The MARYLAND
HEALTH SERVICES COST REVIEW COMMISSION

Peninsula Regional Medical Center

FY 2018 Community Benefit Narrative Report

PART ONE: ORIGINAL NARRATIVE SUBMISSION

Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

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

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

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless marked as optional. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

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

Q2. Please confirm the information we have on file about your hospital for FY 2018.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Peninsula Regional Medical Center.	◉	○	
Your hospital's ID is: 210019.	◉	○	
Your hospital is part of the hospital system called N/A.	◉	○	
Your hospital was licensed for 289 beds during FY 2018.	◉	○	
Your hospital's primary service area includes the following zip codes: 21801, 21802, 21803, 21804, 21810, 21811, 21813, 21814, 21817, 21821, 21822, 21824, 21826, 21829, 21830, 21836, 21837, 21838, 21840, 21841, 21842, 21843, 21849, 21850, 21851, 21852, 21853, 21856, 21857, 21861, 21862, 21863, 21864, 21865, 21866, 21867, 21871, 21872, 21874, 21875, 21890.	◉	○	
Your hospital shares some or all of its primary service area with the following hospitals: Atlantic General Hospital, McCready Health.	◉	○	

Q3. The next two questions ask about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q4. (Optional) Please describe any other community health statistics that your hospital uses in its community benefit efforts.

Please see attached "Market Area and Demographics.docx"

Q5. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Market_Area_and_Demeographics.docx
2.2MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q6. Please select the county or counties located in your hospital's CBSA.

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

Q7. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q8. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q9. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q11. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

☑ 21817	☑ 21824	☑ 21853

- [x] 21821
- [x] 21822
- [x] 21838
- [x] 21851
- [x] 21871

Q26. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

- [x] 21804
- [x] 21811
- [x] 21813
- [x] 21822
- [x] 21829
- [x] 21841
- [x] 21842
- [x] 21851
- [x] 21862
- [x] 21863
- [x] 21864
- [x] 21872

Q31. How did your hospital identify its CBSA?

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

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

Q32. Provide a link to your hospital's mission statement.

https://www.peninsula.org/about-us

Q33. Is your hospital an academic medical center?

- ○ Yes
- ◉ No

Q34. (Optional) Is there any other information about your hospital that you would like to provide?

Q35. (Optional) Please upload any supplemental information that you would like to provide.

Q36.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (•) Yes
- ( ) No

Q37. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q38. When was your hospital's first-ever CHNA completed? (MM/DD/YYYY)

06/01/2013

Q39. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/28/2016

Q40. Please provide a link to your hospital's most recently completed CHNA.

https://www.peninsula.org/community/community-health-needs-assessment-and-implementation-plan

Q41. Did you make your CHNA available in other formats, languages, or media?

- (•) Yes
- ( ) No

Q42. Please describe the other formats in which you made your CHNA available.

The CHNA was made available in an electronic copy format and a hard copy format that was available to be viewed and distributed to residents of our community. The CHNA will be translated into Spanish for our Spanish speaking residents. We are also in the process of reviewing our Creole population to determine if we need to translate the CHNA into Creole.

Q43. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

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

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☑	The Board of Trustees receives a copy of the Community Health Needs Assessment and the Implementation Strategy Plan to review, discuss, and approve. There are also periodic updates to action plans, milestones, and progress updates.
Board of Directors or Board Committee (system level)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☑	The Board of Trustees receives a copy of the Community Health Needs Assessment and the Implementation Strategy Plan to review, discuss, and approve. There are also periodic updates to action plans, milestones, and progress updates.
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Clinical Leadership (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Population Health Staff (facility level)	☐	☐	☑	☐	☑	☑	☑	☑	☐	☐	
Population Health Staff (system level)	☐	☐	☑	☐	☑	☑	☑	☑	☐	☐	
Community Benefit staff (facility level)	☐	☐	☑	☐	☑	☑	☑	☑	☐	☐	
Community Benefit staff (system level)	☐	☐	☑	☐	☑	☑	☑	☑	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☑	☐	☑	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☐	☐	☑	☐	☑	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☐	☐	☑	☐	☑	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit Task Force	☐	☐	☑	☑	☑	☑	☑	☑	☐	☑	Those identified in the preceding positions (nurses, social workers, etc.) make up the Community Benefit Task Force. Others from Behavioral Health, Marketing, and Planning were also participants in the Community Benefit Task Force.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify) Behavioral Health, Marketing, Planning, Diabetes Department, Emergency Department, Cardiac Rehab, Pediatric Endocrinology, and Employee Health and Wellness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Participants in each of these departments used their knowledge and unique expertise to contribute in the CHNA.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q44. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Wicomico County Health Department and Somerset County Health Department	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Area Agency on Aging -- Please list the agencies here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Govt. Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - K-12 -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Colleges and/or Universities -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Post-Acute Care Facilities -- please list the facilities here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q45. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (•) Yes
- ( ) No

Q46. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

11/02/2016

Q47. Please provide a link to your hospital's CHNA implementation strategy.

https://www.peninsula.org/community/community-health-needs-assessment-and-implementation-plan

Q48. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q49. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

- ☐ Access to Health Services: Health Insurance
- ☑ Access to Health Services: Practicing PCPs
- ☐ Access to Health Services: Regular PCP Visits
- ☐ Access to Health Services: ED Wait Times
- ☐ Adolescent Health
- ☐ Arthritis, Osteoporosis, and Chronic Back Conditions
- ☐ Family Planning
- ☐ Food Safety
- ☐ Genomics
- ☐ Global Health
- ☐ Health Communication and Health Information Technology
- ☐ Health-Related Quality of Life & Well-Being
- ☐ Older Adults
- ☐ Oral Health
- ☑ Physical Activity
- ☐ Preparedness
- ☐ Respiratory Diseases
- ☐ Sexually Transmitted Diseases

☐ Blood Disorders and Blood Safety	☐ Hearing and Other Sensory or Communication Disorders	☐ Sleep Health
☑ Cancer	☑ Heart Disease and Stroke	☑ Social Determinants of Health
☐ Chronic Kidney Disease	☐ HIV	☑ Substance Abuse
☐ Community Unity	☐ Immunization and Infectious Diseases	☐ Telehealth
☑ Dementias, Including Alzheimer's Disease	☐ Injury Prevention	☑ Tobacco Use
☑ Diabetes	☐ Lesbian, Gay, Bisexual, and Transgender Health	☐ Violence Prevention
☐ Disability and Health	☐ Maternal & Infant Health	☐ Vision
☐ Educational and Community-Based Programs	☑ Mental Health and Mental Disorders	☐ Wound Care
☐ Emergency Preparedness	☑ Nutrition and Weight Status	Other (specify) ☑ Obesity
☐ Environmental Health		

Q50. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

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

Q51. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

On November 2, 2016, the Board of Trustees approved Peninsula Regional's strategic implementation strategy to proceed with the following three themed initiatives: Chronic Disease Management with an emphasis on Diabetes, Exercise, Nutrition and Weight, and Behavioral Health. The 2018 CHNA will be completed in December and subsequently a strategic implementation plan with an outline of its strategic initiatives will be presented to the Board for approval approximately the first quarter of the New Year.

Q52. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Market_Area_and_Demographics.docx
2.2MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q53. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☐	☐	☐	☐	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☐	☐	☐	☐	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☑	☑	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

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

Community Benefit Task Force	☐	☐	☑	☑	☑	☐	☐	☐	☐	☑	Those identified in the preceding positions (nurses, social workers, etc.) make up the Community Benefit Task Force. Others from Behavioral Health, Marketing, and Planning were also participants in the Community Benefit Task Force.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q54. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: McCready Memorial Hospital, Atlantic General Hospital, Children's National Medical Center	☐	☐	☐	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Wicomico Health Department, Somerset Health Department, and Worcester Health Department	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Wicomico County Local Health Improvement Coalition, Healthy Somerset, and the Worcester County Planning Committee	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Area Agency on Aging -- Please list the agencies here: MAC, Inc. (Maintaining Active Citizens)	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Govt. Organizations -- Please list the organizations here: City of Salisbury	☐	☐	☐	☐	☑	☐	☑	☑	☐	The City of Salisbury continues to work on improving the quality of life through events that promote walkability and healthy lifestyles.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☐	☐	☑	Peninsula Regional Medical Center works with Faith Based Organizations in the community to provide healthy lifestyle education, flu shots, facilitate the pairing of people with local health-based resources. The organizations we have partnered with are: Union United Methodist, Ewell United Methodist, New Dimensions, New Macedonia Church, Mount Carmel Baptist, Emanuel Wesleyan, St. Paul AME Zion Church - Berlin, St. Paul's - Salisbury, St. James, AME, St. Peter's Lutheran, Grace United Methodist, Holy Redeemer, and Mt. Zion Baptist.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - K-12 -- Please list the schools here: Wicomico High, Wicomico Middle, Westside Intermediate, Salisbury Middle, Parkside High, James M Bennett High, Bennett Middle, and Fruitland Intermediate	☐	☐	☐	☐	☐	☐	☑	☑	☑	The coalition coordinates care between 130-150 middle and high school students. Peninsula Regional's team educates and advocates for children in need of specialty care by working with the tri-county school nurses to develop each patient's diabetes management plan for the school year.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Colleges and/or Universities -- Please list the schools here: UMES, Salisbury University, and Wor-Wic Community College	☐	☐	☐	☐	☐	☐	☐	☐	☑	We partner with the local universities in various population health capacities that include participating in university sponsored health fairs. In addition, through sponsorship and education, we support their diabetes and pharmacy education programs. Also, we promote and attend local Walkability events and other exercise events that promote healthy lifestyles.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Nursing School -- Please list the schools here: Salisbury University Nursing School	☐	☐	☐	☐	☐	☐	☐	☐	☑	Nursing students at Salisbury University intern on the Wagner Wellness Van Mobile Outreach Clinic, providing health screenings and health education to medically undeserved areas in the community. The nursing students also learn about the continuum of care from a population health perspective throughout their clinical rotation process among the various departments of Peninsula Regional.

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here: University of Maryland Eastern Shore	☐	☐	☐	☐	☐	☐	☐	☐	☑	Pharmacy students at the University of Maryland Eastern Shore intern with Peninsula Regional's pharmacy department and retail pharmacy HomeScripts.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here: C.O.A.T., CareWrap, Resource and Recovery Center	☐	☐	☐	☐	☐	☐	☑	☑	☑	Resource and Recovery Center provides space for Wagner Wellness Van Mobile Outreach Clinic.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here: Worcester County Social Services	☐	☐	☐	☐	☐	☐	☐	☐	☑	Provided space for Wagner Wellness Van Mobile Outreach Clinic.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Post-Acute Care Facilities -- please list the facilities here: Salisbury Genesis, Anchorage, Coastal Hospice, Aurora Nursing Home, Berlin Nursing Home, White Oak SNF, Harrison House, Hartley Hall, and Deers Head Center	☐	☐	☐	☐	☐	☐	☐	☐	☑	Peninsula Regional Medical Center continues to work with post-acute care facilities to provide appropriate transitions of care for patients.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here: Local EMT Serivces, Lower Shore Clinic, Lower Shore Enterprises, Bayshore Services, Tri-County Diabetes Alliance, Salvation Army, Coastal Hospice, James Leonard Apartments (Low Income Housing), Salisbury Urban Ministries, YMCA Delmarva, and Parents and Children (Childcare Center)	☐	☐	☐	☐	☐	☐	☐	☐	☑	PRMC continues to partner with local community/neighborhood organizations to increase awareness and engagement in healthy lifestyles and behaviors. Peninsula Regional engages in and partners with each neighborhood organization and their vision, whether it's diabetes screenings and education, nutrition and weight loss, social determinants of health and its corresponding correlation to behavioral health, or any unmet identified health need in the community. These organizations also provided space for the Wagner Wellness Van Mobile Outreach Clinic and subsequently refers patients to physician providers and community based services determined by their condition.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here: Crisfield Clinic, HALO, Hope, Inc., Chesapeake Health Care, Other Independent and Employed Physicians, (PRCIN - Peninsula Regional Clinically Integrated Network), Dr. Jonathan Patrowicz, Dr. Alon Davis, Dr. Chris Huddleston, and Dr. Vel Natesan.	☐	☐	☐	☐	☐	☐	☐	☐	☑	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q55. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- ☑ Yes, by the hospital's staff
- ☑ Yes, by the hospital system's staff
- ☐ Yes, by a third-party auditor

☐ No

Q56. Does your hospital conduct an internal audit of the community benefit narrative?

◉ Yes
○ No

Q57. Please describe the community benefit narrative review process.

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

Q58. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

◉ Yes
○ No

Q59. Please explain:

This question was not displayed to the respondent.

Q60. Does the hospital's board review and approve the annual community benefit narrative report?

◉ Yes
○ No

Q61. Please explain:

This question was not displayed to the respondent.

Q62. Does your hospital include community benefit planning and investments in its internal strategic plan?

◉ Yes
○ No

Q63. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

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

Q64. (Optional) If available, please provide a link to your hospital's strategic plan.

www.peninsula.org/publications (Please see Vision 2020 and other strategic planning documents)

Q65. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

Please see following document.

Q66. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Additional_Pop_Health_Initiatives_Collaborations.docx
1.5MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q67. Based on the implementation strategy developed through the CHNA process, please describe *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q68. Initiative 1

Q69. Name of initiative.

Chronic Disease Management

Q70. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q71. Select the CHNA need(s) that apply.

- [ ] Access to Health Services: Health Insurance
- [x] Access to Health Services: Practicing PCPs
- [x] Access to Health Services: Regular PCP Visits
- [x] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Blood Disorders and Blood Safety
- [ ] Cancer
- [ ] Chronic Kidney Disease
- [x] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [x] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [x] Heart Disease and Stroke
- [ ] HIV
- [x] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [x] Mental Health and Mental Disorders
- [x] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [x] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Social Determinants of Health
- [x] Substance Abuse
- [x] Telehealth
- [x] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [x] Other. Please specify. Hypertension

Q72. When did this initiative begin?

01/01/2015

Q73. Does this initiative have an anticipated end date?

- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ( ) The initiative will end when external grant money to support the initiative runs out. Please explain.
- ( ) The initiative will end when a contract or agreement with a partner expires. Please explain.

Other. Please explain. 1. MAC Chronic Disease Management - This initiative will continue into the foreseeable future. 2. Wagner Wellness Van Mobile Outreach Clinic - This initiative has been well received by the community and will be continued into the future. 3. Smith Island Telemedicine - This initiative will be continued into the future because there is a need for the people of Smith Island, which is in PRMC's Primary Service Area. 4. SWIFT - This initiative is grant based and will continue until the grant ends, however, there will be joint meetings to evaluate the continuation of this program.

Q74. Enter the number of people in the population that this initiative targets.

1. MAC Chronic Disease Self-Management - 20,000+ residents. 2. Wagner Wellness Van Mobile Outreach Clinic - 71,058 residents. 3. Smith Island Telemedicine - 250 residents. 4. SWIFT - 300 high ED utilizing residents.

Q75. Describe the characteristics of the target population.

"1. MAC Chronic Disease Self-Management - Patients with uncontrolled chronic diseases which are identified via ER visits, the Wagner Wellness Van Mobile Outreach Clinic, and other providers. 2. Wagner Wellness Van Mobile Outreach Clinic - Residents of PRMC's primary service area who have barriers to care. 3. Smith Island Telemedicine - The average age of the population is 54 years old. A large percentage of the population is below poverty level, living on a remote island isolated from health services. Transportation is limited and can only be done by boat. 4. SWIFT - The target population is patients who rely heavily on EMS for non-emergency care."

Q76. How many people did this initiative reach during the fiscal year?

2,583

Q77. What category(ies) of intervention best fits this initiative? Select all that apply.

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

Q78. Did you work with other individuals, groups, or organizations to deliver this initiative?

Yes. Please describe who was involved in this initiative.

1. MAC Chronic Disease Self-Management -
MAC, Inc. the Area Agency on Aging
2. Wagner Wellness Van Mobile Outreach Clinic -
Atlantic General Hospital
McCready Health
MAC, Inc. the Area Agency on Aging
Wicomico County Health Department
Worcester County Health Department
Somerset County Health Department
City of Salisbury
HALO Shelter
HOPE Inc.
Salisbury Urban Ministries
St. James AME Church
St. Paul's AME Church
St. Peter's Catholic Church
Somerset County Library
Chesapeake Health Center
Community Foundation of the Eastern Shore
Resource and Recovery Center
National Kidney Foundation
Salisbury Fire Department
3. Smith Island Telemedicine -
McCready Health
Crisfield Clinic
Somerset County Health Department
National Kidney Foundation
MAC, Inc. the Area Agency on Aging
4. SWIFT -
City of Salisbury
Wicomico County Health Department
Salisbury Fire Department/EMS

○ No.

Q79. Please describe the primary objective of the initiative.

1. MAC Chronic Disease Self-Management - Managing chronic diseases that ultimately reduce ER visits and admissions. This is done through programs that are designed to assist with the management of chronic diseases, providing the participants awareness and education on controlling their diabetes, hypertension, and pain. These programs give the aging population a higher quality of life and sense of independence, ultimately keeping them healthy, strong, and out of the hospital. 2. Wagner Wellness Van Mobile Outreach Clinic - Providing health education, health resource coordination, screenings, healthy lifestyle promotion, reducing ED utilization. The van visits areas where the social determinants of health indicate the greatest amount of need. It provides care in areas with a higher prevalence of ER visits, lower median incomes, an indigent population, trouble accessing care, communication barriers, and overall poor health outcomes. 3. Smith Island Telemedicine - To increase access of care to island residents, educate residents about chronic disease management, and promote healthy lifestyles. The goal of the partnership was to improve the health of the Smith Island community, provide health literacy to residents, and reduce ED utilization. A major goal was to increase access to care within 48 hours of need being identified. All visits have occurred on the same day as the need was identified. 4. SWIFT - Reducing EMS and ED utilization by identification and intervention for the very highest utilizers. The SWIFT team works collaboratively to reduce overuse of emergency services and improve access by connecting these community members to area resources that address the social determinants of health that are at the root of their unnecessary use of the EMS system. The program also connects clients to more appropriate settings in which to have their care provided, such as primary care offices and FQAC's.

Q80. Please describe how the initiative is delivered.

1. MAC Chronic Disease Self-Management - Workshops/Classes located at MAC, Inc. 2. Wagner Wellness Van Mobile Outreach Clinic - Mobile Clinic serves locations in three counties. The staff includes an NP, RN, a Medical Assistant, and a Social Worker. 3. Smith Island Telemedicine - Clinical Health Worker's serve as liaisons for telemedicine visits with providers. In-person visits by a provider to the island occur every two weeks with the weather permitting. 4. SWIFT - An EMT and NP visit patients who are identified as high utilizers of EMS. A plan is then created based on a home assessment and then patient is followed by a team for an average of six months.

Q81. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

☑ Count of participants/encounters
1. MAC Chronic Disease Self-Management - 269 participants and See Attached Data. 2. Wagner Wellness Van Mobile Outreach Clinic - 2,022 encounters. 3. Smith Island Telemedicine - 100 participants. 4. SWIFT - 192 participants.

☐ Other process/implementation measures (e.g. number of items distributed)

☑ Surveys of participants
1. MAC Chronic Disease Self-Management - See attached.

☑ Biophysical health indicators
3. Smith Island Telemedicine - A couple's A1C levels reduced from the 300s to the 120s. 2. Wagner Wellness Van Mobile Outreach Clinic - Patients have reduced A1C levels in some cases. Other patients have seen hypertension reduced after receiving treatment from the Wagner Wellness Van.

☑ Assessment of environmental change
4. SWIFT - Patients are getting help finding local healthcare instead of calling 911.

☐ Impact on policy change

☑

Effects on healthcare utilization or cost	2. Wagner Wellness Van Mobile Outreach Clinic - Patients are getting referred to Primary Care Physicians instead of going to the ED. 3. Smith Island Telemedicine - 5% reduction in McCready Health ED usage. 4. SWIFT - Total ED Reduction is 37% of those participating in the program.
☐ Assessment of workforce development	
☑ Other	4. SWIFT - Reduction in EMS calls.

Q82. Please describe the outcome(s) of the initiative.

1. MAC Chronic Disease Self-Management - Increased the number of classes offered from 26 to 47. Increasing the number of classes increased encounters to over 450 lives, which has improved the quality of life for those enrolled, and reduced the probability of ER visits and inpatient admissions. 2. Wagner Wellness Van Mobile Outreach Clinic - Of the 893 encounters, repeat patients have shown improvement in their individual health conditions as provisions are made for screenings, health education, matching residents to community health resources, health literacy and healthy lifestyle promotion. 3. Smith Island Telemedicine - Residents are being matched with Community Health Workers to identify and review their chronic diseases, in conjunction with using telemedicine for primary care physician visits- in lieu of ending up in the ED with a possible admission. Over 50% of the residents on Smith Island have participated in our telemedicine primary care program which has also decreased ED utilization at McCready Memorial by 5%. 4. SWIFT - Decreased EMS and ED utilization for enrolled clients. Of the patients enrolled, there was a 35% reduction in EMS calls and a 37% reduction in ED utilization.

Q83. Please describe how the outcome(s) of the initiative addresses community health needs.

1. MAC Chronic Disease Self-Management - There is a need for chronic disease management within our community. There are many residents who have diabetes, are overweight, or are nutritional deficient. As the baby boomer generation ages, there is a need to better manage associated chronic diseases. With the partnership with MAC, many residents are gaining a better understanding of their chronic disease,reducing ER visits and avoiding future utilization of the healthcare system. 2. Wagner Wellness Van Mobile Outreach Clinic - There has been improved control of diabetes and hypertension. The Wagner Wellness Van strives to educate patients by providing nutritional and healthy lifestyle counseling, in addition to medication compliance, to control diabetes and hypertension. Health screenings are performed on residents to help determine appropriate education, self-management class information, or referrals to community resources and services. These screenings include pre-diabetes, hypertension and obesity. When warranted, drug and alcohol misuse screenings are also conducted, and counseling is available. If a resident is at risk for diabetes, an A1C screening is performed to further assist with diagnosis and treatment. 3. Smith Island Telemedicine- Improved health access to this isolated island, providing chronic care management services and preventative care opportunities through the installation of donated exercise equipment (bikes), donated pedometers, and provision of walking logs to residents. With the help of Community Health Workers and telemedicine primary care visits, there were improvements in chronic disease management and bio-metrics among participants. 4. SWIFT - This initiative identifies social determinants that contribute to the negative health outcomes of the patient and the subsequent high utilization of EMS services and the PRMC's Emergency Room. With identification of these single or multiple social determinants, solutions can be provided to these patients which can take the form of coaching, matching the patient to local health resources, or chronic disease management. This program meets the patients where they are at and provides coaching and direction in the management of their life and health.

Q84. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$2,553,274.85

Q85. (Optional) Supplemental information for this initiative.

Chronic_Disease_Management_with_All_Initiatives_a.docx
2MB
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Q86. Initiative 2

Q87. Name of initiative.

Exercise, Nutrition, and Weight

Q88. Does this initiative address a need identified in your CHNA?

- ◉ Yes
- ○ No

Q89. Select the CHNA need(s) that apply.

- ☐ Access to Health Services: Health Insurance
- ☐ Access to Health Services: Practicing PCPs
- ☐ Access to Health Services: Regular PCP Visits
- ☐ Access to Health Services: ED Wait Times
- ☑ Adolescent Health
- ☐ Arthritis, Osteoporosis, and Chronic Back Conditions
- ☐ Blood Disorders and Blood Safety
- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ Heart Disease and Stroke
- ☐ HIV
- ☐ Immunization and Infectious Diseases
- ☐ Injury Prevention
- ☐ Lesbian, Gay, Bisexual, and Transgender Health
- ☐ Maternal and Infant Health
- ☐ Mental Health and Mental Disorders
- ☑ Nutrition and Weight Status
- ☐ Older Adults

- [x] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [x] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [ ] Oral Health
- [x] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Social Determinants of Health
- [ ] Substance Abuse
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Other. Please specify.

Q90. When did this initiative begin?

07/01/2017

Q91. Does this initiative have an anticipated end date?

- ○ The initiative will end on a specific end date. Please specify the date.
- ○ The initiative will end when a community or population health measure reaches a target value. Please describe.
- ○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ○ The initiative will end when external grant money to support the initiative runs out. Please explain.
- ○ The initiative will end when a contract or agreement with a partner expires. Please explain.
- ◉ Other. Please explain. 1. WalkWicomico - This initiative will continue into the foreseeable future. 2. YMCA Exercise, Nutrition, and Weight will continue.

Q92. Enter the number of people in the population that this initiative targets.

103,378

Q93. Describe the characteristics of the target population.

1. WalkWicomico - The targeted population is all ambulatory residents of Wicomico County (100,000+). 2. YMCA Exercise, Nutrition, and Weight - The targeted population is children, adolescents and adults who are obese, overweight, or who have diabetes in Wicomico, Worcester, and Somerset counties.

Q94. How many people did this initiative reach during the fiscal year?

9,809

Q95. What category(ies) of intervention best fits this initiative? Select all that apply.

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

Healthy Lifestyles and Community Interaction

Q96. Did you work with other individuals, groups, or organizations to deliver this initiative?

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

1. WalkWicomico -
City of Salisbury
University of MD Extension
YMCA
Maryland Department of Planning
Shore Transit
Wicomico County Public Schools
Salisbury/Wicomico Metropolitan Planning Organization
Town of Fruitland
Town of Delmar
Wicomico County Health Department
Wicomico County Recreation, Parks, and Tourism
2. YMCA Exercise, Nutrition, and Weight-
YMCA
Children's National Health System
Wicomico County Schools

- ( ) No.

Q97. Please describe the primary objective of the initiative.

1. WalkWicomico - The primary objective is to increase awareness of and engagement in healthy lifestyle behaviors promoting exercise to help with weight loss, increase energy, reduce risk of chronic disease and make people feel happier. "WalkWicomico" is primarily targeting those that reside in the county (pop. 100,000+); however, it would also be an attraction for adjacent counties including visitors. Walk Wicomico is a coalition of partners that meets to create action plans that encourage and provide access and events to "get out" and enjoy the great outdoors by walking your way to health. Peninsula Regional is an active participant in transforming the community's culture by providing education, guidance and resources towards promoting exercise through walkability as an integral part of a healthy lifestyle. The Coalition's initiatives included creating a website and phone app specific to walking in Wicomico County; communicating with the community via social media; working with civic organizations, churches, local businesses, towns, county health departments, and other groups to encourage local walkability. Walk Wicomico has marked walking routes, increased the number of walking routes, participated in and launched walking events, and is engaged with decision makers through input and feedback about making walking safer, easier, and more accessible. 2. YMCA - The primary objective is to reduce the number of child & adolescents/adults in Wicomico, Worcester and Somerset counties who are considered overweight and present a healthy lifestyle of nutrition and exercise opportunities. To address obesity, Peninsula Regional also participates in the Tri-County Diabetes Alliance and Live Healthy Wicomico. The groups meet monthly or every other month to develop partnerships to address prevention and treatment of diabetes, obesity and other health issues. Projects include promoting lifestyle changes for disease prevention, team work in the community, and awareness of pre-diabetes and diabetes services available in the community. To expand our "Healthy Living" message, Peninsula Regional sponsors and participates in many community-based health fairs providing nutrition education, weight loss, and diabetes and health literacy. These health fairs include under served areas like Smith Island, an island on the Chesapeake Bay with a population of only 250, a Haitian Creole Health Fair, Healthfest and screenings at the Governor's Basketball Challenge at the Civic Center in Wicomico County.

Q98. Please describe how the initiative is delivered.

1. WalkWicomico - The initiative is delivered by providing education, guidance, and resources towards promoting exercise through walkability. The Coalition created a website and phone app specific to walking in Wicomico County. There are also community walks and meetings held with local towns and cities to expand walkability in Wicomico County. 2. YMCA Exercise, Nutrition, and Weight - This initiative is delivered by holding monthly group meetings to develop partnerships and address prevention and treatment of diabetes, obesity, and other health issues. Projects and events are sponsored locally with partners that promote lifestyle changes and an opportunity to engage the community in dialog regarding health and nutrition.

Q99. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters — 1. WalkWicomico - 9,809 participants/encounters. 2. YMCA & Community Based Healthy Lifestyles- 3,122
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [ ] Biophysical health indicators
- [x] Assessment of environmental change — 1. WalkWicomico - Mapped new walking trails.
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [x] Other — 1. WalkWicomico - Website and phone app created.

Q100. Please describe the outcome(s) of the initiative.

1. WalkWicomico - A WalkWicomico website and phone app were created which are specific to walking trails in Wicomico County. A Facebook page was launched 12/12/17; more than 193 followers as of 06/30/18. WalkWicomico 1 Billion Steps Challenge team walked 6,342,425 steps, with a final rank of 164 out of 398 teams. There has been an increase in marked walking routes, an increase in the number of walking trails, participation in and launching of walking events. The Coalition also engaged with decision makers through input and feedback about making walking safer, easier, and more accessible. A WalkWicomico partner presented the WalkWicomico program at WiCHD's (Wicomico County Health Department) Outstanding Public Health Leader Awards Ceremony on April 2, 2018. 2. YMCA & Community Based Healthy Lifestyles - We sponsor and participate in many community-based health fairs providing education on nutrition, weight loss, diabetes, and overall health. With over 2,800 encounters, 72 residents referred, and 350 residents screened at health fairs, we are transforming the culture of the community by providing blood pressure, body fat, oral cancer, bone density, and glaucoma screenings among others. PRMC partnered with Children's National Health System to bring pediatric endocrinology services to the Delmarva Peninsula. We are coordinating care between 130-150 elementary, junior high, and high school students that have chronic or long-term endocrine disorders.

Q101. Please describe how the outcome(s) of the initiative addresses community health needs.

1. WalkWicomico - The outcomes of WalkWicomico address the needs to adolescent health, diabetes, physical activity, and health-related quality of life and well-being by creating an avenue to getting people physically active and healthier. There is also community unity by creating new walking trails and by hosting and participating in meetings and community walks. 2. YMCA & Community Based Healthy Lifestyles- The outcomes of this initiative are conducting educational sessions and referring obese pediatric and adult patients to the YMCA. The outcomes of community based healthy lifestyles is the continued presence of PRMC at health fairs, schools, small employers and local under served areas promoting health screenings, health literacy and coordinating residents with local healthcare and social resources.

Q102. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$426,475.00

Q103. (Optional) Supplemental information for this initiative.

Exercise__Nutrition__and_Weight.docx
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Q104. Initiative 3

Q105. Name of initiative.

Behavioral Health

Q106. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q107. Select the CHNA need(s) that apply.

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

Q108. When did this initiative begin?

07/01/2016

Q109. Does this initiative have an anticipated end date?

- ○ The initiative will end on a specific end date. Please specify the date.
- ○ The initiative will end when a community or population health measure reaches a target value. Please describe.
- ○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ○ The initiative will end when external grant money to support the initiative runs out. Please explain.
- ○ The initiative will end when a contract or agreement with a partner expires. Please explain.
- ◉ Other. Please explain. 1. COAT- This initiative will continue into next FY 2019. 2. CareWrap has ended in Spring of FY 2018 coinciding with grant ending.

Q110. Enter the number of people in the population that this initiative targets.

9,874

Q111. Describe the characteristics of the target population.

1. COAT - The targeted population is Wicomico County residents who have substance abuse issues, behavioral health and socialization issues, high utilization of the ED, and/or social determinants of health needs. 2. CareWrap - The targeted population are patients who have a high risk for being readmitted to the hospital within 30 days of discharge due to behavioral health or social determinants of health issues.

Q112. How many people did this initiative reach during the fiscal year?

431

Q113. What category(ies) of intervention best fits this initiative? Select all that apply.

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

Q114. Did you work with other individuals, groups, or organizations to deliver this initiative?

- ◉ Yes. Please describe who was involved in this initiative.

1. COAT-
Wicomico County Health Department
State's Attorney's Office
Salisbury City Government
Wicomico County Sheriff's Office
2. CareWrap -
Lower Shore Clinic

○ No.

Q115. Please describe the primary objective of the initiative.

1. COAT - The primary objective of this initiative is to reduce drug overdoses, substance abuse cases, and get treatment to people who have substance abuse problems presenting at PRMC's Emergency Room. The COAT initiative is a partnership between Peninsula Regional Medical Center, the Wicomico County Health Department, the State's Attorney's Office, the Salisbury City Government, and the Wicomico County Sheriff's Office. COAT, or Community Outreach Addictions Team, is an opioid intervention task force that visit and counsel drug dependent residents of Wicomico County and the surrounding areas. The team consists of peer mentors who were previously addicted to drugs themselves. These mentors talk to those struggling with addiction and try to get them to enroll into treatment. The collaboration begins in the Emergency Department. If a patient comes in as an overdose or is suffering from addiction symptoms, the PRMC staff calls the 24/7 hotline number to have a COAT Team Member visit with the patient. This peer mentor helps to provide a smooth transition to treatment services that link the patient with local mental health and addiction resources in the community or to other areas if necessary. The focal point of having these peer mentors to help with the transition process is that as a previous opioid addict, the mentor has grown in their own recovery and has knowledge and understanding that a professional can't replicate. COAT partners meet monthly at the Wicomico County Health Department to evaluate successes and to plan initiatives for the future of the COAT program since it has been extended into FY 2019. Most recently, the COAT program has expanded to the Labor and Delivery department of the hospital to help pregnant women and substance exposed newborns. 2. CareWrap - The primary objective of this initiative is to reduce 30 day readmission rates and ER utilization rates. CareWrap is hospital-community collaboration between PRMC and Lower Shore Clinic located in Salisbury, Maryland. The model is based on the Pathways model used by Family Services, Inc. The partnership's aim is to decrease thirty-day readmission rates. The "Transitions Team" at Peninsula Regional targets patients that have a high risk for returning to the hospital within 30 days of discharge. Once identified, those individuals are referred to the CareWrap program. The goal is to reduce hospital readmissions by helping patients' access primary care and behavioral health services, and to help fill other social determinants of health gaps to ensure a smooth transition to health stabilization. A centralized e-mail process was developed to facilitate ease of referral and clinical review to determine the appropriateness of referral prior to assignment. Community Health Workers link patients to community resources and access to the healthcare system to eliminate and/or minimize social determinants of health. Examples include: obtaining housing, filling prescriptions, taking medications, finding transportation and linking patients to entitled financial assistance or helping find employment. The CareWrap team provides weekly status updates on all patients. This team discusses participant progress as well as identifying barriers and works toward solutions.

Q116. Please describe how the initiative is delivered.

1. COAT - When a patient enters the ED for a drug overdose seeking treatment, PRMC staff call the 24/7 hotline number to have a COAT Team Member visit with the patient to assist in educating and transitioning into receiving rehabilitation services. This mentor is a former addict who helps to provide a smooth transition to treatment services that link the patient with local mental health and addiction resources in the local community or elsewhere if necessary. This collaboration is overseen by the Wicomico County Health Department and Peninsula Regional. 2. CareWrap - The "Transitions Team" at Peninsula Regional targets patients that have a high risk for returning to the hospital within 30 days of discharge. Once identified, those individuals are referred to the CareWrap program. Community Health Workers link patients to community resources and access to the healthcare system to eliminate and/or minimize social determinants of health. The goal is to reduce hospital readmissions by helping patients' access primary care and behavioral health services, and to help fill other social determinants of health gaps to ensure a smooth transition to health stabilization.

Q117. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- ☑ Count of participants/encounters — 1. COAT - 369 2. CareWrap - 62.
- ☐ Other process/implementation measures (e.g. number of items distributed)
- ☐ Surveys of participants
- ☐ Biophysical health indicators
- ☐ Assessment of environmental change
- ☐ Impact on policy change
- ☑ Effects on healthcare utilization or cost — 1. COAT - Reduction in opioid prescriptions compared to similar peer groups and a reduction in heroin overdoses in the ED by 57% over several years. 2. CareWrap - Reduction in Hospital visits between 4% and 6%.
- ☐ Assessment of workforce development
- ☐ Other

Q118. Please describe the outcome(s) of the initiative.

1. COAT - From the previous year there has been a 42% reduction in opioid-related deaths in Wicomico County. Peninsula Regional ED heroin overdoses have decreased dramatically in the last three years from a high in CY 2016 of 264 to a low of 114 in CY 2018, which is a 57% decrease. Through EMR (Electronic Medical Records), procedural changes and education, our physician staff reduced the overall amount of opioid prescriptions compared to our peer group in an effort to reduce the amount of opioids in the community. 2. CareWrap - Those enrolled in the program on an annual basis experienced a reduction in Peninsula Regional visits between 4% and 6%, and a reduction in the average charge per visit between $800 and $7,200. However, after one year, there was a slight increase in visits of 1% by patients enrolled in this program, continued longitudinal management of these patients would be required to maintain a reduction in utilization of inpatient and outpatient resources.

Q119. Please describe how the outcome(s) of the initiative addresses community health needs.

1. COAT - This initiative addresses substance abuse, behavioral health, and social determinants of health within the Wicomico County population. These patients exhibit a high utilization rate of Peninsula Regional's emergency room. The initiative addresses homelessness, the opioid crisis, the increase of the overall drug culture in the community, and related behavioral health issues. 2. CareWrap - This initiative addresses social determinants of health and behavioral health within the Wicomico County population. The Community Health Workers also help link patients with local healthcare resources and services to improve the social determinants of health.

Q120. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$86,559.74

Q121. (Optional) Supplemental information for this initiative.

Behavioral_Health.docx
95KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q122. (Optional) Additional information about initiatives.

Q123. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

Q124. Were all the needs identified in your CHNA addressed by an initiative of your hospital?

- (•) Yes
- ( ) No

Q125. Please check all of the needs that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q126. How do the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? The State Health Improvement Process (SHIP) seeks to provide a framework for accountability, local action, and public engagement to advance the health of Maryland residents. The SHIP measures represent what it means for Maryland to be healthy. Website: http://ship.md.networkofcare.org/ph/index.aspx. To the extent applicable, please explain how the hospital's community benefit activities align with the goal in each selected measure.

Enter details in the text box next to any SHIP goals that apply.

Reduce infant mortality	
Reduce rate of sudden unexpected infant deaths (SUIDs)	
Reduce the teen birth rate (ages 15-19)	
Increase the % of pregnancies starting care in the 1st trimester	
Increase the proportion of children who receive blood lead screenings	
Increase the % of students entering kindergarten ready to learn	
Increase the %of students who graduate high school	
Increase the % of adults who are physically active	There are several initiatives that align with this SHIP objective, Peninsula Regional's collaboration with the YMCA and the partnership coalition with Walk Wicomico. In addition, the Wagner Wellness Van which is our mobile clinic also screens for obesity and provides education/resources for engaging in healthy lifestyle practices. The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included adults who are obese or overweight and have neglected exercise. The WalkWicomico initiative is designed to improve, encourage, and promote walkability in Wicomico County. The project brings community partners together to discuss creating walking trails and other venues to increase awareness of and engagement in healthy lifestyle behaviors promoting exercise to help with weight loss, increase energy, reduce risk of chronic disease and make people feel happier. Peninsula Regional continues to explore population health initiatives with the YMCA on health-related topics. PRMC clinical teams participate in YMCA programs and services, health literacy programs for families, increased blood pressure and hypertension monitoring, enhanced diabetes education and a focused collaboration around the Y's keeping children moving and active campaign to reduce obesity.
Increase the % of adults who are at a healthy weight	There are several initiatives that align with this SHIP objective, Peninsula Regional's collaboration with the YMCA and the partnership coalition with Walk Wicomico. In addition, the Wagner Wellness Van which is our mobile clinic also screens for obesity and provides education/resources for engaging in healthy lifestyles practices.
Reduce the % of children who are considered obese (high school only)	
Reduce the % of adults who are current smokers	
Reduce the % of youths using any kind of tobacco product (high school only)	
Reduce HIV infection rate (per 100,000 population)	
Reduce Chlamydia infection rate	
Increase life expectancy	All of Peninsula Regional's initiatives outlined in this Community Benefits Report contribute to a potential increase in life expectancy. These initiatives are self-evident as many of the programs (MAC, Smith Island Telemedicine, SWIFT, WalkWicomico) are focused on chronic disease management. MAC- Peninsula Regional Medical Center has continued their partnership with MAC, Inc. Area Agency on Aging to assist with the management of chronic diseases. Members and residents can participate in a wide variety of evidence based classes, exercise classes and wellness programs, including fall prevention. Smith Island Telemedicine- Smith Island, MD is a small, tight knit community of about 250 people. The town is collectively made of strong, loyal, and hard-working people. This area is known for its watermen, the seafood economy, and not having too many â€œoutsidersâ€ come to visit. For this reason, Peninsula Regional Medical Center created a partnership with McCready Health, MAC - Area Agency on Aging, Somerset County Health Department, and the Crisfield Clinic. The goal of the partnership was to improve the health of the Smith Island community, provide health literacy to residents, and reduce ED utilization. The program was led by the Smith Island community health worker staff where they would provide chronic disease educational support and connect the residents of Smith Island with telehealth for primary care purposes. SWIFT- The Salisbury-Wicomico Integrated FirstCare Team (SWIFT), a partnership between the Salisbury Fire Department and Peninsula Regional Medical Center, has earned the MIEMSS Executive Director's Award for Excellence in EMS. The team of a Salisbury paramedic and PRMC nurse provides home visits for individuals who are frequent users of 911. The SWIFT team works collaboratively to reduce overuse of emergency services and improve access by connecting these community members with healthcare options better provided in a primary or specialty care setting. WalkWicomico-The primary objective is to increase awareness of and engagement in healthy lifestyle behaviors promoting exercise to help with weight loss, increase energy, reduce risk of chronic disease and make people feel happier.
Reduce child maltreatment (per 1,000 population)	
Reduce suicide rate (per 100,000)	
Reduce domestic violence (per 100,000)	
Reduce the % of young children with high blood lead levels	

Decrease fall-related mortality (per 100,000)	Peninsula Regional Medical Center has continued their partnership with MAC, Inc. Area Agency on Aging to assist with the management of chronic diseases. Members and residents can participate in a wide variety of evidence based classes, exercise classes and wellness programs, including fall prevention. These programs are designed to assist with the management of chronic diseases, providing the participants awareness and education on controlling their diabetes, hypertension, and pain, giving the aging population a higher quality of life and sense of independence, ultimately keeping them healthy, strong, and out of the hospital. Fall Prevention Classes â€¢ Stepping On falls prevention program: This program focuses on how strength and balancing exercises, medication management, home safety, footwear, vision and mobility are important in preventing falls. â€¢ Tai Ji Quan: Moving for Better Balance: This fall prevention program for older adults is designed to improve balance and functional movement patterns â€¢ Enhance Fitness: This program incorporates all aspects of physical fitness; cardio, upper and lower body, strength and endurance, flexibility and balance.
Reduce pedestrian injuries on public roads (per 100,000 population)	
Increase the % of affordable housing options	
Increase the % of adolescents receiving an annual wellness checkup	
Increase the % of adults with a usual primary care provider	
Increase the % of children receiving dental care	
Reduce % uninsured ED visits	
Reduce heart disease mortality (per 100,000)	The Wagner Wellness Van is staffed with a Certified Nurse Practitioner, Registered Nurse, and Medical Assistant to provide a number of services to residents without appointment that are school age residents or above. For FY 2018 (July 1, 2017 to June 30, 2018) a total of 845 patients were served on the Wagner Wellness Van. The ages of patients ranged from 14 to 95 years old. People of multiple ethnicity, both male and female, received care. A number of health screenings were performed on residents that help determine appropriate education, self-management class information, or referrals to community resources and services. These screenings include pre-diabetes, hypertension and obesity. Heart Smart Community Screenings are provided to the community to promote a healthy heart though understanding of lifestyle and risk factors that can help reduce the risk of heart disease. These are free and comprehensive screenings with several hundred encounters, 155 screened and 3 immediately referred. Comprehensive Screenings include: â€¢ Cholesterol, HDL, triglycerides, fasting blood glucose â€¢ Resting 12-lead EKG â€¢ Body fat and body mass index â€¢ Waist to hip ratio â€¢ Blood pressure testing â€¢ Pulse oximetry testing â€¢ 10-year risk analysis â€¢ Review of current medications â€¢ Follow-up care plan Exercise/nutrition recommendations
Reduce cancer mortality (per 100,000)	
Reduce diabetes-related emergency department visit rate (per 100,000)	There are several Peninsula Regional initiatives that align with this SHIP objective, our collaboration with MAC, Inc. Area Agency on Aging which provides chronic disease management classes for diabetes and our Smith Island Telemedicine program that provides residents of this Chesapeake Bay Island with diabetes management. â€¢ Diabetes Self-Management: Diabetes is associated with an increased risk for a number of serious, even life-threatening complications. Good diabetes control can help reduce the risk of these complications. Topics include nutrition, exercise, stress management, foot care and more. This class is also available in Spanish. â€¢ Diabetes Prevention Program: This lifestyle change intervention program is designed to help participants make lasting changes to reduce their risk of developing Type 2 Diabetes. Developed by the Center for Disease Control, this program offers participants the skills they need to lose weight, be more physically active and manage stress; a trained lifestyle coach to guide and encourage participants; support from other participants, and six monthly follow-up sessions to help participants maintain healthy lifestyle changes. Must be pre-diabetic or demonstrate a high risk of developing Type 2 diabetes. In addition, Peninsula Regional Medical Center has partnered with Children's National Health System, based in Washington, DC, to bring nationally recognized pediatric endocrinology services to the Delmarva Peninsula. Children's pediatric endocrinologists have the expertise to recognize, diagnose, and treat complex endocrine conditions. Our team teaches parents and children how to manage chronic or long-term endocrine disorders, such as diabetes. It has been an endeavor of passionate care that prepares and provides guidance to our youngest and most vulnerable residents, they are taught how to self-manage their diabetes returning their life to normalcy of family, friends, school and sports. Specialties covered that would otherwise be sent across the bridge, to one of 15 pediatric endocrinologists in the state are : Hyperthyroidism, Diabetes Type 1 and 2, Precocious and Delayed Puberty (growth hormone injections), and Failure to Thrive. This program is a multi-collaborative initiative between Peninsula Regional, Children's National, Schools in the Tri-County area and local YMCAs. At any time we are coordinating care between 130-150 elementary students, junior high students and high school students, Peninsula Regional's team educates and advocates for children in need of specialty care by working with the tri-county area school nurses to develop each patient's diabetes management plan for the school year. The team also diligently works to stay up to date on the newest technology available (Dexcom G6), providing the best care management tools for success. Bi-weekly a RN Dietitian follows up with patients immediately after assessment, therefore saving the patient and family a second trip to the clinic. Telemedicine connectivity with Children's DC provides the 24/7 accessibility of on-call physicians, as well as, providing scheduled telemedicine consults for endocrinology and diabetes care. Another fun aspect has been the increased volume of children attending a â€œDiabetes Campâ€ where participation has increased from 1 participant to 11 in five years. The Diabetes and Education Department at Peninsula Regional continues to impact the community through promotion of nutrition, weight loss and diabetes health literacy, as evidenced by the following community visits: â€¢ July 24, 2017 Wagner Wellness Van â€¢ September 7, 2017 Salisbury Urban Ministries (Wagner Wellness Van) â€¢ September 11, 2017 LHIC Chronic Disease Workshop â€¢ September 27, 2017 Read Program Presentation â€¢ September 29, 2017 Somerset County Staff Development Day â€¢ October 7, 2017 Ocean Pines Health Fair â€¢ October 6,2017 Wor-Wic In-service to the Childcare Center â€¢ October 13, 2017 Wor-Wic In-service to the Childcare Center â€¢ October 28, 2017 Wicomico County Board of Education Health Fair â€¢ November 11, 2017 MOHTA Health Fair at Ward Museum â€¢ December 26, 2017 Governor's Challenge at Civic Center
Reduce hypertension-related emergency department visit rate (per 100,000)	The Wagner Wellness Van is staffed with a Certified Nurse Practitioner, Registered Nurse, and Medical Assistant to provide a number of services to residents without appointment that are school age residents or above. For FY 2018 (July 1, 2017 to June 30, 2018) a total of 845 patients were served on the Wagner Wellness Van. The ages of patients ranged from 14 to 95 years old. People of multiple ethnicity, both male and female, received care. A number of health screenings were performed on residents that help determine appropriate education, self-management class information, or referrals to community resources and services. These screenings include pre-diabetes, hypertension and obesity. The Nurse Practitioner on the Wagner Wellness Van could initiate diabetic and hypertension medications and also schedule a follow-up screening on the van to see if the patient had improved. Also, the staff helped to refer users of the van to primary care physicians for those they saw who did not have one. Heart Smart Community Screenings are provided to the community to promote a healthy heart though understanding of lifestyle and risk factors that can help reduce the risk of heart disease. These are free and comprehensive screenings with several hundred encounters, 155 screened and 3 immediately referred. Comprehensive Screenings include: Cholesterol, HDL, triglycerides, fasting blood glucose Resting 12-lead EKG Body fat and body mass index Waist to hip ratio Blood pressure testing Pulse oximetry testing 10-year risk analysis Review of current medications Follow-up care plan

Reduce drug induced mortality (per 100,000)	Peninsula Regional Medical Center located in Salisbury, Maryland has experienced an increase in homelessness, drug addiction, overdoses and behavioral health issues. Peninsula Regional initiatives C.O.A.T (Community Outreach Addictions Team), CareWrap and SWIFT(Salisbury-Wicomico Integrated FirstCare Team) address drug addiction/overdoses and behavioral health within the community. The COAT initiative is a partnership between Peninsula Regional Medical Center, the Wicomico County Health Department, the State's Attorney's Office, the Salisbury City Government, and the Wicomico County Sheriff's Office. COAT, or Community Outreach Addictions Team, is an opioid intervention task force that goes and talks to drug dependent residents of Wicomico County and the surrounding areas. The team consists of peer mentors who were previously addicted to drugs. These mentors talk to those struggling with addiction and try to get them to enroll into treatment. The collaboration begins in the ED if a patient comes in as an overdose or suffering from addiction symptoms. The PRMC staff then calls the 24/7 hotline number to have a COAT Team Member visit with the patient. This peer mentor helps to provide a smooth transition to treatment services that link the patient with local mental health and addiction resources in the community or to other areas if necessary. The focal point of having these peer mentors to help with the transition process is that as a previous opioid addict, the mentor has grown in their own recovery and has knowledge and understanding that a professional can't duplicate. CareWrap is a hospital-community collaboration between PRMC and Lower Shore Clinic located in Salisbury, Maryland. Community Health Workers link patients to community resources and access to the healthcare system to eliminate and/or minimize social determinants of health. Examples include: obtaining housing, medications, transportation and linking to entitled financial assistance or helping find employment. The CareWrap team provides weekly status updates on all patients. This team discusses participant progress as well as identifying barriers and works toward solutions. The goal is to reduce hospital readmissions by helping patients' access primary care and behavioral health services, and to help fill other social determinants of health gaps to ensure a smooth transition to health stabilization. PRMC has also taken steps to curb the abuse of opioids from a medication prescribing standpoint. Using the EMR (Electronic Medical Record) system, PRMC has reduced its High Opioid medication utilization level and implemented a new system for prescribing opioids using a collective of factors. These factors include how to calculate the total daily dose of opioids, morphine equivalent calculations, and non-opioid alternative medication suggestions. SWIFT (Salisbury-Wicomico Integrated FirstCare Team) is a partnership between the Salisbury Fire Department and Peninsula Regional Medical Center, has earned the MIEMSS Executive Director's Award for Excellence in EMS. The team of a Salisbury paramedic and PRMC nurse provides home visits for individuals who are frequent users of 911. The SWIFT team works collaboratively to reduce overuse of emergency services and improve access by connecting these community members with healthcare options better provided in a primary or specialty care setting.
Reduce mental health-related emergency department visit rate (per 100,000)	As presented in the preceding question, Peninsula Regional initiatives COAT (Community Outreach Addictions Team), CareWrap and SWIFT(Salisbury-Wicomico Integrated FirstCare Team) address behavior health-related emergency department visits.
Reduce addictions-related emergency department visit rate (per 100,000)	The COAT (Community Outreach Addictions Team) initiative is a partnership between Peninsula Regional Medical Center, the Wicomico County Health Department, the State's Attorney's Office, the Salisbury City Government, and the Wicomico County Sheriff's Office. The COAT program has seen success since its inception in 2016. According to PRMC ED overdose statistics, in the 2016 calendar year, there were 264 heroin overdoses. Comparing that overdose statistic to the 2017 calendar year, there were 192 heroin overdoses. This declining trend has continued into the 2018 calendar year. Currently, through October 2018, PRMC experienced 114 heroin overdoses. There has been a 42% reduction in opioid-related deaths in Wicomico County. In comparison, the State of Maryland has seen a 12% reduction in opioid-related deaths.

Reduce Alzheimer's disease and other dementias-related hospitalizations (per 100,000)	
Reduce dental-related emergency department visit rate (per 100,000)	
Increase the % of children with recommended vaccinations	
Increase the % vaccinated annually for seasonal influenza	
Reduce asthma-related emergency department visit rate (per 10,000)	

Q127. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q128. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

- [ ] No gaps
- [x] Primary care
- [x] Mental health
- [ ] Substance abuse/detoxification
- [x] Internal medicine
- [ ] Dermatology
- [ ] Dental
- [ ] Neurosurgery/neurology
- [ ] General surgery
- [ ] Orthopedic specialties
- [x] Obstetrics
- [x] Otolaryngology
- [x] Other. Please specify. Pulmonary, Urology

Q129. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand.

Hospital-Based Physicians	
Non-Resident House Staff and Hospitalists	Included in our submission is a subsidy for our employed hospitalist program. A hospitalist program should be a part of any value driven organization which aids in the transformation of a patient from the hospital to home or other designation and avoiding readmissions. Other benefits include shorter length of stay, improved communication between physician and patient/family and ability of community physicians to stay in their offices to treat the community rather than provide inpatient care in what historically has been a medically underserved population.
Coverage of Emergency Department Call	The subsity included for this category is net of Trauma reimbursement funds received for general trauma, orthopedic, neurosurgery and anesthesia physician specialties received by the State of Maryland. Peninsula has to provide these specialties to support its Level III trauma designation plus other specialties that are recommended by comar regulations.
Physician Provision of Financial Assistance	

Physician Recruitment to Meet Community Need	PRMC is committed to being an integrator of health services. As an integrator, we must provide appropriate access to service for the populations we seek to serve across the entire continuum. According to a draft of our most recent medical staff development plan conducted by ECG consultants, they identified a need of thirty-nine physicians across various specialties and a succession risk of an additional 71 providers that are 60 or older that practice on our medical staff and in our service area. Subsidies include amounts for Primary care, Endocrinology, Neurology and pulmonology/critical care. All physician types that typically would not present to our service area which is typically an underserved, rural market area.
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	

Q130. (Optional) Is there any other information about physician gaps that you would like to provide?

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

Q131. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Q132. Upload a copy of your hospital's financial assistance policy.

Appendix I UNCOMPENSATED_CARE_FINANCIAL_ASSISTANCE_06302017.pdf
4.7MB
application/pdf

Q133. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

BRO-086 - Financial Assistance With Your Medical Bills Brochure.docx
1.9MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q134. What is your hospital's household income threshold for medically necessary free care? Please respond with ranges as a percentage of the federal poverty level (FPL).

At 200% of the Federal Poverty Guideline - 100% Discount of PRMC bills: If family size =1, threshold is $24,280.; 2, threshold is $32,920.; 3, threshold is $41,560.; 4, threshold is $50,200.; 5, threshold is $58,840., 6, threshold is $67,480., 7, threshold is $76,120.; 8, threshold is $84,760.

Q135. What is your hospital's household income threshold for medically necessary reduced cost care? Please respond with ranges as a percentage of the FPL.

201% up to 300% of Federal Poverty Guidelines - For medically necessary reduced cost of care of 50% on PRMC bills: If family size = 1, threshold is $36,420.; 2, threshold is $49,380.; 3, threshold is $62,340.; 4, threshold is $75,300; 5, threshold is $88,260; 6, threshold is $101,220.; 7, threshold is $114,180.; 8, threshold is $127,140.

Q136. What are your hospital's criteria for reduced cost medically necessary care for cases of financial hardship? Please respond with ranges as a percentage of the FPL and household income. For example, household income between 301-500% of the FPL and a medical debt incurred over a 12-month period that exceeds 25 percent of household income.

301% - 500% of Federal Poverty Guideline with Medical Hardship - 25% discount on PRMC bills: If family size = 1, threshold is $60,700; 2, threshold is $82,300.; 3, threshold is $103,900.; 4, threshold is $125,500.; 5, threshold is $147,100.; 6, threshold is $168,700.; 7, threshold is $190,300.; 8, threshold is $211,900.

Q137. Provide a brief description of how your hospital's FAP has changed since the ACA Expansion became effective on January 1, 2014.

The hospital continues to anticipate the community's needs for assistance in regards to navigating through the Health Care Coverage Expansion options. PRMC has an internal process for working with patients and others to assist in obtaining coverage. We coordinate with local county offices to aid patients and community members that need assistance or who may have questions.

Q138. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

Q139. (Optional) Please attach any files containing further information about your hospital's FAP.

Plain Language Summary - Financial Assistace.docx
29.3KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q140. You have reached the end of the questions, but you are not quite finished. When you click the button below, you will see a page with all of your answers together. You will see a link to download a pdf document of your answers, near the top of the page. You can download your answers to share with your leadership, board, or others as required by your internal processes. Your report will not be submitted to HSCRC until you have clicked the button at the bottom of the next page, the one with all your answers.

Location Data

Location: (38.350799560547, -75.533798217773)

Source: GeoIP Estimation

PART TWO: ATTACHMENTS

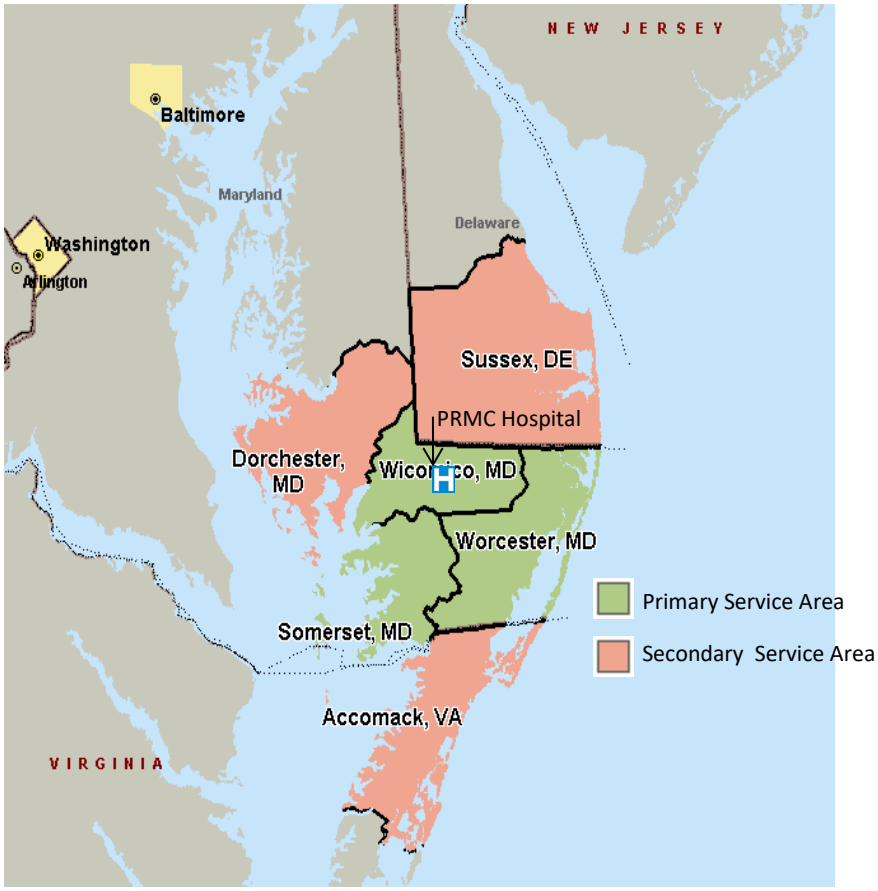
Table II

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

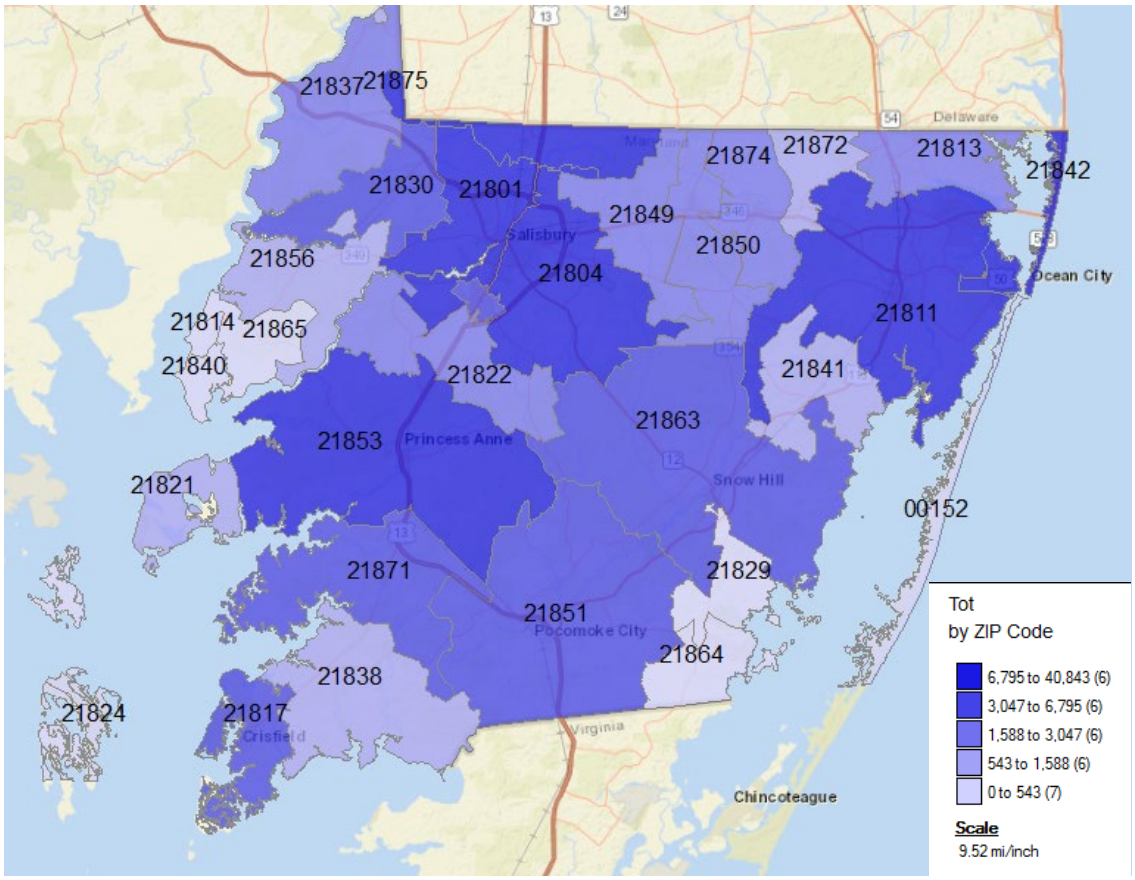
(i) A list of the zip codes included in the organization's CBSA, and

The Community We Serve

Peninsula Regional Medical Center functions as the primary hospital provider for the rural southernmost three counties of the Eastern Shore of Maryland, which includes Wicomico, Worcester and Somerset Counties (highlighted in green). In FY 2018, approximately 78% of the patients discharged from the Medical Center were residents of the primary service area, which has an estimated population of approximately 180,778 in 2018 and is expected to increase to 184,729 in 2023, or by 2.2%. The primary service area population has grown by an estimated 2.3% since 2010.



Peninsula Regional's CBSA consists of those zip codes within our primary service area. The majority of the population resides in Wicomico County (104,845) with Salisbury serving as the capital of the Eastern Shore. Salisbury is located on the headwaters of the Wicomico River and it is located at the crossroads of the Bay and the Ocean. The region is unique; the city of Salisbury has similar socio-economic and demographic characteristics of a large city, however, the area surrounding Salisbury is rural and has like-kind characteristics of small town America. Due to this dichotomy, serving both sometimes presents a challenge in delivering healthcare. The two other counties in Peninsula Regional's CBSA include Worcester County, with a population of 51,455 and Somerset County with a population of 25,945. The map below identifies Peninsula Regional's CBSA by zip codes by population density.



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

The greater *"metropolitan"* Salisbury area (zip codes 21801, 21804) has a higher population density than the surrounding rural areas. This area has a vulnerable population that includes the indigent and a higher Medicaid mix. Moving east towards the beach, located in Worcester County, are several of the larger towns like Berlin (21811) and Ocean City (21842) which have a higher population density. South of Salisbury, located in Somerset County, are the larger towns of Princess Anne (21853) and Crisfield (21817). Excluding the greater Salisbury area, the landscape and environment is considered rural, made up of small businesses and agriculture.

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

The three counties have a diversified economic base; however, it is predominately made up of small employers (companies with less than 50 employees). Major employers include local hospitals, the poultry industry, local colleges and teaching institutions. The median income of $56,241 in our Community Benefits Service Area is considerably less than Maryland's median income of $81,294. In addition, 2017 unemployment rates were higher for Maryland's most Eastern Shore counties. The unemployment rate in Maryland was 6.09%, the Nation 3.7% compared to Wicomico 6.22%; Worcester 9.82%; and Somerset 8.17%. Research indicates lower median incomes and higher unemployment rates contribute to a disparity in access to medical care and a prevalence of untreated chronic disease.

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

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

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

The target population includes patients that have chronic conditions who have demonstrated *to have been high utilizers* at PRMC, or are identified as *being at risk of high utilization* based on his/her chronic conditions and patterns of care. Current data indicates an "overreliance" by local residents on Peninsula Regional's emergency room for primary and chronic condition needs. In response, PRMC has introduced interventions, care management programs, education, and follow-up with measurement and outcomes. Based upon a current assessment there are approximately 1,330 residents that meet the criteria of "Super Utilizers" stratified by socio-demographics and chronic disease.

Peninsula Regional is targeting CBSA zip codes based upon social and economic determinants of health to include the uninsured, indigent population, residents who lack transportation, lack of education and availability of healthy foods. Targeting this by cluster and block groups, we seek to impact the health of these populations by providing primary health services, education, and access to care. More importantly, we want to foster lasting relationships with the communities we serve. For example, our Wagner Wellness Van travels locally to block groups where there was an identified need

for basic health services, in addition to providing health services and education to local ethnic churches and civic organizations. We also have instilled a program conjointly with the Wicomico County Health Department and the City of Salisbury Emergency Medical Services that provides home visits for individuals who are frequent users of 911. This program, named S.W.I.F.T., helps reduce overuse of emergency services and improves access to care for these residents by connecting them with healthcare options provided in a primary or specialty care setting.

PRMC CBSA

Race/Ethnicity	CBSA Primary Service Area		USA % of Total
White Non-Hispanic	118,706	65.7%	60.4%
Black Non-Hispanic	43,758	24.2%	12.4%
Hispanic	8,695	4.8%	18.2%
Asian & Pacific Non-Hisp.	4,644	2.6%	5.8%
All Others	4,975	2.8%	3.2%
Total	180,778	100%	100.0%

Source: Truven Health Analytics 2018

Within our CBSA, Wicomico has the highest Hispanic/Latino population at 5.7%, though all three counties have smaller percentages compared to Maryland. Worcester has the highest percentage of Whites (81.22%), whereas Somerset has the lowest percentage (52.6%). Somerset has the largest proportion of Black/African Americans (42%), whereas Worcester has the lowest (13.4%). The other race groups comprise a tiny sliver of the tri-county population in comparison.

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

CBSA Population Age-Cohorts

Age Group	2018 Population	% of Total	USA 2018 % of Total
0-14	29,374	15.9%	18.7%
15-17	6,640	3.5%	3.9%
18-24	23,064	11.7%	9.7%
25-34	22,151	13.3%	13.4%
35-54	40,552	21.2%	25.5%
55-64	24,469	13.0%	12.9%
65+	34,528	21.3%	15.9%
Total	180,778	100.0%	100.0%

CBSA Population Sex

Population	Primary Service Area
Female Population	92,625
Male Population	88,153
Child Bearing	35,421

Source: Truven Health Analytics 2018

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

Wicomico County

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

Worcester County

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

Somerset County

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

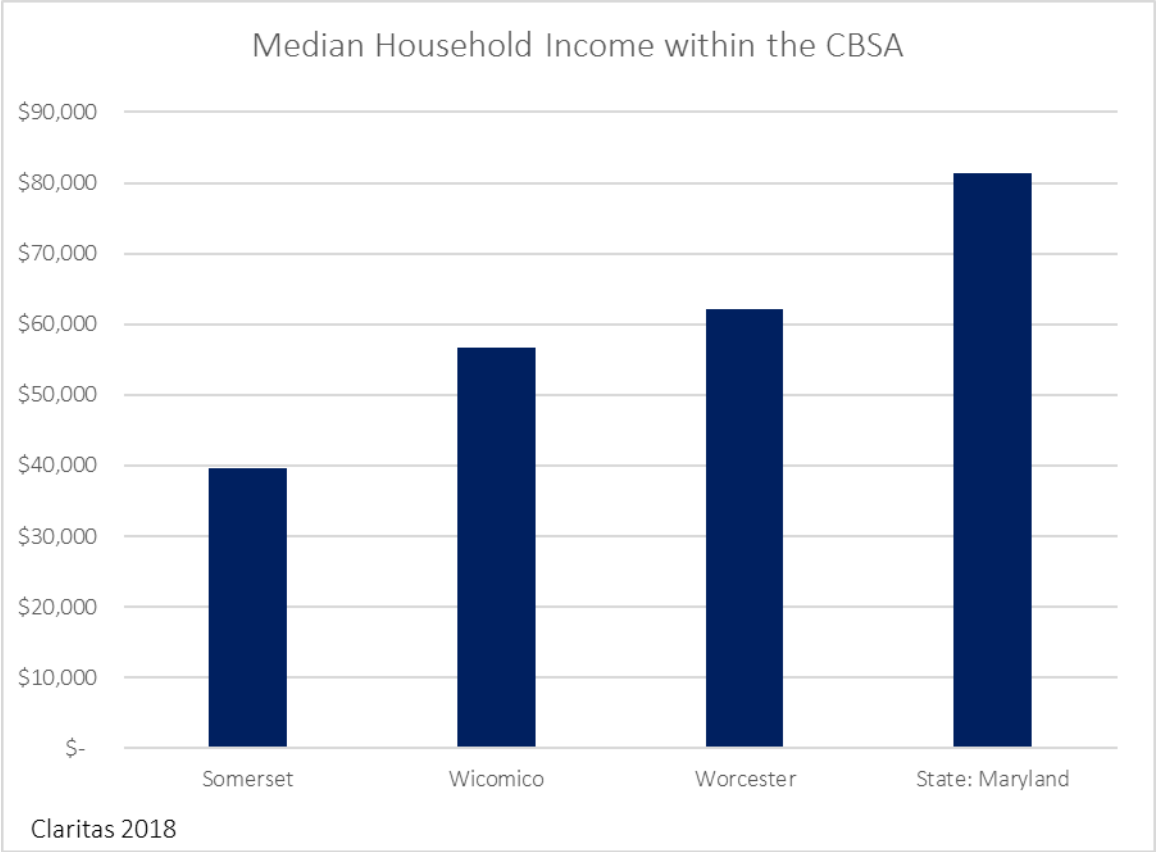
Chronic Disease Management

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

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

Median Household Income within the CBSA

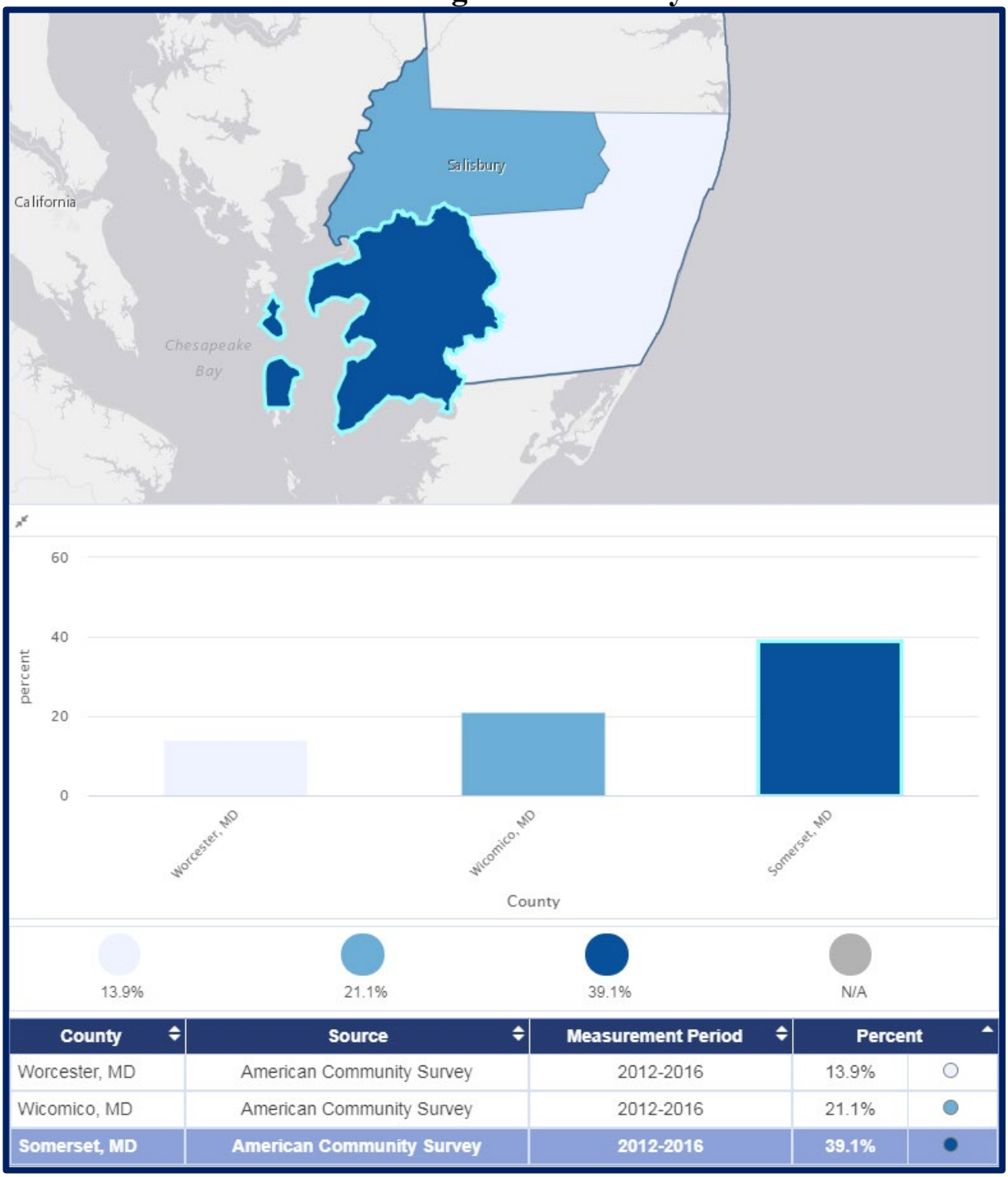
The median household income values in all three counties are lower than that of Maryland. Somerset has the lowest median household income in the tri-county service area with a value of $39,677. Worcester has the highest median household income in the service area at $62,166.
Source: Claritas 2018



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

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

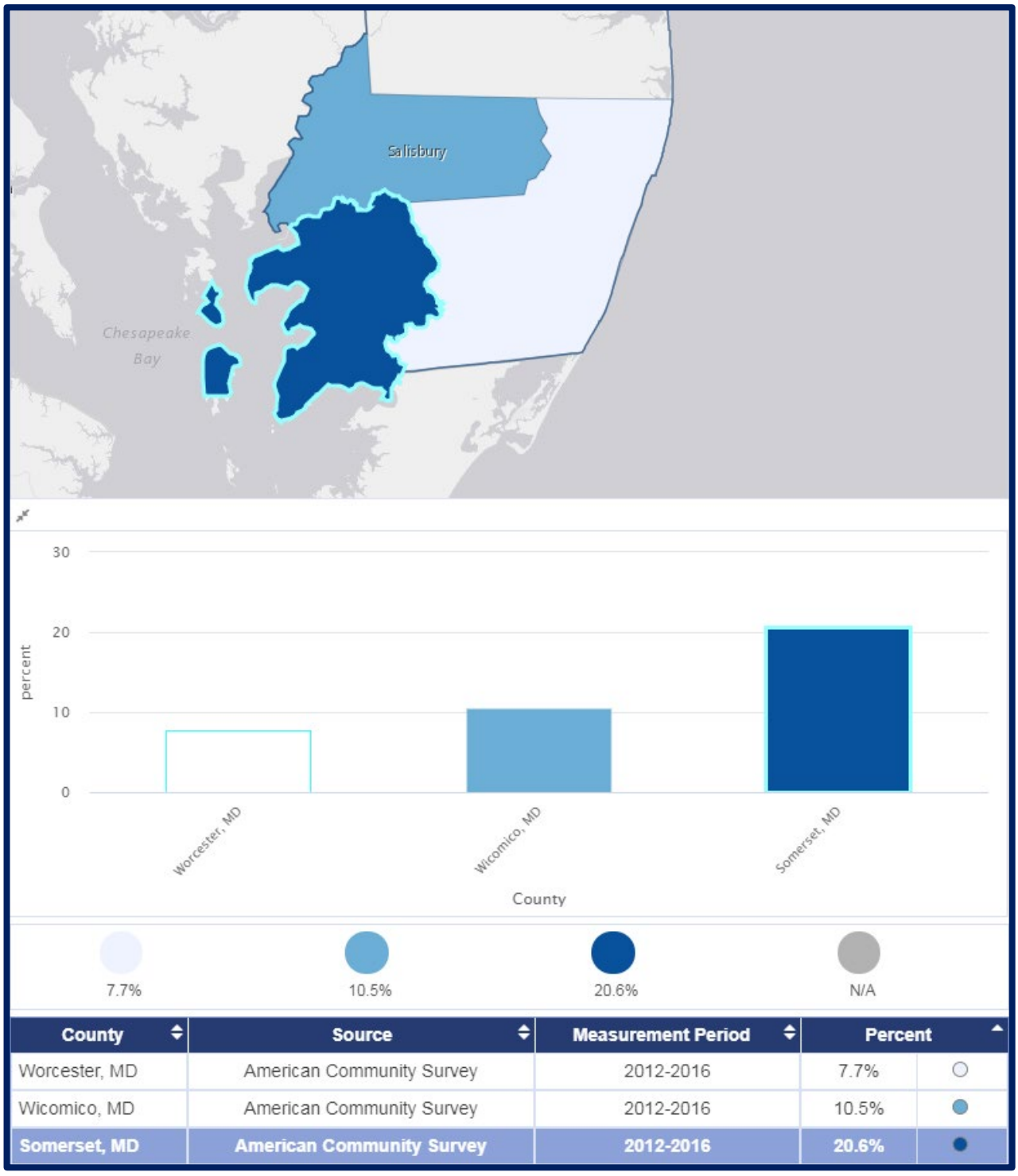
Children Living Below Poverty Level



County	Source	Measurement Period	Percent	
Worcester, MD	American Community Survey	2012-2016	13.9%	
Wicomico, MD	American Community Survey	2012-2016	21.1%	
Somerset, MD	**American Community Survey**	**2012-2016**	**39.1%**	

Source: Healthy Communities Inc. 2017

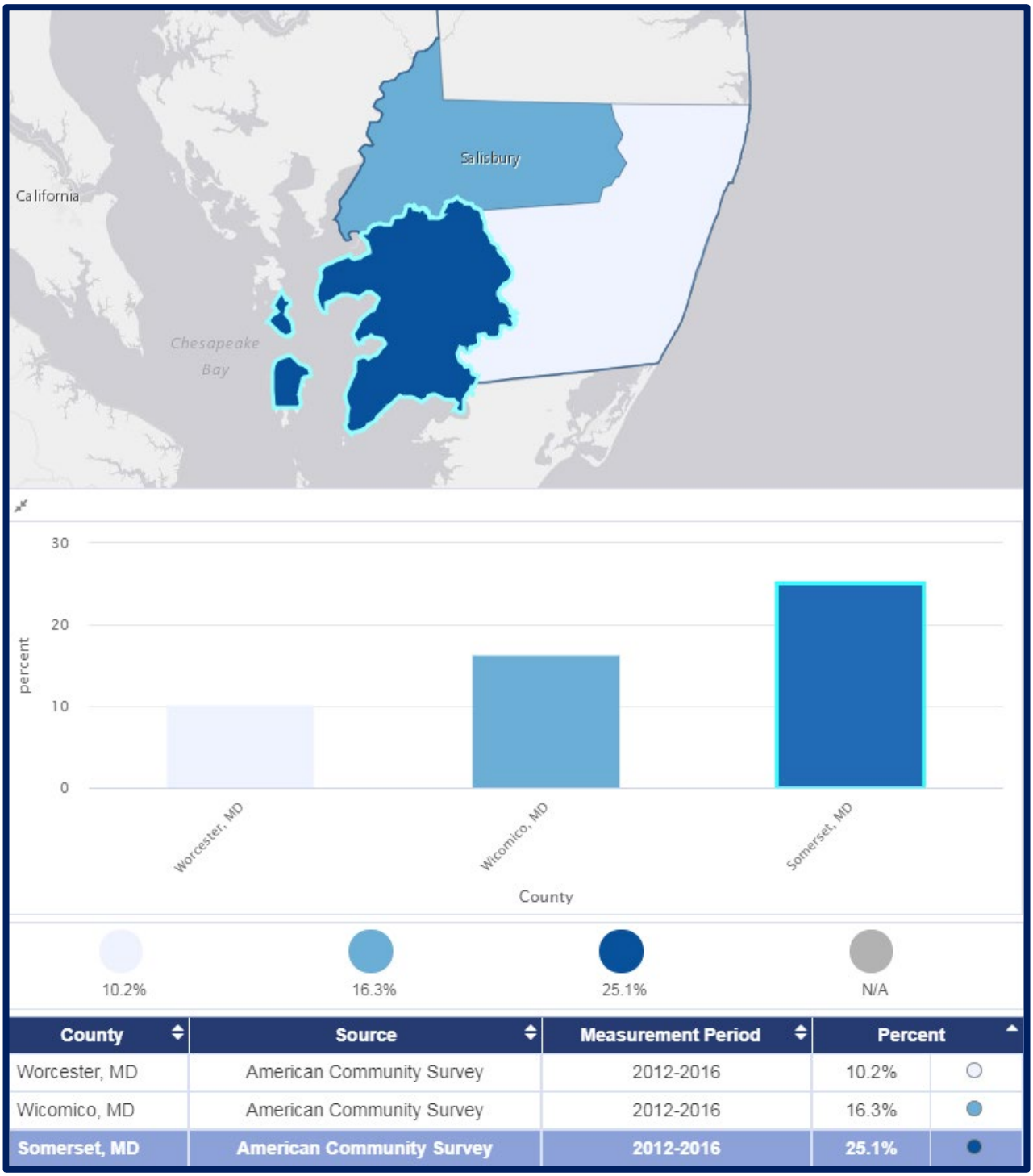
Families Living Below Poverty Level



County	Source	Measurement Period	Percent
Worcester, MD	American Community Survey	2012-2016	7.7%
Wicomico, MD	American Community Survey	2012-2016	10.5%
Somerset, MD	**American Community Survey**	**2012-2016**	**20.6%**

Source: Healthy Communities Inc. 2017

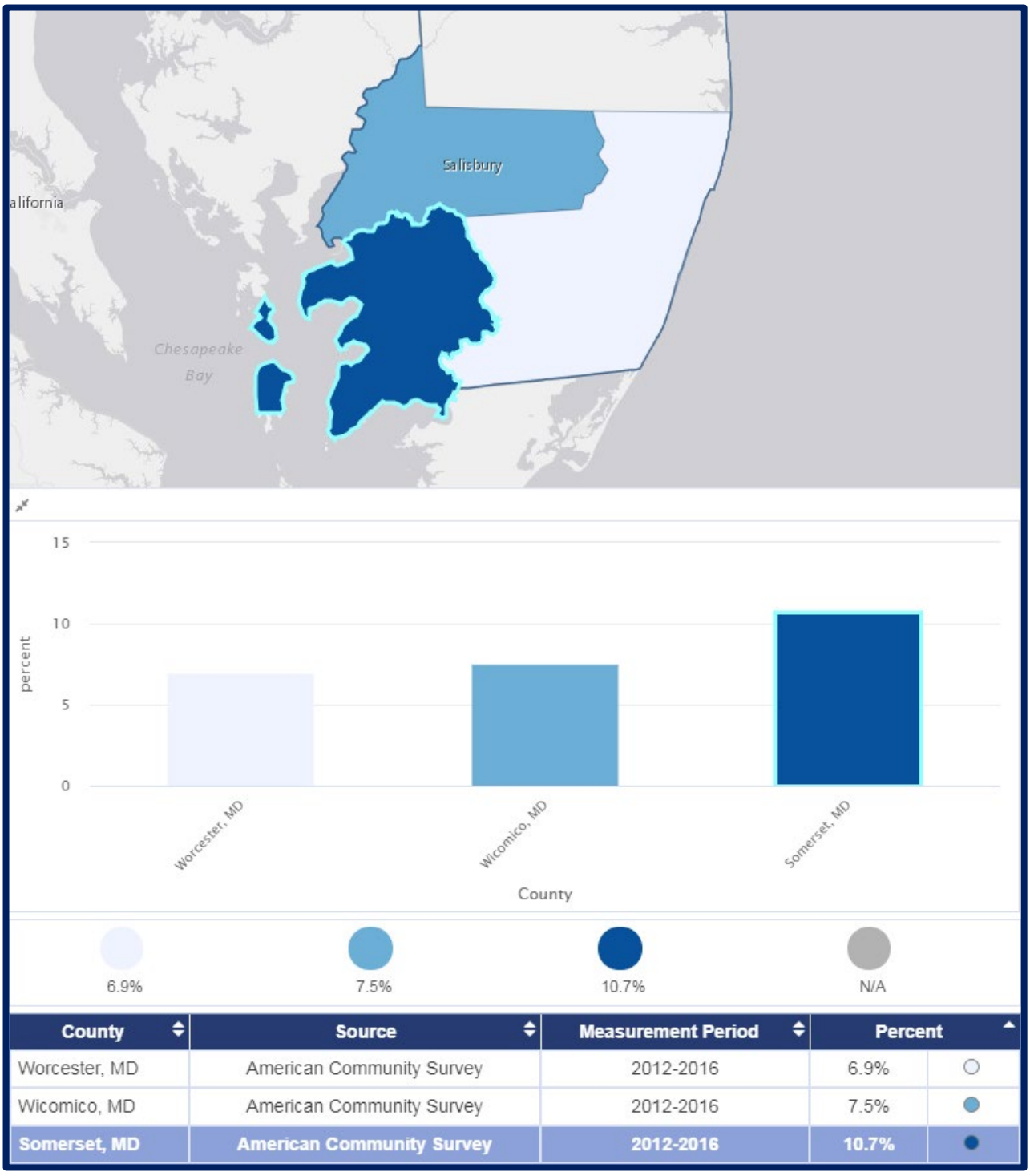
People Below Poverty Level



County	Source	Measurement Period	Percent	
Worcester, MD	American Community Survey	2012-2016	10.2%	
Wicomico, MD	American Community Survey	2012-2016	16.3%	
Somerset, MD	**American Community Survey**	**2012-2016**	**25.1%**	

Source: Healthy Communities Inc. 2017

People 65+ Living Below Poverty Level



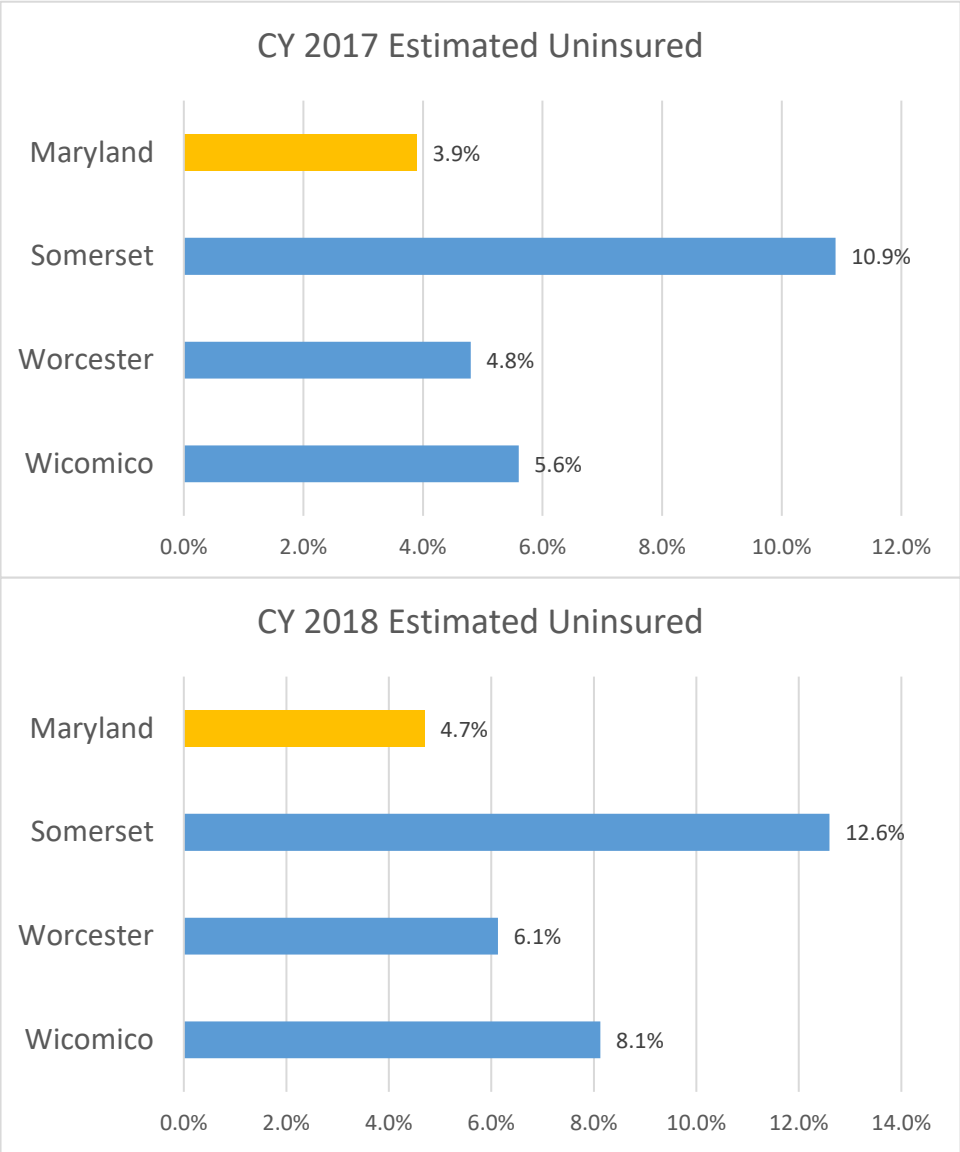
County	Source	Measurement Period	Percent
Worcester, MD	American Community Survey	2012-2016	6.9%
Wicomico, MD	American Community Survey	2012-2016	7.5%
Somerset, MD	**American Community Survey**	**2012-2016**	**10.7%**

Source: Healthy Communities Inc. 2017

For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links:

http://www.census.gov/hhes/www/hlthins/data/acs/aff.html;
http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml

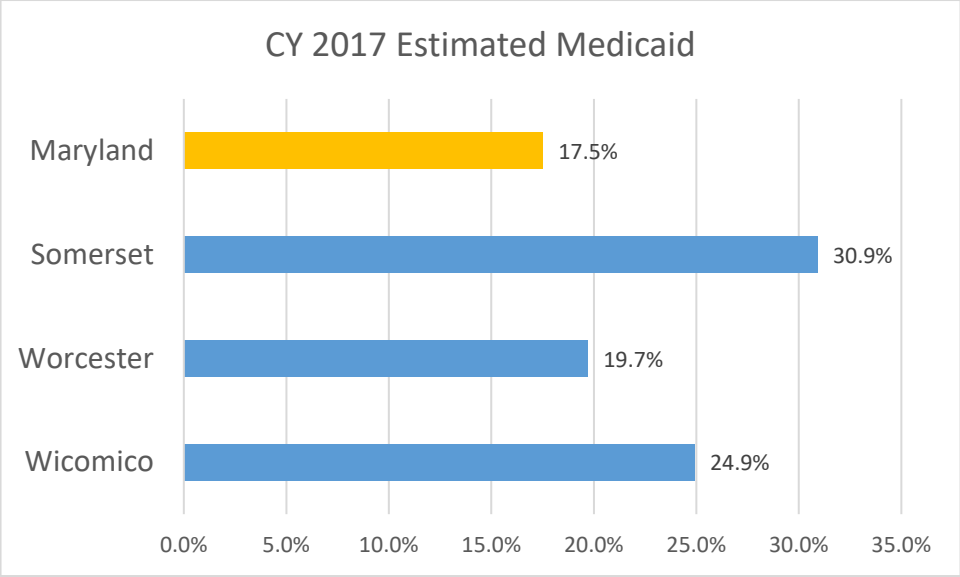
All three counties in Peninsula Regional's CBSA have a greater percentage of its population uninsured. Somerset County is almost three times the amount of uninsured residents compared to the State of Maryland.

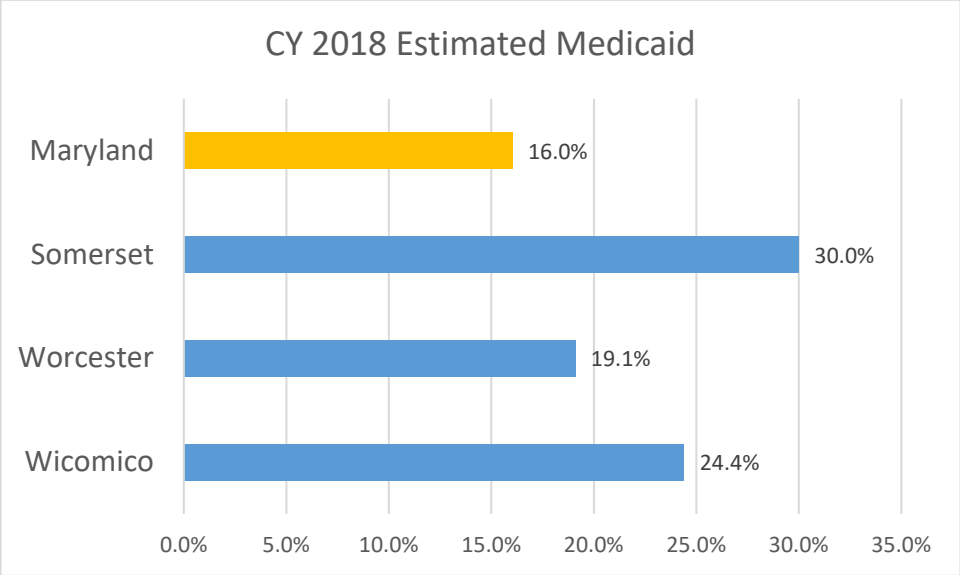


Source: Truven Health Analytics 2017, 2018

Percentage of Medicaid recipients by County within the CBSA.

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





Source: Truven Health Analytics 2017, 2018

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

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

The life expectancy in all three counties is a few years below the Maryland SHIP Target of 79.8 years. Worcester County is very close to meeting the SHIP target of 79.8 years; however, there is a gap of 7 years between Black/African Americans and White residents. Somerset is 5 years behind in meeting the Maryland SHIP longevity target. The top leading causes of death in our CBSA area are heart-related and cancer-related diseases, which as a percentage, are higher than other Maryland counties. Supporting social determinants indicate an underlying lack of healthy lifestyle adoption/education, poverty, and lack of chronic disease management/education.

County	Life Expectancy	Maryland SHIP Target
Wicomico All	76.7	79.8
Black	74.2	79.8
White	77.5	79.8
Worcester All	77.9	79.8
Black	72.2	79.8
White	79.1	79.8
Somerset All	75.0	79.8
Black	75.0	79.8
White	74.7	79.8

Source: Most current available Maryland Vital Statistic Report 2017
Maryland DHMH Vital Statistics Administration (VSA) Annual Report. Date Range 2014-2016

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

Crude Death Rate
The crude death rate for Wicomico County is 967.7, Worcester County 1,249.8, and Somerset County 1207.7, all higher than Maryland at 826.3 deaths/100,000. The large crude death rates reflect multiple factors: specifically, a more aging 65+ population, in addition to healthcare access issues, cultural and lifestyle characteristics not conducive to healthy lifestyles, and lack of education regarding chronic disease management in rural areas.

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

Diseases of the Heart Age-Adjusted Death Rates (2015-2017)
For diseases of the heart, several counties' age-adjusted death rates are much higher than the Maryland average:
Wicomico: 66.9 points 40.2% higher heart age-adjusted death rate than MD.
Worcester: 32.2 points 19.4% higher heart age-adjusted death rate than MD.
Somerset: 134.5 points 80.8% higher heart age-adjusted death rate than MD.

Malignant Neoplasms Age-Adjusted Death Rates (2015-2017)
For malignant neoplasms, all counties' age-adjusted death rates are higher than Maryland.
Wicomico: 42.3 points 27.4% higher malignant neoplasm age-adjusted death rate than MD.
Worcester: 17.2 points 11.1% higher malignant neoplasm age-adjusted death rate than MD.
Somerset: 22.1 points 14.3% higher malignant neoplasm age-adjusted death rate than MD.

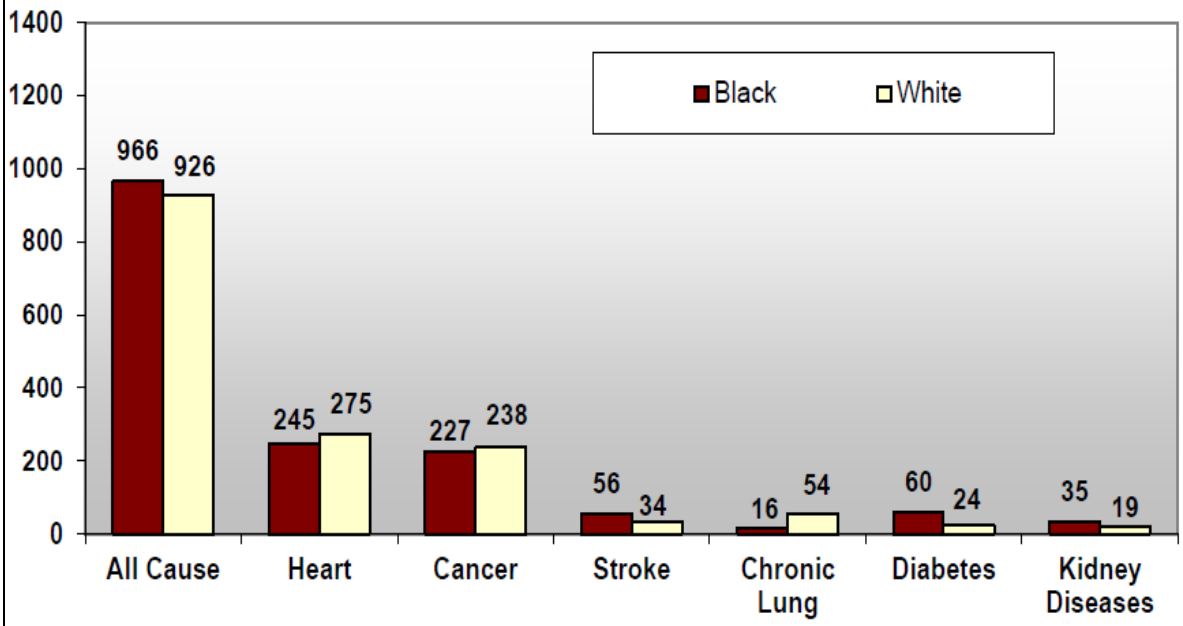
Chronic Lower Respiratory Diseases Age-Adjusted Death Rates (2015-2017)
For chronic lower respiratory diseases, all counties' age-adjusted death rates are higher than Maryland:
Wicomico: 8.8 points 28.9% higher chronic lower respiratory diseases age-adjusted death rate than MD.
Worcester: 1.5 points 4.9% lower chronic lower respiratory age-adjusted death rate than MD.
Somerset: No percentage*** ***Rates based on <20 events in the numerator are not presented since such rates are subject to instability.

Source: Most current available Maryland Vital Statistics Report 2017

Wicomico County

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

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

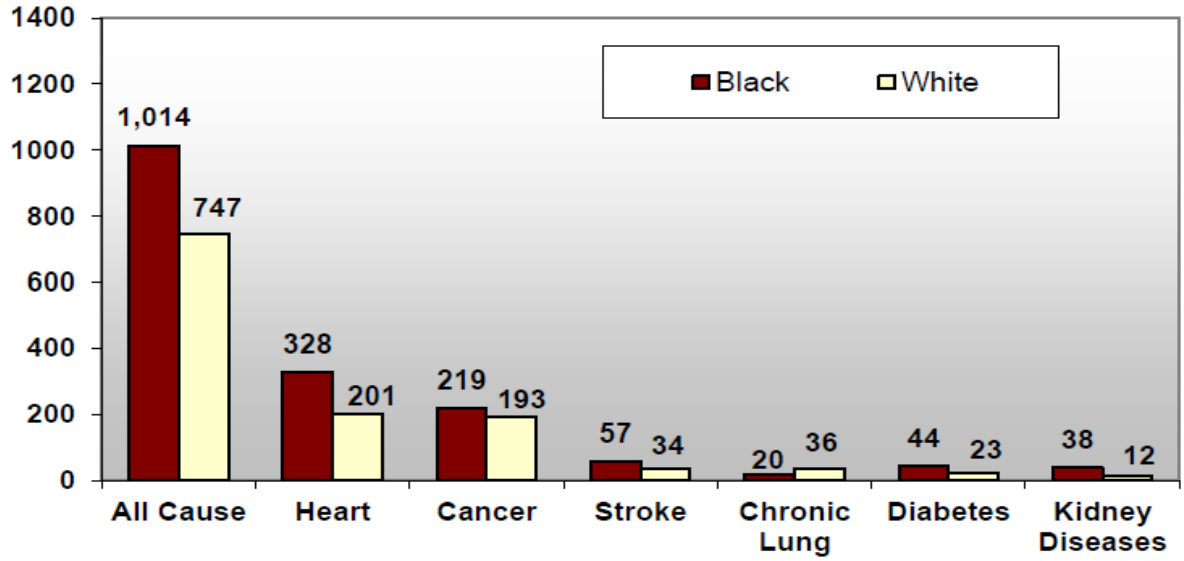


Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

Worcester County

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

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

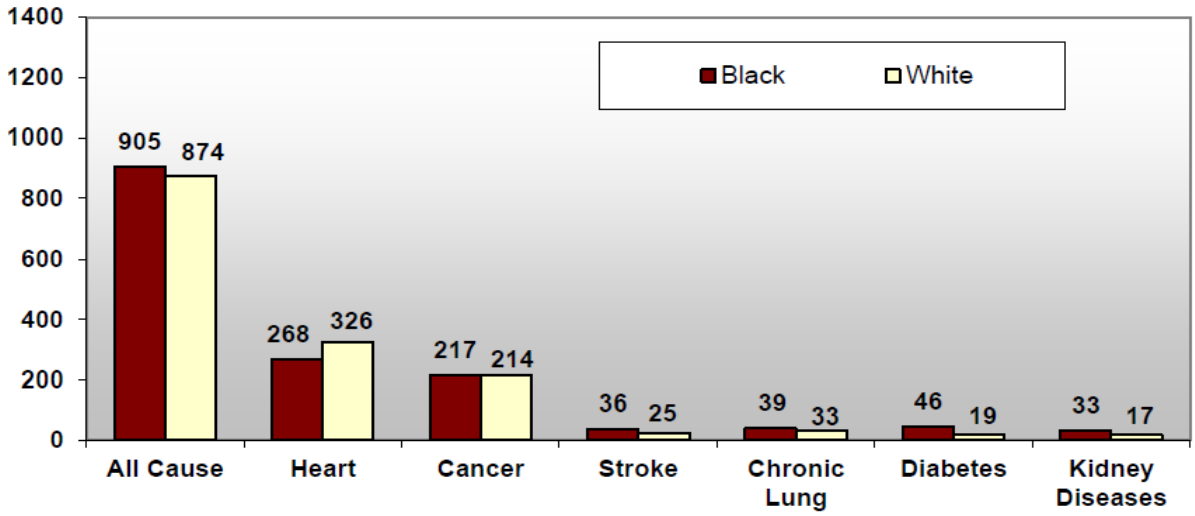


Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

Somerset County

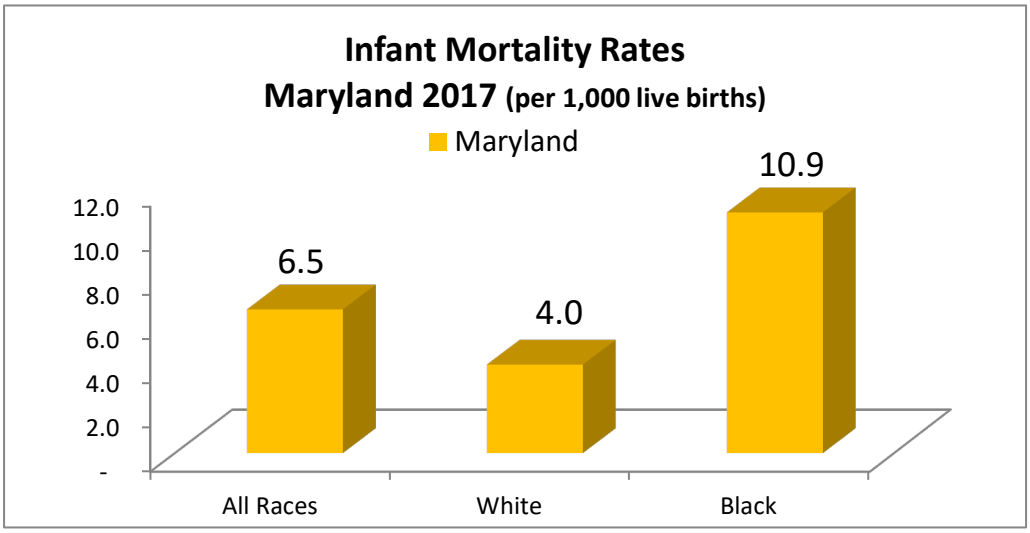
Blacks or African Americans in Somerset County had higher mortality rates than Whites for all-cause mortality and for five of top six causes of death.
The diabetes mortality rate for Blacks or African Americans was 2.4 times higher than for Whites; and the kidney disease mortality rate was 1.9 times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

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

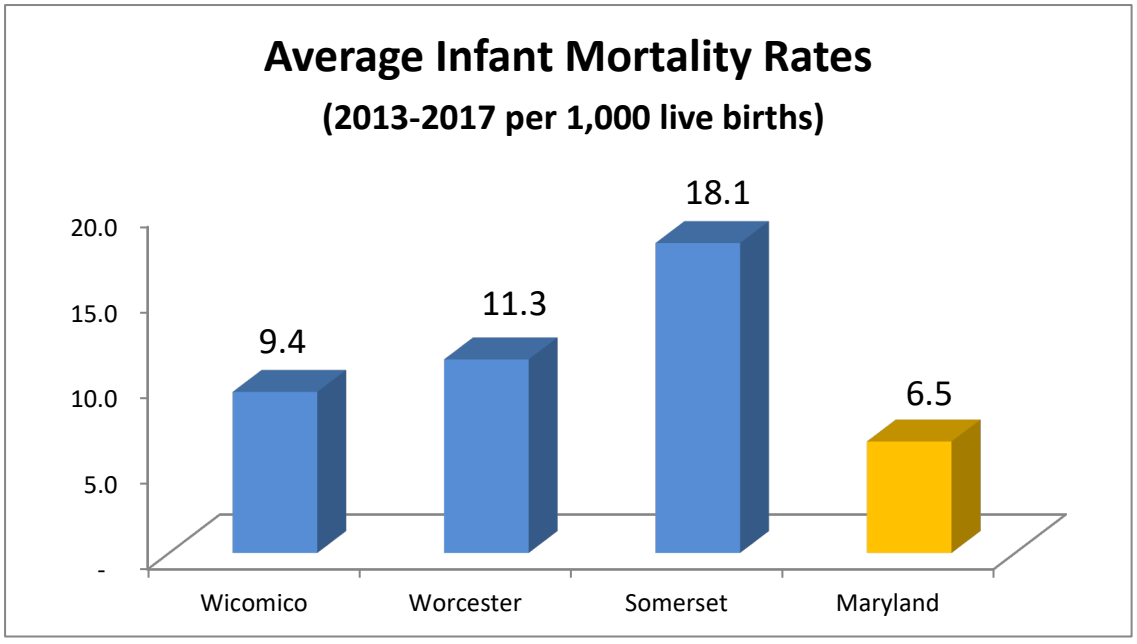


Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

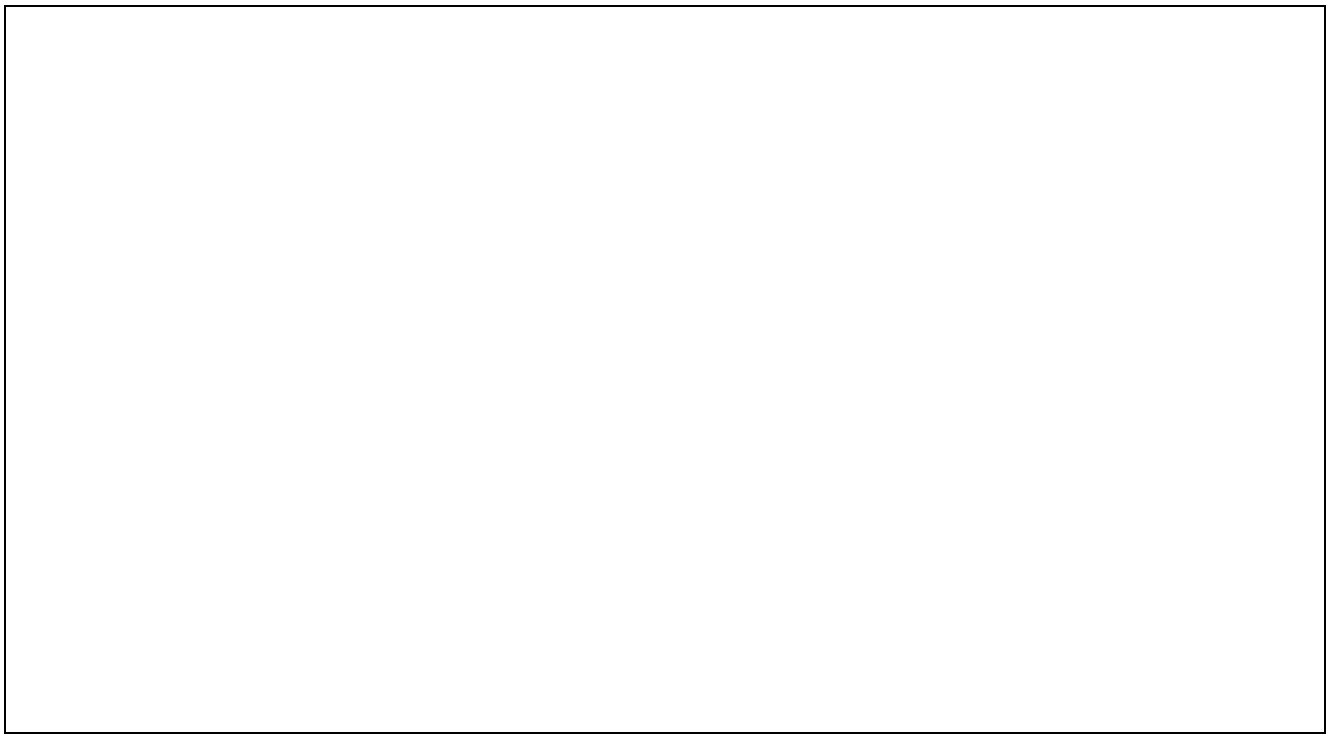
According to the 2017 Maryland Vital Statistics, the average infant mortality rate has fallen in Maryland over the past decade.



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



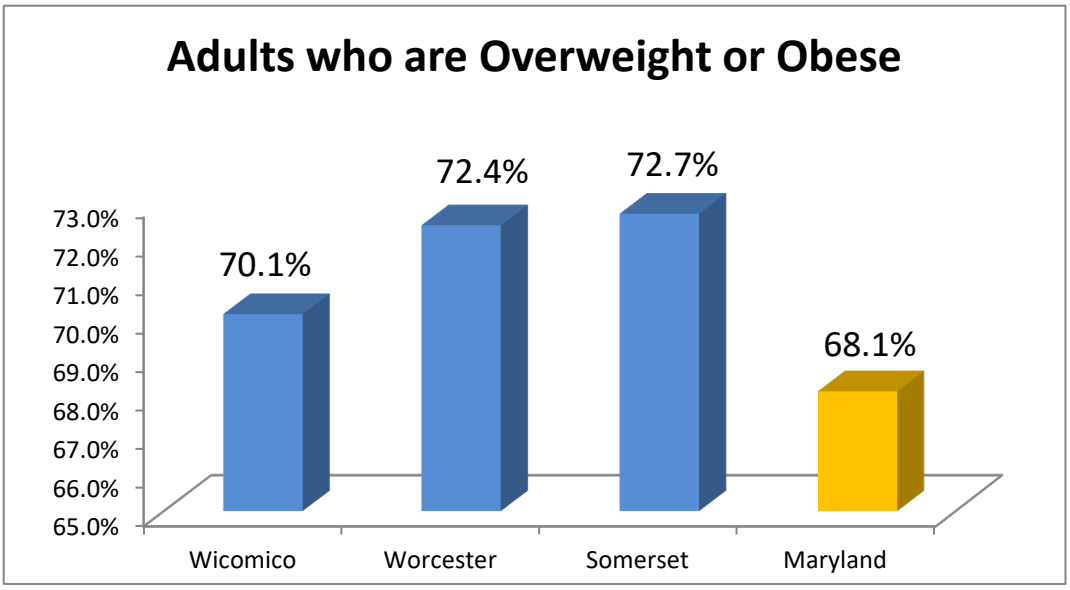
Source: Maryland Department of Health and Mental Hygiene, Infant Mortality in Maryland, 2017



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

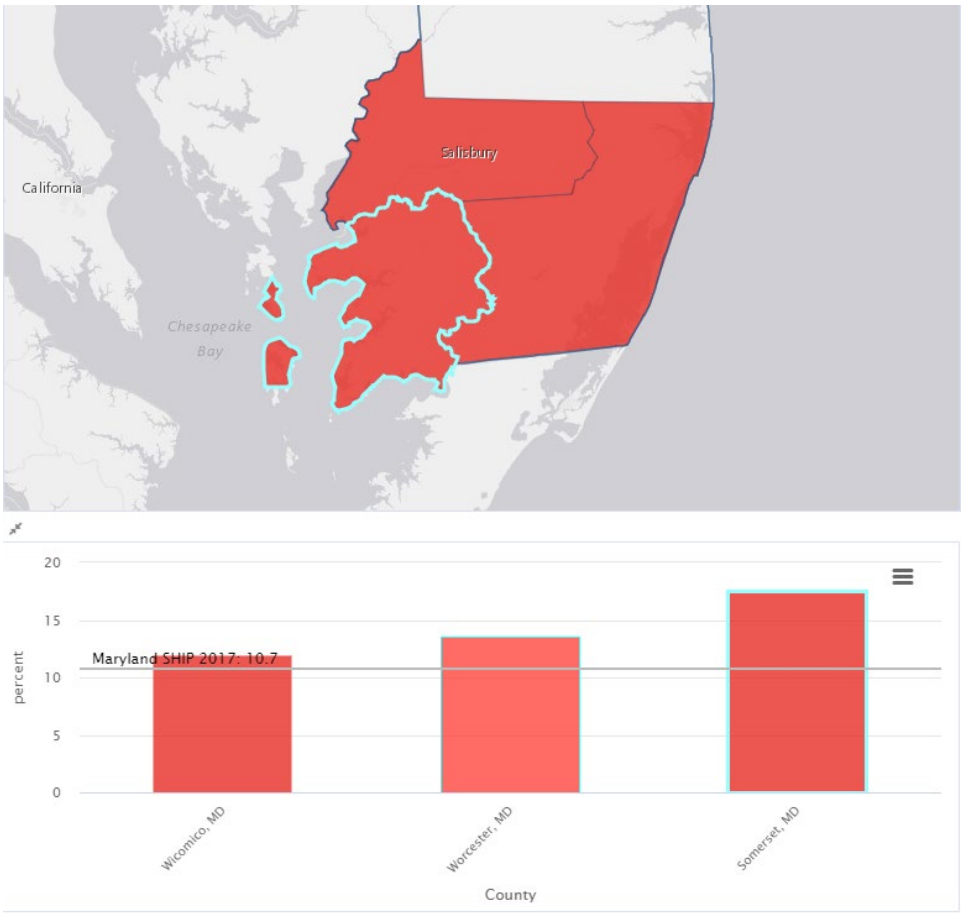
Access to Healthy Food
Healthy Food/Healthy Lifestyle Environmental Factors
Obesity continues to be a health issue in Wicomico, Worcester and Somerset Counties. Somerset County has a high percentage of adolescent obesity: 17.5% compared to the Maryland SHIP 2017 target of 10.7%. The tri-county area has a higher percentage of overweight or obese adults than Maryland, and is an indicator of general overall health. Additional weight and obesity increases the risk of many diseases and health conditions. These include type 2 diabetes, cancer, hypertension, stroke, liver, gallbladder and respiratory problems, all of which we are experiencing. Being obese also carries significant economic costs due to increased healthcare spending.

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



Source: HCI Healthy Communities Inc. 2016

Adolescent Obesity



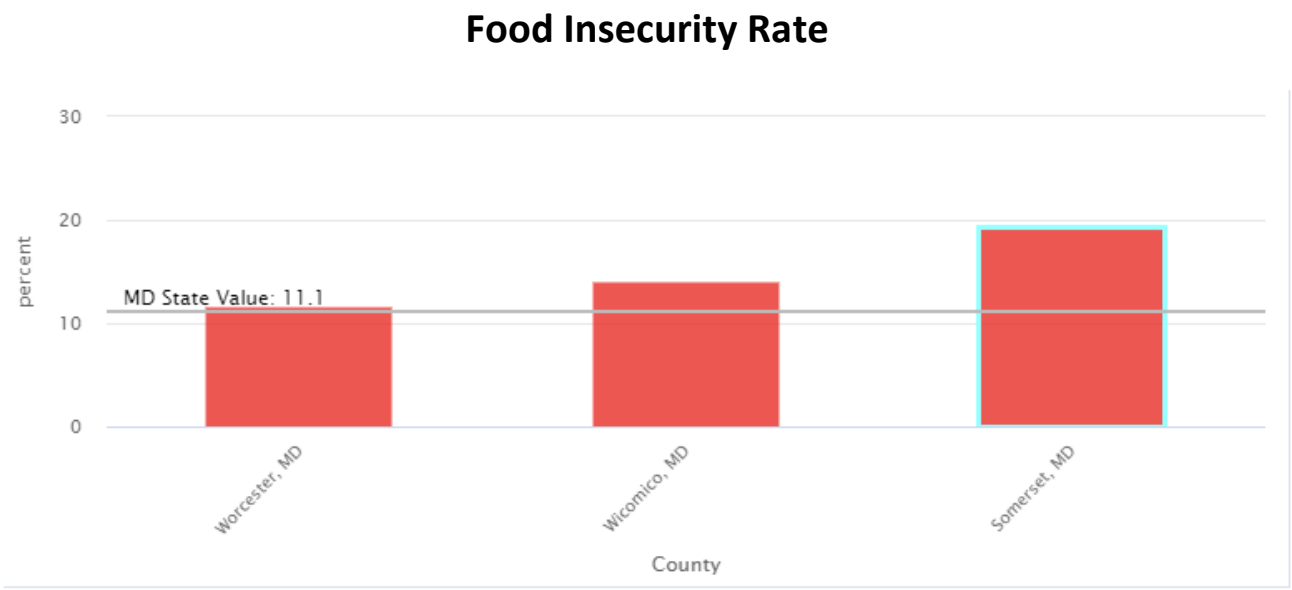
County	Source	Measurement Period	Percent	
Wicomico, MD	Maryland Department of Health	2014	11.9%	
Worcester, MD	Maryland Department of Health	2014	13.5%	
Somerset, MD	**Maryland Department of Health**	**2014**	**17.5%**	

Source: HCI Healthy Communities Inc.

Food Insecurity

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

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



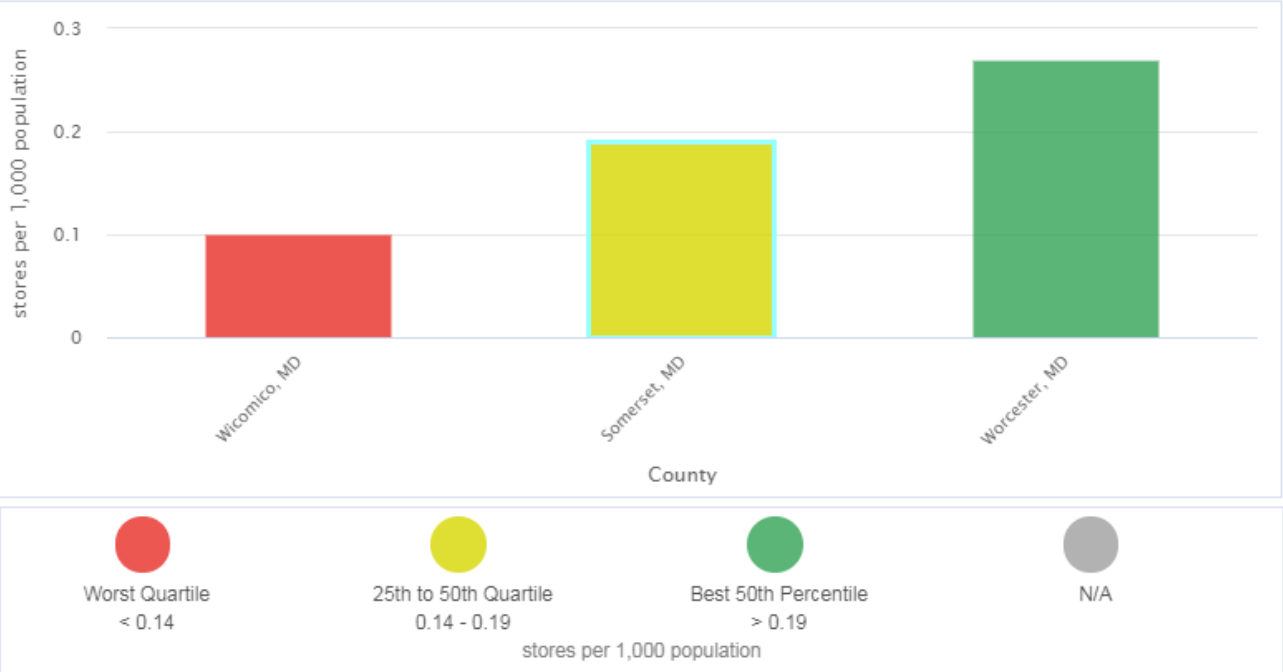
County	Source	Measurement Period	Percent	
Worcester, MD	Feeding America	2016	11.6%	
Wicomico, MD	Feeding America	2016	14.1%	
Somerset, MD	**Feeding America**	**2016**	**19.3%**	

Source: HCI Healthy Communities Inc.

Grocery Store Density

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

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



Source: HCI Healthy Communities Inc.

Adult Fruit and Vegetable Consumption

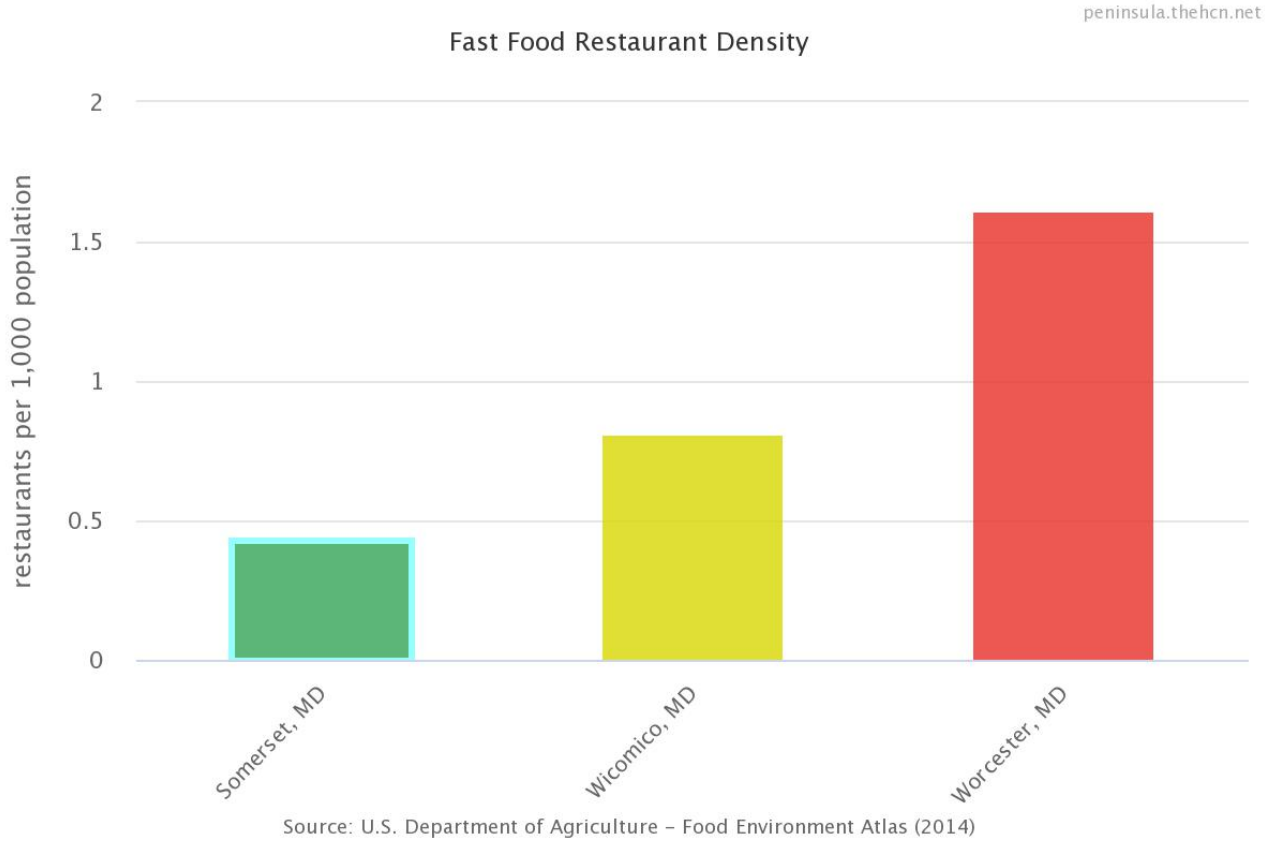
Based upon Maryland's most recent Behavioral Risk Factor Surveillance System, adults living in Wicomico and Somerset counties are not consuming adequate amounts of fruits and vegetables in their diet. This statistic indicates that an opportunity exists for education about healthy lifestyle choices. Worcester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

Adult Fruit and Vegetable Consumption

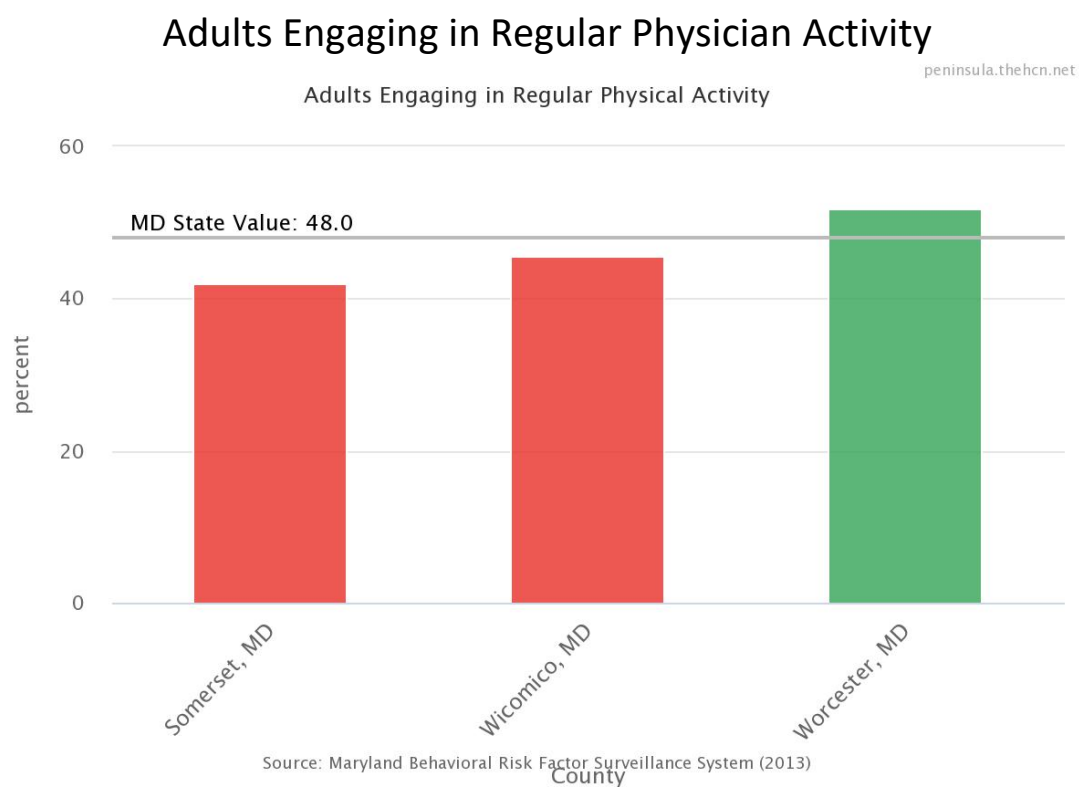
	VALUE	COMPARED TO:
County: Somerset, MD	17.2% (2010)	MD Counties
County: Wicomico, MD	23.1% (2010)	MD Counties
County: Worcester, MD	30.0% (2010)	MD Counties

Source: HCI Healthy Communities Inc.

Fast Food Restaurant Density



Source: HCI Healthy Communities Inc.



Source: HCI Healthy Communities Inc.

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

Transportation Services

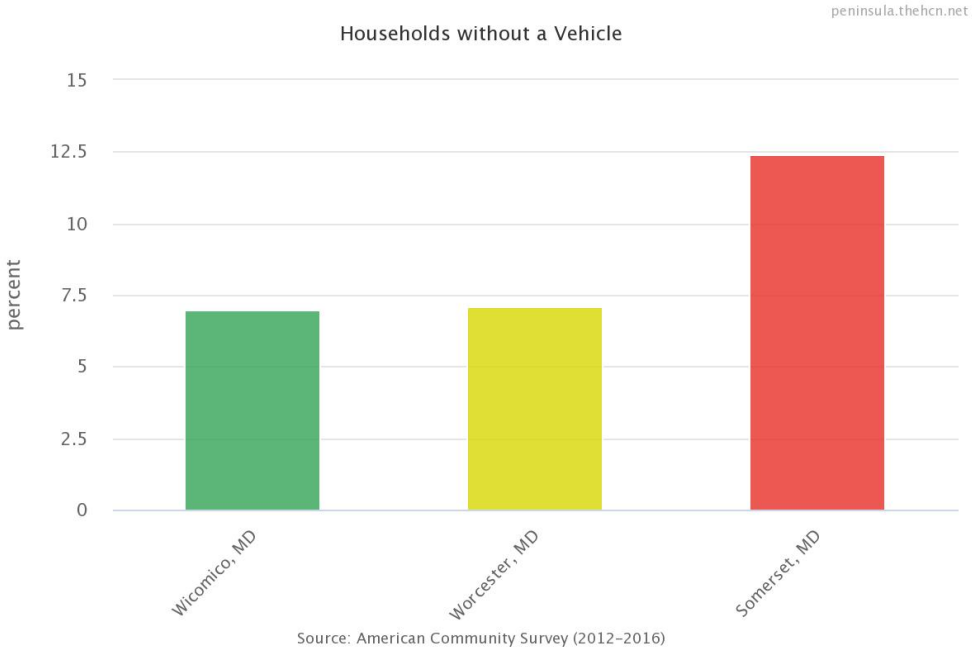
Peninsula Regional does make available transportation services for those in extenuating circumstances. Every effort will be made to assist patients receiving care under a series account like radiation oncology or chemo by utilizing various community resources. When community resources are not available,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

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

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

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

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



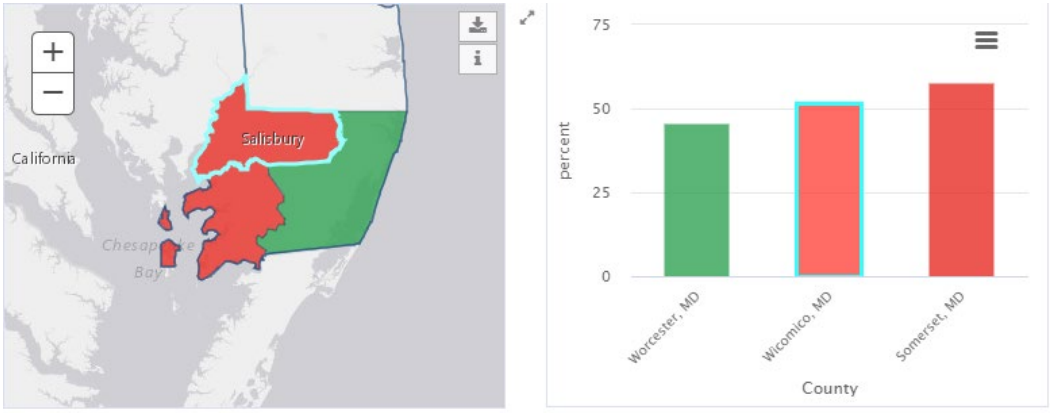
Source: HCI Healthy Communities Inc.

Affordable Housing

Peninsula Regional's CBSA has exceptionally high household rent compared to other Maryland counties. Spending a high percentage of household income on rent can create financial hardship,

especially for lower-income renters. Limited income due to high rent makes it difficult to access health care resources.

Renters Spending 30% or More of Household Income on Rent



Best 50th Percentile
< 46.6%

50th to 75th Quartile
46.6% - 50.5%

Worst 25th Quartile
> 50.5%

N/A

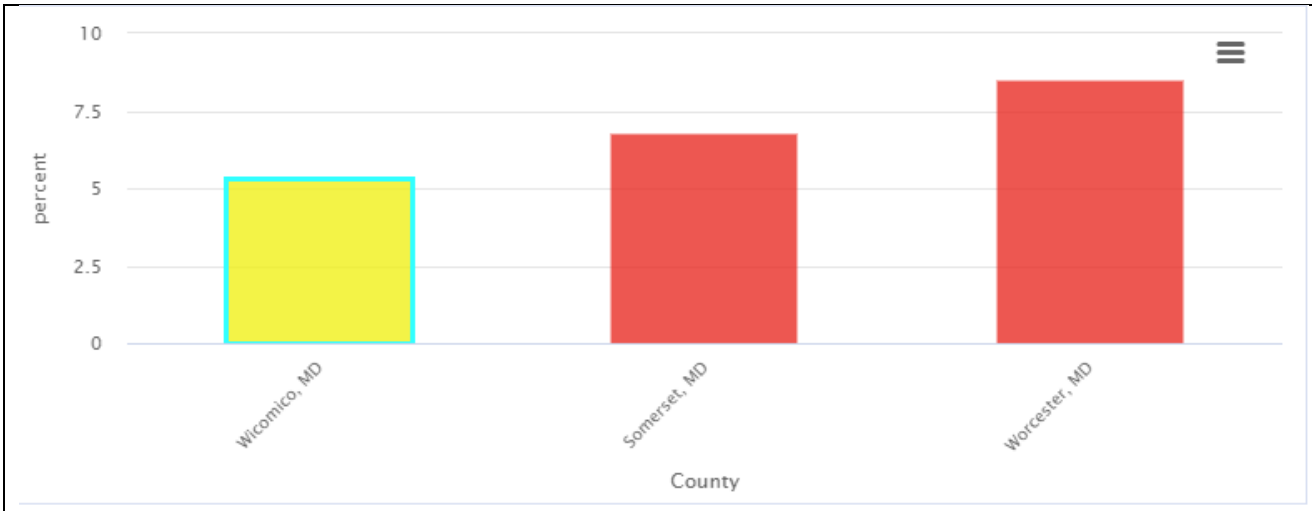
County	Source	Measurement Period	Percent
Worcester, MD	American Community Survey	2012-2016	45.5%
Wicomico, MD	**American Community Survey**	**2012-2016**	**51.5%**
Somerset, MD	American Community Survey	2012-2016	57.7%

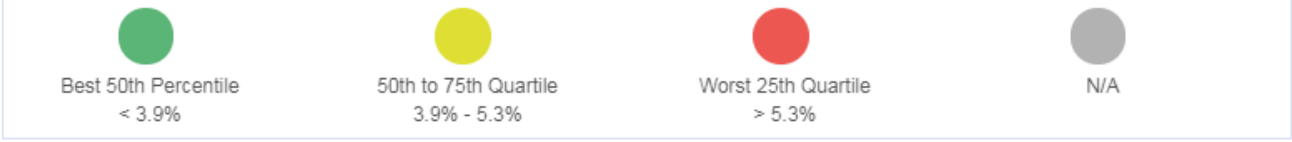
Source: HCI Healthy Communities Inc.

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

Unemployment

Compared to the State of Maryland, which has an unemployment rate of 4.2%, the unemployment rate is higher in Wicomico, Worcester and Somerset counties. Unemployment is a key indicator of the health of the local economy; in addition, high unemployment rates can be related to reduced access to health resources.





County	Source	Measurement Period	Percent	
Wicomico, MD	**U.S. Bureau of Labor Statistics**	**April 2018**	**5.3%**	
Somerset, MD	U.S. Bureau of Labor Statistics	April 2018	6.8%	
Worcester, MD	U.S. Bureau of Labor Statistics	April 2018	8.5%	

Source: HCI Healthy Communities Inc.

Sources:
Healthy Communities (HCI)
www.ers.usda.gov/FoodAtlas/
www.shoretransit.org
Truven Health Analytics 2017

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

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

Within our CBSA, all three counties' average household incomes are considerably less than Maryland's average. In addition, a smaller percentage of the population has a bachelor's degree or above. Wicomico County (11.15%) and Somerset County (19.35%) have a much higher high school drop-out rate than the state of Maryland (10.45%). Research indicates that education level is a social determinant and predictor of a healthy lifestyle and health literacy.

Wicomico has the highest Hispanic/Latino population in the tri-county area although all have smaller percentages compared to Maryland. Worcester has the higher percentage of white population at 81.22%, whereas Somerset has the lowest at 52.57%. Somerset has the largest proportion of Black/African Americans at 41.85%, whereas Worcester has the lowest at 13.39%.

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

Demographics	Wicomico County	Worcester County	Somerset County	Benchmark Maryland
Race/Ethnicity				
White Non-Hispanic	65.12%	81.22%	52.57%	**55.05%**
Black Non-Hispanic	25.76%	13.39%	41.85%	**29.91%**
Hispanic	5.66%	3.62%	3.76%	**10.25%**
Asian & Pacific	3.47%	1.63%	1.11%	**6.82%**
All Others	2.31%	2.0%	1.97%	**4.42%**
Average Household Income	$71,611	$84,656	$54,930	**$110,014**
Pop. 25+ Without H.S. Diploma	11.15%	10.86%	19.35%	**10.45%**
Pop. 25+ With Bachelor's Degree or Above+	27.4%	30.18%	14.95%	**38.4%**
Demographics	**Wicomico County**	**Worcester County**	**Somerset County**	**Benchmark Maryland**
English Spoken at Home	89.6%	94.2%	92.7%	**83.1%**

Spanish Spoken at Home	4.5%	2.4%	3.0%	**7.0%**
Other Spoken at Home	5.9%	3.4%	4.3%	**9.9%**

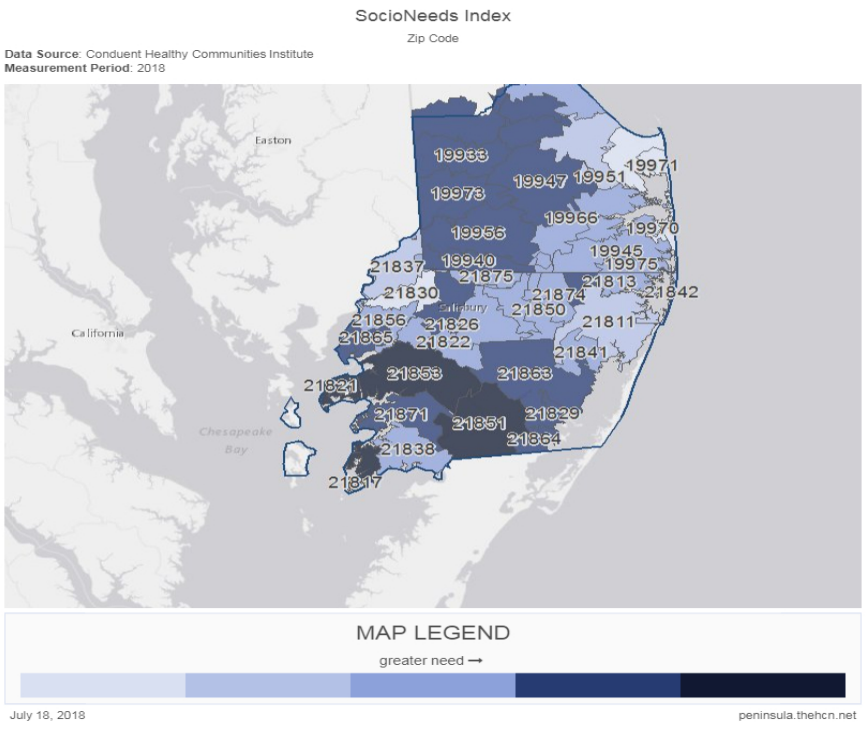
Source: United States Census Bureau, Advisory Board 2016

Other

SocioNeeds Index

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

HCI SocioNeeds Index



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

Social Environment

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

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

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

Economy

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

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

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

Education

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

- Community awareness around health issues
- Healthcare navigation

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

Source: HCI Healthy Communities Inc.

Peninsula Regional as an Integrator of Health along the Continuum

Peninsula Regional is expanding beyond the walls of the hospital into the community, working to find ways to make healthcare more affordable and available. We are doing that through population health expansion, becoming an integrator through clinical health partnerships, and by building a series of full-service health pavilions in population centers with underserved healthcare needs like those in Millsboro, Delaware and Ocean Pines, Maryland. The goal of Vision 2020 is improving the coordination of care both inside and outside the hospital. It will take new partnerships, new relationships, new partnerships, and new approaches to treating patients along the continuum of care, as we will be held accountable for the cost, quality and experience of the care we provide. The following provides a roadmap for some of the advances in healthcare Peninsula Regional is working on:

HealthPartners Delmarva - In 2014 Peninsula Regional and Bayhealth of Dover and Milford, Delaware, formed a partnership called HealthPartners Delmarva. This partnership seeks to improve the health of the patients within our regional population and create ways to provide services in the most affordable setting. Our goal is to identify new opportunities to improve outcomes and innovative ways to share best practices, reduce expenses and leverage the expertise and technology of both partners.

Advanced Health Collaborative - a collaborative with four other leading Maryland health systems: Adventist HealthCare, LifeBridge Health, Mercy Health Services, and Trivergent Health Alliance. The key benefit of this membership will be shared learning and collaboration, allowing partners to manage changes in healthcare more efficiently and effectively with a unified focus on improving health for their patients and communities.

Clinical Partnerships

Johns Hopkins Clinical Research Network - JHCRN is designed to establish a network of academic and community-based clinical researchers who provide new opportunities for research collaborations and accelerate the transfer of new diagnostic, treatment and disease-prevention advances from the research arena to patient care.

Children's National Health System - in 2010, Peninsula Regional launched a collaboration with Children's National Health System in Washington, D.C. Children's National pediatric hospitalists (hospital-based pediatricians) and neonatologists (physicians specializing in treating premature and sick babies) are now available 24 hours a day, 7 days a week and every day of the year at PRMC.

SWIFT – Salisbury Wicomico Integrated FirstCare Team became operational in October 2017. SWIFT is a collaboration of Peninsula Regional, Salisbury Fire Department and the Wicomico County Health Department to expand access to primary and preventative care services and chronic disease management. The project is to operate a Mobile Integrated Health - Community Paramedicine (MIHCP) program.

The program is the formation of a team of a SFD emergency medical technician and a PRMC registered nurse to conduct welfare checks, case management, safety planning, and referrals for frequent utilizers of 911 EMS for nonemergency reasons. "Frequent utilizers" are defined as individuals calling 911 for medical reasons at least five times over a six month period. The SWIFT

team will identify and contact these individuals to see if they are interested in enrollment into the program. Team members will conduct home visits with these patients to conduct vital signs checks, examination for signs of abuse or neglect, conduct safety assessments of the home, and refer patients to primary care physicians, medical specialists, and, if necessary, in-home care providers.

Beyond being frequent utilizers, as defined above, the target population is those that are either disconnected or non-compliant with their medical professionals. As described below, this may result from abuse or neglect, a lack of healthcare education, a lack of transportation, and/or financial barriers. We project that this population will be disproportionately low-income and elderly. Thus, most of these health disparities will stem from their socio-economic status and their lack of healthcare resources.

Health Information Systems

The conversion to **EPIC** EMR (Electronic Medical Record) establishes a foundation from which we are truly sharing information. The University of Maryland, Johns Hopkins, Anne Arundel Medical Center, Mercy, the new Riverside hospital coming to Virginia's Eastern Shore, and our HealthVisions Delmarva partner, Bayhealth in Dover and Milford, DE, are all Epic hospitals or soon will be. "Care Everywhere" is the name of the EPIC program that allows all of us to see the same record, to share the same information at admission or referral or in the Emergency Department when seconds count. And EPIC provides each of us Best Practice Advisories, so we can trade and then potentially implement ourselves what is working best for the patient at our peer hospitals or participating physician offices.

Peninsula Regional's Health Information System software continues to evolve in support of predictive analytics modeling that helps identify high-risk patients, subsequently engaging physicians and caregivers in implementing patient's self-care regimen. Development of processes used to identify high-risk patients for care, identification of quality care issues and improvements to prevent complications and readmissions.

PRCIN (Peninsula Regional Clinically Integrated Network)

In FY2016, the Centers for Medicare & Medicaid Services approved Peninsula Regional Health System's clinically integrated network or ACO (Accountable Care Organization). This new Medicare network brings the Hospital, local physician, and providers together to provide higher-quality, coordinated care to patients. Ultimately, this is about delivering better care, spending dollars more wisely and having healthier people and communities. The PRCIN's mission is to drive health care progress by improving the coordination and integration of health care, and improving the health of patients, with a priority placed on prevention and wellness. There are four domains of ACO quality measures and multiple metrics within each domain:

- Patient/caregivers' experience
- Preventive care
- Care coordination/patient safety
- At-risk population

The **YMCA** of the Chesapeake and Peninsula Regional Medical Center entered into a strategic partnership to explore options to manage and prevent chronic diseases and to engage the Delmarva community to participate in activities and lifestyle changes to sustain lifelong wellness.

The partnership joins the YMCA, the largest human services organization in the region with over 27,000 active members at 7 locations across the Maryland's Eastern Shore and in Chincoteague, VA, with PRMC, the largest and most clinically advanced tertiary medical center on the Delmarva Peninsula.

"The YMCA has a number of successful programs underway now that assist people in managing chronic conditions," said Robbie Gill, Chief Executive Officer of the YMCA of the Chesapeake. "One of the great benefits we expect from this partnership is having PRMC clinicians and educators actively involved in our programs to create those very special one-to-one relationships that bond people emotionally, establish trust and understanding and lead to healthier and happier lives."

Some of the quick wins that the YMCA and PRMC plan to capture immediately from the partnership include: the establishment of monthly educational series on a number of health-related topics, participation by PRMC clinical teams in YMCA programs and services, health literacy programs for families, increased blood pressure and hypertension monitoring, enhanced diabetes education and a focused collaboration around the Y's successful Healthy Us initiative to combat childhood obesity.

"Childhood obesity only leads to adult obesity and with it a slew of chronic conditions including heart disease, diabetes and high blood pressure that strain families and drain healthcare services. PRMC's Population Health team was eager to partner with the YMCA to help entire families to think differently about taking care of themselves and their children when it matters most, and when we can manage peer pressures and provide the peer support that will create some really sustainable lifestyle changes.

Smith Island Telehealth

Smith Island, MD is a small, tight-knit community of about 250 people. The town is collectively made of strong, loyal, and hard-working people. This area is known for its watermen, the seafood economy, and not having too many "outsiders" come to visit. For this reason, Peninsula Regional Medical Center created a partnership with McCready Health, MAC – Area Agency on Aging, Somerset County Health Department, and the Crisfield Clinic. The goal of the partnership was to improve the health of the Smith Island community, provide health literacy to residents, and reduce ED utilization.

The program was led by the Smith Island community health worker staff where they would provide chronic disease educational support and connect the residents of Smith Island with telehealth for primary care purposes. In FY 2018, there were 98 patients served out of the possible 250 residents of Smith Island. The community health workers played an integral part of having the residents change behaviors and actions because the workers weren't "outsiders" and could build and keep relationships with the people of Smith Island. The community health staff also helped patients understand the medications and compliance parameters given by health professionals. Flu shots were also given out by community health workers to ensure the residents of Smith Island can combat the flu season effectively and reduce admissions to the ED. There have been some great successes since the program started. For example, there was a blood sugar reduction in a husband and wife from the 300s level to the 120s level. This is a prime example of improving health, chronic disease education, and possibly eliminated a future Emergency Department visit related to blood sugar or diabetes. There was also an increased knowledge of causes and management of chronic diseases by the residents of Smith Island. As a result of increased knowledge, a frequent user of the ED decided to receive care on Smith Island, which decreased ED utilization. Speaking of ED utilization, there was actually a 5% reduction in ED utilization at McCready Hospital for patients with a Smith Island zip code from October 2017 to June 2018.

Care Wrap

Lower Shore Clinic (LSC) and Peninsula Regional Medical Center (PRMC) are collaborating on an initiative establishing an outreach team of health professionals, called CareWrap, whose goal is to enhance access to community-based primary and mental health care by targeting people at risk of 30-day readmission. Thirty-day readmission refers to a patient returning to the hospital within 30 days of discharge, which is an expensive and undesirable outcome for both patient and hospital.

The Population Health team considers CareWrap an essential piece to the population health puzzle. It's a proven approach to care that lets us touch some of our most at-risk patients, through one-on-one, face-to-face education and instruction. If we ingrain those good habits associated with properly managing chronic conditions, we can keep people healthier and out of our emergency department or hospital.

The CareWrap team, led by a registered nurse and consisting of two medical assistants and a part-time benefits coordinator, closely follows newly discharged inpatients who agree to participate. For up to three months, the team will: assist in filling prescriptions, see that discharge instructions are being followed, schedule appointments and ensure they are kept, provide instruction on maintaining a healthy lifestyle, and link to social supports, housing, and benefits as eligible. If clients do not have a primary health care provider, they will be offered care at a 'Bridge Clinic' for primary and preventive care.

CARE SAGE

Through a program called CareSage, PRMC's Philips Lifeline program identifies patients at risk for falls or who have chronic conditions such as COPD, CHF or diabetes, and offers them Lifeline monitoring service free for 60 days to help keep them safe and reduce readmissions. Peninsula Regional and Phillips have partnered to identify hospital-discharged patients at risk who could benefit. The monitoring service is available for free for 60 days, as well as for those who can't qualify for CareSage but would benefit from in-home monitoring.

Wagner Wellness Van

The Wagner Wellness Van is stationed at a different location in our primary service area (Wicomico, Worcester and Somerset counties) every weekday, serving as a mobile health clinic in collaboration with Atlantic General Hospital and McCready Hospital. It makes routine visits to shelters and local churches and is a population heath platform visiting locals with a nurse practitioner on board. The van staff conducts health screenings, administers vaccinations and acts as a conduit for education and access to other health care providers and facilities. On most Thursdays of every month the van visits Urban Ministries and it has impacted 156 health/wellness community programs.

Child and Adolescent Outpatient Behavioral Health Unit

This is the second year celebration of a successful opening of Peninsula Regional's Rebecca and Leighton Moore Child and Adolescent Outpatient Behavioral Health Unit. The unit offers outpatient therapeutic behavioral health services, including individual therapy and medication management, for children and adolescents. Our clinical team provides a customized treatment plan that is designed to help patients successfully manage their illness and maintain optimal activity at home, work, or school.

Population Health

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

Future Community Benefit Intent:

PRMC has determined that there is a great need to focus activities in the community with embedded Care Managers located in primary care offices to assist primary care physicians in caring for patients with multiple admissions/emergency room visits and with multiple chronic conditions. Further, there is a need

to access care for those patients who do not have a primary care physician by assisting patients within a bridge clinic. Action plans are being developed to assist patients by providing a mobile van to address rural disparities in accessing health. Initiatives include chronic disease management through Heartline, a data collection source, and health coaches who use the information to assist patients in better managing chronic disease. We are also developing care managers to assist primary care practitioners, patients and their families to make palliative care and hospital referrals for outpatient symptom control and counseling as well as in-home services. Finally, in collaboration with multiple partners such as Atlantic General, McCready Hospital, Crisfield Clinic and multiple SNF's/Rehab, PRMC seeks to prevent avoidable admissions by addressing behavioral/chronic health needs and chronic disease management.

Peninsula Regional Ambulatory Access

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

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

Peninsula Regional's Outpatient Breast Center opened several years ago and provides women the most comprehensive breast health services on Delmarva with care plans individualized for each woman. The warm and caring staff believes in a team approach, and will offer 3D mammography, biopsies, physician consultations and surgical services all in a single location.

Corelife- Delmarva's Lower Eastern Shore has much higher rates of obesity compared to the rest of the state. Somerset County's 40 percent obesity rate is the highest in Maryland, with Dorchester at 36 percent, Wicomico at 34 percent and Worcester at 31 percent.

That hasn't escaped the attention of PRHS, which recently collaborated with CoreLife Delmarva to provide weight loss services in a structured, supportive environment to help people take control of their health and manage their weight and nutrition.

The joint venture opened its first Delmarva location in October at 1496 Still Meadow Boulevard in Salisbury, followed by an opening in Easton. Several more offices are planned in the region.

Richard A. Henson Cancer Institute- Ocean Pines

"Having cancer is hard enough we need to make it easier for our patients."

As part of our plan to expand health services outside the hospital walls and into communities, the strategy provides ease of access and promotes continuity of primary and population health services. More recently Peninsula Regional has opened several Health Pavilions within the community; one in Millsboro, Delaware, and one in Ocean Pines, Maryland. In August of 2017 the community was invited to attend the grand opening of the outpatient Richard A. Henson Cancer Institute established in Ocean Pines located next to the newly built primary care center. It's already making treatment easier for patients. A Worcester County cancer patient scheduled for radiation in Salisbury next week came to tour the facility and found out it would be opening the same day as her appointment. Amid the balloons and tours of the grand opening, a staff member was able to log into the scheduling system and change it to an appointment in Ocean Pines.

These health pavilions provide primary care physicians, a pharmacy, rehab, cancer treatments, and partnerships that provide specialty services such as cardiology and orthopedics. Each pavilion has an educational room that can be used by the public and other community health providers to hold health seminars and educational sessions. PRMC continues to develop its ambulatory care presence in addition to affiliations and partnerships as we review the external environment's socio-demographics, gaps in health services and access needs.

Reduce inappropriate Emergency Room Utilization

In FY2017 Peninsula Regional and **Your Doc's In,** established experts in the delivery of ambulatory urgent care created a partnership to provide urgent care on the Eastern Shore of Maryland. The new center is the first urgent care center on Delmarva collaboratively owned and operated by the two local healthcare leaders. It is located on South Salisbury Boulevard near Salisbury University. The team there provides cost-effective, high-quality urgent and occupational health services, giving residents of all ages a new healthcare option on the south side of Salisbury for acute illnesses and injuries that do not require an emergency room visit. This is a continuation of the Peninsula Regional Health System's commitment to offer exceptional healthcare services for the entire Delmarva Peninsula in locations that provide people options close to their homes, in the most appropriate setting, and give them the greatest value for their care.

The partnership is also evaluating other locations for a possible expansion to include additional urgent care centers across the Delmarva Peninsula. Not every acute illness or injury requires the emergency room. We have the responsibility to be good stewards of our community's health, and that includes managing the cost of care in this new era of healthcare. We have an outstanding partner in Your Doc's In as we expand into the urgent care arena and consider new opportunities.

Partners in Health: Our Joint Ventures

Since 1997, Peninsula Regional Medical Center has been pursuing a strategy to expand healthcare choices outside of the Medical Center setting. We've been extremely fortunate to build partnerships extending back almost 20 years with some of the nation's most comprehensive and finest providers of care across the continuum.

We and our Joint Venture partners were well ahead of the recent Population Health explosion by forming these strong relationships two decades ago that are designed to take care of the full spectrum of your health, not just what you require at the bedside.

- **American HomePatient of Delmarva**
- **Delmarva Surgery Center**
- **Peninsula Home Care**
- **Peninsula Imaging, LLC**
- **Your Doc's South Salisbury**
- **Salisbury Rehabilitation and Nursing Center**
- **Corelife Delmarva**

When did this initiative begin?
1. MAC Chronic Disease Self-Management - 01/01/2016.
2. Wagner Wellness Van Mobile Outreach Clinic - 04/01/2017.
3. Smith Island Telemedicine - 10/01/2017.
4. SWIFT (Salisbury Wicomico Integrated First Care Team) - 10/01/2017.

How many people did this initiative reach during the fiscal year?
1. MAC Chronic Disease Self-Management - 452 participants over 47 workshops.
2. Wagner Wellness Van Mobile Outreach Clinic – 2,022.
3. Smith Island Telemedicine - 100.
4. SWIFT – 192.

Implementation Strategy 2016 Priority Area: Diabetes
Strategy 1. Offer Chronic Disease Self-Management Classes (CDSM) Throughout the Tri-County Area.

Peninsula Regional Medical Center has continued their partnership with MAC, Inc. *Area Agency on Aging* to assist with the management of chronic diseases. Members and residents can participate in a wide variety of evidence based classes, exercise classes and wellness programs, including fall prevention. These programs are designed to assist with the management of chronic diseases, providing the participants awareness and education on controlling their diabetes, hypertension, and pain, giving the aging population a higher quality of life and sense of independence, ultimately keeping them healthy, strong, and out of the hospital.

In the last year, MAC Inc. was successful in increasing the total number of educational classes available from 26 to 47, touching the lives of over 450 participants and their supporting caregivers. According to the surveys completed by the participants (attached), they not only agreed they had a better understanding of how to manage the symptoms of their chronic diseases, but they also set action plans for moving forward and felt more motivated to take control of their health.

Point of entry into these ongoing programs at the MAC Center originates from many different providers and other outreach programs that are working locally in unison. Peninsula Regional's Wagner Wellness Van, SWIFT (Salisbury Wicomico Integrated Fisrtcare Team), local churches, physicians and civic organizations are aware of the program and are referring patients.

Coordination for high risk individuals within the three hospitals utilizing care coordination teams, local community agencies, and Community Evidence Based Classes in an effort to reduce unnecessary utilization and improve support for high risk individuals. Peninsula Regional Medical Center; Atlantic General Hospital; McCready Health; MAC – Area Agency on Aging; Wicomico County Health Department; Worcester County Health Department; Somerset County Health Department; City of Salisbury; Chesapeake Health Center; Salisbury Fire Department

Peninsula Regional Medical Center looks forward to our continued relationship with MAC Inc, Area Agency on Aging, to further educate and bring awareness to our community on the successful management of chronic diseases.

MAC Evidence-Based Classes
- **Diabetes Self-Management:** Diabetes is associated with an increased risk for a number of serious, even life-threatening, complications. Good diabetes control can help reduce the risk of these

complications. Topics include nutrition, exercise, stress management, foot care and more. This class is also available in Spanish.

- **Chronic Pain Self-Management:** Chronic pain can be debilitating and may lead to isolation and depression. Better management of chronic pain can help participants feel better, move better and improve quality of life.
- **Chronic Disease Self-Management:** Chronic disease, such as heart disease, stroke, cancer and arthritis, are leading causes of disability in the U.S. Participants will learn to cope with the fatigue, frustration and pain that accompany chronic disease, and exercises for improving strength and endurance, all which have been shown to improve health and decrease hospital stays.
- **Living Well With Hypertension:** Untreated hypertension is the leading cause of kidney disease and failure, and can lead to stroke and heart attacks. Participants will learn blood pressure management strategies.
- **Diabetes Prevention Program:** This lifestyle change intervention program is designed to help participants make lasting changes to reduce their risk of developing Type 2 Diabetes. Developed by the Center for Disease Control, this program offers participants the skills they need to lose weight, be more physically active and manage stress; a trained lifestyle coach to guide and encourage participants; support from other participants, and six monthly follow-up sessions to help participants maintain healthy lifestyle changes. *Must be pre-diabetic or demonstrate a high risk of developing Type 2 diabetes.*

MAC Inc.

Chronic Disease Self-Management

(CDSME)

7/1/17 - 6/30/18

Number of workshops: 14

Average participants per workshop: 9.5

Number of participants: 133

Participants with attendance data: 133

Completers: 120 of 133 (90%)

Number who are caregivers: 25 of 104 (24%)

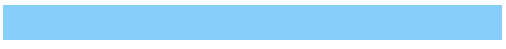
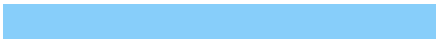
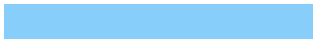
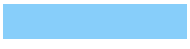
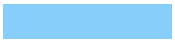
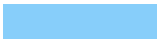
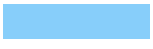
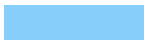
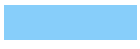
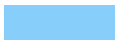
Age	Count	Percent	Bar
0-44	5	5%	

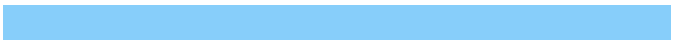
44-49	1	1%	
50-54	2	2%	
55-59	7	7%	
60-64	15	14%	
65-69	26	24%	
70-74	14	13%	
75-79	17	16%	
80-84	9	8%	
85-89	5	5%	
90+	6	6%	
Unknown	26		

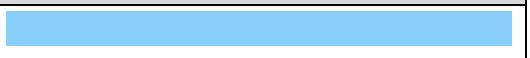
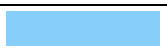
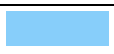
Can Manage Condition	Count	Percent	Bar
8	21	40%	
10	14	26%	
9	12	23%	
7	4	8%	
6	2	4%	
Unknown	80		

Caregiver	Count	Percent	Bar
No	79	76%	
Yes	25	24%	
Unknown	29		

Chronic Condition	Count	Percent	Bar

Hypertension	68	67%	
Diabetes	59	58%	
Arthritis	42	41%	
Cancer	24	24%	
Osteoporosis	22	22%	
Obesity	20	20%	
Heart Disease	19	19%	
Lung Disease	18	18%	
Depression or Mental Illness	17	17%	
Chronic Pain	14	14%	
Kidney Disease	9	9%	
Stroke	8	8%	
Schizophrenia	2	2%	
Other	3	3%	
Unknown	6		

Completers	Count	Percent	Bar
Yes	120	90%	
No	13	10%	

Condition Count	Count	Percent	Bar
Multiple chronic conditions	86	68%	
No chronic conditions	25	20%	
One chronic condition	16	13%	
Unknown	6		

Disabilities	Count	Percent	Bar
Limited Phy/Men/Emotion	18	14%	
Visually impaired	10	8%	
Hearing impaired	10	8%	
Diff. walking or climbing stairs	2	2%	

Education	Count	Percent	Bar
Completed High School	29	29%	
Completed College	28	28%	
Some College	27	27%	
Some High School	16	16%	
Unknown	33		

Ethnicity/Race	Count	Percent	Bar
White/Caucasian	57	53%	
Black or African American	48	44%	
American Indian or AK Native	6	6%	
Hispanic/Latino	6	6%	
Asian or Asian American	3	3%	
Hawaiian Native or Pacific Islander	1	1%	
Unknown	25		

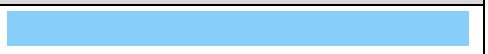
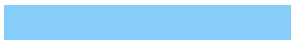
Gender	Count	Percent	Bar
Female	104	79%	
Male	27	21%	
Unknown	2		

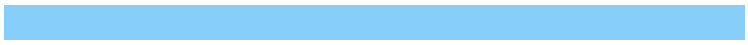
Health	Count	Percent	Bar
Good	53	55%	
Fair	21	22%	
Very Good	16	16%	
Excellent	4	4%	
Poor	3	3%	
Unknown	36		

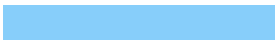
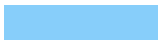
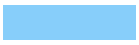
How Did You Hear	Count	Percent	Bar
Not reported	133	100%	

Insurance	Count	Percent	Bar
Medicare	54	75%	
BC/BS	13	18%	
Medicaid	10	14%	
United	9	12%	
Aetna	5	7%	
Humana	3	4%	
No Insurance	2	3%	
AARP	1	1%	
EHP - Johns Hopkins	1	1%	
Veterans Health	1	1%	
Mutual of Omaha	1	1%	
Other	10	14%	

Unknown	61		

Lives Alone	Count	Percent	Bar
No	62	62%	
Yes	38	38%	
Unknown	33		

Organization	Count	Percent	Bar
MAC Inc	133	100%	

Participant County	Count	Percent	Bar
Wicomico, MD	48	36%	
Worcester, MD	26	20%	
Somerset, MD	23	17%	
Dorchester, MD	12	9%	
Queen Annes, MD	12	9%	
Sussex, DE	8	6%	
Kent, MD	2	2%	
Caroline, MD	2	2%	

I have more self-confidence in my ability to manage my health than I did before taking this workshop	Count	Percent	Bar
Strongly Agree (1)	54	81%	
Agree (2)	13	19%	
Average Value	1.2		

The book that we used for the workshop was very helpful	Count	Percent	Bar
Strongly Agree (1)	56	84%	
Agree (2)	10	15%	
Disagree (3)	1	1%	
Average Value	1.2		

I learned how to set an action plan and follow it	Count	Percent	Bar
Strongly Agree (1)	53	79%	
Agree (2)	14	21%	
Average Value	1.2		

I now have a better understanding of how to manage the symptoms of my chronic health conditions	Count	Percent	Bar
Strongly Agree (1)	48	72%	
Agree (2)	18	27%	
Disagree (3)	1	1%	
Average Value	1.3		

The site used for the workshop was conducive to learning	Count	Percent	Bar
Strongly Agree (1)	52	79%	
Agree (2)	14	21%	
Average Value	1.2		

I felt my opinions and contributions to the group were valued by the other participants	Count	Percent	Bar
Strongly Agree (1)	51	76%	
Agree (2)	16	24%	
Average Value	1.2		

The peer leaders were able to manage the group very well	Count	Percent	Bar
Strongly Agree (1)	59	88%	
Agree (2)	8	12%	
Average Value	1.1		

I felt my opinions and contributions to the group were valued by the peer leaders	Count	Percent	Bar
Strongly Agree (1)	55	82%	
Agree (2)	12	18%	
Average Value	1.2		

My peer leaders got along well together	Count	Percent	Bar
Strongly Agree (1)	59	88%	
Agree (2)	8	12%	
Average Value	1.1		

I valued the time to talk to other participants at break time	Count	Percent	Bar
Strongly Agree (1)	50	75%	
Agree (2)	17	25%	
Average Value	1.3		

I noticed that some participants did not come back to the workshop after the first week	Count	Percent	Bar
Strongly Agree (1)	12	19%	
Agree (2)	28	45%	
Disagree (3)	14	23%	
Strongly Disagree (4)	8	13%	
Average Value	2.3		

I feel more motivated to take care of my health since I took this workshop	Count	Percent	Bar
Strongly Agree (1)	51	77%	
Agree (2)	13	20%	
Disagree (3)	1	2%	
Strongly Disagree (4)	1	2%	
Average Value	1.3		

Number of workshops: 9

Average participants per workshop: 8.9

Number of participants: 80

Participants with attendance data: 0

Completers: 0 of 0

Number who are caregivers: 0 of 0

Age	Count	Percent	Bar
60-64	1	14%	
70-74	1	14%	
75-79	1	14%	
80-84	1	14%	
85-89	3	43%	
Unknown	73		

Chronic Condition	Count	Percent	Bar
Arthritis	10	77%	
Diabetes	5	38%	
Heart Disease	4	31%	
Lung Disease	2	15%	
Hypertension	1	8%	
Cancer	1	8%	

Depression or Mental Illness	1	8%	
Other	9	69%	

Completers	Count	Percent	Bar
No	80	100%	

Condition Count	Count	Percent	Bar
No chronic conditions	67	84%	
Multiple chronic conditions	11	14%	
One chronic condition	2	2%	

Disabilities	Count	Percent	Bar
Limited Phy/Men/Emotial	4	5%	

Education	Count	Percent	Bar
Completed High School	7	41%	
Some High School	6	35%	
Some College	3	18%	
Completed College	1	6%	
Unknown	63		

Ethnicity/Race	Count	Percent	Bar
Black or African American	12	71%	
White/Caucasian	5	29%	
Unknown	63		

Gender	Count	Percent	Bar
Female	69	86%	
Male	11	14%	

How Did You Hear	Count	Percent	Bar
Not reported	80	100%	

Insurance	Count	Percent	Bar
Medicare	5	100%	
United	1	20%	
BC/BS	1	20%	
United American, Humana	1	20%	
Other	1	20%	
Unknown	75		

Lives Alone	Count	Percent	Bar
Yes	13	100%	
Unknown	67		

Organization	Count	Percent	Bar
MAC Inc	80	100%	

Participant County	Count	Percent	Bar
Wicomico, MD	46	58%	
Somerset, MD	12	15%	
Dorchester, MD	12	15%	
Worcester, MD	10	12%	

People in Household	Count	Percent	Bar
1	13	100%	
Unknown	67		

Referred	Count	Percent	Bar
No	80	100%	

What year were you born?	
Average Value	1943.2

Are you Male or Female	Count	Percent
Male (1)	8	11%

Female (2)	66	89%
Average Value	1.9	

In the past 3 months, how many times have you fallen?	
Average Value	0.3

If you fell in the past 3 months, how many of these falls caused an injury? (By an injury we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor)?	
Average Value	0.1

Number of falls within the past 3 months	Count	Percent
0 (1)	53	83%
1 (2)	4	6%
2-4 (3)	7	11%
Average Value	1.3	

Number of falls causing injury past 3 months	Count	Percent
0 (1)	57	89%
1 (2)	5	8%
2-4 (3)	2	3%
Average Value	1.1	

How fearful are you of falling?	Count	Percent
Not at all (1)	17	26%
A little (2)	22	34%
Somewhat (3)	20	31%

A lot (4)	6	9%
Average Value	2.2	

Has your weight changed in the past 30 days?	Pre	Post
Yes, gained weight (1)	9%	33%
No, weight stayed the same (2)	76%	33%
Yes, lost weight (3)	15%	33%
Average Value	2.1	2

Have you been trying to change your weight in past 30 days?	Pre	Post
Yes (1)	33%	67%
No (2)	66%	33%
No, changed anyway (3)	2%	0%
Average Value	1.7	1.3

How would you describe your appetite?	Pre	Post
Very good (1)	62%	67%
Good Fair (2)	36%	33%
Poor (3)	2%	0%
Average Value	1.4	1.3

Do you eat one or more meals a day with someone?	Pre	Post
Never or rarely (1)	23%	0%
Sometimes (2)	42%	100%
Often (3)	12%	0%
Almost always (4)	23%	0%

Average Value	2.4	2

Do you have any problems getting your groceries? Problems can be poor health or disability, limited income, lack of transportation, weather conditions, or finding someone to shop.	Pre	Post
Never or rarely (1)	90%	100%
Sometimes (2)	8%	0%
Always (4)	2%	0%
Average Value	1.1	1

During the last 30 days, how often was this statement true? The food I bought just didn't last and I didn't have money to get more.	Pre	Post
Often (1)	2%	0%
Sometimes (2)	8%	0%
Never (3)	90%	100%
Average Value	2.9	3

During the last 30 days, how often was this statement true? I skipped meals.	Pre	Post
Often (1)	9%	0%
Sometimes (2)	41%	67%
Never (3)	50%	33%
Average Value	2.4	2.3

During the last 30 days, how often was this statement true? I know where to get resources if I don't have enough money for food.	Pre	Post
Often (1)	31%	33%
Sometimes (2)	20%	33%
Never (3)	49%	33%

Average Value	2.2	2

Please rate your level of agreement with the following statement. I can identify foods that are good sources of protein.	Pre	Post
Strongly Disagree (1)	12%	33%
Disagree (2)	4%	0%
Neutral (3)	16%	0%
Agree (4)	41%	67%
Strongly Agree (5)	27%	0%
Average Value	3.7	3

Please rate your level of agreement with the following statement. I understand the importance of adequate nutrition to prevent falls.	Pre	Post
Strongly Disagree (1)	4%	33%
Disagree (2)	4%	0%
Neutral (3)	19%	0%
Agree (4)	45%	67%
Strongly Agree (5)	28%	0%
Average Value	3.9	3

Please rate your level of agreement with the following statement. I know how much protein I should consume daily to meet my needs.	Pre	Post
Strongly Disagree (1)	0%	50%
Disagree (2)	10%	0%
Neutral (3)	33%	50%
Agree (4)	43%	0%
Strongly Agree (5)	14%	0%

Average Value	3.6	2

Please rate your level of agreement with the following statement. I know how much fluid I need to consume daily to meet my needs.	Pre	Post
Strongly Disagree (1)	4%	50%
Disagree (2)	8%	0%
Neutral (3)	14%	50%
Agree (4)	48%	0%
Strongly Agree (5)	26%	0%
Average Value	3.8	2

Please rate your level of agreement with the following statement. I can list ways to increase my fluid intake.	Pre	Post
Strongly Disagree (1)	0%	50%
Disagree (2)	6%	0%
Neutral (3)	21%	0%
Agree (4)	49%	50%
Strongly Agree (5)	25%	0%
Average Value	3.9	2.5

Please rate your level of agreement with the following statement. I understand the importance of muscle strength to prevent falls.	Pre	Post
Strongly Disagree (1)	2%	50%
Disagree (2)	2%	0%
Neutral (3)	14%	0%
Agree (4)	50%	0%
Strongly Agree (5)	32%	50%

Average Value	4.1	3

Please rate your level of agreement with the following statement. I understand my nutrition risk and ways to improve it.	Pre	Post
Strongly Disagree (1)	0%	50%
Disagree (2)	8%	0%
Neutral (3)	21%	50%
Agree (4)	43%	0%
Strongly Agree (5)	28%	0%
Average Value	3.9	2

How often do you have someone with whom you can: Engage in physical activity	Pre	Post
Never (1)	6%	0%
Rarely (2)	15%	0%
Sometimes (3)	41%	67%
Often (4)	39%	33%
Average Value	3.1	3.3

How often do you have someone with whom you can: Eat healthy meals	Pre	Post
Never (1)	4%	0%
Rarely (2)	13%	0%
Sometimes (3)	31%	67%
Often (4)	52%	33%
Average Value	3.3	3.3

I feel confident that... I can set a healthy eating goal	Pre	Post
Strongly Disagree (1)	4%	0%

Disagree (2)	4%	0%
Agree (3)	61%	100%
Strongly Agree (4)	31%	0%
Average Value	3.2	3

I feel confident that... I can read food labels	Pre	Post
Strongly Disagree (1)	2%	0%
Disagree (2)	2%	0%
Agree (3)	44%	33%
Strongly Agree (4)	52%	67%
Average Value	3.5	3.7

I feel confident that... I can identify the recommended portion sizes for different foods	Pre	Post
Strongly Disagree (1)	2%	0%
Disagree (2)	13%	0%
Agree (3)	55%	33%
Strongly Agree (4)	30%	67%
Average Value	3.1	3.7

I feel confident that... I can identify ways to get healthy foods	Pre	Post
Strongly Disagree (1)	2%	0%
Disagree (2)	7%	0%
Agree (3)	54%	33%
Strongly Agree (4)	37%	67%
Average Value	3.3	3.7

Were you able to accomplish your action plan goals around improving your eating habits?	Pre	Post
Yes (1)	0%	100%
Average Value		1

What was your action plan goal? Check all that apply.	Pre	Post
Weigh myself weekly	2%	14%
Eat at least 3 meals a day	4%	7%
Eat more protein	25%	14%
Eat more fruits/vegetables	26%	21%
Eat with others	2%	7%
Try new foods	2%	14%
Drink more fluid	39%	14%
Talk with doctor or dietitian	2%	7%

The material in this course met my expectations.	Pre	Post
Strongly Disagree (1)	0%	33%
Strongly Agree (4)	0%	67%
Average Value		3

Were you able to complete your Action Plan?	Pre	Post
Yes (1)	0%	100%
Average Value		1

Did you attend a Stepping On or Chronic Disease Self-Management workshop?	Pre	Post
SO (1)	62%	62%
CDSME (2)	38%	38%
Average Value	1.4	1.4

What was your handgrip score?	Pre	Post
Average Value	53.1	75

What was your Nutrition Risk Score?	Pre	Post
Average Value	44.2	44.2

MAC Inc.

Living Well with Hypertension (BP)

7/1/17 - 6/30/18

Number of workshops: 9

Average participants per workshop: 6.2

Number of participants: 56

Participants with attendance data: 0

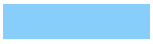
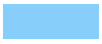
Completers: 0 of 0

Number who are caregivers: 10 of 44 (23%)

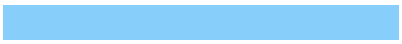
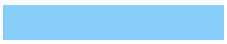
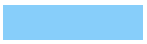
Age	Count	Percent	Bar
0-44	3	7%	
44-49	1	2%	
50-54	1	2%	
55-59	3	7%	
60-64	4	9%	
65-69	14	31%	
70-74	10	22%	
75-79	4	9%	
80-84	3	7%	
85-89	1	2%	
90+	1	2%	
Unknown	11		

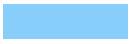
Caregiver	Count	Percent	Bar
No	34	77%	
Yes	10	23%	
Unknown	12		

Chronic Condition	Count	Percent	Bar
Hypertension	32	76%	
Diabetes	17	40%	
Arthritis	13	31%	

Cancer	8	19%	
Lung Disease	6	14%	
Heart Disease	5	12%	
Chronic Pain	4	10%	
Depression or Mental Illness	4	10%	
Osteoporosis	2	5%	
Stroke	2	5%	
Alzheimer's	1	2%	
Kidney Disease	1	2%	
Other	7	17%	
Unknown	5		

Completers	Count	Percent	Bar
No	56	100%	

Condition Count	Count	Percent	Bar
Multiple chronic conditions	27	53%	
One chronic condition	15	29%	
No chronic conditions	9	18%	
Unknown	5		

Disabilities	Count	Percent	Bar
Limited Phy/Men/Emotial	9	16%	
Hearing impaired	1	2%	

Education	Count	Percent	Bar

Some College	17	37%	
Completed High School	13	28%	
Completed College	12	26%	
Some High School	4	9%	
Unknown	10		

Ethnicity/Race	Count	Percent	Bar
Black or African American	24	51%	
White/Caucasian	23	49%	
Asian or Asian American	2	4%	
Unknown	9		

Gender	Count	Percent	Bar
Female	42	75%	
Male	14	25%	

Health	Count	Percent	Bar
Very Good	5	62%	
Good	2	25%	
Fair	1	12%	
Unknown	48		

How Did You Hear	Count	Percent	Bar
Not reported	56	100%	

Insurance	Count	Percent	Bar
Medicare	34	92%	
Medicaid	11	30%	
United	2	5%	
Aetna	1	3%	
BC/BS	1	3%	
AARP	1	3%	
Veterans Health	1	3%	
Humana	1	3%	
Other	2	5%	
Unknown	19		

Lives Alone	Count	Percent	Bar
No	36	80%	
Yes	9	20%	
Unknown	11		

Organization	Count	Percent	Bar
MAC Inc	56	100%	

Participant County	Count	Percent	Bar
Wicomico, MD	42	75%	
Worcester, MD	5	9%	

Queen Annes, MD	4	7%	
Kent, MD	2	4%	
Sussex, DE	2	4%	
Somerset, MD	1	2%	

People in Household	Count	Percent	Bar
2	18	53%	
1	9	26%	
5	3	9%	
3	2	6%	
4	1	3%	
6	1	3%	
Unknown	22		

Referred	Count	Percent	Bar
No	56	100%	

My facilitator(s) made me feel welcome and a part of the group	Count	Percent	Bar
Strongly Agree (1)	29	69%	
Agree (2)	13	31%	
Average Value	1.3		

The facilitator(s) was prepared for the workshop	Count	Percent	Bar
Strongly Agree (1)	28	67%	
Agree (2)	13	31%	
Disagree (3)	1	2%	
Average Value	1.4		

I know more about lifestyle changes like diet and physical activity that are recommended for my health condition	Count	Percent	Bar
Strongly Agree (1)	24	59%	
Agree (2)	17	41%	
Average Value	1.4		

The materials that we used for the workshop were very helpful	Count	Percent	Bar
Strongly Agree (1)	26	62%	
Agree (2)	16	38%	
Average Value	1.4		

I now have a better understanding of how to manage my health and/or physical activity	Count	Percent	Bar
Strongly Agree (1)	26	62%	
Agree (2)	16	38%	
Average Value	1.4		

Taking an active role in my own health care is the most important factor in determining my health and ability to function	Count	Percent	Bar
Strongly Agree (1)	27	64%	
Agree (2)	15	36%	
Average Value	1.4		

The site used for the workshop helped in my learning	Count	Percent	Bar
Strongly Agree (1)	23	56%	
Agree (2)	18	44%	
Average Value	1.4		

I would recommend this workshop to a friend	Count	Percent	Bar
Strongly Agree (1)	29	71%	
Agree (2)	12	29%	
Average Value	1.3		

I felt my opinions and contributions to the group were valued by the other participants	Count	Percent	Bar
Strongly Agree (1)	25	62%	
Agree (2)	15	38%	
Average Value	1.4		

The facilitator(s) was able to manage the group very well.	Count	Percent	Bar
Strongly Agree (1)	22	61%	
Agree (2)	14	39%	
Average Value	1.4		

I felt my opinions and contributions to the group were valued by the facilitators	Count	Percent	Bar
Strongly Agree (1)	23	68%	
Agree (2)	11	32%	
Average Value	1.3		

I am confident that I can keep my health problems from interfering with the things I want to do	Count	Percent	Bar
Strongly Agree (1)	15	42%	
Agree (2)	21	58%	
Average Value	1.6		

I valued the time to talk to other participants during the workshop	Count	Percent	Bar
Strongly Agree (1)	16	44%	
Agree (2)	20	56%	
Average Value	1.6		

I feel more motivated to take care of my health since I took this workshop	Count	Percent	Bar
Strongly Agree (1)	18	50%	
Agree (2)	17	47%	
Disagree (3)	1	3%	
Average Value	1.5		

The only way for a person to know if they have high blood pressure is to have their blood pressure checked.	Pre	Post
True (1)	83%	92%
False (2)	17%	8%
Average Value	1.2	1.1

The treatment for a person with pre-hypertension or hypertension includes:	Pre	Post
Medications only (0)	92%	93%
Lifestyle only (0)	92%	93%

Average Value	0	0

Which of the following is NOT a risk factor for high blood pressure:	Pre	Post
Sodium (0)	93%	4%
Sodium (0)	93%	4%
Activity (0)	93%	4%
Smoking (0)	93%	4%
Smoking (0)	93%	4%
Average Value	0	0

What is the recommended daily allowance for sodium for people living with high blood pressure:	Pre	Post
1000 mg or less (0)	38%	85%
1000 mg or less (0)	38%	85%
1800 mg or less (0)	38%	85%
1800 mg or less (0)	38%	85%
Average Value	0	0

Which of the following is NOT an effective strategy for reducing salt intake when you eat out:	Pre	Post
Grilled items (0)	51%	63%
Grilled items (0)	51%	63%
Ask for no salt (0)	51%	63%
Ask for no salt (0)	51%	63%
Smaller portions (0)	51%	63%
Smaller portions (0)	51%	63%
Average Value	0	0

Which of the following are you doing right now to help you manage high blood pressure: (check all that apply)	Pre	Post
Read food labels	20%	17%
Low salt groceries	20%	17%
Low salt groceries	20%	17%
Physical activity	20%	17%
Physical activity	20%	17%
Home monitoring	20%	17%
Home monitoring	20%	17%
Relaxation activities	20%	17%
Relaxation activities	20%	17%
Reducing salt at table	20%	17%
Reducing salt at table	20%	17%
Use eating plan	20%	17%
Use eating plan	20%	17%

I am currently taking prescribed blood pressure medications	Pre	Post
Yes (1)	91%	86%
No (2)	9%	14%
Average Value	1.1	1.1

Please check the statement that most closely matches how regularly you take your prescribed blood pressure medication:	Pre	Post
Never miss (2)	56%	14%
Never miss (2)	56%	14%
Occasionally miss (1)	35%	46%

Frequently miss (0)	0%	4%
N/A (2)	56%	14%
Average Value	1.6	1.5

My health care provider recently reduced the amount of medicatio I take for my high blood pressure:	Pre	Post
Yes (1)	83%	4%
No (0)	4%	80%
N/A (2)	12%	16%
Average Value	1.1	0.4

I currently smoke cigarettes or use other tobacco products	Pre	Post
Daily (0)	10%	8%
Quit less than 3 months (2)	0%	4%
Quit more than 3 months (3)	32%	12%
Never (4)	58%	76%
Average Value	3.3	3.5

I am currently overweight	Pre	Post
Yes (1)	90%	68%
No (2)	10%	32%
Average Value	1.1	1.3

I am in the process of losing weight now	Pre	Post
Yes (1)	67%	67%
No (0)	19%	14%
N/A (2)	15%	19%

Average Value	1.0	1.0

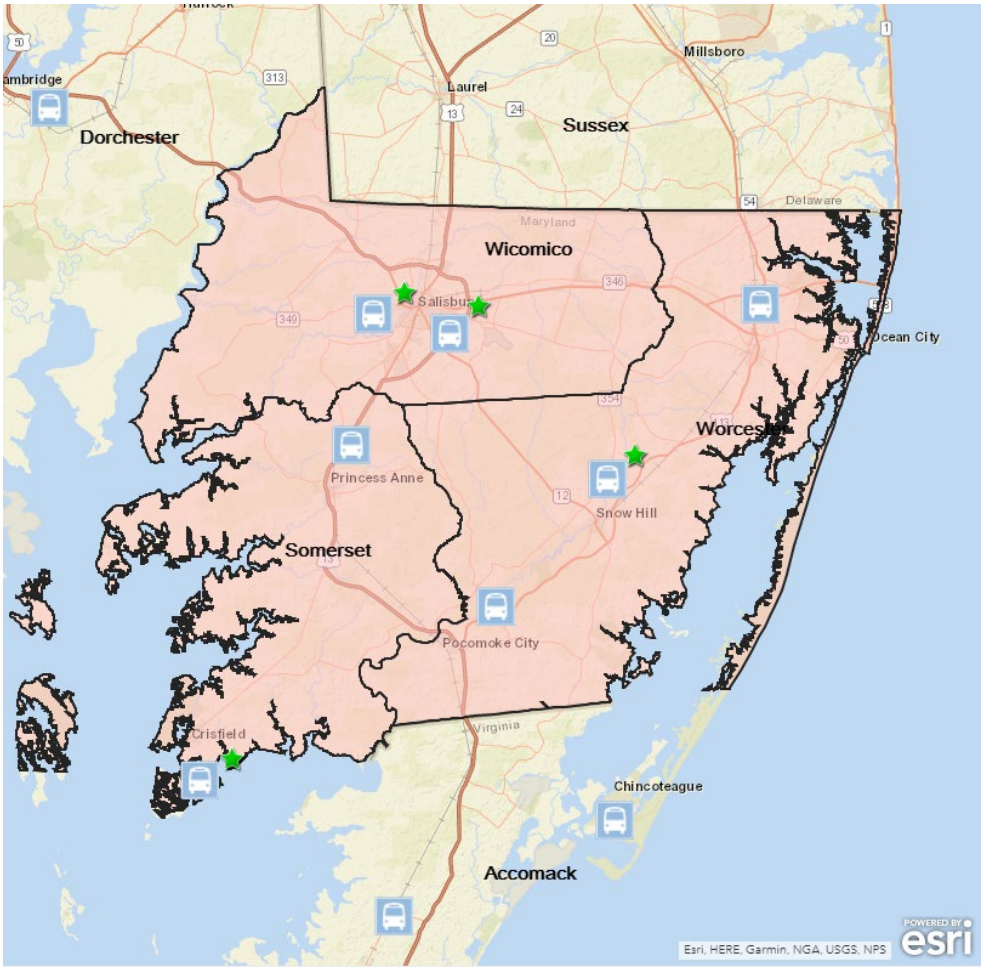
Has your blood pressure gone down recently?	Pre	Post
Yes (1)	62%	82%
No (2)	38%	18%
Average Value	1.4	1.2

What was your most recent systolic blood pressure reading?	Pre	Post
Average Value	134.2	137.2

What was your most recent diastolic blood pressure reading?	Pre	Post
Average Value	77.3	82.9

Implementation Strategy 2016 Priority Area: Diabetes
Strategy 2. Expand Wagner Wellness Van mobile clinic services frequency and outreach.

The Wagner Wellness Van is a mobile clinic that visits local shelters, churches, and other areas in PRMC's Primary Service Area where underserved residents can receive non-emergency medical care. The van visits areas where the social determinants of health indicate the greatest amount of need. It provides care in areas with a higher prevalence of ER visits, lower median incomes, an indigent population, trouble accessing care, communication barriers, and overall poor health outcomes. The map below shows Wagner Wellness Van stops according to the county and the day of the week. In Wicomico County, the van is at the corner of Route 13 and Newton Street in Salisbury, MD. In Somerset County, the van is at the Crisfield Library on 100 Collins Street, Crisfield, MD. In Worcester County, the van is parked at the Worcester County Health Department in Snow Hill, MD. These locations are marked by green stars on the map. The other Bus Icons are locations that the van visits for health fairs, heart screenings, educational literacy, community health services, etc.



The Wagner Wellness Van is staffed with a Certified Nurse Practitioner, Registered Nurse, and Medical Assistant to provide a number of services to residents without appointment that are school age residents or above. For FY 2018 (July 1, 2017 to June 30, 2018) a total of 843 patients were served on the Wagner Wellness Van. The ages of patients ranged from 14 to 95 years old. People of multiple ethnicities, both male and female, received care. A number of health screenings were performed on residents that help

determine appropriate education, self-management class information, or referrals to community resources and services. These screenings include pre-diabetes, hypertension and obesity. When warranted, drug and alcohol misuse screenings were also conducted. If a resident is at risk for diabetes, an A1C screening is performed to further diagnose the condition. There are multiple education subjects that were provided like smoking cessation and chronic disease prevention that could help limit ED utilization. Sick visits were also performed by the NP with follow-ups when needed. The Nurse Practitioner on the Wagner Wellness Van could initiate diabetic and hypertension medications and also schedule a follow-up screening on the van to see if the patient had improved. Also, the staff helped to refer users of the van to primary care physicians for those they saw who did not have one. For FY 2018, the van had about 340 community members who did not have a PCP. The van provided each person with a list of local PCPs and made appointments for most of these community members who screened positive for HTN or DM, or who the van was seeing for a sick visit. The staff also helped refer users of the van to financial counselors, insurance counselors, and other community services that these residents needed such as food pantries and shelters. This serves a need in the tri-county area because there are a number of residents who are uninsured, do not have a primary care provider, or need other community social or behavioral services to improve health.

Wagner Wellness Van Annual Screenings

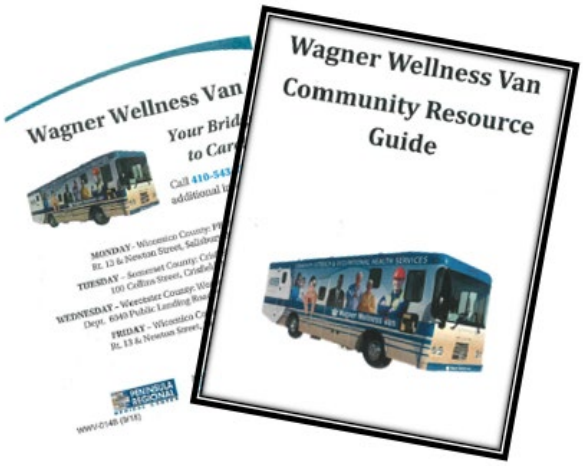
Hypertension	845
Diabetes	392
Referrals to PCP	340

Ethnicity	**%**
Caucasian	23%
African-American	63%
Hispanic	6%
Unknown	5%
Total	**100%**

Gender	**%**
Female	47%
Male	53%
Total	**100%**

Location *	**%**
Somerset	14%
Wicomico	56%
Worcester	30%
Total	**100%**

*The Wagner Wellness Van promotes a Tri-County **Community Resource Guide** distributed to residents that visit the Van. This multipage guide provides names, location and phone numbers for low or no cost transportation, local shelters, social services, Health Departments, medical assistance, Veterans Services, prescription aid, etc.*



*The Wagner Wellness Van has a set schedule for Monday, Tuesday, Wednesday, and Friday and travels within Peninsula Regional's Primary Service Area. The Van also travels to various festivals within our secondary service area (Dorchester, MD, Accomack, VA, Sussex, DE) and provides health education, screenings and health resource connections to residents in attendance.

The Wagner Wellness Van also participates with the local university, Salisbury University, to make sure students are prepared for flu season. The mobile unit was parked on campus to provide students with flu shots who may not have gotten the shot earlier in the year. The Wagner Wellness Van also participated in National Night Out, an event organized by the Salisbury Police Department, to build police-community partnerships. At the National Night Out event, the Wagner Wellness Van staff completed 36 blood pressure screenings and completed blood pressure education with the patients. There is also the possibility of the Wagner Wellness Van to work jointly with the Salisbury YMCA to provide screenings to the community of the YMCA in the future.

Smith Island Telehealth

Smith Island, MD is a small, tight knit community of about 250 people. The town is collectively made of strong, loyal, and hard-working people. This area is known for its watermen, the seafood economy, and not having too many "outsiders" come to visit. For this reason, Peninsula Regional Medical Center created a partnership with McCready Health, MAC – Area Agency on Aging, Somerset County Health Department, and the Crisfield Clinic. The goal of the partnership was to improve the health of the Smith Island community, provide health literacy to residents, and reduce ED utilization.

The program was led by the Smith Island community health worker staff where they would provide chronic disease educational support and connect the residents of Smith Island with telehealth for primary care purposes. In FY 2018, there were 98 patients served out of the possible 250 residents of Smith Island. The community health workers played an integral part of having the residents change behaviors and actions because the workers weren't "outsiders" and could build and keep relationships with the people of Smith Island. The community health staff also helped patients understand the medications and compliance parameters given by health professionals. Flu shots were also given out by community health workers to ensure the residents of Smith Island can combat the flu season effectively and reduce admissions to the ED. There have been some great successes since the program started. For example, there were blood sugar reductions from residents that started in the 300s level and decreased to the 120s level. This is a prime example of improving health, chronic disease education, and possibly eliminated a future Emergency Department visit related to blood sugar or diabetes. There was also an increased knowledge of causes and management of chronic diseases by the residents of Smith Island. As a result of increased knowledge, a frequent user of the ED decided to receive care on Smith Island, which decreased ED utilization. Speaking on ED utilization, there was actually a 5% reduction in ED utilization at McCready Hospital for patients with a Smith Island zip code from October 2017 to June 2018.

In the future, the relationships between the community health workers and the residents of Smith Island need to remain constant and even get better over time. There is exercise equipment on Smith Island for its residents to use and there are even walking clubs with marked paths to walk. Adding more Primary Care Physicians and specialists to the growing list of Telemedicine providers is something the partnership wants to evolve. It is the goal of Peninsula Regional and the incorporated partners in this endeavor that a higher percentage of people from Smith Island will look to receive primary care and chronic disease education from the community health workers. Reaching this goal means better health and education for residents, reduced admissions to the Emergency Departments, and developing trusting relationships with the health care professionals in the event that more than primary care is needed for a resident

S.W.I.F.T.

The Salisbury–Wicomico Integrated FirstCare Team (SWIFT), a partnership between the Salisbury Fire Department and Peninsula Regional Medical Center, has earned the MIEMSS Executive Director's Award for Excellence in EMS. The team of a Salisbury paramedic and PRMC nurse provides home visits for individuals who are frequent users of 911. The SWIFT team works collaboratively to reduce overuse of emergency services and improve access by connecting these community members with healthcare options better provided in a primary or specialty care setting.

Since October 2017, the SWIFT team has been assisting a population of frequent EMS users who call for non-emergency aid at least five times over any six-month period. SWIFT's goal is to lessen users' reliance on Salisbury First Department (SFD) EMS and PRMC for healthcare services that are more appropriately provided in a primary or specialty care setting.

Many EMS systems throughout the United States are expanding the role of emergency medical services through innovative Mobile Integrated Health (MIH) programs. These programs link frequent users of EMS services to the preventative and chronic health services that those patients need, thereby reducing 9-1-1 EMS call volumes and helping patients avoid costly treatment at an emergency department. This new model of health care delivery is the foundation for seven MIH programs in Maryland that have embraced this expanded role for EMS. Maryland's MIH programs have identified the health care needs of their local communities and partnered with other health care providers to link patients who rely heavily on EMS for non-emergency care with the most appropriate services. MIH programs not only help address patients' health needs, these programs also improve the availability of EMS for actual emergency incidents and drive down the cost of health care.

SWIFT has a lead dedicated Emergency Medical Technician Paramedic (EMT-P) who acts as the point person to identify the long-term needs of patients, make necessary referrals, and enroll interested frequent users into the SWIFT program. Those enrolled in the SWIFT program had called EMS for assistance 296 times pre-enrollment and only 194 times post enrollment, a 34.5% reduction in annual 911 calls and an overall ER reduction rate of 37%. Since SWIFT's implementation, of those enrolled in the program there has been an average 35% reduction of 911 calls and a 20%-35% decrease in ER visits on a month-to-month basis.

SWIFT Program Totals

10/1/2017- 10/31/2018

Totals Enrolled Patients:	51
Pre-enrollment 911 Use:	296
Post Enrollment 911 Use:	194
Total 911 Reduction:	34.5%
Pre-enrollment ED Visit:	335
Post Enrollment ED Visit:	211
Total ED Reduction:	37%

Patients with 6 Month Enrollment

Total Enrolled:	36
Pre-enrollment 911 Use:	215
Post Enrollment 911 Use:	140
Total Reduction:	35%
Pre-enrollment ED Visit:	215
Post Enrollment ED Visit:	171
Total ED Reduction:	20.5%

Referrals

Allied Health:	24
Mental Health:	10
Social Services:	19
Health Department:	10
PT/OT:	9
Transportation:	18
Other (Home safety repairs, Ramps, etc.):	15

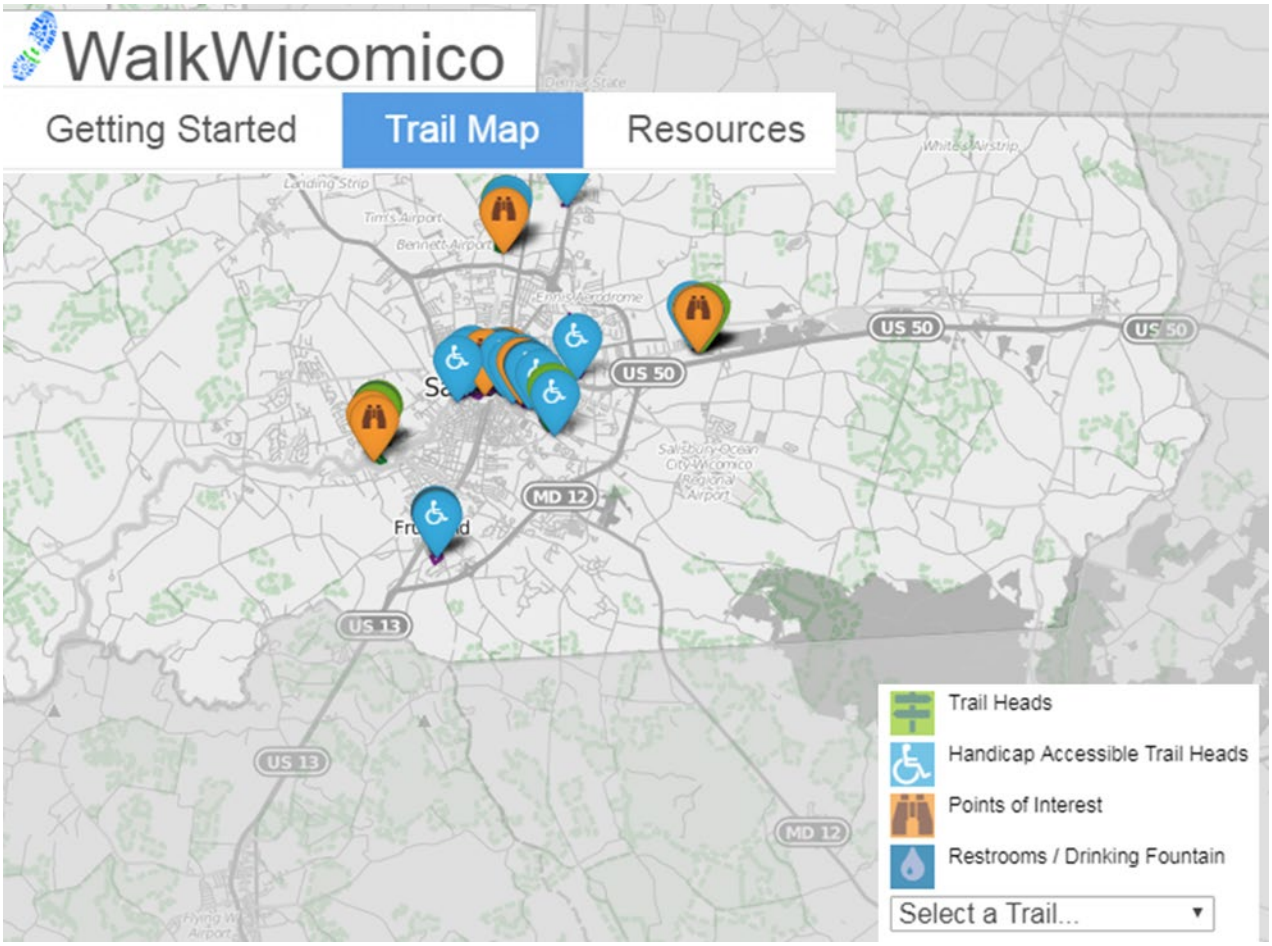
All Patients either had or were found Primary Care Provider

Exercise, Nutrition, and Weight

WalkWicomico

The primary objective is to increase awareness of and engagement in healthy lifestyle behaviors promoting exercise to help with weight loss, increase energy, reduce risk of chronic disease and make people feel happier. “WalkWicomico” is primarily targeting those that reside in the county (pop. 100,000+); however, it would also be an attraction for adjacent counties including visitors. Walk Wicomico is a coalition of partners that meets to create action plans that encourage and provides access and events to “get out” and enjoy the great outdoors by walking your way to health.

Peninsula Regional is an active participant in transforming the community’s culture by providing education, guidance and resources towards promoting exercise through walkability as an integral part of a healthy lifestyle. The Coalition’s initiatives included creating a website and phone app specific to walking in Wicomico County; communicating with the community via social media; working with civic organizations, churches, local businesses, towns, county health departments, and other groups to encourage local walkability. Walk Wicomico has marked walking routes, increased the number of walking routes, participated in and launched walking events, and is engaged with decision makers through input and feedback about making walking safer easier and more accessible.



Coalition Partners Include:

- Wicomico County, Maryland
- University of Maryland Extension
- YMCA
- Maryland Department of Planning
- Shore Transit
- Peninsula Regional Medical Center
- Wicomico County Public Schools
- Salisbury/Wicomico Metropolitan Planning Organization
- Town of Salisbury
- Town of Fruitland
- Town of Delmar
- Wicomico County Health Department
- Wicomico County Recreation, Parks & Tourism

Milestones

July 1, 2017 – September 30, 2017

- Information on the Walk MD Day Challenge (most steps walked in 24 hours) was sent to all Wicomico Co HMBs which included the Wicomico Co. Health Dept. (9,480 employees in 33 businesses); the winner received a Fitbit Alta that was graciously donated.
- Information was sent to all Lower Shore HMBs for Walk MD Day Oct 4th which encouraged businesses to register their event on EVENTBRIGHT (sent to 60 businesses).
- Walk MD Day information was also sent to WalkWicomico partners and posted on Wicomico County Health Department's Facebook Page.
- WalkWicomico met on July 26th. The website developer presented on website progress.
- WalkWicomico was asked to provide input regarding website links for the website; 1 partner responded.
- Information was sent to all Wicomico HMBs on Heroin and Opioid forum to be held on Oct 19th (9,480 employees in 33 businesses received the info).
- WalkWicomico coordinator and 1 partner met with City of Fruitland on Aug 9th to discuss the city hosting a community walk. This is planned for the evening of Oct 12th at the sports fields during practice in the hope of getting parents and siblings to walk. The city took responsibility for the planning and promotion of the walk and is providing water. The partner secured pretzels.
- Eastern Shore Regional GIS Collaborative was funded to continue work on WalkWicomico website.

October 1, 2017 – December 30, 2017

- WalkWicomico meeting 10/26/17 at Fruitland City Hall. 7 partners attended. Discussed website update, photo challenge, doing presentation at MPO meeting, town walks, disability accessibility, and Year 1 review.
- Met with City of Salisbury 11/6/17 to discuss starting WalkWicomico Facebook & Instagram pages. Facebook page was launched 12/12/17; more than 100 followers as of 12/31/17. Posting most days (plan to increase to at least once a day).
- Building website content.
- Created 1 Billion Steps Challenge WalkWicomico team; 13 members so far.

January1, 2018 – March 30, 2018

- Several WalkWicomico meetings were held; January 23 and March 19, 2018. 11 partners attended in January and 3 partners in March.
- As of March meeting, Facebook has 167 followers and Instagram, 51. Along with motivational posts, event flyers are now being shared on social media.
- Coalition provided options for a tag line (to be used in communications), voted, and selected "Walk this Way".
- WalkWicomico 1 Billion Steps Challenge team has 15 members and ranked midway nationally in team steps.
- Partner presented about WalkWicomico to Live Healthy Wicomico, Wicomico's LHIC chronic disease prevention team.
- Staff met with 2 partners to discuss outside funding for incentives, etc.

April 1, 2018 – June 30, 2018

- One WalkWicomico meeting was held on May 7, 2018. 3 partners and 2 guest speakers attended.
- As of this report, Facebook has 193 followers and Instagram, 116. Along with motivational/educational/interactive posts, event flyers are now being shared on social media.
- WalkWicomico partners were asked for feedback on the Community Walking/Walkability Plan revision and videos for the phone app.
- Facebook followers were asked for input about videos for phone app.
- WalkWicomico 1 Billion Steps Challenge team walked 6.342.425 steps, with a final rank of 164 out of 398.

- Partner presented WalkWicomico at WiCHD's Outstanding Public Health Leader Awards Ceremony on April 2, 2018.
- Town of Delmar held a community walk on May 3rd, which was not well attended. It was determined that they had not adequately prepared or promoted it.
- Partner manned a table at WiCHD's annual Walk@Lunch on May 16, 2018; 20 email addresses of people interested in WalkWicomico were captured.
- Staff was trained as a Walking Audit Leader on May 22, 2018, and led an audit at the Be Active Maryland conference on May 23, 2018.
- Staff presented about WalkWicomico at WiCHD's Health Equity Workshop on June 27, 2018.
- Website was completed; official launch is forthcoming. Quarterly maintenance will include changing seasonal pictures.
- Walking College fellow is focusing on health equity/diversity for personal Walking Action Plan; work on plan will continue throughout fellowship.
- Interviewed a vision impaired person to hear their perspective on walking/mobility in Wicomico County.
- Participated in calls and completed modules/evaluations.

Initiative will continue into the foreseeable future.

YMCA

Reduce the number of child & adolescents/adults in Wicomico, Worcester and Somerset who are considered overweight and present a healthy lifestyle of nutrition and exercise opportunities.

Peninsula Regional's Diabetes Education Department has a working relationship with the YMCA and conducts educational sessions about diabetes on site several times a year. Nutrition, exercise, obesity and diabetes are a top priority community health issue, as referrals are forthcoming from PRMC clinicians to the YMCA for obese pediatric and adult patients.

The Diabetes and Education Department at Peninsula Regional continues to impact the community through promotion of nutrition, weight loss and diabetes health literacy, as evidenced by the following community visits:

- July 24, 2017 Wagner Wellness Van
- September 7, 2017 Salisbury Urban Ministries (Wagner Wellness Van)
- September 11, 2017 LHIC Chronic Disease Workshop
- September 27, 2017 Read Program Presentation
- September 29, 2017 Somerset County Staff Development Day
- October 7, 2017 Ocean Pines Health Fair
- October 6, 2017 Wor-Wic In-service to the Childcare Center
- October 13, 2017 Wor-Wic In-service to the Childcare Center
- October 28, 2017 Wicomico County Board of Education Health Fair
- November 11, 2017 MOHTA Health Fair at Ward Museum
- December 26, 2017 Governor's Challenge at Civic Center
- February 2, 2018 Go Red Event at UMES
- March 28, 2018 Coders Meeting at PRMC
- April 6, 2018 Radio Program at WOCM in Ocean City, MD
- April 11, 2018 Healthfest
- June 5, 2018 Smith Island Health Fair
- June 11, 2018 Lions Club, Salisbury
- June 16, 2018 Wicomico Middle School Fun Run

To address obesity, Peninsula Regional also participates in Tri County Diabetes Alliance and Live Healthy Wicomico. Groups meet monthly or every other month to develop partnerships to address prevention and treatment of diabetes, obesity and other health issues. Projects include promoting lifestyle changes for disease prevention, team work in community, and awareness of pre-diabetes and diabetes and services available in the community. Susan Cottongim from PRMC is serving as co-chair for the TCDA.

Currently Medical Nutrition Therapy Services are provided by Peninsula Regional Registered Licensed Dietitians. Pediatric overweight and diabetes patients and family meet with the dietitian to manage diabetes, high blood pressure, high cholesterol, early kidney disease, weight loss management and healthy eating habits. Individual instruction for injections and training for the Dexcom and Freestyle Libre are also provided. Support groups are available and meet bi-monthly for children and teens with diabetes to discuss in a non-judgmental environment – a place where peers can share healthy lifestyle tips, challenges of living with diabetes, weight loss and nutrition tips, all under the careful leadership of a registered dietitian. The pediatric support groups meet every other month and have a typical attendance of 5-10

students. Students are encouraged and taught how to manage their diabetes, eat healthy and participate in exercise programs and activities offered by the YMCA.

In addition, Peninsula Regional Medical Center has partnered with Children's National Health System, based in Washington, DC, to bring nationally recognized pediatric endocrinology services to the Delmarva Peninsula. Children's pediatric endocrinologists have the expertise to recognize, diagnose, and treat complex endocrine conditions. Our team teaches parents and children how to manage chronic or long-term endocrine disorders, such as diabetes. It has been an endeavor of passionate care that prepares and provides guidance to our youngest and most vulnerable residents. They are taught how to self-manage their diabetes returning their life to normalcy of family, friends, school and sports. Specialties covered that would otherwise be sent across the bridge, to one of 15 pediatric endocrinologists in the state are Hypothyroidism, Hyperthyroidism, Diabetes Type 1 and 2, Precocious and Delayed Puberty (growth hormone injections), and Failure to Thrive.

This program is a multi-collaborative initiative between Peninsula Regional, Children's National, Schools in the Tri-County area and local YMCAs. At any time we are coordinating care between 130-150 elementary students, junior high students and high school students. Peninsula Regional's team educates and advocates for children in need of specialty care by working with the tri-county area school nurses to develop each patient's diabetes management plan for the school year. The team also diligently works to stay up to date on the newest technology available (Dexcom G6), providing the best care management tools for success. An RN or Dietitian follows up with patients immediately after assessment biweekly, therefore saving the patient and family a second trip to the clinic. Telemedicine connectivity with Children's DC provides the 24/7 accessibility of on call physicians, as well as providing scheduled telemedicine consults for endocrinology and diabetes care. Another fun aspect has been the increased volume of Children attending a "Diabetes Camp" where participation has increased from 1 participant to 11 in five years.

To expand our "Healthy Living" message, Peninsula Regional sponsors and participates in many community-based health fairs providing nutrition education, weight loss, diabetes, and health literacy. These health fairs include underserved areas like Smith Island, an island on the Chesapeake Bay with a population of only 300, a Haitian Creole Health Fair, Healthfest and screenings at the Governor's Basketball Challenge at the Civic Center in Wicomico County.

Transforming the culture through health fairs and festivals, Peninsula Regional participates and sponsors the following to improve the health of the community:

HealthFest - an annual health fair sponsored by Peninsula Regional for the residents of Salisbury (1,000+ attendance) which promotes health lifestyles through nutritional education and exercise, targeting hypertension, and chronic disease among other screenings:

- Blood Pressure
- Vascular Disease Testing
- Height/Weight/Waist Measurement/ Nutritional Counseling
- Body Fat
- Kidney Health
- Mental Health Assessment
- Oral Cancer
- Skin Cancer

- Colorectal Information
- Breast Education
- Bone Density
- Hearing /Vision
- Diabetes Assessment
- Glaucoma

Festivals	Encounters	Referred	Screened
Apple Scrapple	10	0	10
Governor's Challenge	92	0	8
Haitian Creole Health Fair	180	15	75
HealthFest	1,743	0	100
MOHTA Health Fair	15	0	1
Ocean Pines Health Fair	595	57	107
Smith Island Health Fair	22	0	0
UMES Health Fair	100	0	29
Worcester Parks & Recs Health Fair	50	0	8
Total	**2,807**	**72**	**338**

Sundaes in the Park are held once a week from Memorial Day to Labor Day in Worcester County, in Ocean City Maryland. Peninsula Regional participates and promotes healthy lifestyles to include nutritional education, weight loss, sunscreen/skin cancer and chronic disease management resources and appointments.

Heart Smart Community Screenings are provided to the community to promote a healthy heart though understanding of lifestyle and risk factors that can help reduce the risk of heart disease. These are free and comprehensive screenings with several hundred encounters, 162 screened and 3 immediately referred.

Comprehensive Screenings include:

- Cholesterol, HDL, triglycerides, fasting blood glucose
- Resting 12-lead EKG
- Body fat and body mass index
- Waist to hip ratio
- Blood pressure testing
- Pulse oximetry testing
- 10-year risk analysis
- Review of current medications
- Follow-up care plan

- Exercise/nutrition recommendations

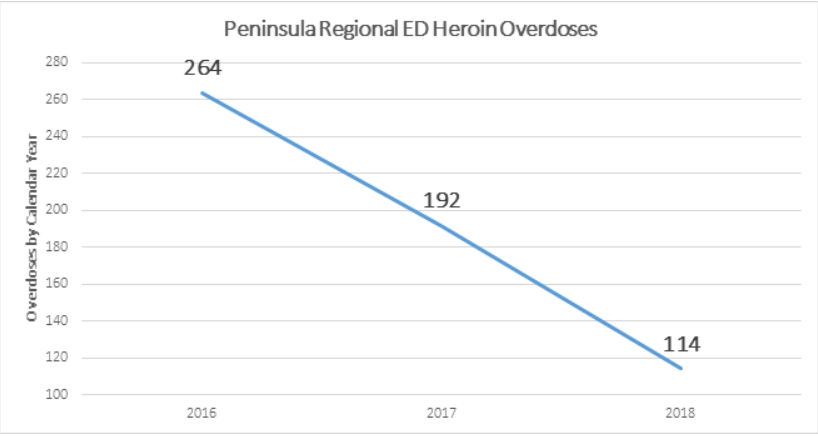
Peninsula Regional recently launched the Health Literacy Challenge, aimed at improving health literacy across the region. Only 12% of adults are proficient in health literacy. To change that, in concert with the United Way of the Lower Eastern Shore and the Eastern Shore Regional Library, we hope to raise at least $250,000 to support a health literacy campaign. Peninsula Regional will donate $50,000 to support this initiative. We believe this partnership with the library and the United Way will help us to share culturally and linguistically appropriate information and, over time, will improve our rates of health literacy and the overall health of the communities we serve.

C.O.A.T.

The COAT initiative is a partnership between Peninsula Regional Medical Center, the Wicomico County Health Department, the State's Attorney's Office, the Salisbury City Government, and the Wicomico County Sheriff's Office. COAT, or Community Outreach Addictions Team, is an opioid intervention task force that goes and talks to drug dependent residents of Wicomico County and the surrounding areas. The team consists of peer mentors who were previously addicted to drugs. These mentors talk to those struggling with addiction and try to get them to enroll into treatment. The collaboration begins in the ED if a patient comes in as an overdose or suffering from addiction symptoms. The PRMC staff then calls the 24/7 hotline number to have a COAT Team Member visit with the patient. This peer mentor helps to provide a smooth transition to treatment services that link the patient with local mental health and addiction resources in the community or to other areas if necessary. The focal point of having these peer mentors to help with the transition process is that as a previous opioid addict, the mentor has grown in their own recovery and has knowledge and understanding that a professional can't duplicate. According to PRMC ED data, the opioid overdose ED treatment rate has increased since the partnership with COAT was initiated in July 2016. For the calendar year of 2018, there has been 151 referrals from the ED to the COAT team. The COAT partners meet monthly at the Wicomico County Health Department to evaluate successes and to plan initiatives for the future of the COAT program since it has been extended into FY 2019.

PRMC has an MOU with the Wicomico County Community Health Services that allows for COAT team members to distribute Wicomico County Health Department Naloxone HCI nasal spray kits to patients and/or to patient's caregivers at an appropriate time during a COAT team member's contact with the patient or upon patient discharge. Most recently, the COAT program has expanded to the Labor and Delivery department of the hospital to help pregnant women and substance exposed newborns.

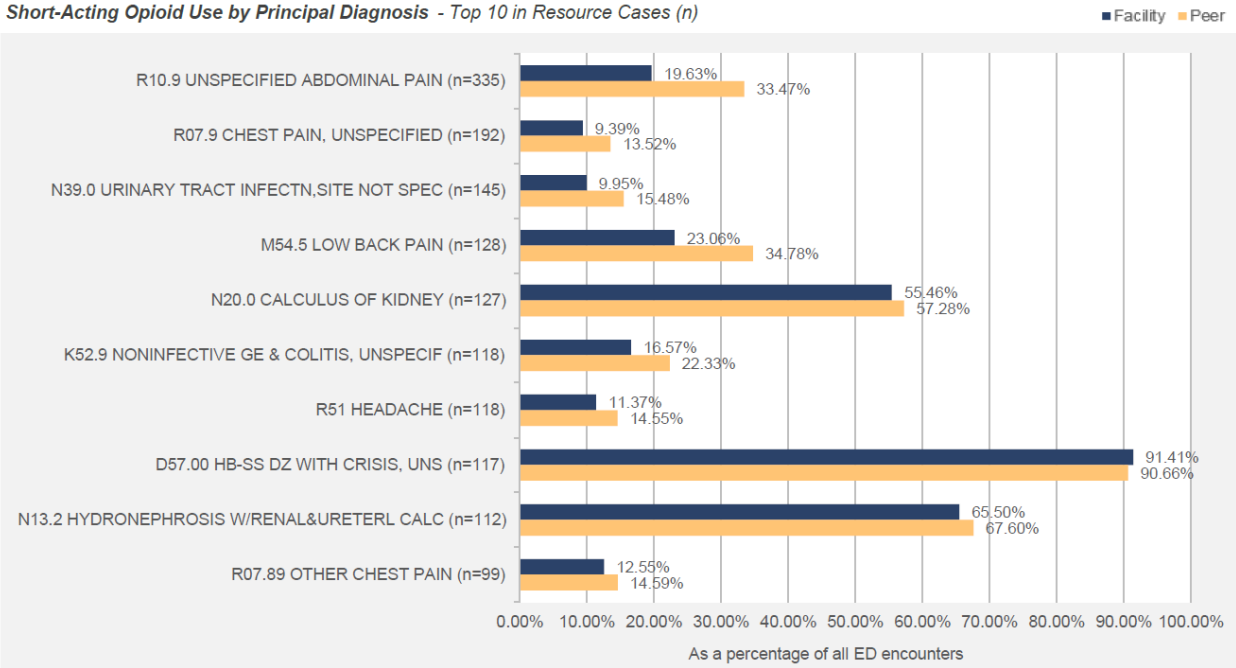
The COAT program has seen success since its inception in 2016. According to PRMC ED overdose statistics, in the 2016 calendar year, there were 264 heroin overdoses. Comparing that overdose statistic to the 2017 calendar year, there were 192 heroin overdoses. This declining trend has continued into the 2018 calendar year. With the most up to date data being October 2018, PRMC has currently had 114 heroin overdoses for the 2018 calendar year. The goal is to have no overdoses and to eliminate the opioid epidemic affecting Wicomico County, but these declining trends are a good start. There has also been a 42% reduction in opioid-related deaths in Wicomico County. In comparison, the State of Maryland has only seen a 12% reduction in opioid-related deaths.



From July 17-June 18
COAT received calls for 369 unique individuals battling addiction or related substance use issues. Of those calls they were able to meet with 247 individuals identifying as homeless residents and 115 individuals providing an address from another location outside of Wicomico County. Of the 247 Wicomico individuals 119 accessed some type of additions treatment service (92 of which were directly assisted by COAT with access). Of the 115 other jurisdiction individuals 30 accessed some type of licensed treatment service (26 directly assisted by COAT), which is pretty significant given we have limitations serving those individuals outside the county with transportation and follow up.
During the course of the year COAT made 1,672 contacts or attempts to contact individuals in the community they had previously encountered for assistance providing on average at least 4 contacts (sometimes more sometimes less depending on phone numbers, reception etc).

PRMC has also taken steps to curb the abuse of opioids from a medication prescribing standpoint. Using the EMR (Electronic Medical Record) system, PRMC has reduced its High Opioid medication utilization level and implemented a new system for prescribing opioids using a collective of factors. These factors include how to calculate the total daily dose of opioids, morphine equivalent calculations, and non-opioid alternative medication suggestions. PRMC has seen a reduction is opioid prescription and is below the national average. The opioid prescription percentage from June 2017 to May 2018 was 9.3% for PRMC vs a Peer Hospital that had a percentage of 15.22%. There has also been a reduction in opioid emergency room use comparing the time frame of September 2016 - August 2017 to June 2017 - May 2018. There was a 1.45% reduction in males and 2.15% reduction in females. Also in February 2017, PRMC installed a Medication Drop Off Container in the ED to assist in the ease of disposing of unwanted prescriptions in the home.

Opioid Use Compared to Peer
June 2017 – May 2018



Source: PRMC Pharmacy Department/EPIC

CareWrap

CareWrap is hospital-community collaboration between PRMC and Lower Shore Clinic located in Salisbury, Maryland. The model is based on the Pathways model used by Family Services, Inc., the partnership's aim is to decrease thirty-day readmissions.

The "Transitions Team" at Peninsula Regional targets patients that have a high risk for returning to the hospital within 30 days of discharge. Once identified, those individuals are referred to the CareWrap program. The goal is to reduce hospital readmissions by helping patients' access primary care and behavioral health services, and to help fill other social determinants of health gaps to ensure a smooth transition to health stabilization.

Program education was provided to PRMC physicians, social workers and RN case managers to identify and refer high-risk patients with dual diagnosis in need of community support. A centralized e-mail process was developed to facilitate ease of referral and clinical review determines appropriateness of referral prior to assignment.

Community Health Workers link patients to community resources and access to the healthcare system to eliminate and/or minimize social determinants of health. Examples include: obtaining housing, medications, transportation and linking to entitled financial assistance or helping find employment. The CareWrap team provides weekly status updates on all patients. This team discusses participant progress as well as identifying barriers and works toward solutions.

The total number of CareWrap members in the panel for the FY was 62 patients. As based upon a CRISP analysis of a 3, 6 and12 month pre/post analysis there was reduction in the number of visits between 4% and 6%, however, after 12 months there was a slight increase in visits of 1%. In order to sustain the gains continued longitudinal social-determinants of health need to be addressed, in addition to providing access to health care. There was a corresponding decrease in the average charge per visit between $800 and $7,200 over a 1,3, 6, and 12 month period.

In Fiscal Year 2018 the grant ended and the service was not renewed, however, a similar service outlined in this submission named C.O.A.T provides similar transition services to those struggling with social determinants of health; triple issue addiction, behavioral and primary care access issues.

PENINSULA REGIONAL MEDICAL CENTER
Part of Peninsula Regional Health System

ADMINISTRATIVE POLICY MANUAL

Subject: Uncompensated Care / Financial Assistance

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

POLICY

Peninsula Regional Medical Center (PRMC) will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their hospital bill. For purposes of this policy, PRMC shall include the hospital, medical center, and physician services billed by PRMC, commonly referred to as Peninsula Regional Medical Group (PRMG). A patient's payment for reduced-cost care shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission (HSCRC).

Definitions:

a. Elective Care: Care that can be postponed without harm to the patient or that is not medically necessary. An appropriate nursing or physician representative will be contacted for consultation in determining the patient status.
b. Medical Necessity: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.
c. Immediate Family: A family unit is defined to include all individuals taken as exemptions on the income tax return for the individual completing the application, whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not been filed, then income from all members living in the household will be considered.
d. Liquid Assets: Cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc. The availability of liquid assets plus annual income may be considered in relation to the current poverty guidelines published in the Federal Register.
e. Medical Debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs for medical costs billed by PRMC.
f. Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

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

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

PRMC will provide reduced-cost medically necessary care to low-income patients with family income between 301% and 500% of the Federal poverty level who have a financial hardship as defined by Maryland Law. Medical hardship is medical debt, incurred by a family over a 12 month period that exceeds 25% of the family income. Other healthcare fees and professional fees that are not provided by PRMC/PRMG are not included in this policy. Pre-planned service may only be considered for financial assistance when the service is medically necessary. As an example, cosmetic surgery is excluded. Inpatient, outpatient, emergency services, and services rendered by PRMG are eligible.

PRMC's financial assistance is provided only to bills related to services provided at PRMC or at a PRMC site including services provided by physicians employed by PRMC. These services are generally referred to as PRMG. To determine if your physician services are covered by the PRMC financial assistance program, please see the roster of providers that deliver emergency and other medically necessary care, indicating which providers are covered under the policy and which are not. The list of providers is updated quarterly and available on the medical center website. If you prefer, you may contact any financial counselor or patient accounting representative by calling (410) 543-7436 or (800) 235-8640, or in person at the hospital.

PROCEDURE

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

a. Available free of charge and upon request by calling (410) 543-7436 or (800) 235-8640.
b. Are located in the registration areas.
c. Downloaded from the hospital website:
   https://www.peninsula.org/patients-visitors/patient-forms
   https://www.peninsula.org/patients-visitors/billing-center
   https://www.peninsula.org/patients-visitors/billing-center/billing-information
d. The plain language summary is inserted in the Admission packet and with all patient statements.
e. Through signs posted in the main registration areas.
f. Annual notification in the local newspaper.
g. The application is available in English and Spanish. No other language constitutes a group that is 5% or more, or more than 1,000 residents (whichever is less) of the population in our primary service area (Worcester, Wicomico and Somerset Counties) based on U.S. Census data.
h. For patients who have difficulty in filling out an application, the information can be taken orally.

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

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

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

c. Preliminary eligibility will be made within 2 business days of receipt of a completed application. If approved, a financial assistance discount will be applied to the patient's responsibility in accordance with Finance Division policy FD-030.

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

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

f. If the application is ineligible, normal dunning processes will resume, which includes notifying the agency if applicable to proceed with ECA efforts. A copy of the Medical Center Collections Policy may be obtained by calling (410) 543-7436 or (800) 235-8640.

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

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

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

The following assets are excluded:

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

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

Collection Coordinator

a. If eligible, and under $2,500, the account will be written off to FA when the "Request for Financial Assistance" form is finalized. A copy is retained in the patient's electronic file. If eligible, and the balance is $2,500 or above, the Collection Coordinator will obtain the appropriate adjustment signature(s) as defined in Finance Division Policy FD-30 and complete the process.

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

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

Note: Effective 7-1-16, FD-162 (Finance Division policy #162) Financial Assistance was combined into the Medical Center policy. A Division policy is no longer required or maintained.

Attachment I – Provider Roster
Attachment II – Plain Language Summary
Attachment III – Federal Poverty Guidelines
Attachment IV – Financial Assistance Application - English

P. Naleppa

Peggy Naleppa
President/CEO

Bruce Ritchie
Vice President of Finance/CFO

Peninsula Regional Medical Center
Physician List indicates whether the physician is part of Peninsula Regional which also means the physician services / bill is covered by the Peninsula Regional Medical Center Financial Assistance Policy
Excerpt for information purposes only

Provider (Physician and Mid-level)		Group Affiliation	PRMC Provider	Financial Assistance PRMC
Abdella	Sarah	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Acevedo	Jorge	Peninsula Regional Neurosurgery	PRMG Staff	Yes
AfsharImani	SeyedAmirHossein	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Ahmed	Andaleeb	PRMC - Department of Anesthesiology	PRMG Staff	Yes
Akers	Jeremy	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Alu-Parks	Nicole	Peninsula Regional Family Medicine Salisbury	PRMG Staff	Yes
Arnaout	Karim	Peninsula Regional Oncology & Hematology	PRMG Staff	Yes
Asrat	Habtamu	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Baibars	Mohammad Motaz	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Baker	Kathryn	Peninsula Regional Neurosurgery	PRMG Staff	Yes
Barbouletos	Sareen	Peninsula Regional Family Medicine Millsboro	PRMG Staff	Yes
Batool	Aisha	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Coker	Robert	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Crum	Michael	Peninsula Regional Family Medicine Snow Hill	PRMG Staff	Yes
Daniels	Daniel	Peninsula Regional Gastroenterology	PRMG Staff	Yes
Davidson	Michael	Peninsula Regional Pulmonary & Critical Care	PRMG Staff	Yes
Abbott	Trevor	Peninsula Orthopaedic Associates, PA	Independent	No
Achampong	Henry	Fairwood Spine and Pain Center	Independent	No
Acle	Fernando	Drs. Acle & Visioli, PA	Independent	No
Acs	George	TLCCS, Inc Dentistry	Independent	No
Adeyeye	Adeola	Peninsula Regional Hospitalists/Inpatient Providers	Independent	No
Adrignolo	Anthony	Peninsula Orthopaedic Associates, PA	Independent	No
Agarwal	Ramesh	Ramesh K. Agarwal, MD, PA	Independent	No
Ahmad	Zaaira	Retina Consultants of Delmarva	Independent	No
Ali	Shoaib	Peninsula Nephrology Associates, PA	Independent	No
Allen	Robert	Delmarva Internal & Family Medicine, PA	Independent	No
Alvarado	Jose	Jose F. Alvarado, MD & Associates	Independent	No
Amaka	Dorothy	PRMC - Department of Anesthesiology	Independent	No
Ames	Sheena	Alon Davis, MD, PA	Independent	No

Partial list for policy - full list is available on the Peninsula website

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

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

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

Peninsula Regional Medical Group (PRMG) physician charges and physicians outside of PRMG Medical group are not included in the hospital bill and are billed separately. Physician charges outside of PRMG are not covered by Peninsula Regional Medical Center's financial assistance policy. A list of providers that deliver emergency and other medically necessary care at PRMC is provided on the website, indicating which providers are covered under PRMC's financial assistance policy and which are not.

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

Eligibility Determination Process

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

How to Apply

- Applications can be taken orally by calling 1-800-235-8640 between 9:00 a.m. and 4:00 p.m., Monday through Friday
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:30 a.m. and 4:30 p.m., Monday through Friday
- On the internet at https://www.peninsula.org/patients-visitors/patient-forms
  https://www.peninsula.org/patients-visitors/billing-center
  https://www.peninsula.org/patients-visitors/billing-center/billing-information
- Applications are available in English and in Spanish

Qualifications

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

- An independent third party to verify your household income (one of the following)
  - Recent pay stub showing current and year-to-date earnings
  - Most recent tax return showing your Adjusted Gross Income or W-2 form
  - Written documentation of Social Security benefits, SSI disability, VA benefits, etc.

- Letter from an independent source such as clergy, neighbor, former employer, etc.
- Completed application

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

Need Assistance?

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

Maryland Medical Assistance Program

To find out if you are eligible for Maryland Medical Assistance or other public assistance, please apply at your local Department of Social Services (DSS) office, or you may visit mmcp.dhmh.maryland.gov for information about the various Medicaid programs available. You may apply online for Maryland Medicaid at marylandhealthconnection.gov. If you are applying for assistance for a child or are pregnant, you may apply for the Maryland Children's Health Program (MCHP). If you are only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your DSS for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. Delaware Residents may obtain information online at dhss.delaware.gov or apply online at assist.dhss.delaware.gov. Virginia residents may obtain information at www.dmas.Virginia.gov.

Patients' Rights and Obligations

Rights:

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

Obligations:

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

Cómo hacer la solicitud

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

Date: 05/09/16
Reviewed:
Revised:

2016 Federal Poverty Guidelines
Updated 04/28/2016

If your family size is:	And, your family income is at or below:		
Family Size	200% Federal Poverty Guideline	201% up to 300% Federal Poverty Guideline	301% - 500% Federal Poverty Guideline with Financial Hardship
1	$23,760	$35,640	$59,400
2	$32,040	$48,060	$80,100
3	$40,320	$60,480	$100,800
4	$48,600	$72,900	$121,500
5	$56,880	$85,320	$142,200
6	$65,160	$97,740	$162,900
7	$73,460	$110,190	$183,650
8	$81,780	$122,670	$204,450
You receive a discount off PRMC bills of:	**100%**	**50%**	**25%**

MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION

Information About You

Name: _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated
US Citizen Yes No Permanent Resident: Yes No

Home Address _____

_____

_____ _____
City State Zip Code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip Code

Household Members:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you applied for Medical Assistance ? Yes No
If yes, what was the date you applied? _____
If yes, what was the determination _____

Do you receive any state or County Assistance? Yes No

PRMC - Patient Accounts
100 East Carroll Street
Salisbury, MD 21801

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/Pension Benefits	_____
Social Security Benefits	_____
Public Assistance Benefits	_____
Disability Benefits	_____
Unemployment Benefits	_____
Veterans Benefits	_____
Alimony	_____
Rental Property Income	_____
Strike Benefits	_____
Military Allotment	_____
Farm or Self-Employment	_____
Other Income Source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking Account	_____
Savings Account	_____
Stocks, Bonds, CD, or Money Market	_____
Other Accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____		Approximate Value_____
Automobile	Make _____	Year_____	Approximate Value_____
Additional Vehicle	Make _____	Year_____	Approximate Value_____
Additional Vehicle	Make _____	Year_____	Approximate Value_____
Other Property			Approximate Value_____
			Total _____

IV. Monthly Expense

	Amount
Rent or Mortgage	_____
Utilities	_____
Car Payment(s)	_____
Credit Card(s)	_____
Car Insurance	_____
Health Insurance	_____
Other Medical Expenses	_____
Other Expenses	_____
Total	_____

Do you have any other unpaid medical Bills? **Yes** **No**
For what service? _____
If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within 10 days.

Applicant Signature _____ Date _____

Relationship to Patient _____

PA-059 (12/05)

Patients' Rights and Obligations

Rights:

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

Obligations:

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

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

Financial Assistance With Your Medical Bills

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

BRO-086 (8/16)

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

Financial Assistance Policy

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

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

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

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

Eligibility Determination Process

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

How To Apply

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

Qualifications

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

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

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

Need Assistance?

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

Medical Assistance Program

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

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

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

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

Peninsula Regional Medical Group (PRMG) physician charges and physicians outside of PRMG Medical group are not included in the hospital bill and are billed separately. Physician charges outside of PRMG are not covered by Peninsula Regional Medical Center's financial assistance policy. A list of providers that deliver emergency and other medically necessary care at PRMC is provided on the website, indicating which providers are covered under PRMC's financial assistance policy and which are not.

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

Eligibility Determination Process

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

How to Apply

- Applications can be taken orally by calling 1-800-235-8640 between 9:00 a.m. and 4:00 p.m., Monday through Friday
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:30 a.m. and 4:30 p.m., Monday through Friday
- On the internet at https://www.peninsula.org/patients-visitors/patient-forms
  https://www.peninsula.org/patients-visitors/billing-center
  https://www.peninsula.org/patients-visitors/billing-center/billing-information
- Applications are available in English and in Spanish

Qualifications

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

- An independent third party to verify your household income (one of the following)
  - Recent pay stub showing current and year-to-date earnings
  - Most recent tax return showing your Adjusted Gross Income or W-2 form
  - Written documentation of Social Security benefits, SSI disability, VA benefits, etc.

- Letter from an independent source such as clergy, neighbor, former employer, etc.
- Completed application

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

Need Assistance?

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

Maryland Medical Assistance Program

To find out if you are eligible for Maryland Medical Assistance or other public assistance, please apply at your local Department of Social Services (DSS) office, or you may visit mmcp.dhmh.maryland.gov for information about the various Medicaid programs available. You may apply online for Maryland Medicaid at marylandhealthconnection.gov. If you are applying for assistance for a child or are pregnant, you may apply for the Maryland Children's Health Program (MCHP). If you are only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your DSS for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. Delaware Residents may obtain information online at dhss.delaware.gov or apply online at assist.dhss.delaware.gov. Virginia residents may obtain information at www.dmas.Virginia.gov.

Patients' Rights and Obligations

Rights:

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

Obligations:

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

Cómo hacer la solicitud

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

Date: 05/09/16
Reviewed:
Revised: