults over 45, is becoming more common in young people (NDEP, 2011). Per Peninsula Regional's Community Needs Assessment questionnaire/survey "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was listed the 2nd highest concern. The correlating link between rising obesity and increasing prevalence and incidence rates of diabetes was key to choosing both these health care initiatives. Diabetes, a chronic disease, is a leading cause of stroke and kidney failure and the cost of not controlling the disease is monumental.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Reduce the # of child & adolescents in Wicomico, Worcester and Somerset who are considered overweight.
c. Total Number of People Within the Target Population	PRMC services a rural population where the percentage of adults who are obese is very high. The three Lower Counties obesity rate per population is: Somerset County 54.3%, Wicomico County31.3% and Worcester County30.7%. County: Somerset, MD — 54.3 — Maryland Behavioral Risk Factor Surveillance System County: Wicomico, MD — 31.3 — Maryland Behavioral Risk Factor Surveillance System County: Worcester, MD — 30.7 — Maryland Behavioral Risk Factor Surveillance System

	Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community wide health care initiative. County: Somerset, MD  21.3 Maryland Department of Health and Mental Hygiene County: Wicomico, MD  14.9 Maryland Department of Health and Mental Hygiene County: Worcester, MD  12.4 Maryland Department of Health and Mental Hygiene *Source: 2013 Maryland Risk Factor Behavioral Surveillance System. Maryland Department of Health and Mental Hygiene*
d. Total Number of People Reached by the Initiative Within the Target Population	Total Community Benefit Obesity encounters or "touchpoints" in FY2015 was over 2,000 residents.
e. Primary Objective of the Initiative	PRMC will develop educational modules and increase educational awareness around childhood & adolescent obesity to reduce the total number of children that are overweight.
f. Single or Multi-Year Initiative –Time Period	This is a multi-year initiative that will continue into the future.
g. Key Collaborators in Delivery of the Initiative	PRMC Health and Wellness Committee working with local employers, community groups and attending community events.
h. Impact/Outcome of Hospital Initiative?	Track number of venues information was distributed. We participated in a total of 11 local health festivals at which 2,052 encounters, "touch points" occurred. These encounters included weight/healthy lifestyle screenings 266 including subsequent suggested referrals. Over 750 "Healthy Eating Coloring Books" passed out. Over 200 "Fast Food Calorie Guides" distributed. 100 "Portion Control Plates" for Adult and Children sizes. 100+ pedometers distributed. Over 1,100 beach balls, jump ropes, frisbees and airplanes distributed to children to promote outdoor physical activity.

i. Evaluation of Outcomes:	The outcomes are evaluated individually based upon response rate and participation and by the Community Benefits Task Force.	
j. Continuation of Initiative?	Yes, plan to continue all of these initiatives.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 36,935	B. Direct Offsetting Revenue from Restricted Grants: N/A

Initiative 2

a. 1. Identified Need 2. Was this identified through the CHNA process?	SHIP 31. Reduce the proportion of children and adolescents who are considered obese. ***Identified Need:*** *The Centers for Disease Control and Prevention states that, sixty-eight percent of all Americans are overweight, and according to the Maryland Behavioral Risk Factor Surveillance System (2010) nearly 2.7 million or about sixty-six percent of all Maryland adults were classified as obese. Obesity has been linked to a number of diseases including diabetes, colorectal cancer, kidney cancer, breast cancer, and many types of cardiovascular disease. Childhood obesity is also on the rise due to the amount of sugary drinks and high energy foods that have become so easily available (CDC, 2013).* *Our Community Healthcare Dashboard indicates that both Somerset and Wicomico counties have higher obesity or overweight adults than most counties in the State of Maryland. Low-income preschoolers in Wicomico County were moderately more obese than other counties in the United States, and Somerset County preschoolers were more obese than other counties across the United States.* *Adults with no college education and with a household income of less than $75,000 were significantly more likely to be obese (Maryland's BRFSS, 2010). The median income of our community benefits service area is considerably less ($41,671 - $56,613) than Maryland's median income of $73,123. In addition, the June 2013 unemployment rate for each one of the counties is; Wicomico 8.1%, Worcester 10.2% and Somerset 9.3% higher than both the state & national averages. Based upon the low density of grocery stores per 1,000 population residents of Wicomico and Somerset have limited access to grocery stores that sell healthy foods. The density of fast food/convenience stores is quite high which contributes to poor eating habits (HCI 2013).* *As obesity rates in American children continue to increase, Type II diabetes, a disease that used to be seen primarily in adults over 45, is becoming more common in young people (NDEP, 2011). Per Peninsula Regional's Community Needs Assessment questionnaire/survey "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was listed the 2nd highest concern. The correlating link between rising obesity and increasing prevalence and incidence rates of diabetes was key to choosing both these health care initiatives. Diabetes, a chronic disease, is a leading cause of stroke and kidney failure and the cost of not controlling the disease is monumental.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Healthy Day Care Program.
c. Total Number of People Within the Target Population	Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community wide health care initiative. As part of our "Healthy Day Care Program "our target population is the (100 +-) children within the program and their parents.

	County: Somerset, MD  21.3 Maryland Department of Health and Mental Hygiene County: Wicomico, MD  14.9 Maryland Department of Health and Mental Hygiene County: Worcester, MD  12.4 Maryland Department of Health and Mental Hygiene *Source: Maryland Department of Health and Mental Hygiene*
d. Total Number of People Reached by the Initiative Within the Target Population	Total Community Benefit Obesity encounters or "touchpoints" in FY2015 included the 100 Day Care Children and their parents.
e. Primary Objective of the Initiative	The primary objective is to educate our children on how to make better healthy lifestyle choices at a young age, and to involve the parents in healthy lifestyle activities so that they will start to commit to a healthier lifestyle and reinforce this with their children.
f. Single or Multi-Year Initiative –Time Period	This is a multi-year initiative that will continue into the future.
g. Key Collaborators in Delivery of the Initiative	PRMC Health and Wellness Committee PRMC Day Care Parents
h. Impact/Outcome of Hospital Initiative?	Continuance of the monthly healthy choices educational program, and have expanded to include other educational health initiatives. (12 classes a year). • Healthy Heart Curriculum • Healthy Body Curriculum • Cleanliness • Importance of Exercise • Plate Portions • Pretend Food Activity (*Interactive with heart model, dance routines, films, coloring books etc.)* The children now have baseline health information to make wise lifestyle choices. Exercise/gym class every Friday for 7 child classes. "Active Group" activities twice a day for 20 minutes is part of the routine. • Jump Frog • Water Exercise • Dance & Music • Red Light, Green Light • Jumping Jacks Dramatically improved the nutritional value of the Child Care lunch and snack options. Replaced most of the prepackaged and processed foods with fruits and wheat products. (See attachment B)

	Instituted a Healthy Kids and Parents Program. Teachers, students and parents participate and discuss healthy food choices and try various healthy food options. Includes healthy snack/party celebrations.	
i. Evaluation of Outcomes:	Develop healthy habits program for day care participants and develop program materials appropriate for preschooler's. Feedback from children during Q & A. Implement and continue to develop the healthy choices educational program. Evaluate healthy snack alternatives and children's response to the initiative.	
j. Continuation of Initiative?	Plan to continue.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $ 0	b. Direct Offsetting Revenue from Restricted Grants: N/A

FY2015 Obesity Table III

Initiative 3

a. 1. Identified Need 2. Was this identified through the CHNA process?	SHIP 31. Reduce the proportion of children and adolescents who are considered obese. ***Identified Need:*** *The Centers for Disease Control and Prevention states that, sixty-eight percent of all Americans are overweight, and according to the Maryland Behavioral Risk Factor Surveillance System (2010) nearly 2.7 million or about sixty-six percent of all Maryland adults were classified as obese. Obesity has been linked to a number of diseases including diabetes, colorectal cancer, kidney cancer, breast cancer, and many types of cardiovascular disease. Childhood obesity is also on the rise due to the amount of sugary drinks and high energy foods that have become so easily available (CDC, 2013).* *Our Community Healthcare Dashboard indicates that both Somerset and Wicomico counties have higher obesity or overweight adults than most counties in the State of Maryland. Low-income preschoolers in Wicomico County were moderately more obese than other counties in the United States, and Somerset County preschoolers were more obese than other counties across the United States.* *Adults with no college education and with a household income of less than $75,000 were significantly more likely to be obese (Maryland's BRFSS, 2010). The median income of our community benefits service area is considerably less ($41,671 - $56,613) than Maryland's median income of $73,123. In addition, the June 2013 unemployment rate for each one of the counties is; Wicomico 8.1%, Worcester 10.2% and Somerset 9.3% higher than both the state & national averages. Based upon the low density of grocery stores per 1,000 population residents of Wicomico and Somerset have limited access to grocery stores that sell healthy foods. The density of fast food/convenience stores is quite high which contributes to poor eating habits (HCI 2013).* *As obesity rates in American children continue to increase, Type II diabetes, a disease that used to be seen primarily in adults over 45, is becoming more common in young people (NDEP, 2011). Per Peninsula Regional's Community Needs Assessment questionnaire/survey "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was listed the 2nd highest concern. The correlating link between rising obesity and increasing prevalence and incidence rates of diabetes was key to choosing both these health care initiatives. Diabetes, a chronic disease, is a leading cause of stroke and kidney failure and the cost of not controlling the disease is monumental.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Create public awareness and education regarding healthy lifestyles within the tri-county region (Wicomico, Worcester & Somerset).
c. Total Number of People Within the Target Population	PRMC services a rural population where the percentage of adults who are obese is very high. The three Lower Counties obesity rate per population is: Somerset County 54.3%, Wicomico County31.3% and Worcester County30.7%.

	County: Somerset, MD — 54.3 — Maryland Behavioral Risk Factor Surveillance System County: Wicomico, MD — 31.3 — Maryland Behavioral Risk Factor Surveillance System County: Worcester, MD — 30.7 — Maryland Behavioral Risk Factor Surveillance System Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community wide health care initiative. County: Somerset, MD — 21.3 — Maryland Department of Health and Mental Hygiene County: Wicomico, MD — 14.9 — Maryland Department of Health and Mental Hygiene County: Worcester, MD — 12.4 — Maryland Department of Health and Mental Hygiene *Source: 2013 Maryland Risk Factor Behavioral Surveillance System. Maryland Department of Health and Mental Hygiene*
d. Total Number of People Reached by the Initiative Within the Target Population	The Tri-County Diabetes Alliance provides support and a presence at many public events, elevating healthy lifestyle choices and diabetes awareness in collaboration with their partners.
e. Primary Objective of the Initiative	Create diabetes community awareness and provide education regarding healthy lifestyles within the tri-county region (Wicomico, Worcester & Somerset).
f. Single or Multi-Year Initiative –Time Period	This is a multi-year initiative that will continue into the future.
g. Key Collaborators in Delivery of the Initiative	Peninsula Regional Tri-County Diabetes Alliance and Partners
h. Impact/Outcome of Hospital Initiative?	Create awareness around healthy lifestyles and choosing the right foods. TCDA partners promotes use of existing resources available to the students i.e. support groups, screenings, health lifestyle education, etc. In addition provides education and counseling for health needs. TCDA and partners administer the ADA risk assessment paper screening to individuals for diabetes throughout region. FY2015 PRMG venues 11
i. Evaluation of Outcomes:	The Tri-County Diabetes Alliance walk brings public attention to the importance of exercising and knowing if you are at risk for diabetes. Worksite Wellness Symposium UMES Health Fair included screenings and healthy foods focus.
j. Continuation of Initiative?	Yes we will continue into the future our long standing partnership with the Tri-County

	Diabetes Alliance.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $ 482	b. Direct Offsetting Revenue from Restricted Grants: N/A

Initiative 4

a. 1. Identified Need 2. Was this identified through the CHNA process?	SHIP 31. Reduce the proportion of children and adolescents who are considered obese. ***Identified Need:*** *The Centers for Disease Control and Prevention states that, sixty-eight percent of all Americans are overweight, and according to the Maryland Behavioral Risk Factor Surveillance System (2010) nearly 2.7 million or about sixty-six percent of all Maryland adults were classified as obese. Obesity has been linked to a number of diseases including diabetes, colorectal cancer, kidney cancer, breast cancer, and many types of cardiovascular disease. Childhood obesity is also on the rise due to the amount of sugary drinks and high energy foods that have become so easily available (CDC, 2013).* *Our Community Healthcare Dashboard indicates that both Somerset and Wicomico counties have higher obesity or overweight adults than most counties in the State of Maryland. Low-income preschoolers in Wicomico County were moderately more obese than other counties in the United States, and Somerset County preschoolers were more obese than other counties across the United States.* *Adults with no college education and with a household income of less than $75,000 were significantly more likely to be obese (Maryland's BRFSS, 2010). The median income of our community benefits service area is considerably less ($41,671 - $56,613) than Maryland's median income of $73,123. In addition, the June 2013 unemployment rate for each one of the counties is; Wicomico 8.1%, Worcester 10.2% and Somerset 9.3% higher than both the state & national averages. Based upon the low density of grocery stores per 1,000 population residents of Wicomico and Somerset have limited access to grocery stores that sell healthy foods. The density of fast food/convenience stores is quite high which contributes to poor eating habits (HCI 2013).* *As obesity rates in American children continue to increase, Type II diabetes, a disease that used to be seen primarily in adults over 45, is becoming more common in young people (NDEP, 2011). Per Peninsula Regional's Community Needs Assessment questionnaire/survey "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was listed the 2nd highest concern. The correlating link between rising obesity and increasing prevalence and incidence rates of diabetes was key to choosing both these health care initiatives. Diabetes, a chronic disease, is a leading cause of stroke and kidney failure and the cost of not controlling the disease is monumental.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Health Fest Expo
c. Total Number of People Within the Target Population	The target population focused on the indigent, uninsured and those that have limited access to health care (7,000 residents) in and around the city of Salisbury, Maryland. PRMC services a rural population where the percentage of adults who are obese is very high. The three Lower Counties obesity rate per population is: Somerset County 54.3%, Wicomico County31.3% and Worcester County30.7%.

	County: Somerset, MD — 54.3 — Maryland Behavioral Risk Factor Surveillance System County: Wicomico, MD — 31.3 — Maryland Behavioral Risk Factor Surveillance System County: Worcester, MD — 30.7 — Maryland Behavioral Risk Factor Surveillance System Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community wide health care initiative. County: Somerset, MD — 21.3 — Maryland Department of Health and Mental Hygiene County: Wicomico, MD — 14.9 — Maryland Department of Health and Mental Hygiene County: Worcester, MD — 12.4 — Maryland Department of Health and Mental Hygiene *Source: 2013 Maryland Risk Factor Behavioral Surveillance System. Maryland Department of Health and Mental Hygiene*
d. Total Number of People Reached by the Initiative Within the Target Population	Total Health Expo encounters or "touchpoints" in FY2015 was over 1,000 residents.
e. Primary Objective of the Initiative	Provide screenings and education for underserved and uninsured members of the community.
f. Single or Multi-Year Initiative –Time Period	This is an annual event.
g. Key Collaborators in Delivery of the Initiative	Peninsula Regional Wicomico County Board of Education
h. Impact/Outcome of Hospital Initiative?	Approximately 1,000 local community members attended. **Over 20 different screenings were available.** • Sample: • Blood Pressure • Height • Weight • Waist Measurement • Body Fat • Kidney Health • Mental Health Assessment • Oral Cancer • Colorectal

	• Breast Exam • Bone Density • Hearing • Vision • Diabetes Assessment • Glaucoma • Foot Sensation	
i. Evaluation of Outcomes:	Promote program and hold screenings Well received by public, and referrals to providers.	
j. Continuation of Initiative?	Yes, PRMC will continue to plan this as an annual event.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	C. Total Cost of Initiative $ 28,169	D. Direct Offsetting Revenue from Restricted Grants: N/A

New Initiative 5

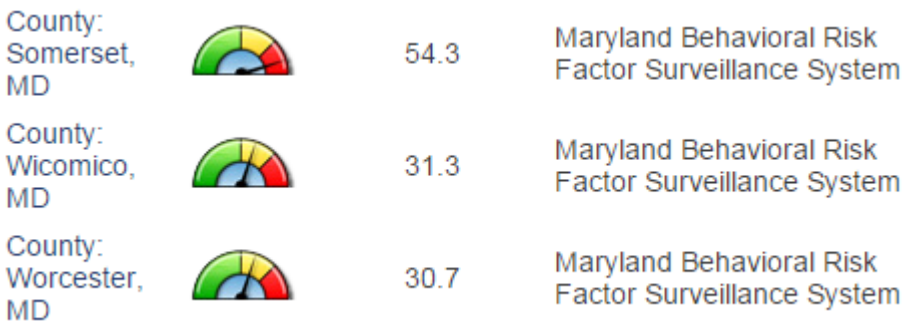
a. 1. Identified Need 2. Was this identified through the CHNA process?	SHIP 31. Reduce the proportion of children and adolescents who are considered obese. ***Identified Need:*** *The Centers for Disease Control and Prevention states that, sixty-eight percent of all Americans are overweight, and according to the Maryland Behavioral Risk Factor Surveillance System (2010) nearly 2.7 million or about sixty-six percent of all Maryland adults were classified as obese. Obesity has been linked to a number of diseases including diabetes, colorectal cancer, kidney cancer, breast cancer, and many types of cardiovascular disease. Childhood obesity is also on the rise due to the amount of sugary drinks and high energy foods that have become so easily available (CDC, 2013).* *Our Community Healthcare Dashboard indicates that both Somerset and Wicomico counties have higher obesity or overweight adults than most counties in the State of Maryland. Low-income preschoolers in Wicomico County were moderately more obese than other counties in the United States, and Somerset County preschoolers were more obese than other counties across the United States.* *Adults with no college education and with a household income of less than $75,000 were significantly more likely to be obese (Maryland's BRFSS, 2010). The median income of our community benefits service area is considerably less ($41,671 - $56,613) than Maryland's median income of $73,123. In addition, the June 2013 unemployment rate for each one of the counties is; Wicomico 8.1%, Worcester 10.2% and Somerset 9.3% higher than both the state & national averages. Based upon the low density of grocery stores per 1,000 population residents of Wicomico and Somerset have limited access to grocery stores that sell healthy foods. The density of fast food/convenience stores is quite high which contributes to poor eating habits (HCI 2013).* *As obesity rates in American children continue to increase, Type II diabetes, a disease that used to be seen primarily in adults over 45, is becoming more common in young people (NDEP, 2011). Per Peninsula Regional's Community Needs Assessment questionnaire/survey "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was listed the 2nd highest concern. The correlating link between rising obesity and increasing prevalence and incidence rates of diabetes was key to choosing both these health care initiatives. Diabetes, a chronic disease, is a leading cause of stroke and kidney failure and the cost of not controlling the disease is monumental.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Develop Healthy US Pediatric Weight Management Program.
c. Total Number of People Within the Target Population	Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community health care initiative.

	County: Somerset, MD — 21.3 — Maryland Department of Health and Mental Hygiene County: Wicomico, MD — 14.9 — Maryland Department of Health and Mental Hygiene County: Worcester, MD — 12.4 — Maryland Department of Health and Mental Hygiene *Source: 2013 Maryland Risk Factor Behavioral Surveillance System. Maryland Department of Health and Mental Hygiene*
d. Total Number of People Reached by the Initiative Within the Target Population	This program is an 8 week program that typically has 12-15 children.
e. Primary Objective of the Initiative	Provide pediatric obesity screenings and education for under and uninsured community members. Increase breast feeding rates to help lower pediatric obesity. Promote physical activity.
f. Single or Multi-Year Initiative –Time Period	Multi-Year 3 years
g. Key Collaborators in Delivery of the Initiative	PRMC Children's National Medical Center YMCA PRMC Foundation
h. Impact/Outcome of Hospital Initiative?	**Pediatric Obesity Program:** **Oct 13 Class** Participants 14 Avg. Weight Loss 9.4 BMI Decrease .76 Decrease Mile Time 3.0 minutes **March 14 Class** Participants 12 Avg. Weight Loss 2.3 BMI Decrease .73 Decrease Mile Time 3.5 minutes **FY 2015 Class** Participants 36 Avg. Weight Loss 1.6 BMI Decrease .1.8 Decrease Mile Time 1.35 minutes ***FY2015 Success Stories:** Child loss 125 lbs.

	Child loss 40 lbs. Child loss 25lbs. Peninsula Regional's breastfeeding rates: 2015- 80% (Healthy People 2020 Goal 82%)	
i. Evaluation of Outcomes:	Hold several 8-week programs to educate children & families on health lifestyle choices. Evaluate the lifestyle changes. Increase breast feeding rates to lower pediatric obesity	
j. Continuation of Initiative?	We plan to continue our partnership with the YMCA promoting pediatric weight loss. In addition, PRMC is looking to expand our collaborative this Calendar Year by proposing a MOU with The YMCA of the Chesapeake Region (6 Centers). Whereas PRMC and YMCA desire to enter into a strategic relationship to extend the continuum of health, wellness, preventive and educational programs to the Delmarva community. Plan to continue.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $ 0	b. Direct Offsetting Revenue from Restricted Grants: N/A

New Initiative 6

a. 1. Identified Need 2. Was this identified through the CHNA process?	SHIP 31. Reduce the proportion of children and adolescents who are considered obese. ***Identified Need:*** *The Centers for Disease Control and Prevention states that, sixty-eight percent of all Americans are overweight, and according to the Maryland Behavioral Risk Factor Surveillance System (2010) nearly 2.7 million or about sixty-six percent of all Maryland adults were classified as obese. Obesity has been linked to a number of diseases including diabetes, colorectal cancer, kidney cancer, breast cancer, and many types of cardiovascular disease. Childhood obesity is also on the rise due to the amount of sugary drinks and high energy foods that have become so easily available (CDC, 2013).* *Our Community Healthcare Dashboard indicates that both Somerset and Wicomico counties have higher obesity or overweight adults than most counties in the State of Maryland. Low-income preschoolers in Wicomico County were moderately more obese than other counties in the United States, and Somerset County preschoolers were more obese than other counties across the United States.* *Adults with no college education and with a household income of less than $75,000 were significantly more likely to be obese (Maryland's BRFSS, 2010). The median income of our community benefits service area is considerably less ($41,671 - $56,613) than Maryland's median income of $73,123. In addition, the June 2013 unemployment rate for each one of the counties is; Wicomico 8.1%, Worcester 10.2% and Somerset 9.3% higher than both the state & national averages. Based upon the low density of grocery stores per 1,000 population residents of Wicomico and Somerset have limited access to grocery stores that sell healthy foods. The density of fast food/convenience stores is quite high which contributes to poor eating habits (HCI 2013).* *As obesity rates in American children continue to increase, Type II diabetes, a disease that used to be seen primarily in adults over 45, is becoming more common in young people (NDEP, 2011). Per Peninsula Regional's Community Needs Assessment questionnaire/survey "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was listed the 2nd highest concern. The correlating link between rising obesity and increasing prevalence and incidence rates of diabetes was key to choosing both these health care initiatives. Diabetes, a chronic disease, is a leading cause of stroke and kidney failure and the cost of not controlling the disease is monumental.* Yes, this was identified through the CHNA process.
b. Hospital Initiative	Develop community wide awareness and education regarding heart disease, hypertension, **obesity** and healthy lifestyles.
c. Total Number of People Within the Target Population	PRMC services a rural population where the percentage of adults who are obese is very high. The three Lower Counties obesity rate per population is: Somerset County 54.3%, Wicomico County31.3% and Worcester County30.7%.

	Obesity as a Percentage of the Population  *Source: 2013 Maryland Risk Factor Behavioral Surveillance System. Maryland Department of Health and Mental Hygiene*
d. Total Number of People Reached by the Initiative Within the Target Population	The total number of underserved residents screened by this specific initiative in FY2015 was 240.
e. Primary Objective of the Initiative	Provide healthy heart screenings to residents of Delmarva using a mobile van to reach communities that have limited access to healthcare. The two healthy heart initiatives include: • CCC- Coastal Cardiac Checks • Women's Heart Screenings **Obesity Component** An integral component of these heart screenings includes an educational session that highlights reducing obesity, exercising, healthy food choices all which contribute to a healthy heart. • Obesity Screening Component Includes: • Height • Weight • BMI • Body Fat % • Educational Session on Nutrition and Healthy Lifestyles • Resources Available • Potential Referral if Needed
f. Single or Multi-Year Initiative –Time Period	Multi-year initiative that will continue into the future.
g. Key Collaborators in Delivery of the Initiative	PRMC Underserved Community Locations.
h. Impact/Outcome of Hospital Initiative?	**Coastal Cardiac Checks/Obesity Screening Component** Locations Visited: 15 Patients Screened: 186 Referred: 6 **Women's Heart/Nutrition Session Component** Patients Screened: 54 Referred: 1

i. Evaluation of Outcomes:	Number of underserved residents screened and low access areas visited.	
j. Continuation of Initiative?	Response is very positive, we plan to continue.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	a. Total Cost of Initiative $ 5,249	b. Direct Offsetting Revenue from Restricted Grants: N/A

Identified Need	Over the past 12 months, PRMC has further enhanced its population health efforts. The following initiatives have been implemented since our last Community Benefit plan as part of our population health foundation.
Most Recent 12 months The following initiatives have been implemented as we begin our population health journey.	1. Chronic Disease Management i) Health Coaches who focus on chronic conditions such as heart failure and chronic kidney disease and patients who are at risk for readmission
	2. Care Management i) Utilization of Community Health workers ii) Peninsula Regional Medical Center: primary care providers developing care plans that are patient centric and are targeted to patients with chronic conditions iii) Creation of Transitions of Care Nurses: nurses who follow patients for 30 days, patients who are screened as high risk iv) Medication reconciliation process upon admission and prior to discharge v) Social workers who assist the care team in assessing the social needs of the patients vi) Partial Hospitalization Program: secondary to a community assessment for gaps in services for the region vii) To provide behavioral health services for patients either in the community or prior to discharge who need extra care prior to discharge to home

Identified Need	PRMC is seeking to further enhance its population health efforts by focusing on the following nine future initiatives that address specific community health needs: access to care, health education, chronic disease management, care management and filling gaps in services like behavioral health. We are currently seeking additional funding through the HSCRC Care Coordination Grant process to enhance these initiatives as our strategic intent is to pursue the following (1-9) in collaboration and partnership with others as was outlined in our "Population Health Strategic Transformation Plan."
Future Grant & Strategic Intent The following 9 future initiatives are being pursued by the hospital in collaboration with other partners.	1. Provide a bridge clinic to patients who do not have a primary care physician or need to see a primary care physician a) To increase access to care to an aging population b) Patients who are a high risk for readmission and need to see a physician within 48-72 hours of discharge and whose own PCP cannot accommodate will be referred and an appointment will be established prior to discharge by Transitions RNs. Patients without PCPs who require post discharge follow up will be referred for a 2-5 day appointment.
	2. Mobile Van a) A medical van that was originally outfitted for wellness checks will now be used to make "rounds" on patients in their communities b) The van is targeting communities with high ED utilization and readmissions as well as isolated and disparate communities where access to primary care and/or transportation is problematic c) The van will assist patients in managing their chronic conditions but live remotely from providers d) PRMC is collaborating with Atlantic General Hospital and McCready Health to assist with their high utilizers in remote and disparate communities
	3. In Collaboration with Atlantic General Hospital and McCready Health a) Provide Care Management and communication between PRMC's, AGH's and McCready's emergency rooms b) To assist patients in accessing the appropriate chronic care management and mental health professionals to reduce ED utilization c) Utilizing CRISP to establish a "community plan of care" for patients who utilize all three institutions
	4. Community Case Management and Transitions of Care a) Provide case managers in employed primary care practices and in affiliated primary care practices to manage Medicare high utilizers who are attributed to these practices b) Additional high risk for readmission patients not attributed to these primary care practices will be managed for up to 90 days c) The Care Manager will assist the primary care physician in actively managing the patients chronic conditions to prevent avoidable utilization of PRMC's acute care setting d) Care Managers/Nurse Practitioner who provide care in patients homes to

	support extremely sick patients whose chronic conditions are at the end of their disease state e) Patients and their health partners (family, friends) are taught to assist patients in management of their health
	5. In collaboration with 7 SNF's/Rehab: i) Work with 7 nursing homes who have agreed to work on pathways to telecommunicate with hospitalist at PRMC to discuss high risk patient who may need care within the nursing home versus care in the acute care setting
	6. Smith Island/Crisfield Clinic: Telemedicine a) Working with EMT's who will assess patients within the home setting and work with hospitalist at PRMC via telemedicine for patients who need care but may or may not need to be admitted to PRMC
	7. Health, Wellness and Chronic Disease Management Competencies. a) Engage PRHS's self-insured covered lives in health and wellness programs b) Engage PRHS's self-insured covered lives with chronic disease controlled through case management or other disease management programs. c) Formulate a health and wellness program for the community.
	8. Develop clinical integration including physician alignment and new partnerships a) Stand up an Accountable Care Organization b) Develop a path to connect community physicians with the new EMR
	9. Cultivate an environment that encourages inquiry and innovation contributing to solutions, improvements and generalizable knowledge that positively impacts our community. Develop research based protocols.

VI. PHYSICIANS

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

ECG Management Consultants was engaged by Peninsula Regional to assist in developing a "Medical Staff Development Plan" based on the healthcare needs of our medical service area. The current Plan *(11/11/2015)* includes an analysis of PRMC's service area and specific recommendations regarding appropriate staffing levels in a variety of medical specialties. Peninsula Regional feels it is important to continually monitor specialties where a significant amount of patient care within the service area is provided by older physicians, as a sudden or unexpected loss of coverage could have an adverse effect on provision of medical services to the community. Succession planning and recruitment go hand-in-hand, as does socio-demographics and governmental initiatives all which must be considered to assess appropriate physician recruitment.

Key findings according to the most recent Medical Staff Development Plan indicate that certain specialties have very long wait times as indicated by the following table:

Specialty	Peer-Reported Wait Time
Dermatology (30 respondents)	133 days
Endocrinology (23 respondents)	74 days
Neurology (8 respondents)	50 days
Pulmonology (8 respondents)	54 days
Rheumatology (8 respondents)	56 days
Psychiatry (7 respondents)	41 days
Pain Management (6 respondents)	61 days

Current immediate recommendations include recruitment of 4 Primary Care Physicians to engage in chronic disease management as part of our Population Health Management mandate. Under the new payment methodology GBR (Global Budget Revenue) Peninsula

Regional is looking to expand its Primary Care Physician base in Salisbury and its surrounding communities. Other risks include succession of medical staff. Of the medical staff 32% is either at or above the age of 55. Recommendations for succession risk include:

- 10.3 primary care FTEs
- 30.1 medical specialty FTEs
- 19.7 surgical specialty FTEs

Medical specialty needs are driven by the overall market supply, wait times for new patient appointments, and call coverage and inpatient consultation needs. Current medical specialty recommendations include recruitment of the following physicians a recruiting for the following specialties due to community needs assessment, market demand and retirement; Allergy/immunology, Dermatology, Endocrinology, Infectious Disease, Neurology, OB/GYN, Pain Management, Psychiatry and Rheumatology.

As part of our strategy to bring a wide array of health services to local communities, Peninsula Regional recently opened up Delmarva Health Pavilion Ocean Pines this year to provide outpatient primary and specialty care in Worcester County. This ambulatory care complex is 20,000 square feet and will provide Family Medicine, Family Lab, Prescriptions, Cardiovascular and Pulmonary Rehabilitation with additional specialties to be added in the future. Peninsula Regional's continuing rural ambulatory strategy, assesses the need and viability for placing outpatient services via easy access for patients and their families. This is a continuation of Peninsula Regional's commitment to population health management and to offering services for the entire Delmarva Peninsula in locations that provide our communities exceptional healthcare options close to home.

A summary of specialty recommendations for ***community-wide*** need for physicians is included in the following Table.

Specialty	Evaluate for Potential Recruitment
Primary Care- Family Medicine	11
Primary Care- Internal Medicine	11
Primary Care- Pediatrics	3
Emergency Medicine	4
Allergy	1
Dermatology	1
Endocrinology	1
Infectious Disease	1
Neurology	1
OB/GYN	4
Pain Management	1
Psychiatry	4
Pulmonology	2
Rheumatology	1
Neurosurgery	1
ENT	1
Otolaryngology	1
Plastic Surgery	1
Urology	1
Vascular Surgery	1

Deficiencies and surpluses in the current supply of physicians were determined by reviewing physician-to-population ratios, physician patient volumes, population data, and other factors. Peninsula Regional has embarked on recommendations that succession planning discussions with physicians and recruitment of physicians in underserved specialties is important to serving the health care needs of a growing population.

VI. PHYSICIANS

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.

Peninsula Regional employs approximately 15 hospitalists – physicians whom specialize in the care of hospitalized patients to coordinate and provide a consistent level of quality inpatient care. Inpatients benefit from having dedicated physicians available onsite to care for them, and primary care physicians also value hospitalists who can act as "inpatient partners" for their patients. Besides improving quality and access, employing Hospitalists also effectively reduces local community physician office wait times especially in our medically underserved areas where it has been estimated that the region needs another **22** primary care physicians. Freeing up time for community based family practice and internal medicine physicians is critical as our population continues to age - providing more office time and extended hours as necessary.

Rural hospitals and communities are typically challenged in both recruitment and retention of physicians due to numerous factors. Some of these challenges are due to the location and geography of the area and availability of healthcare resources. Retaining and recruiting resources in sub-specialties can be hard for regional rural hospitals and Peninsula Regional Medical Center is no exception. To address specific community healthcare needs the Medical Center has had to recruit, retain, employ and subsidize some of the following sub-specialties; Pulmonary, Neuro-Hospitalist, Neurosurgery, Medical Oncology & Hematology, Gastroenterology, Pediatric Specialties, Endocrinology, Cardiology, Cardiovascular Surgery, and Pain Management . Rural communities lack the cultural and educational resources that larger urban centers provide making it harder to retain and recruit these physicians, the spouse/significant other and children. Low population patterns by geography make it more costly and harder for communities and businesses to provide various types of services especially specialty physician services. Overall our local economy

is not as robust as the urban centers as acknowledged by our low median income in the Tri-County area:

Wicomico $52,348
Worcester $62,956
Somerset $40,146
Compared to Maryland $77,385
Source: ESRI

Low median income, higher than average unemployment rates and many other factors puts rural communities at a disadvantage in providing some of these specialty healthcare services that metropolitan centers easily provide.

Exclusive contracting arrangements are common among the traditional hospital-based physician specialties and Peninsula Regional is no exception. The Medical Center is a regional ***rural*** hospital that serves three states and six counties. Serving a rural population of approximately 466,000 with a growing Medicare population (which is greater than Maryland and National average), physician recruitment is critical. In addition the Medical Center's primary service area has been identified as a Health Professional Shortage Area and a Medically Underserved Area by the Health Resources and Services Administration. Based upon our current "Medical Staff Needs Study," findings suggest evaluation for potential recruitment of an additional 112 physicians of varying specialties is needed to meet future demand.

As the only level III trauma center that serves the region and an emergency room with close to 90,000 visits annually, Peninsula Regional must have certain specialties on-call and exclusive contracts with provider groups to guarantee coverage and meet patient demand for these services. The regulatory requirements and benefits of having exclusive arrangements for a large rural tertiary hospital include some of the following:

- On-call Trauma Surgeon within 30 minutes of call
- On-call Anesthesiologists with CRNA who is in the hospital
- On-call Orthopedic Surgeon within 30 minutes of call

- On-call Neurosurgeon within 30 minutes of call
- Enhances providers' response time to critical care patients in a rural setting
- Assures competent coverage and availability of services
- Aids in supervision, administration, training and scheduling of coverage

The Medical Center's challenge as a large rural regional tertiary care provider has been to recruit and retain for underserved specialties, and to create comprehensive succession planning that supports the diverse medical needs of the region spread throughout a large geographical area.

Conclusion:

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

Appendix I

Peninsula Regional Medical Center
Policy/Procedure

Finance Division

Subject: Financial Assistance

Affected Areas: Patient Accounting, Financial Services

Policy/Procedure Number: FD-162

Policy:

Peninsula Regional Medical Center will provide free and reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their hospital bill. A patient's payment for reduced-cost care shall not exceed the charges minus the hospital mark-up.

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

Peninsula Regional Medical Center will provide reduced-cost medically necessary care to low-income patients with family income between 201% and 300% of the federal poverty level.

Peninsula Regional Medical Center will provide reduced-cost medically necessary care to low-income patients with family income between 301% and 500% of the federal poverty level who have a financial hardship, as defined by Maryland law.

Peninsula Regional Medical Center will make available interest free payment plans to uninsured patients whose income falls between 200% and 500% of the federal poverty guideline.

Procedure:

If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies. In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, Peninsula Regional Medical Center will provide care at reduced or zero cost.

When no third party assistance is available to cover the total bill and the patient indicates that they have insufficient funds, the following procedure will occur.

1) The Maryland State Uniform Financial Assistance Application should be reviewed by staff, in consultation with the patient, to make initial assessment of eligibility.

2) Compare patient's income to current Federal Poverty Guidelines (on file with Collection Coordinator). The Collection Coordinator will get new guidelines as published in the Federal Register annually. If patient is not eligible, stop here and pursue normal collection efforts.

3) If preliminarily eligible per Guidelines, send Maryland State Uniform Financial Assistance Application to patient/guarantor for completion and signature. Patient should attach appropriate documentation and return to representative within 10 days.

   Upon receipt of the financial assistance request, the Representative will review income and all documentation. The patient must be notified within two business days of their probable eligibility and informed that the final determination will be made once the completed form and all supporting documents are received, reviewed, and the information verified. Income information will be verified using the documentation provided by the patient and external resources when available.

   A financial assistance discount will be applied to the patient's responsibility in accordance with Attachment 1.

4) If ineligible, the Representative will notify the patient and resume normal dunning process and file denial with the account. The denials will be kept on file in the collection office. All denials will be reviewed by the Collection Coordinator level or above.

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

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

If one of the above three scenarios are applicable in the application, liquid assets may be considered including: checking and savings accounts, stocks, bonds, CD's, money market or any other accounts for the past three months along with the past year's tax return, and a credit report may be reviewed. The following assets are excluded:

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

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

5. Collection Coordinator will review documentation.

   a. If eligible, and under $2,500, the account will be written off to financial assistance and the "Request for Financial Assistance" form finalized. A copy is retained in the patient's file. The Representative will call the patient and notify him/her of the final determination of eligibility.

   b. If eligible, and the balance is $2,500 or above, the Collection Coordinator will obtain the appropriate adjustment signature(s) as defined in Policy FD-30 and continue as per 5.a.

6. Peninsula Regional Medical Center will review only those accounts where the patient or guarantor inquire about financial assistance, mails in an application, or in the normal working of the account there is indication that the patient may be eligible. Any patient/customer service representative, financial counselor, or collection representative may begin the request process.

   Pre-planned service may only be considered for financial assistance when the service is medically necessary. For example, no cosmetic surgery will be eligible.

   Inpatient, outpatient, emergency, and Peninsula Regional Medical Group physician charges are all eligible.

7. Special exceptions:

   a. Financial assistance will be considered if patient is over income criterion, but have a financial hardship. A financial hardship exists when the amount of medical debt at Peninsula Regional Medical Center exceeds 25% of the family's income in a year. Financial hardship cases must be reviewed by Manager, Patient Accounts level or higher.

   b. A patient that has qualified for Maryland Medical Assistance is deemed to automatically qualify for PRMC's Financial Assistance program. The amount due from a patient on these accounts may be written off to Financial Assistance with verification of Medicaid eligibility. Normal documentation requirements are waived for financial assistance granted upon the basis of Maryland Medical Assistance eligibility.

   c. Patients who are beneficiaries/recipients of certain means-tested social services programs administered by the State of Maryland are deemed to have presumptive eligibility for PRMC's Financial Assistance program. The amount due from a patient on these accounts may be written off to Financial Assistance with verification of eligibility for one of these programs. Normal documentation requirements are waived for financial assistance granted upon the basis of presumptive eligibility. It is the responsibility of patients to notify the hospital they are in a means tested program and provide the documentation.

8. Once a request has been approved, service three months before the approval and twelve months after the approval may be included in the adjustment. All encounters included with the application must reference the original encounter number where the electronic image of the application is stored. Service dates outside this fifteen month window may be included if approved by a Supervisor, Manager, or Director. Any amount exceeding $25 that has already been collected from the patient or guarantor for approved dates of service shall be refunded to the patient.

Note: This policy was formerly part of FD-030 established in 11/85. Name was changed from Charity Care 8/05.

Date: 6/03 Split into policies FD-030 & FD-162.
Reviewed: 7/86, 7/89, 7/91, 12/13
Revised: 9/88, 4/92, 6/93, 2/95, 8/97, 7/98, 9/99, 6/02, 6/03, 9/04, 4/05, 8/05, 8/07, 3/09, 4/10, 5/10, 10/10, 12/11, 12/12, 12/14

PENINSULA REGIONAL MEDICAL CENTER
Part of Peninsula Regional Health System

ADMINISTRATIVE POLICY MANUAL

Subject: Uncompensated Care / Financial Assistance

Effective Date:	August 1981
Approved by:	President/CEO
Responsible Parties:	Director of Patient Financial Services
Revised Date:	12/86, 6/88, 3/90, 3/91, 7/93, 7/94, 8/98, 12/05, 8/08, 5/10, 10/10, 12/14
Reviewed Date:	8/83, 12/85, 2/88, 6/92, 8/95, 7/96, 9/97, 6/00, 6/01, 10/02, 10/04, 12/11, 12/12, 12/13

POLICY

It is the intention of Peninsula Regional Medical Center to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render medically necessary care at zero cost for patients with income at or below 200% of the Federal Poverty Guideline and reduced cost for patients with income between 201% and 300% of the Federal Poverty Guideline. Financial assistance is considered for patients with income between 301% and 500% of the Federal Poverty Guideline that document a financial hardship as defined by Maryland law. If the patient is approved for Financial Assistance at the hospital, they may also be approved for Peninsula Regional Medical Group.

The Hospital will make available interest-free payment plans to uninsured patients whose income falls between 200% and 500% of the Federal Poverty Guideline.

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

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

ELIGIBILITY DETERMINATION PROCESS

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

PUBLIC NOTIFICATION

- An annual notice regarding financial assistance will be published in a local, widely circulated newspaper.
- Appropriate notices will be posted in patient registration, financial services, the emergency department, labor and delivery and on the PRMC website.
- Individual notice to patients and other persons regarding our financial assistance policy are available at community outreach events, prenatal services, pre-admission, and admission.
- Brochures are available in the outpatient registration area where the Financial Counselor is located.

ADMINISTRATION OF POLICY

Procedures are maintained in the Finance Division office related to the administration of the uncompensated care/financial assistance to patients' policy. Refer to Finance Division Policies FD-30, FD-53, FD-141, FD-162, and FD-167.

REFERENCE

Board of Trustees

Keywords
Financial Assistance
Federal Poverty Guidelines
Uncompensated
Charity Care

_____
Peggy Naleppa
President/CEO

Appendix II

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

Answer:

The hospital anticipated the community's needs for assistance in regards to navigating through the Health Care Coverage Expansion options. PRMC has coordinated with Wicomico County to have a Navigator and Assister on-site to aid patients or any community members that needs assistance or who may have questions.

Patients' Rights and Obligations

Rights:

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

Obligations:

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

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

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

BRO-086 (7/15)

Financial Assistance With Your Medical Bills

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

Financial Assistance Policy

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

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

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

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

Eligibility Determination Process

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

How To Apply

- Call 1-800-235-8640 between 9:00 a.m. and 4:00 p.m., Monday through Friday
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:30 a.m. and 4:30 p.m., Monday through Friday
- On the internet at www.peninsula.org. Click on Patients & Visitors then Billing Center and Billing Information

Qualifications

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

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

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

Need Assistance?

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

Medical Assistance Program

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

APPENDIX IV

THIS NOTICE REQUIRED BY MARYLAND LAW

Financial Assistance Policy

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

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

Physician charges are not included in the hospital bill and are billed separately. Physician charges are not covered by Peninsula Regional Medical Center's financial assistance policy.

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

Eligibility Determination Process

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

How To Apply

- Call 1-800-235-8640 between 9:00 a.m. and 4:00 p.m., Monday through Friday.
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:30 a.m. and 4:30 p.m., Monday through Friday
- On the internet at www.peninsula.org. Click on Patients & Visitors then Patient Financial Services and Billing Information

Qualifications

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

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

APPENDIX IV

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

Need Assistance?

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

Maryland Medical Assistance Program

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

Patients Rights and Obligations

Rights:

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

Obligations:

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

Cómo hacer la solicitud

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

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

MISSION

Improve the health of the communities we serve.

VALUES

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

VISION

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

Mission

Improve the health of the communities we serve.

Values

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

Vision

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

PENINSULA
REGIONAL HEALTH SYSTEM