COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2016 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

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

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

On January 10, 2014, the Center for Medicare and Medicaid Innovation (CMMI) announced its approval of Maryland's historic and groundbreaking proposal to modernize Maryland's all-payer hospital payment system. The model shifts from traditional fee-for-service (FFS) payment towards global budgets and ties growth in per capita hospital spending to growth in the state's overall economy. In addition to meeting aggressive quality targets, the Model requires the State to save at least $330 million in Medicare spending over the next five years. The HSCRC will monitor progress overtime by measuring quality, patient experience, and cost. In addition, measures of overall population health from the State Health Improvement Process (SHIP) measures will also be monitored (see Attachment A).

To succeed in this new environment, hospital organizations will need to work in collaboration with other hospital and community based organizations to increase the impact of their efforts in the communities they serve. It is essential that hospital organizations work with community partners to identify and agree upon the top priority areas, and establish common outcome measures to evaluate the impact of these collaborative initiatives. Alignment of the community benefit operations, activities, and investments with these larger delivery reform efforts such as the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system.

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), the IRS defines a CHNA as a:

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

The written document (CHNA), as provided in the ACA, must include the following:

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

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

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions (LHICs) schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input, who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

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

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

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

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(3) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(4) Local Health Departments;
(5) County Health Rankings (http://www.countyhealthrankings.org);
(6) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(7) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(8) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(9) CDC Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);

(10) CDC Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/)
(16) CRISP Reporting Services

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

The IMPLEMENTATION STRATEGY, as provided in the ACA, must:

a. Be approved by an authorized governing body of the hospital organization;
b. Describe how the hospital facility plans to meet the health need, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and
c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

HSCRC Community Benefit Reporting Requirements

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).
    a. Bed Designation – The number of licensed Beds;
    b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
    c. Primary Service Area Zip Codes;
    d. List all other Maryland hospitals sharing your primary service area;

e. The percentage of the hospital's uninsured patients by county. (please provide the source for this data, i.e. review of hospital discharge data);
f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data, i.e. review of hospital discharge data, etc.).
g. The percentage of the Hospital's patients who are Medicare Beneficiaries. (Please provide the source for this data, i.e. review of hospital discharge data, etc.)

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area Zip Codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of Hospital's Uninsured Patients,:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
48 licensed beds FY16	3,360	21811 21813 21841 21842 21843 21862 21872 21784	McCready Memorial Hospital Peninsula Regional Medical Center	Worcester County Self-pay 2,234 patients (Data: Review of AGH patient vol) 16.4% Adults lack health insurance in Worcester County 6.0% Children lack health insurance in Worcester County (Data: Health Community Institute)	77.05% Worcester County Maryland Medicaid (does not include MD Medicaid MCO vol) (Data: Review of AGH patient vol)	71.80% Worcester County Maryland Medicare (does not include MD Medicare MCO vol) (Data: Review of AGH pt vol)

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

a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):

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

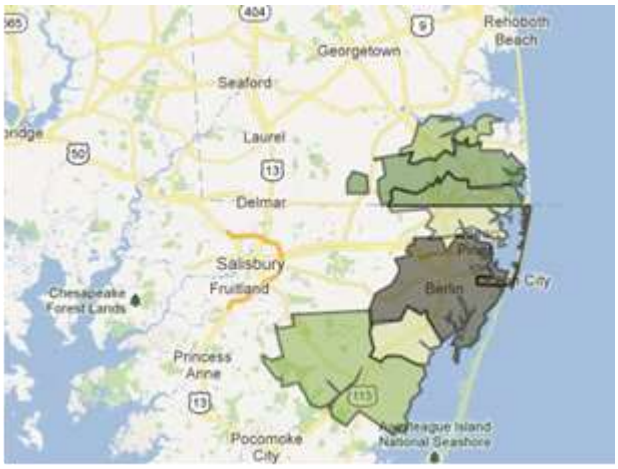
(ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations reside.

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

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/). the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014)(http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf), The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)
Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)

Table II

Demographic Characteristic	Description	Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	Zip codes in CBSA, including broader community who benefit from AGH services and programs: 21811 Berlin, MD – Worcester County 21842 Ocean City, MD- Worcester County 21843 Ocean City, MD- Worcester County 19975 Selbyville, DE- Sussex County 21813 Bishopville, MD- Worcester County 21863 Snow Hill, MD- Worcester County 19945 Frankford, DE- Sussex County 19939 Dagsboro, DE- Sussex County 21851 Pocomoke, MD- Worcester County 19970 Ocean View, DE- Sussex County 21850 Pittsville, MD-Wicomico County 21874 Willards, MD- Worcester County 21841Newark, MD- Worcester County 21872 Whaleyville, MD- Worcester County 21801 Salisbury, MD- Wicomico County 19966 Millsboro, DE- Sussex County 21804 Salisbury, MD- Wicomico County 19930 Bethany Beach, DE- Sussex County 21829 Girdletree, MD- Worcester County 19944 Fenwick Island, DE- Sussex County 21849 Parsonsburg, MD- Wicomico County 21862 Showell, MD- Worcester County 23356 Greenbackville, VA- Accomack County 21864 Stockton, MD- Worcester County 23336 Chincoteague Island, VA- Accomack County	AGH CBSA Primary/Secondary Market Areas
	Atlantic General Hospital's primary service area is defined as those zip codes that total 90% of patient admissions, emergency or outpatient visits from the residents and/or there is a contiguous geographic relationship. Worcester and Sussex County are rural and underserved area. There is a lack of public transportation making geographic location a factor in defining primary market.	AGH CHNA FY16
	CBSA zip codes within Worcester and Sussex County geographical area in which there is an interdependence and belonging: 19939 Dagsboro, DE – Sussex County 19945 Frankford, DE– Sussex County 19975 Selbyville, DE– Sussex County 21811 Berlin, MD – Worcester County 21813 Bishopville, MD -Worcester County 21841Newark, MD– Worcester County 21842 Ocean City, MD– Worcester County	AGH CHNA FY16

	21843 Ocean City, MD– Worcester County 21862Showell, MD– Worcester County 21872Whaleyville, MD– Worcester County 21874 Willards, MD– Worcester County  	AGH CHNA FY16
	Worcester County is the easternmost county located in the U.S. State of Maryland. The county contains the entire length on the state's Atlantic coastline. It is the home to the popular vacation resort area of Ocean City. The county is approximately 60 miles long. According to the U.S. Census Bureau the county has a total area of 695 square miles which 468.28 square miles of it is land and 221 square miles is water. Nearly one fourth of the Worcester County residents are over age 65. Our majority of health care claims are Medicare (more than 55%). The over 65 aged population of the county grew 27% between 2000 and 2010. The largest concentration of the population is in the northern part of the county where the Ocean City resort area is located along with the Berlin/Ocean Pines area. This is a Mecca for retirees, many who divide their time between Maryland and Florida. The population of the resort of Ocean City increases by about 200,000 during the tourist season. Even though there is this area of higher population the entire county is considered rural and is determined to an "underserved" area for healthcare. The needs in the county vary greatly in the southern end from the northern end. Because the largest concentration of the population is in the north that is where the majority of the services are located and public transportation throughout the county is less than adequate. The Community Health Needs Assessment FY16 is a primary tool used by the Hospital to determine its community benefit priorities, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates	AGH CHNA FY16 US Census Bureau AGH CHNA FY16 US Census Bureau AGH CHNA FY16 www.atlanticgeneral

	components of primary data collection and secondary data analysis that focus on the health and social needs of our service area. The process for determining the priorities of the Community Outreach programs involves many people inside and outside the organization. The hospital's strategic initiatives are determined by the Hospital Board of Trustees, the Medical Staff and the Leadership of the hospital. Each year those long term initiatives are evaluated and updated with environmental information, such as the most recent Community Needs Assessment. In addition to input from those groups there are two committees that have a part in setting our priorities; they are the Community Benefit Committee and the Healthy Happenings Advisory Board. Vulnerable Populations and Disparities: A closer look at health disparities in the area through the new Healthy Communities tool, which synthesizes data from several primary sources, provides a clear visual representation of many of the strengths and weakness evident in Worcester and Sussex Counties. In Sussex County: Prostate Cancer – Majority Black Male • Prostate Cancer Incidence by Race/Ethnicity: 214.4 Black male cases /100,000 males compared to 135.8 White male cases /100,000 males • Age Adjusted Death Rate due to Prostate Cancer by Race/Ethnicity 48.0 Black male cases /100,000 males compared to 19.0 White male cases /100,000 males Breast Cancer – Majority Black Female • Age Adjusted Death Rate due to Breast Cancer by Race/Ethnicity 28.0 Black female deaths/100,000 females compared to 19.6 White female deaths/100,000 females Lung and Bronchus Cancer – Majority Males • Lung and Bronchus Cancer Incidence by Gender 68.0 female cases /100,000 population compared to 84.9 male cases/100,000 population Teens who engage in Regular Physical Activity - Majority Males • 60.4% males compared to 39.8% females In Worcester County: Adults Unable to Afford to See a Doctor - Majority Black • 23.3% Black compared to 15.5% White Lung Cancer – Majority Black • Age-Adjusted Death Rate due to Lung Cancer by Race/Ethnicity 73.8 Black male deaths /100,000 population compared to	.org AGH CHNA FY16

	57.6 White deaths /100,000 population Colorectal Cancer – Majority Black Male • Colorectal Cancer Incidence Rate by Gender 46.5 male cases/100,000 population compared to 27.4 female cases/100,000 population • Colorectal Cancer Incidence Rate by Race/Ethnicity 40.5 Black cases/ 100,000 population compared to 33.2 White cases/100,000 population Lung and Bronchus Cancer –Majority Black Males • Lung and Bronchus Cancer Incidence by Gender 59.5 female cases /100,000 population compared to 90.5 male cases/100,000 population • Lung and Bronchus Cancer Incidence Rate by Race/Ethnicity 88.7 Black cases/ 100,000 population compared to 68.5 White cases/100,000 population Prostate Cancer – Majority Black Male • Prostate Cancer Incidence by Race/Ethnicity 302.3 Black male cases /100,000 males compared to 139.6 White male cases /100,000 males	
Median Household Income within the CBSA	Worcester County, MD $60,834 Sussex County, DE $53,752	Statistics available through Healthy Communities Institute on www.atlanticgeneral.org
Percentage of households with incomes below the federal poverty guidelines within the CBSA	2016 Families Below Poverty Level Worcester County, MD 1,067 (7.31%) Sussex County, DE 5,774 (9.80%) 2016 Families Below Poverty Level with Children Worcester County, MD 663 (4.54%) Sussex County, DE 4,336 (7.36%)	Statistics available through Healthy Communities Institute on www.atlanticgeneral.org
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryla	Adults with Health Insurance Worcester County, MD 83.60% Sussex County, DE 83.10% Children with Health Insurance Worcester County, MD 93.60% Sussex County, DE 93.80%	Statistics available through Healthy Communities Institute on www.atlanticgeneral.org

nd.gov/msdc/American_Community_Survey/2009ACS.shtml				
Percentage of Medicaid recipients by County within the CBSA.	Worcester County, MD 13.00% Sussex County, DE 22.60%			Statistics available through Healthy Communities Institute on www.atlanticgeneral.org
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	Life Expectancy Males Females All Races White Black	Worcester County, MD 76.3 81.4 80.0 80.5 75.8	Sussex County, DE 75.7 80.6 77.0	Statistics available through Healthy Communities Institute on www.atlanticgeneral.org http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf DE vital statistics
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Mortality Rates	Worcester County, MD 599 (actual) deaths in Worcester County White - 510 Black – 86 Hispanic – 1 Asian - 1	Sussex County, DE Sussex County – (adjusted rate of deaths per 100,000 population) 687.6 - overall 872.6 - White male 639.7 – White females 1057.8 – Black males 682.6 – Black females	Worcester County Vital Stats (2014) http://dhmh.maryland.gov/vsa/Pages/reports.aspx Sources: vital stats, Worcester and Sussex County Sites

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		Worcester County, MD	Sussex County, DE	Data Source:
	Food Insecurity Index	8%	8.30%	County Health Rankings
	Households Without a Vehicle	6.10%	4.20%	American Community Survey
	Annual Ozone Air Quality (2010 last measurement)	4 or D rating	5 or F rating	American Lung Association
	Severe Housing Problem	15.90%	16.10%	County Health Rankings
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		Worcester County, MD	Sussex County, DE	Data Source:
	Race			Statistics available through Healthy Communities Institute on www.atlanticgeneral.org
	2016 Population	51,769	216,486	
	White	42,024	169,252	
	Black/Af Amer	7,159	26,855	
	Am Ind/AK Native	143	1,817	
	Asian	729	2,582	
	Native HI/PI	13	179	
	Some Other Race	699	10,183	
	2+ Races	1,002	5,618	
	Language			
	Speak only English at Home	89.24%	93.31%	Claritas, updated January 2016
	Speak Spanish at Home	7.70%	2.74%	
	Speak Asian/PI Lang at Home	0.77%	0.38%	
	Speak Indo-European Lang at Home	2.20%	3.28%	

	Speak Other Lang at Home	0.09%	0.29%	
Other	Population per Physician in the CBSA: 3500:1 – Worcester County 2060:1 – Somerset County 1870:1 – Wicomico County 1165:1 – Sussex County			

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?

   __X__ Yes
   ____ No

   Provide date here. 05/05 /16_ (mm/dd/yy)

   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).
   http://www.atlanticgeneral.org/documents/Community-Needs-Assessment-FY2016-BOD-apprvd-live-links.pdf

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 3?

   _X_ Yes (mm/dd/yy) Enter date approved by governing body here: _10/04/16
   ___No

   If you answered yes to this question, provide the link to the document here.
   http://www.atlanticgeneral.org/documents/Implementation-Plan-CHNA-2016-18.pdf

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. Are Community Benefits planning and investments part of your hospital's internal 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 a large part of the planning of the hospital's strategic plan. As we become more focused on population health management, we realize that the hospital's job starts way before someone darkens the doors of our facilities. The key is to coordinate care for our patients by doing all the "Right" things. That is why our strategic plans involve the "Right Principles: Right Care, Right People, Right Place, Right Partners and Right Hospital".

Population Health: Community Education and Health Literacy are one of the key initiatives in the strategic plan. These two things make up a large portion of our Community Benefit contribution. This graphic helps to explain our strategic plan that began in FY15.

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 ✓
2. _X__CFO
3. _X__Other (please specify)

These positions make up our Senior Leadership Team.

VP, Public Relations and Marketing✓
VP, Medical Staff Services
VP, Quality
VP, Planning and Operations
VP, Professional Services
VP, Information Services
VP, Patient Care Services

Hospital Board of Trustees ✓

Describe the role of Senior Leadership.
The role of the Senior Leadership team is to guide the operations of the organization: to develop the strategic plan, to set the annual organizational goals, which ultimately guides the community benefit initiatives. In July through November FY16 the Community Education Manager reported to the VP of Public Relations and those department goals are a reflection of the organizational goals and Strategic Plan. With the hiring of the Population Health Manager in December FY16, the Community Education Department was renamed the Population Health Department and began reporting to the CEO and Executive Care Coordination

Team throughout the remainder of FY16. Departmental goals continued to reflect the organizational goals and strategic plan.

ii. Clinical Leadership

1. _X_ Physician
2. _X_ Nurse
3. _X_ Social Worker
4. _X_ Other (please specify)
   Information Technology
   Nursing
   Patient Care Management
   Emergency Department
   Patient Centered Medical Home
   AGHS
   Behavioral Health Services
   Laboratory
   Endoscopy Center
   Women's Diagnostic Center
   Imaging
   Cancer Care Services
   Surgical Services
   Medical Staff Services
   Medical Information
   Supportive Care Services

Describe the role of Clinical Leadership
Clinical leadership is involved in the Strategic Planning each year. It is through their input that goals and directions are set for the organization. It is through the support of these teams (and course set by the goals) that Community Benefits are accomplished. Each department plays an active role in the process and implementation of the Community benefit goals each year.

iii. Population Health Leadership and Staff

1. ___ Population health VP or equivalent (please list)
2. _X_ Other population health staff (please list staff)

   Other population health staff

   Population Health Manager and Executive Care Coordination Team

Describe the role of population health leaders and staff in the community benefit process.

With the hiring of the Population Health Manager in December FY16, the Community Education Department was renamed the Population Health Department and began reporting to the CEO and Executive Care Coordination Team throughout the remainder of FY16. The Executive Care Coordination Team consists of the Population Health Manager, CEO, CMO, Director of Clinical Operations and Director of AGHS Patient Centered Medical Home. The population health team

plays an active role in the care coordination process and implementation of the organizational goals, strategic plan, and community benefit goals. The team meets twice monthly.

iv. Community Benefit Operations

1. ___Individual (please specify FTE)
2. _X_Committee (please list members)
3. _X_Department (please list staff)
4. ___Task Force (please list members)
5. ___Other (please describe)

Community Benefit Committee

Althea Foreman
Andi West-McCabe
Betty Mitchell
Blanca Adams
Bonnie Mannion
Bonnie Sybert
Brooke Williams
Bruce Todd
Christine Brown
Chuck Gizara
Conni collins
Crystal Mumford
Darlene Jameson
Dawn Denton
Deborah Wolf
Denise Esham
Donna M. Nordstrom
Eileen Haffner
Elizabeth Mueller
Erin Cowder
Gail Mansell
Geri Rosol
Ingrid Cathell
Jane King
Janet Smith
Jill Todd
Kay Rentschler
Kim Chew
kristen Messick
Laurie A. Gutberlet
Leslie Clark

Linda Dryden
Linda Walter
Lisa Iszard
Lou Brecht
Lynne Snyder
Maria Phillips
Michealann Frate
Michele S. Clauser
Michelle Clifton
Nancy Helgeson
Nicole House-Blanc
Nicole Morris
Patti Yocubik
Patty Tull
Scott Rose
Sissy Mumford
Stefanie Morris
Stephanie Banks
Sue Donaldson
Sue Foskey

Tammy Simington
Terry Moore
Toni Keiser
Vinnie Caimi
William Boothe

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

Population Health Manager – Community Benefit oversight; Community Education, Outreach Providers and Health Literacy Liaison department management ; CB Committee Chair

Population Health Clinical Assistant – performs CBISA data base reporting

Outreach Providers – teach workshops, provide first aid and perform many health screenings in the community

Community Benefit Committee – The reporters for each department- responsible for the data input for their department regarding Community Benefits. They meet quarterly and set annual goals for Community Benefits which stem from the organizational goals and the strategic plan. The meet quarterly to monitor the hospital's community benefits and to modify and plan accordingly to ensure goals are met.

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?)

The audit is done quarterly by the Community Benefit Committee, Leadership Team, Senior Leadership and the Hospital Board of Trustees. The Community Benefit Committee and the Population Health Manager sign off on the reporting.

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.

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)

Organization	Name of Key Collaborator	Title	Collaboration Description

AGH Foundation Board of Directors	Todd Ferrante	Board Member	Promotes the philanthropic support for the enhancement of the health of our community. We will achieve this mission through supporting the objectives of Atlantic General Hospital and Health System to continually improve the health of our residents and visitors to Maryland's lower Eastern Shore.
AGH Junior Auxiliary Group	Jill Ferrante	Auxiliary Member	Promotes the welfare of the hospital by fostering good public relations, providing service to the hospital, organizing health related projects and spearheading fund raising activities
American Cancer Society Tri-County Leadership Committee	Arlene Schneider	Regional Representative, Committee Leader	Nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem. The Tri County Leadership Committee is the overseeing body for all of the ACS

			initiatives in Worcester, Wicomico and Somerset County.
Bethany/Fenwick Chamber of Commerce Board of Directors	Richard Mais	Board Member	Provides oversight and guidance to the Executive Director in carrying out Chamber business.
Big Brothers Big Sisters	Kristie Maravalli	Area Coordinator	National organization which matches boys and girls with mentors.
Blood Bank of Delmarva	Roy Roper Suzanne Murray	President/CEO Chapter Leader	Promote blood donation and lifesaving activities.
Cricket Center Board	Wendy Meyer Beau Oglesby Andi West-McCabe Althea Foreman	Advocacy Board Member State's Attorney ED Director ED Manager	Advocate for the care of children that have been physically or sexually abused. Look at processes, use of our forensic nurses and the team, partnering for their care and seeking prosecution for the acts.
CRT Advisory Board	Monica Martin	Supervisor Mobile Crisis Response Team	Address the care of our behavioral health patients and getting them to another level of care. Ex inpatient psych, alcohol rehab, etc…

Worcester County Local Emergency Planning Committee	Fred Webster	Emergency Services Director	
Ocean City Local Emergency Planning Committee	Bob Rhode	OC Emergency Services	
Delmarva Regional Health Mutual Aid Group (DRHMAG)	Kristen McMenamin	Worcester County Emergency Services	
DMV Youth Council Several	Several		Provide expertise in youth policy and assist the local board in developing and recommending local youth employment and training policy and practice. The Youth Council also endeavors to broaden the youth employment and training focus in a community and to incorporate a youth development perspective.
Domestic Violence Fatality Review Board	Several		Explores reasons/cause for domestic violence and tries to see if there are resources that are available to stop future crimes against victims of domestic violence.

EMS Advisory Board	Andi West-McCabe, Dr. Jeff Greenwood, Alana Long (ED), Colleen Wareing Chuck Barton Dr. Jeff Greenwood	EMS Advisory Board	Meets with all the EMS companies from DE, MD, and VA to ensure ambulance patients are appropriate to be cared for here and address any concerns.
ENCARE	Kathy Cioccio	Staff nurse at AGH and ENCARE rep	Emergency health care professionals that provide education to communities about injury prevention.
Faith Based Coalition	Gail Mansell	Chair	A group of community members from various places of worship in our area who meet to plan programming to meet health needs.
Greater Salisbury Committee	Mike Dunn	Executive Director	A non-profit association of business leaders on the Delmarva peninsula, who work together to improve the communities in which we live.
Greater Ocean City Chamber of Commerce Board of Directors, Legislative, Scholarship and Special Events Committees	Several		Provide community leadership in the promotion and support of economic development and

			the continued growth of tourism in Ocean City. The Chamber serves as the hub for the development, education and communication within the business community of Ocean City to preserve the viability, quality of life and aesthetic values of our town.
Habitat for Humanity		Volunteer	Local volunteer group which builds houses for those in need
Healthcare Provider Council in DE	Anna Short	Clinic Coordinator Sussex County Health Department	Regional group of healthcare providers who work in collaboration with one another to provide needed services throughout the area
Healthy Weight Coalition	Several		A sub-committee of the Maryland SHIP (state health improvement plan) which is working on the promoting programs which challenge healthy weight for everyone in our area.

Komen MD Coalition for Eastern Shore	Lori Yates	Regional Representative	Group of community members and health agencies which looks at breast cancer services and gaps in the area and works to fill gaps and promote programming
Lower Shore Red Cross			Provides disaster relief. The board plans events in collaboration with other agencies to meet the needs in our area.
March of Dimes	Jessica Hales	Area Executive Director	Supports local initiatives by education and financial contributions to prenatal and premature births
Maryland eCare	Michael Franklin	Chair	The Limited Liability Corporation (LLC) comprised of 7 hospitals/health systems in Maryland for the purposes of contracting for and managing telemedicine ICU physician services for Maryland hospitals. I serve on the Board of Directors, and

			AGH is a member of the LLC.
Maryland Hospital Association Community Connections Advisory Board	Toni Keiser	Board Member	The mission of this committee is to Help small, rural and independent hospitals and health systems to better communicate and serve their communities by providing them leadership, advocacy, education, and innovative programs and services.
Maryland Society for Healthcare Strategy and Market Development	Shannon Martin	President	The mission of the Maryland Chapter of the Society for Healthcare Strategy and Market Development is to provide healthcare planning, marketing, and communications professionals with the most highly valued resources for professional development.
Ocean City Drug and Alcohol Abuse and Prevention Committee	Toni Keiser	Committee Member	In 1989, then Governor William Donald Schaefer asked the Mayor of Ocean City, Roland Powell, to

			set up a committee to fight the abuse of alcohol and other drugs in our community. Thus, was born the Ocean City Drug Alcohol Abuse Prevention Committee Inc. that works in a partnership with state and local government agencies, as well as many businesses and concerned citizens. Currently the committee is comprised of members from the Town of Ocean City including elected officials and town employees from the Town of Ocean City Police Department and Ocean City Recreation & Parks Department, Worcester County Health Department and Department of Juvenile Services personnel, local school administrators, and teachers, volunteers from community service organizations, and

			many caring and concerned citizens
Ocean Pines Chamber of Commerce Board of Directors	Ginger Fleming Amy Unger	Director President	Provides oversight and guidance to the Executive Director in carrying out Chamber business.
Opioid Task Force	Beau Olgesby	State's Attorney	– looking a t use, trends and prevention in the community
Parkside Technical High School Board	Tracy Hunter	Teacher	Oversees from the community healthcare perspective the CNA and GNA program at the technical high school.
Play it Safe Committee	Toni Keiser	Committee Member	THE MISSION OF PLAY IT SAFE is to encourage high school graduates to make informed, healthy choices while having responsible fun without the use of alcohol and other drugs
Relay For Life	Debbie White	Area Coordinator	American Cancer Society group with raises money, awareness and educates the public on cancers
Retired Nurses of Ocean Pines	Joyce Brittan	Volunteer Coordinator	Help with volunteer projects

			and give feedback for programming in the healthcare field.
Resource Coordination Committee	Phyllis Burton, RN	Administrative Care Coordination, Care Coordination and Ombudsman Program.	
SAFE SART	Althea Foreman	Clinical Manager, ED, AGH	SAFE -Sexual Assault Forensic Examiners – Meetings of the certified RNs and standardizing care for domestic violence, elder abuse, play it safe, lethality assessment, etc. SART, Same as SAFE except it involves all the agencies from Worcester County including Social Services, Patient Advocates, Law Enforcement, States' Attorney, etc
Save a Leg, Save a Life	Geri Rosol, Director Atlantic General Wound Center	Local Representative	A grass roots organization founded in Jacksonville, Florida. There are approximately 45 SALSAL chapters in the U.S., Latin America, and overseas. The immediate goal is a 25% reduction in

			lower extremity amputations in communities where SALSAL Chapters are established. Currently the Eastern Shore Chapter spans from Dover, DE – Easton, MD – Salisbury, MD – Berlin, MD
State Advisory Council on Quality Care at the End of Life	Gail Mansell, Chaplain, AGH	Local Representative	Discuss quality initiatives for quality palliative medicine and end of life services that may result in legislative actions for the state of Maryland.
Suicide Awareness Board	Brittany Hines	Worcester County Health Department	Community members working together to raise awareness and prevention of suicides
Tobacco and Cancer Coalition – Worcester County	Mimi Dean	Director Worcester County Health Department Prevention Office	Sharing group of partners from different agencies and community members looking at measures, outcomes and prevention of cancers in the area.

Tri County Diabetes Alliance	Mimi Dean Dawn Wells	Co-chair Co-chair	Collaborative group from Worcester, Wicomico and Somerset County who plan collaborative programming to educate, treat and prevent diabetes.
Tri County Health Planning Council	Kim Justice	Member – representative from AGH	To improve the health of residents of Somerset, Wicomico and Worcester counties; increase accessibility, continuity, availability of quality of health services; optimize cost-effectiveness of providing health services and prevent unnecessary duplication of health resources.
The Tri-County Board	Colleen Wareing	Member – representative from AGH	Provides input into the development of statewide health planning documents and uses the State Health Improvement Plan (SHIP) and individual county community health assessments and health improvement

			plans to identify the Tri-County Health Improvement Plan (T-CHIP).
Tri county SHIP	Kim Justice	Member – representative from AGH	Serve to lend support, guidance, planning, collaboration on the State Health Improvement programs
United Way	Kathleen Momme'	Local Director	An organization that provides funding for non-profit groups in the local community. Through this board many community needs are identified and partnerships are formed to meet the needs.
Visions (Health Happening) Board, Hospital and Community members	Donna Nordstrom	Chair	who plan and implement health education in the community.
Worcester County Board of Education	Robert Rosenthal	Board President	Oversees the public education in Worcester County.
Worcester County Drug and Alcohol Board Community	Colleen Wareing	Member – representative from AGH	partners working together to oversee the safe use of alcohol and tobacco in the community by planning

			awareness/ educational events and compliance checks for the merchants
Worcester County School Health Council.	Dr. Aaron Dale	Supervisor of Student Services	The purpose of this Council will be to act as an advisory body to the Worcester County Board of Education in the development and maintenance of effective and comprehensive health programs which afford maximum health benefits to students enrolled in Worcester County Public Schools. Recognizing that citizen participation is inherent in the development and maintenance of an effective comprehensive health program, the Council will broadly represent the views of Worcester County citizens

Worcester County Health Department Regional Planning Board	Debbie Goeller	Worcester County Health Department, Health Officer	Community entities work with the Worcester County Health Department to plan and implement needed initiatives in the area. Some are prevention, education, health promotion and healthy living activities
Worcester County Health and Medical Emergency Preparedness Committee			to prepare for emergency situation responses and to protect the health of the community.
Worcester County Crisis Response Team	Monica Martin	Supervisor Mobile Crisis Response Team	The Crisis response team is a crisis intervention team composed of psychiatric social workers and other team members that respond to mental health crisis/issues of patients within the Worcester County area. Their goal is diversion of patients from the Emergency Department and act as a link to community mental health resources
Worcester GOLD: Giving Other Lives Dignity	Claire Otterbein	Director	A non -profit organization that provides

			assistance to community members of all ages such as school supplies, utilities assistance, summer camp sponsor for children, Christmas support to families, replacement of a roof, rainbow room; children's clothing & food supplies. All families or person (s) are screened by Social Services Department of Worcester County
Child Fatality Review Team	Dr. Andrea Mathias	Medical Director, Worcester Co HD	A team that reviews cases in Worcester County.
Drug Overdose Fatality Review Team	Dr Andrea Mathias Doug Dodd	Medical Director, Worcester Co HD	A team that reviews cases in Worcester County.
National Alliance for Mental Illness (NAMI) Lower Shore	Carole Spurrier	Local Representative	A grassroots organization dedicated to advocacy, education and support for persons with mental illness, their families, and the wider community.

Lower Shore Critical Incident Crisis Management	Gail Mansell	Committee Member	CISM is a method of helping first responders and others who have been involved with events that leave them emotionally and/or physically affected by those incidents. CISM is a process that enables peers to help their peers understand problems that might occur after an event. This process also helps people prepare to continue to perform their services or in some cases return to a normal lifestyle.
Hudson Health Services	Leslie Brown, BS	President & Chief Executive Officer	offers inpatient treatment for Substance Use Disorders in Salisbury, Maryland, as well as Halfway and Recovery Housing in Maryland
Worcester County Warriors Against Opioid Use	Heidi McNeely	Director of committee	To provide support and education about opioid use to the community

Focus groups through our Chronic Disease Workshops

Living Well –
Jan. 2014 – Indian River Senior Center, Millsboro, DE
Jan 2015, North Worcester Senior Center, Berlin, MD
April 2015, Ocean Pines Community Center, Berlin, MD
June 2015, Captains Cove, Greenbackville, VA

Stepping On Falls Workshop –
July 2014, Atlantic Health Center, Berlin, MD
September 2014, Indian River Senior Center, Millsboro, DE
March 2015, Worcester County Parks and Rec, Snow Hill, MD
June 2015, Pocomoke Senior Center, Pocomoke, MD

Diabetes Workshop –
July 2014, The Park, Berlin, MD
October 2014, Worcester Youth and Family Counseling Center, Berlin, MD
March 2015, Indian River Senior Center, Millsboro, DE
July 2015, North Worcester Senior Center, Berlin, MD
October 2015, Snow Hill Senior Center, Snow Hill, MD
October 2015, Ocean City Senior Center, Ocean City, MD
November 2015, Pocomoke Senior Center, Pocomoke, MD

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

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 links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/)
(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? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)

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.

   Identified Needs Not Met:

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

Needs Not Addressed In Plan	Rationale
Dental/Oral Health	-Need addressed by Worcester County Health Department's Dental Services for pregnant women and children less than 21 years of age -Priority Area Worcester CHIP -Need addressed by Lower Shore Dental Task Force & Mission of Mercy for adult population -Need addressed by AGH ED referral to community resources -Need addressed by La Red Sussex County -Need addressed by TLC, a federally funded dental clinic for Somerset and Wicomico Counties
Injury & Violence	-Need addressed by Worcester County Health Department Programs: Child Passenger Safety Seats Injury Prevention Highway Safety Program Safe Routes to School -Need addressed by Worcester County Sheriff's Department, State Police and Municipal Law Enforcement Agencies -Need addressed by AGH Health Literacy Program
Immunizations & Infectious	-Need addressed by Worcester County Health Department Programs: Immunization Program Communicable Disease -Priority Area Worcester CHIP -Need addressed by DHMH World Hepatitis Day
HIV & STD (<2% ea)	-Need addressed by Worcester County Health Department Communicable Disease Programs
Alcohol	-Need addressed by Worcester County Health Department Behavioral Health and Prevention Services Addictions Program -Need addressed by local AA organization -Need addressed by Drug and Alcohol Council

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)

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

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.

Because of the rural area we serve and because of the demographics of our population we are considered an underserved area and there are physician gaps in all specialty areas. We are always in the recruitment mode for specialties; some which are more of a priority than others because of demonstrated need.
The number one determined specialty gap in services in our county is mental health providers. There is one full time psychiatrist for the nearly 50,000 residents. Because many of those, in need of mental health services, end up in the emergency department at the hospital it is a drain on the system. We continue to develop out Mental Health team and continue to utilize telemedicine collaboration with Shepard Pratt Hospital and other providers in the Baltimore area.
Another gap in specialty physicians is endocrinology. The diabetes rate in Worcester County is higher than the national rate. In this area, there are two endocrinology practices and neither is located in this county. This puts a large burden on the primary care doctors, and diabetes programs to educate and manage diabetic patients. Because of lack of services many residents must go outside of the eastern shore area for diabetic care and many go untreated or minimally managed. There is a Tri County Diabetes Alliance that we are part of that through their web site and community activities provides screenings and education for diabetes. There are several Diabetes Education programs in the area, including the program at AGH. We also have a Diabetes community education program using the Stanford Chronic Disease Diabetes curriculum. We continue to recruit for this specialty to add to our AGHS staff of physicians.
Dermatology continues to be a specialty gap for us; however we have hired another full time provider.
AGHS has hired a Pediatrician, a Urologist/gynecologist, and Oncologist in FY15. AGHS hired a Dermatologist and Gynecologist in FY16.

Population per Physician in the
CBSA:
3500:1 – Worcester County
2060:1 – Somerset County
1870:1 – Wicomico County
1165:1 – Sussex County

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.

Our Physician Subsidies listed in Category "C" are losses of 6,034,925 associated with Hospital-based physicians with whom the hospital has an exclusive contract. Included in that figure is 91,364 spent on physician recruitment. Our area is deemed an underserved area for primary care providers and specialty providers. It is listed as one of the top three reasons for not seeking medical care in our area. See the question above to see the ratio of population to provider in our service areas.

3. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to 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.

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	
Non-Resident House Staff and Hospitalists	
Coverage of Emergency Department Call	
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VII. APPENDICES

To Be Attached as Appendices:

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

For ***example***, state whether the hospital:

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
    - in a culturally sensitive manner,
    - at a reading comprehension level appropriate to the CBSA's population, and

        - in non-English languages that are prevalent in the CBSA.
    - posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
    - provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
    - provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
    - includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
    - besides English, in what language(s) is the Patient Information sheet available;
    - discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).
c. Include a copy of your hospital's FAP (label appendix III).
d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

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


ATLANTIC
GENERAL HOSPITAL
care.givers
VISION
To be the leader in caring for people and advancing health for the residents of and visitors to our community.
MISSION
To create a coordinated care delivery system that will provide access to quality care, personalized service and education to improve individual and community health.
VALUES
(Keeping "PATIENTS" at the Center of our Values)
P Patient safety first
A Accountability for financial resources
T Trust, respect & kindness
I Integrity, honesty & dignity
E Education – continued learning & improvement
N Needs of our community – Participation & community commitment
T Teamwork, partnership & communication
S Service & personalized attention
These values are honored in all we do for our patients, visitors, medical staff, associates, partners and volunteers.
ETHICAL COMMITMENT
To conduct ourselves in an ethical manner that emphasizes community service and justifies the public trust.
QUALITY STATEMENT
We deliver care that is accessible, safe, appropriate, coordinated, effective, and centered on the needs of individuals within a system that demonstrates continual improvement.

Attachment A

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) SELECT POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy
- Reduce infant mortality
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers
- Reduce the % of youth using any kind of tobacco product
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- Increase the % vaccinated annually for seasonal influenza
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce hospital ED visits from asthma
- Reduce hospital ED visits related to mental health conditions
- Reduce hospital ED visits related to addictions
- Reduce Fall-related death rate

FY16 CB Table III – Initiative 1 Increase community access to comprehensive, quality health care services

<table>
<tr><td>Identified Need</td><td>
<u>Access to Care</u>
During the FY16 CHNA process, PRC and Community Surveys identified access to care as the greatest community concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to access to care. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.

Atlantic General Hospital is the only hospital in Worcester County, a DHMH federally-designated medically-underserved area, a state-designated rural community, and a HRSA-designated Health Professional Shortage Area for primary care, mental health, and dental health. In AGH's service area, the top reasons for patients not seeking health care in our communities are cost, transportation, and lack of providers. According to the Community Health Needs Assessment (CHNA) FY2016, the community rated the follow as the top barriers to access health care:
• Too expensive/can't afford it 65.3%
• No health insurance 53.5%
• Couldn't get an appointment with my doctor 19.6%
• No transportation 18.1%
• Local doctors are not on my insurance plan 13.7%
• Service is not available in our community 9.2%
• Doctor is too far away from my home 4.8%
<table>
<tr><th></th><th>Worcester County</th><th>Sussex County</th><th>U.S. Median</th><th>Healthy People 2020 Target</th></tr>
<tr><td>Cost Barrier to Care</td><td>16.1%</td><td>12.2%</td><td>15.6%</td><td>9%</td></tr>
<tr><td>Older Adult Preventable Hospitalizations (Medicare Enrollees)</td><td>51.9/1,000</td><td>53/1,000</td><td>71.3/1,000</td><td>-</td></tr>
<tr><td>Primary Care Provider Access</td><td>58.2/100,000</td><td>57.4/100,000</td><td>48/100,000</td><td>-</td></tr>
<tr><td>Uninsured</td><td>14.2%</td><td>14.0%</td><td>17.7%</td><td>-</td></tr>
<tr><td>Dentist Access</td><td>50.5/100,000</td><td>22.0/100,000</td><td>-</td><td>-</td></tr>
<tr><td>Poverty</td><td>11.1%</td><td>15.7%</td><td>16.3%</td><td>-</td></tr>
<tr><td>Overall Health Status</td><td>13.3%</td><td>14.6%</td><td>16.5%</td><td>-</td></tr>
</table>
(CHSI. 2015)
</td></tr>
<tr><td>Hospital Initiative</td><td>
<u>Initiative</u>:
Increase community access to comprehensive, quality health care services.
(Healthy People 2020 Goal: Improve access to comprehensive, quality health care services)
</td></tr>
<tr><td>Total Number of People Within Target Population</td><td>
14.2% uninsured Worcester County
14.0% uninsured Sussex County
(Data: CHSI)

Population Worcester County:
Total Population 51,769
White 42,024
Black/Af Amer 7,159
Am Ind/AK Native 143
Asian 729
Native HI/PI 13
Some Other Race 699
2+ Races 1,002
(Data: Healthy Communities Institute)
</td></tr>
</table>

	Population Sussex County: Total Population 216,486 White 169,252 Black/Af Amer 26,855 Am Ind/AK Native 1,817 Asian 2,582 Native HI/PI 179 Some Other Race 10,183 2+ Races 5,618 (Data: Healthy Communities Institute) 3500:1 Worcester County 2060:1 Somerset County 1870:1 Wicomico County 1165:1 Sussex County
Total Number of People Served By Initiative	8,265 persons served by initiative
Primary Objectives	1) Reduce unnecessary healthcare costs and reduction in hospital admissions and readmissions during FY16 a) Description: Through AGH's initiative to improve access to care reduction in unnecessary healthcare costs would be an impact of objectives improving access to care, educating the community on ED appropriate use, chronic illness self-management, and collaboration efforts with community organizations with a shared vision. b) Metrics: Hospital readmission rate 2) Increase in awareness and self-management of chronic disease during FY16 a) Description: Utilize Faith-based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management b) Metrics: Community Survey Track Wellness Workshops 3) Reduce health disparities during FY16 a) Description: *Strategy #1*-Partner with poultry plants to promote wellness by community education events and access to screenings. *Strategy #2*-Provide community health events to target minority populations by increasing relationships with faith-based partnerships, local businesses and cultural/ethnic community events. *Strategy #3*-Educate community on financial assistance options to improve affordability of care and reduce delay in care. b) Metrics: Community Survey CHSI AGH databases on ethnicity Maryland SHIP Healthy People 2020 4) Increase community capacity and collaboration for shared responsibility to address unmet health needs during FY16 a) Description: Partnering with community organizations and participation on committees that address access to care and health disparities: -Partner with homeless shelters and food pantries to promote wellness -Refer community to local agencies such as Shore Transit and Worcester County Health Department for transportation assistance -Participate on Tri County Health Planning Council

	-Participate on Lower Shore Dental Task Force -Participate on Worcester County Healthy Planning Advisory Council -Participate on Homelessness Committee b) Metrics: Track committee participation and partnerships 5) Increase number of practicing primary care providers and specialists to community during FY16 a) Description: Provider recruitment b) Metrics: Track provider recruitment Community Survey

Single or Multi-Year Initiative Time Period	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	Hospital Resources: • Population Health Department • AGH/HS • Human Resources • Registration/Billing Services • Emergency Department • Executive Care Coordination Team Community Resources: • Faith-based Partnership • Lower Shore Dental Task Force • Homelessness Committee • Worcester County Healthy Planning Advisory Council • Worcester County Health Department • Diakonia • Samaritan Shelter • Perdue • Shore Transit • Tri County Health Planning Council
How were the outcomes evaluated?	-The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements include: Community Survey to be completed as part of CHNA FY18 CHSI Maryland SHIP Healthy People 2020

Outcomes (Include process and impact measures)	Objective 1: Reduce unnecessary healthcare costs and reduction in hospital admissions and readmissions during FY16 Metrics: Hospital readmission rate • Outcome: As of June 30, 2016, AGH Hospital readmission rate 9.1% (MHA). Objective 2:Increase in awareness and self-management of chronic disease during FY16 Metrics: -Community Survey to be completed as part of CHNA FY18 -Track Wellness Workshops • Outcome: Population Health offered the following wellness workshops in FY16: HTN – 4, CDSMP – 2, CPSMP – 1, Stepping On – 2, DSMP – 4 = total 13 Objective 3: Reduce health disparities during FY16 Metrics: Community Survey to be completed as part of CHNA FY18 CHSI AGH databases on ethnicity Maryland SHIP Healthy People 2020 • Outcome: *Strategy #1*-Developed relationship with Perdue Georgetown poultry plant, to explore and assess need for opportunities to promote wellness via community education events and access to screenings. Will continue to build relationship efforts FY17. -Community health education events during FY16 targeting minority population: 28 events *Strategy #2* -Screenings during FY16: BMI, 62 persons screened, 62% overweight/obese Bone Density, 345 persons screened, 27% referred for follow-up Breast Exams, 19 persons screened, 21% referred for follow-up BP Screenings, 1696 persons screened, 20% referred for follow-up Respiratory Screenings, 63 persons screened, 37% referred for follow-up Skin Cancer Screenings, 145 persons screened, 37% referred for follow-up Carotid Artery Screenings, 212 screened, 81% referred for follow-up *Strategy #3* -Community health education events that educated community on financial assistance options to improve affordability of care and reduce delay in care during FY16: 12 events Objective 4:Increase community capacity and collaboration for shared responsibility to address unmet health needs during FY16

	Metrics: Track committee participation and partnerships * Outcome: --Developed relationship with Shepherd's Crook Food Pantry through Faith-Based Partnership as well as Diakonia (a homeless shelter) to explore and assess need for opportunities to promote wellness via community education events and access to screenings. Will continue to promote relationship efforts FY17. -Population Health Manager active participation on the following committees FY16 to promote care coordination and community collaboration: Tri County Health Planning Council, Lower Shore Dental Task Force, Worcester County Healthy Planning Advisory Council, and Homelessness Committee. Objective 5: Increase number of practicing primary care providers and specialists to community during FY16 Metrics: Track provider recruitment Community Survey • Outcome: - Community Survey to be completed as part of CHNA FY18 - During FY16, AGH/AGHS hired one GYN and one Dermatologist. However, much recruitment efforts in FY16 will not come to fruition until FY17. Will continue to track.

Continuation of Initiative	We will continue to monitor connections made to community programming for access to care programs in FY17.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $285,043	B. Direct offsetting revenue from Restricted Grants none

FY16 CB Table III – Initiative 2 Decrease the incidence of advanced breast, lung, colon, and skin cancer in community

<table>
<tr><td>Identified Need</td><td>
<u>Cancer</u>
During the FY16 CHNA process, PRC and Community Surveys identified cancer as significant community area of great concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to cancer diagnoses. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.

According to Healthy People 2020, continued advances in cancer detection, research and cancer treatment have decreased cancer incidences and death rates in the United States. Despite continued advances, cancer remains a leading cause of death second to heart disease in the United States. (Healthy People 2020)
<table>
<tr><th>(rate per 100,000 persons)</th><th>Worcester County</th><th>Sussex County</th><th>U.S. Median</th><th>Healthy People 2020</th></tr>
<tr><td>Cancer Deaths</td><td>188.0</td><td>184.1</td><td>185</td><td>161.4</td></tr>
<tr><td>Cancer</td><td>506.1</td><td>505.8</td><td>457.6</td><td>-</td></tr>
<tr><td>Colon Rectum Cancer</td><td>43.2</td><td>46.3</td><td>-</td><td>-</td></tr>
<tr><td>Female Breast Cancer</td><td>138.5</td><td>125.7</td><td>-</td><td>-</td></tr>
<tr><td>Lung Bronchus Cancer</td><td>71</td><td>77.7</td><td>-</td><td>-</td></tr>
<tr><td>Male Prostate Cancer</td><td>190.1</td><td>156.6</td><td>-</td><td>-</td></tr>
</table>
(CHSI, 2015)
<table>
<tr><th></th><th>Worcester County</th><th>Sussex County</th><th>U.S. Median</th><th>Healthy People 2020</th></tr>
<tr><td>Melanoma Deaths (age adjusted per 100,000)</td><td>4.6</td><td>2.6</td><td>2.7</td><td>2.4</td></tr>
</table>
(State Cancer Profiles, 2009-2013)
</td></tr>
<tr><td>Hospital Initiative</td><td>
<u>Initiative</u>:
Decrease the incidence of advanced breast, lung, colon, and skin cancer in community.
(Healthy People 2020 Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.)
Community Education
Clinical Screenings
Grant Writing
Care Coordination
Community Partnerships
Provider Recruitment
</td></tr>
<tr><td>Total Number of People Within the Target Population</td><td>
Worcester County 506.1/100,000 persons with Cancer
Sussex County 505.8/100,000 persons with Cancer
(Data: CHSI, 2015)
</td></tr>
<tr><td>Total Number of People Served by Initiative</td><td>
2,151 persons were served at community education and community clinical screening events. Due to size of initiative, education and screening events are the only accurate tracking record for number of persons served.
</td></tr>
</table>

Primary Objectives	1) Increase awareness around importance of prevention and early detection and reduce health disparities a) Description: -Improve proportion of minorities receiving women's preventative health services -Improve proportion of minorities participating in community health screenings b) Metrics: Healthy People 2020 AGH databases on ethnicity CHSI 2) Increase provider services in community to provide for cancer related treatment a) Description: Recruit proper professionals in community to provide for cancer related treatment b) Metrics: Track provider recruitment FY16 3) Improve access and referrals to community resources resulting in better outcomes a) Description: Partner with local health agencies to facilitate grant application to fund cancer programs b) Metrics: Track grant opportunities and formal partnerships FY16 4) Increase support to patients and caregivers a) Description: Patients and caregivers need support throughout the cancer treatment process. Patients experience the physical and emotional stressors undergoing treatment while caregivers fulfill a prominent and unique role supporting cancer patients and multitude of services such as home support, medical tasks support, communication with healthcare providers and patient advocate. AGH community education opportunities provide support and promote an informed patient and caregiver. b) Metrics: Track cancer prevention and educational opportunities FY16 5) Increase participation in community cancer screenings – especially at-risk and vulnerable populations a) Description: -Provide community health screenings: -Improve proportion of minorities receiving colonoscopy screenings -Improve proportion of minorities receiving LDCT screenings -Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn through melanoma education and skin cancer screenings b) Metrics: Track community screening events and persons screened FY16

Single or Multi-Year Initiative Time Period	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.

Key Partners in Development and/or Implementation	Hospital Resources: •Population Health Department •Human Resources •Foundation •Women's Diagnostic Center •Endoscopy •Imaging •Pulmonary Clinic •Dermatology •Medical Oncology •Regional Cancer Care Center •Radiation Oncology •AGH Cancer Committee Community Resources: Worcester County Health Department Komen Consortium Relay for Life Women Supporting Women Red Devils
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements: Community Needs Survey Healthy People 2020 AGH databases on ethnicity CHSI

Outcomes (Include process and impact measures)	Objective 1: Increase awareness around importance of prevention and early detection and reduce health disparities Metrics: Track Community Health Needs Assessment data FY16 AGH internal data • Outcome: 2014-2016 AGH data top cancers seen: Melanoma remains majority of cancer seen in ED FY16 29.89% Breast Cancer female 15.50% Prostate Cancer 8.61% Colon Cancer 7.87% Lung Cancer 7.63% According to CHNA FY16 Worcester County data: Lung Cancer – Majority Black • Age-Adjusted Death Rate due to Lung Cancer by Race/Ethnicity 73.8 Black male deaths /100,000 population compared to 57.6 White deaths /100,000 population Colorectal Cancer – Majority Black Male • Colorectal Cancer Incidence Rate by Gender 46.5 male cases/100,000 population compared to 27.4 female cases/100,000 population • Colorectal Cancer Incidence Rate by Race/Ethnicity 40.5 Black cases/ 100,000 population compared to 33.2 White cases/100,000 population

	Lung and Bronchus Cancer –Majority Black Males • Lung and Bronchus Cancer Incidence by Gender 59.5 female cases /100,000 population compared to 90.5 male cases/100,000 population • Lung and Bronchus Cancer Incidence Rate by Race/Ethnicity 88.7 Black cases/ 100,000 population compared to 68.5 White cases/100,000 population Prostate Cancer – Majority Black Male • Prostate Cancer Incidence by Race/Ethnicity 302.3 Black male cases /100,000 males compared to 139.6 White male cases /100,000 males According to CHNA FY16 Sussex County data: Prostate Cancer – Majority Black Male • Prostate Cancer Incidence by Race/Ethnicity: 214.4 Black male cases /100,000 males compared to 135.8 White male cases /100,000 males • Age Adjusted Death Rate due to Prostate Cancer by Race/Ethnicity 48.0 Black male cases /100,000 males compared to 19.0 White male cases /100,000 males Breast Cancer – Majority Black Female • Age Adjusted Death Rate due to Breast Cancer by Race/Ethnicity 28.0 Black female deaths/100,000 females compared to 19.6 White female deaths/100,000 females Lung and Bronchus Cancer – Majority Males • Lung and Bronchus Cancer Incidence by Gender 68.0 female cases /100,000 population compared to 84.9 male cases/100,000 population <u>Objective 2:</u> Increase provider services in community to provide for cancer related treatment <u>Metrics</u>: Track provider recruitment FY16 • <u>Outcome:</u> -One Dermatologist was hired in FY16 -Capital Campaign for Regional Cancer Care Center <u>Objective 3:</u> Improve access and referrals to community resources resulting in better outcomes <u>Metrics</u>: Track grant opportunities and formal partnerships FY16 • <u>Outcome</u>: Community Foundation awarded grant for RCCC Integrative Therapies Two other grants submitted to Komen and MHA during FY16 on behalf of the Regional Cancer Care Center (RCCC) to increase cancer care services. Formal partnerships during FY16 include: Komen 21st Century Oncology Local Health Departments Women Supporting Women American Cancer Society Red Devils

	Objective 4: Increase support to patients and caregivers Metrics: Track cancer prevention and educational opportunities FY16 • Outcome: The following community education activities were tracked in FY16: Increase awareness around importance of prevention and early detection and reduce health disparities – 16 events Improve proportion of minorities receiving women's preventative health services – 4 events Objective 5: Increase participation in community cancer screenings – especially at-risk and vulnerable populations Metrics: Track community screening events and persons screened FY16 • Outcome: Screenings provided at health fairs and clinical screening events FY16: Breast Exams, 19 persons screened, 21% referred for follow-up Respiratory Screenings, 63 persons screened, 37% referred for follow-up Skin Cancer Screenings, 145 persons screened, 37% referred for follow-up AGH provided 16 events which were aimed to improve proportion of minorities participating in community health screenings. No data available at this time to report on the proportion of minorities receiving colonoscopy screenings. Will continue to track FY17.

Continuation of Initiative	We will continue to monitor connections made to community programming for access to cancer prevention and screenings FY17.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $23,732	B. Direct offsetting revenue from Restricted Grants none

FY16 CB Table III – Initiative 3 - Promote community respiratory health through better prevention, detection, treatment, and education efforts

<table>
<tr><td>Identified Need</td><td>
<u>Respiratory Disease & Smoking</u>
During the FY16 CHNA process, PRC and Community Surveys identified respiratory disease and smoking cancer as significant community area of great concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to respiratory disease and smoking. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.

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

<table>
<tr><th></th><th>Worcester County</th><th>Sussex County</th><th>U.S. Median</th><th>Healthy People 2020</th></tr>
<tr><td>Adults Smoking</td><td>21.9%</td><td>21.7%</td><td>21.7%</td><td>12%</td></tr>
<tr><td>Older Adult Asthma</td><td>3.8%</td><td>3.6%</td><td>3.6%</td><td>-</td></tr>
<tr><td>Chronic Lower Respiratory Deaths</td><td>34.1/100,000</td><td>41.6/100,000</td><td>49.6/100,000</td><td>-</td></tr>
</table>
(CHSI, 2015)
</td></tr>
<tr><td>Hospital Initiative</td><td>
<u>Initiative</u>:
Promote community respiratory health through better prevention, detection, treatment, and education efforts. (Healthy People 2020 Goal: Promote respiratory health through better prevention, detection, treatment, and education efforts.)
Community Screenings
Care Coordination/Community Partnerships
CDSMP (evidence based)
Speaker’s Bureau
Integrated Health Literacy Program (IHLP)
</td></tr>
<tr><td>Total Number of People Within The Target Population</td><td>
Adults smoking Worcester County 21.9% and Sussex County 21.7% (CHSI, 2015)
Older adult asthma Worcester County 3.8% and Sussex County 3.6% (CHSI, 2015)
Asthma in younger adults admission rate not available via MD SHIP
2,013 adults have COPD in Worcester County (MD SHIP, 2013)
</td></tr>
<tr><td>Total Number of People Served By The Initiative</td><td>3,138 persons served by initiative</td></tr>
</table>

Primary Objectives	1) Decrease tobacco use in Worcester County a) Description: *Strategy #1* -Provide speakers to community groups on smoking cessation *Strategy #2* - Collaborate with Worcester County Health Department Prevention Department to promote smoking cessation and tobacco use reduction in community b) Metric: *Strategy #1* -Track smoking cessation education opportunities during FY16 *Strategy #2* - Track collaboration opportunities with Worcester County Health Department FY16 2) Increase participation in community lung/respiratory screenings – especially at-risk and vulnerable populations a) Description: Improve proportion of minorities receiving LDCT screenings b) Metric: Track persons served by lung/respiratory screening events FY16 3) Increase awareness around importance of prevention and early detection a) Description: Participate in community events to spotlight pulmonary clinic services Provide community education events to the community to increase awareness around the importance of prevention and early detection. b) Metric: Track community events which spotlight pulmonary clinic services FY 16 Track community education opportunities FY16 4) Increase health literacy for health conditions/healthy living a) Description: Improve Health Literacy in middle schools related to tobacco use b) Metric: Track students participating in tobacco use lessons provided by the Integrated Health Literacy Program FY16 5) Increase provider services in community to provide for respiratory related treatment a) Description: Recruit Pulmonologist to community b) Metric: Track recruitment efforts of Pulmonologist to the community FY16 6) Decrease hospital admissions and readmissions a) Description: Reduce emergency department (ED) visits for chronic obstructive pulmonary disease (COPD) and asthma b) Metric: Track ED visits related to COPD and asthma FY 16

Single or Multi-Year Initiative Time Period	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	Hospital Resources: •Pulmonary Clinic •Imaging •Emergency Department •Population Health Department •Human Resources

	•Pulmonology Community Resources: •Worcester County Health Department •Worcester County Public Schools
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements: -Healthy People 2020 -Decrease ED visits due to acute episodes related to respiratory condition -CHSI

Outcomes (Include process and impact measures)	Objective #1: Decrease tobacco use in Worcester County Metric: Strategy #1 -Track smoking cessation education opportunities during FY16 Strategy #2 - Track collaboration opportunities with Worcester County Health Department FY16 • Outcome: *Strategy #1 – S*moking cessation education opportunities available to report FY16 stem from health fair educational opportunities which include 4 events. Persons served are referred to the local health department's program. *Strategy #2* – AGH continues to collaborate with WCHD by providing referrals to patients needing assistance with smoking cessation. Will continue to monitor FY17. AGH collaborated with the WCHD as part of a Tobacco Retailer Education Mini Grant to promote education to retailers regarding tobacco sales to minors, including health effects and legal implications. 101 tobacco retailers in Worcester County were served by this program during FY16. Objective #2: Increase participation in community lung/respiratory screenings – especially at-risk and vulnerable populations Metric: Track persons served by lung/respiratory screening events FY16 • Outcome: 63 persons were served through lung/respiratory screening events FY16 Objective #3:Increase awareness around importance of prevention and early detection Metric: *Strategy #1* -Track community events which spotlight pulmonary clinic services FY 16 *Strategy #2* - Track community education opportunities FY16 • Outcome: *Strategies 1 and 2 combined* – total person served 997 persons served from the following events: Healthy Happenings Snow Hill Nov 2015 Spirit Kitchen February 2016 UMES Health Fair April 2016 Ocean City Health Fair May 2016

	Strategy 2 – CDSMP Ocean City Senior Center April 2016, 8 persons served Captains Cove Health Fair July 2015, 8 persons served Objective #4: Increase health literacy for health conditions/healthy living Metric: Track students participating in tobacco use lessons provided by the Integrated Health Literacy Program FY16 • Outcome: 67 students participate in lessons on substance abuse, tobacco and e-cigarettes during FY16. Objective #5: Increase provider services in community to provide for respiratory related treatment Metric: Track recruitment efforts of Pulmonologist to the community FY16 • Outcome: AGH continues recruitment efforts to increase healthcare providers in the community service area. No Pulmonologist was hired in FY16. Recruitment efforts will continue FY17. Objective #6: Decrease hospital admissions and readmissions Metric: Track ED visits related to COPD and asthma FY 16 • Outcome: According to AGH ED data FY16: 934 persons presented in the ED with Asthma 960 persons presented in the ED with COPD

Continuation of Initiative	We will continue to monitor connections made to community programming for respiratory disease and smoking prevention/cessation during FY17.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $15,147	B. Direct offsetting revenue from Restricted Grants Tobacco Retailer Ed Mini-grant $6,000

FY16 CB Table III – Initiative 4 Support community members in achieving a healthy weight

<table>
<tr><td>Identified Need</td><td>
<u>Nutrition, Physical Activity & Weight</u>
During the FY16 CHNA process, PRC and Community Surveys identified nutrition, physical activity and weight as significant community areas of great concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to poor nutrition, poor physical activity and obesity. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.

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

According to the CDC National Center for Health Statistics (2015), the prevalence of obesity was slightly more than 36 percent in adults and 17 percent in youth.
•The prevalence of obesity was higher in women 38.3% than in men 34.3%. No significant difference was noted by gender among youth.
•The prevalence of obesity was higher among middle-aged and older adults than younger adults. (2013 – 2014)

<table>
<tr><th></th><th>Worcester County</th><th>Maryland</th><th>Sussex County</th><th>Delaware</th></tr>
<tr><td>Adult Obesity</td><td>30%</td><td>28%</td><td>31%</td><td>29%</td></tr>
<tr><td>Physical Inactivity</td><td>27%</td><td>23%</td><td>27%</td><td>25%</td></tr>
<tr><td>Limited Access to Health Foods</td><td>4%</td><td>3%</td><td>5%</td><td>6%</td></tr>
</table>
(County Health Rankings, 2016)
</td></tr>
<tr><td>Hospital Initiative</td><td>
<u>Initiative</u>: Support community members in achieving a healthy weight.
(Healthy People 2020: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights)
BMI Screenings
Hypertension Screenings
Nutrition Counseling
Nutrition Speakers through Speaker’s Bureau
Education through Faith based Partnerships
Integrated Health Literacy Program
Support Groups TOPS and Overeaters Anonymous
CDSMP (evidence based)
</td></tr>
<tr><td>Total Number of People in Target Population</td><td>
Adult obesity Worcester County 30% and Sussex County 31%
Adolescent obesity 2010 data 12.4% Healthy People 2020 in Worcester County
Target according to MD SHIP is 11.3% of adolescents.
</td></tr>
<tr><td>Total Number of Persons Served By Initiative</td><td>4,593 persons served</td></tr>
</table>

Primary Objectives	1) Increase health literacy and self-management for health conditions/healthy living by increasing awareness around importance of nutrition, exercise and healthy weight Description: *Strategy #1* - Improve Health Literacy in elementary and middle schools related to nutrition and exercise through the integrated health literacy program. Students in grades one through five county-wide participated in curriculum that included nutrition and/or physical exercise lessons. The sixth grade pilot at Snow Hill Middle School also included a lesson on nutrition. *Strategy #2* – Provide AGH based support groups/wellness classes to the community that promote healthy eating habits and exercise Metric: Strategy #1 -Track student participation in nutrition and physical activity lessons FY16. Strategy #2 - Track Support Groups TOPS and Overeaters Anonymous FY16 2) Increase patient engagement in self-management of chronic conditions Description: Continue to provide education on health living topics to Faith-based Partnership and community senior centers Metric: Track CDSMP workshops FY16 3) Increase awareness of community resources, programs and services Description: *Strategy #1* - Distribution brochure to public about Farmer's Market & fresh produce preparation *Strategy #2* - Participate in community events to spotlight surgical and non-surgical weight loss services Metric: *Strategy #1* -Track brochure distribution FY16 *Strategy #2* – Track persons served by events to spotlight surgical and non-surgical weight loss services FY16 4) Increase participation in community BMI screenings and Hypertension screenings – especially at-risk and vulnerable populations Description: Provide Hypertension and BMI screenings in the community Metric: Track persons screened FY16 5) Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs Description: *Strategy #1* -Integrate Healthy People 2020 objectives into AGHS offices *Strategy #2* - Participate in the "Just Walk" program of Worcester County Metric: *Strategy #1* - Track integration of Healthy People 2020 objectives into AGHS offices FY16 *Strategy #2* - Track participation in the "Just Walk" program of Worcester County FY16

	6) Increase access to healthy foods and nutritional information Description: Provide speakers to community groups on nutrition Metric: Track community education/ speakers bureau events and persons served FY16

Single or Multi-Year Initiative Time Period	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	Hospital Resources: Population Health Department AGHS Offices Overeaters Anonymous Support Group Nutrition Services Atlantic General Bariatric Center AGH New Direction Medical Weight Loss Program Community Resources: Faith-based Partnership Worcester County Public Schools Worcester County Health Department MAC, Inc. Community Senior Centers Yoga/Tai Chi Programs TOPS of Berlin
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements: Healthy People 2020 Objectives CDC National Center for Health Statistics County Health Rankings

Outcomes (Include process and impact measures)	Objective #1: Increase health literacy and self-management for health conditions/healthy living by increasing awareness around importance of nutrition, exercise and healthy weight Metric: *Strategy #1* -Track student participation in nutrition and physical activity lessons FY16. *Strategy #2* - Track Support Groups TOPS and Overeaters Anonymous FY16 • Outcome: *Strategy#1* - Based on the enrollment totals, there are 2411 students in grades two through six that participated in IHLP lessons on nutrition and physical activity during FY16. There were approximately 67 students who took part in this lessons in the sixth grade pilot during FY16. 100% of students recognize MyPlate. Increase in number of students who recognize the term "heart healthy" from FY15 63%. *Strategy #2* – Support Group TOPS served 42 persons served through presentations FY16 Persons served unavailable for Support Group Overeaters Anonymous FY16. OA increased support groups to twice a month. Yoga group had insignificant change from person served FY15 to FY16. FY16 255 persons served. Tai Chi group approved and will track FY17. 2) Increase patient engagement in self-management of chronic conditions Metric: Track CDSMP workshops FY16 • Outcome: 2 CDSMP workshops were offered in FY16 serving 16 persons total Ocean City Senior Center April 2016 Captain's Cove Community Center July 2015 3) Increase awareness of community resources, programs and services Metric: *Strategy #*1 -Track brochure distribution FY16 *Strategy #2* – Track persons served by events to spotlight surgical and non-surgical weight loss services FY16 • Outcome: *Strategy #1* – Brochure distribution numbers unavailable FY16. 2000 distributed FY15. Will continue to monitor FY17. *Strategy#2* – Bariatric nonsurgical support group implemented March 2016 and served 33 persons FY16. 4) Increase participation in community BMI screenings and Hypertension screenings – especially at-risk and vulnerable populations Metric: Track persons screened FY16

	• Outcomes: BMI Screenings FY16 62 persons served. Hypertension Screenings FY16 1696 persons served. 5) Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs Metric: *Strategy #1* - Track integration of Healthy People 2020 objectives into AGHS offices FY16 *Strategy #2* - Track participation in the "Just Walk" program of Worcester County FY16 • Outcome: *Strategy #1* – No data available for tracking purposes. Healthy People Objectives integrated into AGHS offices FY16. *Strategy #2* – 11 persons served at "Just Walk" program in Worcester County FY16 6) Increase access to healthy foods and nutritional information Metric: Track community education/speakers bureau events and persons served FY16 • Outcome: 380 persons were served by nutritional information and information on access to healthy foods during FY16 .

Continuation of Initiative	We will continue to monitor connections made to community programming for nutrition, physical activity and weight in FY17.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $75,890	B. Direct offsetting revenue from Restricted Grants none

FY16 CB Table III – Initiative 5 Decrease incidence of diabetes in the community

<table>
<tr><td>Identified Need</td><td>
<u>Diabetes</u>
During the FY16 CHNA process, PRC and Community Surveys identified diabetes as significant community area of concern. Diabetes management and numbers were associated concerns. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to diabetes. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.

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

<table>
<tr><th></th><th>Worcester County</th><th>Maryland</th><th>Sussex County</th><th>Delaware</th></tr>
<tr><td>Diabetic Monitoring (Medicare)</td><td>88%</td><td>85%</td><td>89%</td><td>86%</td></tr>
<tr><td>Diabetes Prevalence</td><td>13%</td><td>10%</td><td>13%</td><td>11%</td></tr>
</table>
(County Health Rankings, 2016)
</td></tr>
<tr><td>Hospital Initiative</td><td>
<u>Initiative</u>:
Decrease incidence of diabetes in the community.
(Healthy People 2020 Goal: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.)
Clinical Screening
Support Group
Diabetes Education
Chronic Disease Self-Management Program (evidence based)
Patient Centered Medical Home
Faith-based Partnerships
Care Coordination Team
Speaker’s Bureau
Community Education
</td></tr>
<tr><td>Total Number of People Within Target Population</td><td>
Worcester County 13% Diabetes Prevalence
Sussex County 13% Diabetes Prevalence
(Data: County Health Rankings)
</td></tr>
<tr><td>Total Number Of People Served By Initiative</td><td>1,665 persons served through diabetes education, clinical screenings, and support groups.</td></tr>
<tr><td>Primary Objectives</td><td>
1) Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions
a) <u>Description:</u> Through AGH’s initiative to improve access to care reduction in unnecessary healthcare costs would be an impact of objectives improving access to care, educating the community on ED appropriate use, Diabetes chronic illness self-management, Diabetes prevention, and collaboration efforts with community organizations with a shared vision.

b) <u>Metric:</u> Track hospital admission rate and ED rate FY16

2) Increase awareness around importance of prevention of diabetes and early detection
a) <u>Description:</u>
Strategy #1 -Provide diabetes screenings in community via health
</td></tr>
</table>

	fairs and clinical screening events *Strategy #2* - Increase prevention behaviors in persons at high risk for diabetes with prediabetes through community education opportunities b) <u>Metric:</u> *Strategy #1* - Track Diabetic community screening opportunities. *Strategy #2* - Track community education opportunities that highlight Diabetes and pre-Diabetes. 3) Increase patient engagement in self-management of chronic conditions a) Description: AGH partners with MAC, local senior centers and faith-based partnerships to bring Stanford self-management workshops to the community to increase patient engagement and self-management of chronic disease b) Metric: Track DSMP wellness workshops 4) Increase provider services in community to provide for diabetes related treatment a) <u>Description:</u> *Strategy #1* - Continue to provide Diabetes Education and chronic disease care via Patient Centered Medical Home *Strategy #2* - Recruit Endocrinologist to community b) <u>Metric:</u> *Strategy #1* -Track Diabetes Education via PCMH progress. *Strategy #2* -Track Endocrinologist recruitment efforts. 5) Increase participation in community glucose screenings – especially at-risk and vulnerable populations a) <u>Description:</u> AGH partners with local community organizations, including faith-based partnerships to bring glucose screening services to at-risk individuals such as minority populations and vulnerable populations such as homeless persons or those without adequate insurance coverage. b) <u>Metric:</u> Compare FY16 and FY15 glucose screening events 6) Increase community capacity and collaboration for shared responsibility to address unmet health needs a) <u>Description:</u> -Partner with local health agencies to facilitate grant applications to fund diabetes programs b) <u>Metric:</u> -Track partnerships with local health agencies

Single or Multi-Year Initiative Time Period	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	Hospital Resources: •Diabetes Outpatient Education Program/PCMH •Diabetes Support Group •Population Health Department •Emergency Department

	•Foundation •Human Resources •Endocrinology •Lab Services Community Resources: •Worcester County Health Department •MAC, Inc. •Tri-County Diabetes Alliance
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Primary Objectives Long Term Measurements: -Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics--objectives/topic/diabetes/objectives -Incidence of adult diabetes -Decrease ED visits due to acute episodes related to diabetes condition -County Health Rankings

Outcomes (Include process and impact measures)	Objective #1 -Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions <u>Metric</u>: Track hospital admission rate and ED rate FY16 • <u>Outcome:</u> According to AGH ED and IP data during FY16, AGH served 1436 persons with Diabetes Objective #2 -Increase awareness around importance of prevention of diabetes and early detection <u>Metric</u>: *Strategy #1* - Track Diabetic community screening opportunities FY16 *Strategy #*2 - Track community education opportunities that highlight Diabetes and pre-Diabetes during FY16 • <u>Outcome</u>: *Strategy #1 and Strategy #2 combined*– Captain's Cove Health Fair Blackwater Village Health Fair MSEA Convention Berlin Senior. Center. – Speaker's Bureau event Ocean Pines Community Center –Speaker's Bureau event Community Resource Day – screening and education X 5 events Wor Wic Community College Ocean City Health Fair Snow Hill Career Café Diabetes Support Group x 14 Objective #3 - Increase patient engagement in self-management of chronic conditions <u>Metric</u>: Track DSMP wellness workshops during FY16 • <u>Outcome</u>:

	DSMP 4 workshops offered to the community FY16 Objective #4 -Increase provider services in community to provide for diabetes related treatment Metric: *Strategy #1* -Track Diabetes Education via PCMH progress FY16 *Strategy #2* -Track Endocrinologist recruitment efforts FY16 • Outcome: *Strategy #1*- FY16 the Diabetes Education Program via PCMH served a total of 42 persons obtaining new referrals to program every 1 ½ to 2 months. The program provided education and community resource navigation for supplies to those needing assistance. *Strategy #2*- AGH continues to recruit specialty providers. Will continue to track recruitment progress as most efforts will not come to fruition until FY17. Objective #5 - Increase participation in community glucose screenings – especially at-risk and vulnerable populations Metric: Compare FY16 and FY15 glucose screening events • Outcome: In FY15 AGH provided glucose screenings to 150 persons. In FY16, AGH increased glucose screening opportunities and provided screenings to 394 persons served. Objective #6 - Increase community capacity and collaboration for shared responsibility to address unmet health needs Metric: Track partnerships with local health agencies FY16 • Outcome: AGH continues to partner with the following: -Referral process in place with local health departments -Area Agencies on Aging -Faith-based partnerships -AGH continues to partner with local health agencies to facilitate grant applications to fund Diabetes Programs. Will continue to track FY17. -Tri-County Diabetes Alliance active participation FY16

Continuation of Initiative	We will continue to monitor connections made to community programming for diabetes in to FY17.

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $16,439	B. Direct offsetting revenue from Restricted Grants none

FY16 CB Table III – Initiative 6 Improve cardiovascular health of community

<table>
<tr><td>Identified Need</td><td><u>Heart Disease & Stroke</u>
During the FY16 CHNA process, PRC and Community Surveys identified heart disease and stroke as significant community area of concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via PRC and Community Surveys and met with community partners to determine that community health problems and hospital re-admissions were significant related to heart disease and stroke. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.

According to the CDC Heart Disease Statistics and Maps (2015), approximately 610,000 people die of heart disease in the United States yearly. Heart disease is the leading cause death among most ethnic groups. Hypertension, high cholesterol and smoking are key risk factors and 47 percent of Americans have at least one risk factor Heart Disease Statistics and Maps (CDC, 2015).
<table><tr><th>(per 100,000)</th><th>Worcester County</th><th>Sussex County</th><th>U.S. Median</th><th>Healthy People 2020 Target</th></tr><tr><td>Coronary Heart Disease Deaths</td><td>141.7</td><td>143.2</td><td>126.7</td><td>103.4</td></tr><tr><td>Stroke Deaths</td><td>34.3</td><td>34.1</td><td>46</td><td>34.8</td></tr></table>(CHSI, 2015)</td></tr>
<tr><td>Hospital Initiative</td><td><u>Initiative</u>:
Goal: Improve cardiovascular health of community.
(Healthy People 2020 Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events)
AGH Tobacco Free Campus
Community Screenings
CDSMP (evidence based)
Living Well with Hypertension Workshops (evidence based)
Speaker’s Bureau
Faith Based Partnership
Integrated Health Literacy Program with Worcester County Board of Education
Support Groups</td></tr>
<tr><td>Total Number of People Within Target Population</td><td>Coronary Artery Disease Worcester County 141.7/100,000 and Sussex County 143.2/100,000</td></tr>
<tr><td>Total Number of People Served By Initiative</td><td>2,326 persons served through screenings, workshops, speaker’s bureau and community education
500 students identified through the Integrated Health Literacy Program
898 employees served and identified through AGH tobacco free campus
1,321 Inpatients with heart disease.</td></tr>
</table>

Primary Objectives	1) Increase awareness around importance of prevention and early detection of heart disease and hypertension a) Description: Provide community education opportunities b) Metrics: Track number of community education events FY16 2) Increase health literacy for health conditions/healthy living a) Description: Improve Health Literacy in elementary and middle schools related to heart health. Heart health lessons are taught in the second grade. b) Metrics: Track number of students served by program FY16 3) Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations a) Description: Increase community health screenings for high blood pressure, carotid artery and cholesterol b) Metrics: Track number of persons screened FY16 4) Increase provider services in community to provide for cardiovascular related treatment a) Description: Ensure proper professionals in community to provide vascular care b) Metrics: Track provider recruitment efforts FY16 5) Increase community capacity and collaboration for shared responsibility to address unmet health needs a) Description: Develop partnerships and participate on committees b) Metrics: Track active participation FY16 6) Increase patient engagement in self-management of chronic conditions a) Description: Utilize Faith Based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management b) Metrics: Track number of wellness workshops FY16 7) Increase care for individuals suffering from chronic conditions and decrease hospital admissions and readmissions a) Description: Decrease readmissions to hospital for chronic disease management and reduce unnecessary healthcare costs b) Metrics: Track readmission rate FY16 8) Decrease tobacco use in Worcester County a) Description: Maintain AGH/HS campus and locations as tobacco free b) Metric: Track measures to decrease tobacco use in Worcester FY16

Single or Multi-Year Initiative Time Period	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	Hospital Resources: Population Health Department AGH/HS Lab Services Human Resources Cardiology – Peninsula Cardiology and Delmarva Heart

	PCMH Stroke Center Community Resources: Faith-based Partnership MAC, Inc. Worcester County Health Department Sussex County Employees Worcester County Employees Healthiest Business Initiative Local Pharmacies MSEA MD Barr Assoc
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements include: Measurement: Healthy People 2020 Readmission rate

Outcomes (Include process and impact measures)	Objective #1 -Increase awareness around importance of prevention and early detection of heart disease and hypertension Metrics: Track number of community education events FY16 • Outcome: Speakers Bureau 2 events in FY16 the title was Heart and Stroke Risks Tri-County Go Red Event Feb 2015 Stroke Support Groups monthly meetings FY16 Objective #2 - Increase health literacy and self-management for health conditions/healthy living Metrics: Track number of students served by health literacy program FY16 • Outcome: The health literacy program provided heart health lessons to 500 second grade students during FY16. Objective #3 - Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations Metrics: Track number of persons screened FY16 • Outcome: BP Screenings during FY16 – 1696 persons served, 20% referred for follow-up Carotid Screening during FY16 – 212 persons screened, 81% referred for follow-up Cholesterol Screenings during FY16 – 223 persons served compared to 150 persons served in FY15 Objective #4 - Increase provider services in community to provide for cardiovascular related treatment

	Metrics: Track provider recruitment efforts FY16 • Outcome: AGH/HS continues efforts to recruit providers to meet the needs of the community. Will continue to track efforts in FY17. No data to report at this time. Objective #5 - Increase community capacity and collaboration for shared responsibility to address unmet health needs Metrics: Track active participation FY16 • Outcome: AGH continues collaboration and shared responsibility to meet health needs through partnership with the local health departments: Tri-County Go Red Event – Feb 2016 WCHD referrals to patients needing assistance with smoking cessation Local business such as Sussex County and Worcester County Employees, MSEA, Maryland Barr Association to promote heart health and wellness opportunities Objective #6 - Increase patient engagement in self-management of chronic conditions Metrics: Track number of wellness workshops FY16 • Outcome: CDSMP – 2 events, total 16 persons served Captain's Cover Community Center July 2016 Ocean City Senior Center April 2016 Living Well With HTN- 4 events, total 40 persons served Pocomoke Senior Center May 2016 Indian River Senior Center May 2016 Captain's Cove Community Center March 2016 Captain's Cove Community Center Feb 2016 Objective #7 - Increase care for individuals suffering from chronic conditions and decrease hospital admissions and readmissions related to cardiovascular health. Metrics: Track readmission rate FY16 • Outcome: AGH inpatients with heart disease 1321 persons (AGH internal data) Objective #8 - Decrease tobacco use in Worcester County Metric: Track measures to decrease tobacco use in Worcester FY16 • Outcome: AGH remains a tobacco free campus during FY16 and will continue initiative. During FY16, 898 employees were served by AGH providing a tobacco free campus.

Continuation of Initiative	We will continue to monitor connections made to community programming for heart disease and stroke in to FY17.

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $42,309	B. Direct offsetting revenue from Restricted Grants none

FY16 CB Table III – Initiative Promote and ensure local resources are in place to address mental health.

<table>
<tr><td>Identified Need</td><td><u>Mental Health Disorders</u>
During the FY16 CHNA process, PRC and Community Surveys identified mental health disorders a significant community concern. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.

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

<table><tr><th></th><th>Worcester County</th><th>Maryland</th><th>Sussex County</th><th>Delaware</th></tr><tr><td>Mental Health Providers</td><td>520:1</td><td>470:1</td><td>610:1</td><td>440:1</td></tr><tr><td>Poor Mental Health Days</td><td>3.5</td><td>3.4</td><td>3.5</td><td>3.7</td></tr></table>(County Health Rankings, 2016)
.</td></tr>
<tr><td>Hospital Initiative</td><td><u>Hospital Initiative</u>:
Promote and ensure local resources are in place to address mental health.
(Healthy People 2020 Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.)</td></tr>
<tr><td>Total Number of People Within the Target Population</td><td>2914 patients served IP and ED for mental health disorders during FY16
Poor mental health days: Worcester County 3.5 and Sussex County 3.5 (County Health Rankings, 2016)
Care Coordination
Community Partnerships
Support Groups
Community Education
Faith Based Partnerships
Telemedicine</td></tr>
<tr><td>Total Number of People Served by Initiative</td><td>1849 persons served by initiative</td></tr>
<tr><td>Primary Objectives</td><td>1) Increase accurate and up-to-date information and referral service

<u>a)Description:</u> Engage Critical Response Tea, when a mental health crisis is discovered

<u>b)Metric:</u> Track CRT service and referrals during FY16

2) Improve Health Literacy in elementary and middle schools related to mental health

<u>a)Description:</u> Improver health literacy in schools related to mental health and emotional health. IN FY16, AGH’s Integrated Health Literacy Program (IHLP) partnered with Worcester County Public School (WCPS) to provide lessons on mental health topics.

<u>b)Metric</u>: Track number of students in IHLP participating in mental health lesson topics in WCPS during FY16

3) Increase awareness of community resources, programs and services

<u>a)Description</u>: Participate in community events that spotlight mental health services. During FY16, AGH collaborated on a variety of community events. Partnerships included the local health departments, local scholarship foundation, and a motivational speaker event.</td></tr>
</table>

	b)Metric: Track number of events that highlight mental health services and education during FY16 4) Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs a)Description: Increase access and continue to collaborate with Sheppard Pratt telemedicine services to provide additional psychiatry professional b)Metric: Track service collaboration with Sheppard Pratt during FY16 5) Increase provider services in community to provide for mental health related treatment a)Description: Recruit Psychiatrist to the community b)Metric: AGH recruitment of Psychiatrist to community by end of FY16

Single or Multi-Year Initiative Time Period	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	Hospital Resources: Population Health Department Atlantic Health Center Human Resources Pastoral Care Services Bereavement Support Group Community Resources: Sheppard Pratt Worcester County Health Department Worcester Youth and Family Services Hudson Health Services NAMI Lower Shore Support Group Jesse's Paddle Organization Surfer's Healing Camps Autism Speaks Chapter
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements: Healthy People 2020 Behavioral Risk Factor Surveillance System County Health Rankings

Outcomes (Include process and impact measures)	Objective 1) Increase accurate and up-to-date information and referral service Metric: Track CRT service and referrals during FY16 • Outcome: AGH continue to partner with local community resources, such as the local health

	departments for timely and accurate referral of service. No data to report at this time for CRT tracking due to HIPAA guidelines for mental health patients' data is unavailable. Objective 2) Improve Health Literacy in elementary and middle schools related to mental health Metric: Track number of students in IHLP participating in mental health lesson topics in WCPS during FY16 • Outcome: In FY16, the only grade that discussed mental health was grade 5. The topic was anxiety. In fifth grade there were 435 impacted by the program. AGH will continue to increase mental health and education opportunities with WCPS. Will track expansion of lessons in FY17. Objective 3) Increase awareness of community resources, programs and services Metric: Track number of events that highlight mental health services and education during FY16 • Outcome: -Presentation on PTSD from CPT. Montalvan Sept 2015 – 75 persons served -Out of Darkness Walk Sept 2015 and sit on planning community throughout year -50 persons served -Community Resources Planning Board and Resource Days – 50 persons served -Suicide prevention vendor, Jesse Klump Foundation, attendance at several health fairs -722 persons served -Surfer's Healing event August 2016 – 150 persons served -Monthly AGH based NAMI Support Group - 102 persons served -Monthly Bereavement Support Group – 87 persons served Objective 4) Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs Metric: Track service collaboration with Sheppard Pratt during FY16 • Outcome: During FY16, AGH noted increase in services by one additional provider and 2 extra hours per week/8 per month. The additional hours will be provided to children with Autism Spectrum Disorders. Objective 5) Increase provider services in community to provide for mental health related treatment Metric: AGH recruitment of Psychiatrist to community by end of FY16 • Outcome: AGH will continue recruitment efforts FY17. At this time, one additional provider added through Sheppard Pratt telemedicine services during FY16.

Continuation of Initiative	We will continue to monitor connections made to community programming for mental health disorders and access to care during FY17.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $35,554	B. Direct offsetting revenue from Restricted Grants none

FY16 CB Table III – Initiative 8 Reduce opioid substance abuse to protect community health, safety, and quality of life for all

<table>
<tr><td>Identified Need</td><td>
<u>Opioid Abuse</u>
During the FY16 CHNA process, the Community Survey identified drug abuse as a significant community health concern. Atlantic General Hospital analyzed data (see Worcester County and Sussex County data below), identified community need via survey and met with community partners to determine that opioid abuse and drug death overdose are growing community health problems. Based on community need, AGH dedicated resources to those areas, thereby making the greatest possible impact on community health status.

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

<table>
<tr><th></th><th>Worcester County</th><th>Maryland</th><th>Sussex County</th><th>Delaware</th></tr>
<tr><td>Drug Death Overdose</td><td>15</td><td>16</td><td>16</td><td>18</td></tr>
<tr><td>Drug Death Overdose - modeled</td><td>18.1-20.0</td><td>17.4</td><td>16.1-18.0</td><td>20.9</td></tr>
</table>
(County Health Rankings, 2016)

Worcester County SMART data show rising rates of entry to treatment for opioid addiction, which likely reflects increased risk of opioid related overdose, or death:
● The number of admissions to treatment for Heroin doubled in Worcester during a period in which statewide the number remained constant (2009-2011)
● The number of admissions to treatment for Oxycodone increased 8x in Worcester, while the number increased 3X (tripled) statewide
● The total number of Opioid-related admissions to treatment tripled in Worcester while the number increased by less than 2% statewide
Anecdotally, in communication with law enforcement, and Addictions treatment program counselors, Worcester has begun to see locally the trend of increasing incidence of heroin abuse and overdose, while the incidence of prescription opioid related overdose may be decreasing. This reflects an emerging trend statewide
(http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/Documents/WorcesterCountyOPP_FinalPlan.pdf)
</td></tr>
<tr><td>Hospital Initiative</td><td>
<u>Initiative</u>:
Reduce opioid substance abuse to protect community health, safety, and quality of life for all.
(Healthy People 2020 Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children)
IHLP
Community Education
CPSMP (evidence based)
Opioid Task Force
Narcan Training
Pain Management
PDMP
Care Coordination/Community Collaboration
</td></tr>
<tr><td>Total Number of People Within Target Population</td><td>
In 2014 we treated less than 50 opioid related incidences in the ED and in 2016 we are on target to treat over 200, a 75% increase. (AGH Internal Data)
Drug death overdose modeled: Worcester County 18.1-20.o and Sussex County 16.1 – 18.0. (County Health Rankings, 2016)
FY16 11 Atlantic Immediacare visits were related to opioid dependency (AGH Internal Data)
FY16 67 ED visits were related to opioid dependency and 203 total overdose/poisonings (AGH Internal Data)
</td></tr>
<tr><td>Total Number of People Served by Initiative</td><td>508 persons served</td></tr>
</table>

Primary Objectives	1) Improve health literacy in middle schools related to opioid abuse. a) Description: FY16 IHLP pilot, Pocomoke Middle and Snow Hill Middle 6th grades, focused on a substance abuse component as part of DARE Program. There were 62 sixth graders during the pre-test and 67 during the post-test due to enrollment change. In order to promote awareness via IHLP the Health Literacy Liaison is involved in multiple councils/committees such as Worcester County Opioid Awareness Task Force, Worcester County Health Council and Worcester County Warrior's Education Subcommittee. Due to community need FY17 IHLP will incorporate opioid education in eighth grade during the "Heroin and Substance Abuse" unit. These lessons include the effects of heroin in the body, consequences related to heroin use as well as a component that discusses the criminal justice system's role in the heroin epidemic. b) Metrics: Track number of middle school students participating in the Health Literacy (IHLP) Program related to substance/opioid use by the end of the FY16. 2) Increase accurate and up-to-date information and referral service. a) Description: In FY16, AGH began focusing on three strategies 1)Increasing the proportion of persons who are referred for follow-up care for opioid problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED) 2) Evaluate and educate organization and community on appropriate prescribing practices 3) Implement Prescription Drug Maintenance Program (PDMP) via CRISP. Implementing the Prescription Drug Monitoring Program (PDMP) to give healthcare providers and public health and safety authorities a new tool to reduce prescription drug abuse b) Metrics: *Strategy #1* -Track ED referrals for follow-up care at Atlantic Health Center Pain Management Clinic *Strategy #2* – Track education opportunities to educate community and organization on prescribing practices *Strategy #3* – Reported implementation of PDMP via Crisp 3) Decrease opioid abuse and over dose rates a) Description: As FY16 progressed, AGH focused on 1)Providing educational opportunities to raise community awareness about opioid use and 2)Participate in Worcester County Health Department naloxone training sessions sponsored by Opiate Overdose Prevention Program b) Metrics: *Strategy #1* – Track number of community educational opportunities *Strategy #2* – Track number of classes and participants receive Narcan training

	4) Increase and strengthen capacity for shared responsibility to address unmet health needs. a) Description: The ability to increase and strengthen capacity for shared responsibility to address unmet health needs involves community wide collaborations. In FY16, AGH increased participation on committees and councils to promote community involvement and shared responsibility. Two key programs include WOW Committee (Worcester Warriors) and the Opioid Task Force. These councils and committees include community members, local health department, health agencies, law enforcement, etc b) Metrics: Participation on WOW Committee and Opioid Task Force by the end of the fiscal year.
Single or Multi-Year Initiative Time Period	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	Hospital Resources: •Population Health Department •Emergency Department •Atlantic Health Center/Pain Management •Pharmacy Community Resources: •Worcester County Health Department •Worcester County Public Schools •WOW Committee •Opioid Task Force •CRISP
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measures include Healthy People 2020 and Community Survey.

Outcomes (Include process and impact measures)	Objective 1: Improve health literacy in middle schools related to opioid abuse. Metrics: Track number of students participating in the Health Literacy (IHLP) Program by the end of the FY16 • Outcome: As part of the substance abuse component in DARE Program, there were 62 sixth graders during the pre-test and 67 during the post-test due to enrollment change. Outcomes related to the FY17 opioid education into IHLP curriculum will be reported next fiscal year. Objective 2: Increase accurate and up-to-date information and referral service. Metrics: *Strategy #*1 -Track ED referrals for follow-up care at Atlantic Health Center Pain Management Clinic *Strategy #2* – Track education opportunities to educate community and organization on prescribing practices • Outcome: *Strategy #1* - ED Referral process to Pain Management Clinic Algorithm implemented. Pain Management Clinic served 252 patients referred to clinic. Will continue to track in FY17. *Strategy #2* - Reported implementation of PDMP via Crisp. Will track success of program FY17.

	Objective 3: Decrease opioid abuse and over dose rates a) Metrics: *Strategy #1* – Track number of community educational opportunities *Strategy #2* – Track number of classes and participants receive Narcan training • Outcomes: *Strategy #1* – Due to the ongoing awareness of opioid initiatives, community education opportunities will still continue to be tracked into FY17. In FY16, events with an indirect effect on the opioid epidemic: •National Night Out (Pocomoke and Berlin) – August 2015 •La Red Baby Shower (helping under privileged mom's) – November 2015 •Community Resource Days (throughout Worcester County) – December 2015, January, February, March, April 2016 •Chronic Pain Workshops - April/May and May/June 2016 •Support of Play It Safe Program in OC – June 2016 *Strategy #2* – AGH Employee Education Department partnered with the Worcester County Health Department during FY16 offering 2 Narcan training sessions with 20 participants. Objective 4: Increase and strengthen capacity for shared responsibility to address unmet health needs. a) Metrics: Participation on WOW Committee and Opioid Task Force by the end of the fiscal year. • Outcomes : Active participation on WOW Committee FY16 by VP Patient Care Services, Health Literacy Liaison, and Opioid Nurse. Active participation on Opioid Task Force Committee FY16 by VP Patient Care Services, Pharmacy, Population Health Manager and Opioid Nurse.
Continuation of Initiative	We will continue to monitor connections made to community programming for opioid abuse initiatives in FY17.

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $17,310	B. Direct offsetting revenue from Restricted Grants none