Q1.

Introduction:

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

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

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

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

	Is this information correct?		If no, please provide the correct information here:
	Yes	No	
The proper name of your hospital is: Atlantic General Hospital Corporation	◉	○	
Your hospital's ID is: 210061	◉	○	
Your hospital is part of the hospital system called Atlantic General Hospital/Health System.	◉	○	

Q4. 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.

Q5. (Optional) Please describe any other community health statistics that your hospital uses in its community benefit efforts.

> AGH FY19-21 CHNA, County Health Rankings, MD SHIP, Healthy People 2020, Worcester County Health Department Data, Community Survey, Healthy Communities Institute, US Census Bureau, CHSI, MHA Data, Vital Statistics

Q6. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q7. Section I - General Info Part 2 - Community Benefit Service Area

Q8. Please select the county or counties located in your hospital's CBSA.

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

☐ Cecil County ☐ Montgomery County ☑ Worcester County

Q9. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q11. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q26. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

☐ 21817	☐ 21838	☐ 21866
☐ 21821	☑ 21851	☐ 21867
☐ 21822	☑ 21853	☑ 21871
☐ 21824	☐ 21857	☐ 21890
☐ 21836		

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

☑ 21801	☐ 21826	☐ 21852
☐ 21802	☐ 21830	☐ 21856
☐ 21803	☐ 21837	☐ 21861
☑ 21804	☐ 21840	☐ 21865
☐ 21810	☐ 21849	☐ 21874
☐ 21814	☐ 21850	☐ 21875
☐ 21822		

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

☐ 21792	☑ 21829	☑ 21862
☑ 21804	☑ 21841	☑ 21863
☑ 21811	☑ 21842	☑ 21864
☑ 21813	☑ 21843	☑ 21872
☑ 21822	☑ 21851	

Q33. 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.

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Appendix E: Definition of Hospital's
Service Area. The HSCRC will use zip
codes and/or counties for market
analysis.

The Primary Service Area (PSA) of the
Hospital consists of the following zip
codes (or counties): 21811, 21842,
19975,19945, 21813
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☑

Based on patterns of utilization. Please describe.

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ED and IP utilization, targeted
activities based upon diagnosis
patient volumes
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☑ Other. Please describe.

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Tri County partnerships expand CBSA.
Close proximity, rural community, and
lack of transportation to Delaware
expands CBSA to Sussex County and
Accomack County, Virginia
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Q34. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Q35. ## Section I - General Info Part 3 - Other Hospital Info

Q36. Provide a link to your hospital's mission statement.

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https://www.atlanticgeneral.org/about-us/vision-and-mission/
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Q37. Is your hospital an academic medical center?

○ Yes
◉ No

Q38. (Optional) Is there any other information about your hospital that you would like to provide?

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AGH provides clinical site opportunities to various health occupations, i.e. rad tech, nursing, pharmacy interns, med student interns, etc., students/interns from local
universities and colleges. Distance learners are provided local clinical site opportunities as well through their online studies and expanding partnerships with other
universities in Maryland. AGH supports and provides high school mentoring opportunities to local tech school programs from Worcester, Wicomico, and Somerset counties
and Project SEARCH.
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Q39. (Optional) Please upload any supplemental information that you would like to provide.

Q40. ## Section II - CHNA Part 1 - Timing & Format

Q41.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

◉ Yes
○ No

Q42. 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.

Q43. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

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05/12/2019
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Q44. Please provide a link to your hospital's most recently completed CHNA.

https://www.atlanticgeneral.org/documents/AGH-9313-CHNA-Report-2019-21-booklet-form-050319.pdf

Q45. Did you make your CHNA available in other formats, languages, or media?

◉ Yes
◯ No

Q46. Please describe the other formats in which you made your CHNA available.

Public Dissemination This Community Health Needs Assessment is available to the public on its website http://atlanticgeneral.org. • Informs readers that the CHNA Report is available and provides instructions for downloading it; • Offers the CHNA Report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report; • Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website. AGH will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. AGH will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.

Q47. Section II - CHNA Part 2 - Internal Participants

Q48. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

	CHNA Activities									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)	
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
CB/ Community Health/ Population Health Director (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☐	☑	☐	☐	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
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)	☐	☐	☑	☑	☐	☐	☑	☑	☐	☐	
Nurse(s)	☐	☐	☑	☑	☐	☐	☑	☑	☐	☐	
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 expla... below:
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 expla... 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 expla... below:
Other (specify) [_____]	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	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 expla... below:

Q49. Section II - CHNA Part 2 - External Participants

Q50. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the 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: PRMC, McCready	☐	☐	☑	☐	☑	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the 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: Worcester, Wicomico, Somerset	☐	☐	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the 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: WCHD LHIC, Healthy Weight Coalition and Tri County SHIP, Resource Coordination Committee	☐	☐	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the 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 in the 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:

Organization	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the 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	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	☐	☐	☐	☐	☑	☐	☐	☑	☐	
Maryland Department of Transportation	☐	☐	☐	☐	☑	☐	☐	☑	☐	
Maryland Department of Education	☐	☐	☐	☐	☑	☐	☐	☑	☐	
Area Agency on Aging -- Please list the agencies here: MAC	☐	☐	☑	☐	☑	☑	☑	☑	☐	
Local Govt. Organizations -- Please list the organizations here: OIT, SAFE, Worcester CRT, Lower Shore CISM, Worcester Drug and Alcohol Board, OC Drug and Alcohol Council, Drug Overdose Fatality Review Team, Child Fatality Review Team, Worcester EMS, WCHD Planning Board, EMS Advisory Board, Domestive Violence Fatality Review Team, OC Local EMS Planning Board, Suicide Awareness Board, Tobacco Cancer Coalition, State Adv Council on Quality Care at End of Life	☐	☑	☑	☐	☐	☑	☑	☐	☐	
Faith-Based Organizations	☐	☑	☑	☐	☑	☑	☑	☐	☐	
School - K-12 -- Please list the schools here: Worcester County School Health Council	☐	☑	☑	☐	☐	☑	☑	☐	☐	

Organization	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the 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:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Behavioral Health Organizations -- Please list the organizations here: Hudson Health Services, Worcester Warriors Against Opioid Use, NAMI	☐	☐	☐	☐	☐	☑	☑	☐	☐	
Social Service Organizations -- Please list the organizations here: SART, Cricket Center	☐	☐	☐	☐	☐	☑	☑	☐	☐	
Post-Acute Care Facilities -- please list the facilities here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

Organization	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the 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: DMV Youth Council, Play It Safe	☐	☐	☐	☐	☐	☑	☑	☐	☐	

Organization	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the 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: ACS, March of Dimes, United Way, Worcester GOLD, Komen, Lower Shore Red Cross, Blood Bank, Save a Leg Save a Life, Habitat for Humanity, Big Bros Big Sisters	☐	☐	☐	☐	☐	☑	☑	☐	☐	

Organization	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the 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: MD Society for Healthcare Strategy, MHA, Maryland eCare, DRHMAG, Healthcare Provider Council Delaware, Ocean Pines Chamber, Ocean City Chamber, Bethany/Fenwick Chamber	☐	☐	☐	☐	☐	☑	☑	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the 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:

Q51. Section II - CHNA Part 3 - Follow-up

Q52. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

⦿ Yes
◯ No

Q53. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

11/07/2019

Q54. Please provide a link to your hospital's CHNA implementation strategy.

https://www.atlanticgeneral.org/community-health-wellness/community-health-needs-assessments/

Q55. 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.

Q56. 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	☐ Environmental Health	☑ Oral Health
☑ Access to Health Services: Practicing PCPs	☐ Family Planning	☑ Physical Activity
☐ Access to Health Services: Regular PCP Visits	☐ Food Safety	☑ Respiratory Diseases
☐ Access to Health Services: ED Wait Times	☐ Global Health	☑ Sexually Transmitted Diseases
☐ Access to Health Services: Outpatient Services	☐ Health Communication and Health Information Technology	☐ Sleep Health
☐ Adolescent Health	☐ Health Literacy	☑ Telehealth
☑ Arthritis, Osteoporosis, and Chronic Back Conditions	☐ Health-Related Quality of Life & Well-Being	☑ Tobacco Use
☑ Behavioral Health, including Mental Health and/or Substance Abuse	☑ Heart Disease and Stroke	☑ Violence Prevention
☑ Cancer	☑ HIV	☐ Vision

☐ Children's Health	☑ Immunization and Infectious Diseases	☐ Wound Care
☐ Chronic Kidney Disease	☑ Injury Prevention	☐ Housing & Homelessness
☐ Community Unity	☐ Lesbian, Gay, Bisexual, and Transgender Health	☐ Transportation
☐ Dementias, Including Alzheimer's Disease	☐ Maternal & Infant Health	☐ Unemployment & Poverty
☑ Diabetes	☑ Nutrition and Weight Status	☑ Other Social Determinants of Health
☐ Disability and Health	☐ Older Adults	☐ Other (specify)
☐ Educational and Community-Based Programs		

Q57. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

FY19-21 CHNA identified health needs: #1 Cancer #2 Diabetes/Sugar #3 Overweight/Obesity #4 Smoking, drug or alcohol use #5 Heart Disease #6 Mental Health #7 High Blood Pressure/Stroke #8 Access to Healthcare / No Health Insurance #9 Dental Health #10 Asthma / Lung Disease #11 Injuries #12 Sexually transmitted disease & HIV

Q58. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q59. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q60. Section III - CB Administration Part 1 - Internal Participants

Q61. 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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
CB/ Community Health/ Population Health Director (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	develops trategic plan, sets organizational oals which guides community benefit activities
Senior Executives (CEO, CFO, VP, etc.) (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)			✔	✔	✔				✔		
Board of Directors or Board Committee (system level)	✔										
Clinical Leadership (facility level)			✔	✔	✔	✔	✔	✔	✔	✔	active role in strategic planning and implementation
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)			✔	✔	✔			✔	✔		
Nurse(s)			✔	✔	✔			✔	✔		
Social Workers			✔	✔	✔			✔	✔		

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit Task Force	☐	☐	✔	✔	✔	☐	☐	✔	✔	☐	
Hospital Advisory Board	☐	☐	✔	✔	✔	☐	☐	☐	✔	✔	involved with senior leadership strategic planning, goal setting, d guiding CB initiatives
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q62. Section III - CB Administration Part 1 - External Participants

Q63. 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								
	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: PRMC, MCCready	☐	✔	✔	✔	✔	✔	✔	✔	✔	Tri County Health anning Committee, TriCounty Go Red
Local Health Department -- Please list the Local Health Departments here: Worcester, Wicomico, Somerset	☐	✔	✔	✔	✔	✔	✔	✔	✔	TriCounty Partnerships
Local Health Improvement Coalition -- Please list the LHICs here: Worcester LHIC, Tricounty Health planning	☐	✔	✔	✔	☐	☐	☐	☐	☐	
Maryland Department of Health	✔	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Human Resources	✔	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	✔	☐	☐	☐	☐	☐	☐	☐	☐	

Organization	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	☐	☐	☐	☐	☐	☐	☐	☐	☑	Use MDE data to target outreach
Maryland Department of Transportation	☐	☐	☐	☐	☐	☐	☐	☐	☑	Data to target outreach
Maryland Department of Education	☐	☐	☐	☐	☐	☐	☐	☐	☑	FARM data to target outreach
Area Agency on Aging -- Please list the agencies here: MAC, WorCOA	☐	☑	☑	☑	☐	☐	☑	☐	☐	
Local Govt. Organizations -- Please list the organizations here: Worcester County Government	☐	☐	☐	☐	☐	☐	☑	☐	☑	location to provide outreach to county employees
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☑	☐	☐	
School - K-12 -- Please list the schools here: WCPS	☐	☐	☐	☐	☐	☐	☑	☐	☑	High school mentoring, PAC, Integrated Health Literacy Program, Schoolbased Telehealth, Health Fairs
School - Colleges and/or Universities -- Please list the schools here: SU,UMES, WWCC, DelTech, DE Univ, Ches College, Frostburg, South Hills, Oakwood, Lynchburg, Wilmu	☐	☐	☐	☐	☐	☐	☑	☐	☐	
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Nursing School -- Please list the schools here: SU, WWCC, DelTech, Frostburg, Ches College, DE Univ	☐	☐	☐	☐	☐	☐	☑	☐	☐	nursing preceptorships, interns

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: UMES

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: Local Drug and Alcohol Coalition, local BHA, WOWAOA, Shep Pratt, Hudson Health, SUN, WCHD

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: WorGOLD, Cricket Center, MD Food Bank, local pantries/shelters

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:

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: Worcester WarriorsAOA, Atlantic Club, WorcGOLD

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: Komen, March of Dimes, Red Cross, local Chambers

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:

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:

Q64. Section III - CB Administration Part 2 - Process & Governance

Q65. 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

Q66. Does your hospital conduct an internal audit of the community benefit narrative?

- ◉ Yes
- ○ No

Q67. Please describe the community benefit narrative audit process.

Director Community Health - CB oversight, Community Education/Population outreach providers, health literacy, and Virtual Care Coordinator, CB Chair, Community Education Clinical Coordinator - performs CBISA data base reporting Outreach Providers teach workshops, provide first aid - perform many health screenings in the community. Community Benefits Committee - reporters in each department responsible for the input for their department regarding CB. Committee meets quarterly and set annual goals which stem from e organizational goals and strategic plan. Monitor hospital's community benefits and to modify and plan accordingly to ensure goals re met. The audit is done quarterly by he Community Benefit Committee, Leadership Team, Senior Leadership, and Hospital Board of Trustees. The Community Benefits Committee and Director Community Health sign off n the reporting.

Q68. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

◉ Yes
◯ No

Q69. Please explain:

This question was not displayed to the respondent.

Q70. Does the hospital's board review and approve the annual community benefit narrative report?

◉ Yes
◯ No

Q71. Please explain:

This question was not displayed to the respondent.

Q72. Does your hospital include community benefit planning and investments in its internal strategic plan?

◉ Yes
◯ No

Q73. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

Community Benefits is a large part of the planning of the hospital's strategic plan. As we become more focused on population health management, we realize that the hospital's job starts way before someone darkens the doors of our facilities. The key is to coordinate care for our patients by doing all the "Right" things. That is why our strategic plans involve the "Right Principles: Right Care, Right People, Right Place, Right Partners and Right Hospital. Population Health: Community Education and Health Literacy are one of the key initiatives in the strategic plan and make up a large portion of our Community Benefit contribution. The role of the Senior Leadership team is to guide the operations of the organization: to develop the strategic plan, to set the annual organizational goals, which ultimately guides the community benefit initiatives. Clinical leadership is involved in the Strategic Planning each year. It is through their input that goals and directions are set for the organization. It is through the support of these teams (and course set by the goals) that Community Benefits are accomplished. Each department plays an active role in the process and implementation of the Community benefit goals each year. The Executive Care Coordination Team plays an active role in the care coordination process and implementation of the organizational goals, strategic plan, and community benefit goals. The team meets twice monthly.

Q74. (Optional) If available, please provide a link to your hospital's strategic plan.

https://www.atlanticgeneral.org/documents/2020-Strategic-Plan-final.pdf

Q75. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

AGH demonstrates that we are engaging partners to move toward specific and rigorous processes aimed at generating improved population health and collectively solving complex health and social problems that result in health inequities. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners. AGH collaborates with the following community partners: Other hospital organizations, Local Health Departments, Schools, Behavioral health organizations, Local health improvement coalitions (LHICs), Faith based community organizations, and Social service organizations

Q76. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Q77. 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.

Q78. Section IV - CB Initiatives Part 1 - Initiative 1

Q79. Name of initiative.

Increase community access to comprehensive quality health care services

Q80. Does this initiative address a community health need that was identified in your most recently completed CHNA?

◉ Yes
○ No

Q81. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Arthritis, Osteoporosis, and Chronic Back Conditions, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Heart Disease and Stroke, HIV, Immunization and Infectious Diseases, Injury Prevention, Nutrition and Weight Status, Oral Health, Physical Activity, Respiratory Diseases, Sexually Transmitted Diseases, Telehealth, Tobacco Use, Violence Prevention, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

☑ Access to Health Services: Health Insurance   ☐ Heart Disease and Stroke

☑ Access to Health Services: Practicing PCPs   ☐ HIV

☐ Access to Health Services: Regular PCP Visits   ☐ Immunization and Infectious Diseases

☐ Access to Health Services: ED Wait Times   ☐ Injury Prevention

☐ Access to Health Services: Outpatient Services   ☐ Lesbian, Gay, Bisexual, and Transgender Health

☐ Adolescent Health   ☐ Maternal and Infant Health

☐ Arthritis, Osteoporosis, and Chronic Back Conditions ☐ Nutrition and Weight Status

☐ Behavioral Health, including Mental Health and/or Substance Abuse ☐ Older Adults

☐ Cancer   ☐ Oral Health

☐ Children's Health   ☐ Physical Activity

☐ Chronic Kidney Disease   ☐ Respiratory Diseases

☐ Community Unity   ☐ Sexually Transmitted Diseases

☐ Dementias, including Alzheimer's Disease   ☐ Sleep Health

☐ Diabetes   ☐ Telehealth

☐ Disability and Health   ☐ Tobacco Use

☐ Educational and Community-Based Programs   ☐ Violence Prevention

☐ Environmental Health   ☐ Vision

☐ Family Planning   ☐ Wound Care

☐ Food Safety   ☐ Housing & Homelessness

☐ Global Health   ☐ Transportation

☐ Health Communication and Health Information Technology ☐ Unemployment & Poverty

☐ Health Literacy   ☑ Other Social Determinants of Health

☐ Health-Related Quality of Life & Well-Being   ☐ Other (specify) [   ]

Q82. When did this initiative begin?

07/01/2019

Q83. Does this initiative have an anticipated end date?

◉ No, the initiative has no 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.

Q84. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

Population Worcester County: Total Population 51,823; Population estimates, July 1, 2018, (V2018) 229,286 Sussex County, DE; Total Population 216,486; Provider Access 3500:1 Worcester County 2060:1 Somerset County 1870:1 Wicomico County 1165:1 Sussex County; Worcester County 78.3% have a regular PCP; Worcester County uninsured ED visits 7.6%; Adults with health insurance 91.1%; see uploaded attachment for demographic information

Q85. Enter the estimated number of people this initiative targets.

51,823

Q86. How many people did this initiative reach during the fiscal year?

23,008

Q87. 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.

Q88. Did you work with other individuals, groups, or organizations to deliver this initiative?

◉

Yes. Please describe who was involved in this initiative.

```
Hospital Resources:
• Population Health Department
• AGH/HS
• Human Resources
• Registration/Billing Services
• Emergency Department
• Executive Care Coordination Team
Community Resources:
• Faith-based Partnership
• Homelessness Committee
• Worcester County Healthy Planning
Advisory Council
• Worcester County Health Department
• Worcester County Public Schools
• Diakonia
• Samaritan Shelter
• MD Food Bank and local pantries/soup
kitchens
• Shore Transit
• Tri County Health Planning Council
• LHIC
• United Way
```

○ No.

Q89. Please describe the primary objective of the initiative.

> Reduce unnecessary healthcare costs and reduction in hospital admissions and readmissions during FY19; Reduce health disparities during FY19; Increase community capacity and collaboration for shared responsibility to address unmet health needs during FY20; Increase in awareness and self-management of chronic disease during FY20

Q90. Please describe how the initiative is delivered.

> Through AGH's initiative to improve access to care reduction in unnecessary healthcare costs would be an impact of objectives improving access to care, educating the community on ED appropriate use, chronic illness self-management, and collaboration efforts with community organizations with a shared vision; Utilize Faith-based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management; Provide community health events to target minority populations by increasing relationships with faith-based partnerships, local businesses and cultural/ethnic community event; Educate community on financial assistance options to improve affordability of care and reduce delay in care; Partnering with community organizations and participation on committees that address access to care and health disparities; Provider recruitment to medically underserved area; Health equity campaign; Adult health literacy initiative; School-based telehealth pilot planning; Partner with homeless shelters and food pantries; Participate on local health planning councils and committees

Q91. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- ☑ Count of participants/encounters event participants
- ☐ Other process/implementation measures (e.g. number of items distributed)
- ☑ Surveys of participants community survey
- ☑ Biophysical health indicators screenings/referrals
- ☐ Assessment of environmental change
- ☐ Impact on policy change
- ☑ Effects on healthcare utilization or cost hospital readmission rate
- ☐ Assessment of workforce development
- ☑ Other number events, provider recruitment, pre-post surveys, committee participation

Q92. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

> May 2020 (HSCRC) Inpatient readmission risk adjusted rate (MD only) –attainment Jan-Mar 2020 7.66% (Target 8.94%) Population Health met frequently with MAC regarding wellness workshops for FY20. Unable to fill workshops due to Covid latter part of the fiscal year. Population Health Dept has worked to transition community education offerings to virtual events and will continue the discussion with MAC in FY21. Community Education Events/Health Fairs: 322 occurrences. AGH Health Equity Steering Committee previously became chartered committee as part of MHA Health Equity Campaign. Community education on campaign x 1 community article in Care.giver. Goal of committee reduce health disparities tracking demographic data; diversity in leadership; and increase expand cultural awareness and competency across the organization. Associate education completed as part of an expanded cultural competence training. SOGI data collection and educational materials throughout organization. Will continue to monitor activity as initiatives create community outreach opportunities FY21. Screenings during FY20: -Community health education events during FY20 targeting minority population: 33 events; topics included free health screenings, kidney health, stroke and heart health, colon cancer, hypertension, diabetes, covid testing, etc. Community health education events that educated community on financial assistance options to improve affordability of care and reduce delay in care. During FY20: 1 events – Ocean Pines Health Fair. The Ocean City Healthy Fair was cancelled due to Covid. Promote patient engagement through adult health literacy initiative AGH Health Equity Steering Committee working on adult health literacy campaign utilizing tools such as Ask ME 3 for health system and shared at community outreach activities in order to promote patient engagement and communication with providers. Will continue to monitor through affiliation with United Way – community health literacy strategic planning and interventions Pilot School based telehealth program -In FY19 discussions and early planning for school based telehealth program partnership with WCPS. Equipment purchased with partial funding through a CFES grant. Participated in regular planning meetings in FY20. FY20 Spring program launch was delayed due to school closures in response to Covid. Schools transitioned to online learning. Continuing to work with WCBOE,MDH, and MSDE on program approval. Will continue to monitor FY21 for implementation of program and steering committee efforts. Continued relationship with local shelters and food pantries through FaithBased Partnership to explore and assess need for opportunities to promote wellness via community education events and access to screenings. Will continue to promote relationship efforts FY20 pending Covid restrictions. Continuation of HSCRC Regional Grant partnership with PRMC Wellness Van outreach project FY2017 – FY2020. -Director Community Health active participation on the following committees FY20 to promote care coordination and community collaboration: Tri County Health Planning Council, Worcester County Healthy Planning Advisory Council, LHIC, and Homelessness Committee (HOT). Community Survey completed as part of CHNA FY19-21 -During FY20 the following providers were recruited to address medical underserved area needs: One Physician Psychiatry, One Urologist, Two NP Urgent Care, Two Physician Primary Care, One Physician General Surgery, One Physician Gastroenterology, Three NP Primary Care, One PA Primary Care, One Part-time NP Psychiatry, One NP Gynecology, One NP Gastroenterology, One LSCW Psychiatry. Will continue to monitor as multiple provider recruitment came to fruition in FY21.

Q93. Please describe how the outcome(s) of the initiative addresses community health needs.

Access to care was the number one health priority area for AGH CHNA FY19-21. The initiative addresses ED utilization and hospital recidivism; community education/prevention/self-management, physician recruitment addressing medically underserved rural area needs, free community screenings addressing earlier detection, care coordination and referral to treatment. Financial and under- insured issues addressed at community events with linkage to primary care. Disparities addressed through health equity and removal of barriers to care. -The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements include: Community Survey to be completed as part of CHNA FY22-24 CHSI Maryland SHIP Healthy People 2020

Q94. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$163,412.00 Total Cost of Initiative for current fiscal year; Restricted Grants/Direct offsetting revenue CFES Grant for School Based Telehealth $4,278 for telehealth equipment HSCRC Regional Grant wellness van $4,225.00

Q95. (Optional) Supplemental information for this initiative.

FY20_CB_TableIIINarrative_1 Access to Care.pdf
413.6KB
application/pdf

Q96. Section IV - CB Initiatives Part 2 - Initiative 2

Q97. Name of initiative.

Decrease incidence of diabetes in community

Q98. Does this initiative address a need identified in your most recently completed CHNA?

◉ Yes
○ No

Q99. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Arthritis, Osteoporosis, and Chronic Back Conditions, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Heart Disease and Stroke, HIV, Immunization and Infectious Diseases, Injury Prevention, Nutrition and Weight Status, Oral Health, Physical Activity, Respiratory Diseases, Sexually Transmitted Diseases, Telehealth, Tobacco Use, Violence Prevention, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

☐ Access to Health Services: Health Insurance	☐ Heart Disease and Stroke
☐ Access to Health Services: Practicing PCPs	☐ HIV
☐ Access to Health Services: Regular PCP Visits	☐ Immunization and Infectious Diseases
☐ Access to Health Services: ED Wait Times	☐ Injury Prevention
☐ Access to Health Services: Outpatient Services	☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Adolescent Health	☐ Maternal and Infant Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions	☑ Nutrition and Weight Status
☐ Behavioral Health, including Mental Health and/or Substance Abuse	☐ Older Adults
☐ Cancer	☐ Oral Health
☐ Children's Health	☐ Physical Activity
☐ Chronic Kidney Disease	☐ Respiratory Diseases
☐ Community Unity	☐ Sexually Transmitted Diseases
☐ Dementias, including Alzheimer's Disease	☐ Sleep Health
☑ Diabetes	☐ Telehealth
☐ Disability and Health	☐ Tobacco Use
☐ Educational and Community-Based Programs	☐ Violence Prevention
☐ Environmental Health	☐ Vision
☐ Family Planning	☐ Wound Care
☐ Food Safety	☐ Housing & Homelessness
☐ Global Health	☐ Transportation

☐ Health Communication and Health Information Technology   ☐ Unemployment & Poverty

☐ Health Literacy   ☑ Other Social Determinants of Health

☐ Health-Related Quality of Life & Well-Being   ☐ Other (specify) [_____]

Q100. When did this initiative begin?

[07/01/2019]

Q101. Does this initiative have an anticipated end date?

◉ No, the initiative does not 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.

[   ]

Q102. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

Worcester County 14% Diabetes Prevalence Sussex County 13% Diabetes Prevalence (Data: County Health Rankings 2019) Access to Care The 2019-2021 CHNA combined population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH used Healthy Communities Worcester County 14% Diabetes Prevalence Sussex County 13% Diabetes Prevalence (Data: County Health Rankings 2019) Access to Care The 2019-2021 CHNA combined population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH used Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs. Access to care was identified as a community health concern and the number one prioritized health need in the 2019-21 CHNA. Prioritization was based on the following criteria: • Size and severity of the problem determined by what percentage of the population is affected by risks • Health system's ability to impact the need • Availability of resources Atlantic General Hospital is the only hospital in Worcester County, a DHMH federally-designated medically-underserved area, a state-designated rural community, and a HRSA-designated Health Professional Shortage Area for primary care, mental health, and dental health. In AGH's service area, the top reasons for patients not seeking health care in our communities are cost, transportation, and lack of providers. According to the Community Health Needs Assessment (CHNA) FY2019, the community rated the follow as the top barriers to access health care: Worcester County, MD Sussex County, DE MD Value MD SHIP 2017 HP 2020 People with usual PCP 78.3% (2016) NA 84.8% 83.9% NA Uninsured ED visits 7.6% (2014) NA 11.0% 14.7% NA Adults with health insurance 91.1% (2017) 91.6% (2017) NA NA 100% Child with health insurance 95.6% (2017) 96.4% (2017) NA NA 100% People with health insurance 92.2% (2017) NA NA NA 100% Source: https://www.atlanticgeneral.org/community-health-wellness/creatinghealthy-communities/

Q103. Enter the estimated number of people this initiative targets.

[7250]

Q104. How many people did this initiative reach during the fiscal year?

[995]

Q105. 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.

Q106. Did you work with other individuals, groups, or organizations to deliver this initiative?

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

  ```
  Hospital Resources:
  •Diabetes Outpatient Education Program
  •Diabetes Support Group
  •Population Health Department
  •Emergency Department
  •Foundation
  •Endocrinology
  •Outpatient Lab Services

  Community Resources:
  •Worcester County Health Department
  •MAC, Inc.
  ```

- ○ No.

Q107. Please describe the primary objective of the initiative.

Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions; Increase awareness around importance of prevention of diabetes and early detection; Increase patient engagement in self-management of chronic conditions; Increase provider services in community to provide for diabetes related treatment;Increase community capacity and collaboration for shared responsibility to address unmet health needs

Q108. Please describe how the initiative is delivered.

1) Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions a) Description: Through AGH's initiative to improve access to care reduction in unnecessary healthcare costs would be an impact of objectives improving access to care, educating the community on ED appropriate use, Diabetes chronic illness selfmanagement, Diabetes prevention, and collaboration efforts with community organizations with a shared vision. b) Metric: Track hospital admissions ED and inpatient FY19 2) Increase awareness around importance of prevention of diabetes and early detection a) Description: Strategy #1 -Provide diabetes screenings in community via health fairs and clinical screening events Strategy #2 - Increase prevention behaviors in persons at high risk for diabetes with prediabetes through community education opportunities and support groups. b) Metric: Strategy #1 - Track Diabetic community screening opportunities and support groups. Strategy #2 - Track community education opportunities that highlight Diabetes and pre-Diabetes. 3) Increase patient engagement in self-management of chronic conditions a) Description: AGH partners with MAC, local senior centers and faith-based partnerships to bring Stanford self-management workshops to the community to increase patient engagement and self-management of chronic disease b) Metric: Track DSMP wellness workshops 4) Increase provider services in community to provide for diabetes related treatment a) Description: Strategy #1 – Explore Diabetes Education opportunities via telehealth b) Metric: Strategy #1 -Track Diabetes Education telehealth opportunities 6) Increase community capacity and collaboration for shared responsibility to address unmet health needs a) Description: -Partner with local health agencies to facilitate grant applications to fund diabetes programs -DPP for associates b) Metric: -Track partnerships with local health agencies

Q109. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- ☑ Count of participants/encounters | number participant encounters
- ☐ Other process/implementation measures (e.g. number of items distributed)
- ☑ Surveys of participants | AGH CHNA
- ☑ Biophysical health indicators | screening and referral
- ☐ Assessment of environmental change
- ☐ Impact on policy change
- ☑ Effects on healthcare utilization or cost | hospital data
- ☐ Assessment of workforce development
- ☑ Other | community data

Q110. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

Objective #1 -Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions Metric: Track hospital admissions IP and ED FY20 • Outcome: AGH Internal Data: Diabetes (top 3 diagnosis codes) *see supplemental information attached. Objective #2 -Increase awareness around importance of prevention of diabetes and early detection Metric: Strategy #1 - Track Diabetic community screening opportunities and support groups FY20 Strategy #2 - Track community education opportunities that highlight Diabetes and pre-Diabetes during FY20 • Outcome: Strategy #1 and Strategy #2 combined– South Bethany Library Diakonia Snow Hill Elementary School Worcester County Parks and Recreation Captain's Cove Health Fair UMES Ocean Pines Health Fair Multiple Faith-based Partnership Church Health Fairs Diabetes Support Group x 12 TOPS Objective #3 - Increase patient engagement in self-management of chronic conditions Metric: Track DSMP wellness workshops during FY20 • Outcome: DSMP zero enrollment in workshops offered to the community FY20 due to Covid. Will continue to monitor FY21 and seek workshop opportunities with MAC. Objective #4 -Increase provider services in community to provide for diabetes related treatment b) Metric: Strategy #1 -Track Diabetes Education telehealth opportunities • Outcome: Strategy #1- No data to track for FY20. Will continue to monitor FY21. Objective #6 - Increase community capacity and collaboration for shared responsibility to address unmet health needs Metric: Track partnerships with local health agencies FY20 • Outcome: AGH continues to partner with the following: -MD Diabetes Action Plan community workgroups -Referral process in place with local health departments -Area Agencies on Aging/MAC -Faith-based partnerships -AGH continues to partner with local health agencies to facilitate grant applications to fund Diabetes Programs. Will continue to track FY21. -AGH and WCHD partnership which provided DPP training to expand services in Worcester targeting AGH employees and family members.

Q111. Please describe how the outcome(s) of the initiative addresses community health needs.

Diabetes The 2019-2021 CHNA combined population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH used Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs. Diabetes was identified as a community health concern and the number three prioritized health need in the 2019-21 CHNA. Prioritization was based on the following criteria: • Size and severity of the problem determined by what percentage of the population is affected by risks • Health system's ability to impact the need • Availability of resources According to the CDC National Center for Health Stats (2015), national data trends for people with Diabetes show a significant rise in diagnoses. In the U.S., Diabetes is becoming more common. Diagnoses from 1980 – 2014 increased from 5.5 million to 22 million. Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY19 – FY21. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS. The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Primary Objectives Long Term Measurements: -Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics--objectives/topic/diabetes/objectives -Incidence of adult diabetes -Decrease ED visits due to acute episodes related to diabetes condition -County Health Rankings -MD SHIP

Q112. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$7,510.00 community education, screenings, health fairs and support groups

Q113. (Optional) Supplemental information for this initiative.

FY20_CB_TableIIINarrative 3 Diabetes (2).docx.pdf
587.8KB
application/pdf

Q114. Section IV - CB Initiatives Part 3 - Initiative 3

Q115. Name of initiative.

Decrease the incidence of advanced breast, lung, colon and skin cancer in the community

Q116. Does this initiative address a need identified in your most recently completed CHNA?

○ Yes
○ No

Q117. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Arthritis, Osteoporosis, and Chronic Back Conditions, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Heart Disease and Stroke, HIV, Immunization and Infectious Diseases, Injury Prevention, Nutrition and Weight Status, Oral Health, Physical Activity, Respiratory Diseases, Sexually Transmitted Diseases, Telehealth, Tobacco Use, Violence Prevention, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were addressed by this 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
☐ Access to Health Services: Outpatient Services
☐ Adolescent Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions
☐ Behavioral Health, including Mental Health and/or Substance Abuse
☑ Cancer

☐ Heart Disease and Stroke
☐ HIV
☐ Immunization and Infectious Diseases
☐ Injury Prevention
☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Maternal and Infant Health
☐ Nutrition and Weight Status
☐ Older Adults
☐ Oral Health

☐ Children's Health	☐ Physical Activity
☐ Chronic Kidney Disease	☐ Respiratory Diseases
☐ Community Unity	☐ Sexually Transmitted Diseases
☐ Dementias, including Alzheimer's Disease	☐ Sleep Health
☐ Diabetes	☐ Telehealth
☐ Disability and Health	☑ Tobacco Use
☐ Educational and Community-Based Programs	☐ Violence Prevention
☐ Environmental Health	☐ Vision
☐ Family Planning	☐ Wound Care
☐ Food Safety	☐ Housing & Homelessness
☐ Global Health	☐ Transportation
☐ Health Communication and Health Information Technology	☐ Unemployment & Poverty
☐ Health Literacy	☑ Other Social Determinants of Health
☐ Health-Related Quality of Life & Well-Being	☐ Other (specify) [_____]

Q118. When did this initiative begin?

07/01/2019

Q119. Does this initiative have an anticipated end date?

◉ No, the initiative does not 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.

Q120. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

Worcester County 533/100,000 persons Sussex County 548.8/100,000 persons Rate if all new cancer cases (2012-2016) https://gis.cdc.gov/Cancer/USCS/DataViz.html Atlantic General Hospital is the only hospital in Worcester County, a DHMH federally-designated medically-underserved area, a state-designated rural community, and a HRSA-designated Health Professional Shortage Area for primary care, mental health, and dental health. In AGH's service area, the top reasons for patients not seeking health care in our communities are cost, transportation, and lack of providers. Worcester County, MD Sussex County, DE MD Value MD SHIP 2017 HP 2020 People with usual PCP 78.3% (2016) NA 84.8% 83.9% NA Uninsured ED visits 7.6% (2014) NA 11.0% 14.7% NA Adults with health insurance 91.1% (2017) 91.6% (2017) NA NA 100% Child with health insurance 95.6% (2017) 96.4% (2017) NA NA 100% People with health insurance 92.2% (2017) NA NA NA 100% Source: https://www.atlanticgeneral.org/community-health-wellness/creating-healthy-communities/

Q121. Enter the estimated number of people this initiative targets.

51,823

Q122. How many people did this initiative reach during the fiscal year?

1,586

Q123. 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.

Q124. Did you work with other individuals, groups, or organizations to deliver this initiative?

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

```
Hospital Resources:
•       Population Health Department
•       Human Resources
•       Foundation
•       Women's Diagnostic Center
•       Endoscopy
•       Imaging
•       Respiratory Therapy Department
•       Regional Cancer Care Center
•       AGH Cancer Committee

Community Resources:
•       Worcester County Health
Department
•       Komen Consortium
•       Relay for Life
•       Women Supporting Women
```

- ◯ No.

Q125. Please describe the primary objective of the initiative.

Increase awareness around importance of prevention and early detection and reduce health disparities; Increase provider services in community to provide for cancer related treatment; Improve access and referrals to community resources resulting in better outcomes Increase support to patients and caregivers; Increase participation in community cancer screenings – especially at-risk and vulnerable populations

Q126. Please describe how the initiative is delivered.

1) Increase awareness around importance of prevention and early detection and reduce health disparities a) Description: -Improve proportion of minorities receiving women's preventative health services -Improve proportion of minorities participating in community health screenings b) Metrics: Healthy People 2020 MD SHIP AGH databases AGH CHNA Vital Statistics 2) Increase provider services in community to provide for cancer related treatment a) Description: Recruit proper professionals in community to provide for cancer related treatment b) Metrics: Track provider recruitment FY20 3) Improve access and referrals to community resources resulting in better outcomes a) Description: Partner with local health agencies to facilitate grant application to fund cancer programs b) Metrics: Track grant opportunities and formal partnerships FY20 4) Increase support to patients and caregivers a) Description: Patients and caregivers need support throughout the cancer treatment process. Patients experience the physical and emotional stressors undergoing treatment while caregivers fulfill a prominent and unique role supporting cancer patients and multitude of services such as home support, medical tasks support, communication with healthcare providers and patient advocate. AGH community education opportunities provide support and promote an informed patient and caregiver. b) Metrics: Track cancer prevention and educational opportunities FY20 5) Increase participation in community cancer screenings – especially at-risk and vulnerable populations a) Description: -Provide community health screenings: -Improve proportion of minorities receiving colonoscopy screenings -Improve proportion of minorities receiving LDCT screenings -Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn through melanoma education and skin cancer screenings b) Metrics: Track community screening events and persons screened FY20

Q127. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- ☑ Count of participants/encounters event participants encounters

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

☑ Surveys of participants [AGH CHNA]

☑ Biophysical health indicators [screening and referral]

☐ Assessment of environmental change [   ]

☐ Impact on policy change [   ]

☑ Effects on healthcare utilization or cost [Hospital data]

☐ Assessment of workforce development [   ]

☑ Other [number outreach opportunities]

Q128. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

Objective 1: Increase awareness around importance of prevention and early detection and reduce health disparities Metrics: HP 2020 MD SHIP AGH database AGH CHNA Vital Statistics Outcome: AGH Regional Cancer Care *see attached. Objective 2: Increase provider services in community to provide for cancer related treatment Metrics: Track provider recruitment FY20 • Outcome: Regional Cancer Care Center grand opening FY18 and second full fiscal year of operation FY20 promoting rural community access to state of the art cancer treatment services. The Burbage Regional Cancer Care Center continues to offer genetic counseling services through its telehealth partnership with the University of Maryland Medical Center's Greenebaum Cancer Center. Telegenetics is available for individual with a family history of cancer and for patient sin treatment who are concern about their family's risk. Zero providers were hired in FY20 for RCCC. Will continue to monitor in FY21. Objective 3: Improve access and referrals to community resources resulting in better outcomes Metrics: Track grant opportunities and formal partnerships FY20 • Outcome: There were zero grant awards for RCCC FY20. Formal partnerships during FY20 include: Komen Local Health Departments Women Supporting Women Support Group Objective 4: Increase support to patients and caregivers Metrics: Track cancer prevention and educational opportunities FY20 • Outcome: The following community education activities were tracked in FY20: Increase awareness around importance of prevention and early detection and reduce health disparities – 26 occurrences Improve proportion of minorities receiving women's preventative health services – 1 event at the Ocean Pines Health Fair. A Hope In Bloom event was planned for April 2020 but postponed to Sept 2020 due to Covid. Objective 5: Increase participation in community cancer screenings – especially at-risk and vulnerable populations Metrics: Track community screening events and persons screened FY20 • Outcome: Screenings provided at health fairs and clinical screening events FY20: Zero Prostate Screenings in FY20. One event planned but cancelled due to Covid. One Respiratory Screening event in FY 20, 19% referred to follow-up. AGH provided 2 screening events which were aimed to improve proportion of minorities participating in community health screenings. Decline in events offered due to Covid restrictions. Provided community via social media information on raising screening awareness and linkage to providers. No community data available at this time to report on the proportion of minorities receiving colonoscopy screenings. Will continue to track FY21.

Q129. Please describe how the outcome(s) of the initiative addresses community health needs.

Cancer The 2019-2021 CHNA combined population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH used Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs. Cancer was identified as a community health concern and the number two prioritized health need in the 2019-21 CHNA. Prioritization was based on the following criteria: • Size and severity of the problem determined by what percentage of the population is affected by risks • Health system's ability to impact the need • Availability of resources According to Healthy People 2020, continued advances in cancer detection, research and cancer treatment have decreased cancer incidences and death rates in the United States. Despite continued advances, cancer remains a leading cause of death second to heart disease in the United States. (Healthy People 2020) The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements: AGH CHNA AGH databases Healthy People 2020 SHIP Measures Vital Statistics We will continue to monitor connections made to community programming for access to cancer prevention and screenings FY21.

Q130. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$2,905.00 Community education, free screening events, Speaker's Bureau, and Support Groups

Q131. (Optional) Supplemental information for this initiative.

FY20_CB_TableIIINarrative 2 Cancer.docx.pdf
454.2KB
application/pdf

Q132. Section IV - CB Initiatives Part 4 - Other Initiative Info

Q133. Additional information about initiatives.

Q134. (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.

Q135. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

○ Yes

○ No

Q136.
In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Arthritis, Osteoporosis, and Chronic Back Conditions, Behavioral Health, including Mental Health and/or

Substance Abuse, Cancer, Diabetes, Heart Disease and Stroke, HIV, Immunization and Infectious Diseases, Injury Prevention, Nutrition and Weight Status, Oral Health, Physical Activity, Respiratory Diseases, Sexually Transmitted Diseases, Telehealth, Tobacco Use, Violence Prevention, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q137. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q138. Do any of the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? Specifically, do any activities or initiatives correspond to a SHIP measure within the following categories?

See the SHIP website for more information and a list of the measures:
https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx

	Select Yes or No	
	Yes	No
Healthy Beginnings - includes measures such as babies with low birth weight, early prenatal care, and teen birth rate	◉	○
Healthy Living - includes measures such as adolescents who use tobacco products and life expectancy	◉	○
Healthy Communities - includes measures such as domestic violence and suicide rate	◉	○
Access to Health Care - includes measures such as adolescents who received a wellness checkup in the last year and persons with a usual primary care provider	◉	○
Quality Preventive Care - includes measures such as annual season influenza vaccinations and emergency department visit rate due to asthma	◉	○

Q139. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q140. # Section V - Physician Gaps & Subsidies

Q141. 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
- ☑ Primary care
- ☑ Mental health
- ☑ Substance abuse/detoxification
- ☑ Internal medicine
- ☑ Dermatology
- ☑ Dental
- ☑ Neurosurgery/neurology
- ☑ General surgery
- ☐ Orthopedic specialties
- ☑ Obstetrics
- ☑ Otolaryngology
- ☑ Other. Please specify. `Allergy, immunology, Infectious Disease, Nephrology, Pediatric Endocrinology`

Q142. 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

Coverage of Emergency Department Call

Physician Provision of Financial Assistance

Physician Recruitment to Meet Community Need	Category C Medically Underserved Rural 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)	

Q143. (Optional) Is there any other information about physician gaps that you would like to provide?

Q144. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Q145. Section VI - Financial Assistance Policy (FAP)

Q146. Upload a copy of your hospital's financial assistance policy.

Financial Assistance Policy FINAL Board Approved 9 6 2018.pdf
458.6KB
application/pdf

Q147. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

Plain-Language-Summary_Final.pdf
134.2KB
application/pdf

Q148. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL). Please select the percentage of FPL below which your hospital's FAP offers free care.

	100	150	200	250	300	350	400	450	500	
Percentage of Federal Poverty Level			●							200
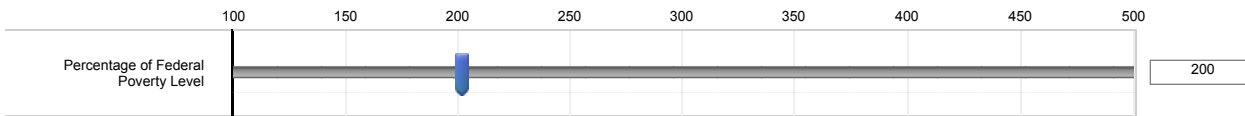
Q149. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.

	200	250	300	350	400	450	500	
Lowest FPL	●							201
Highest FPL			●					300
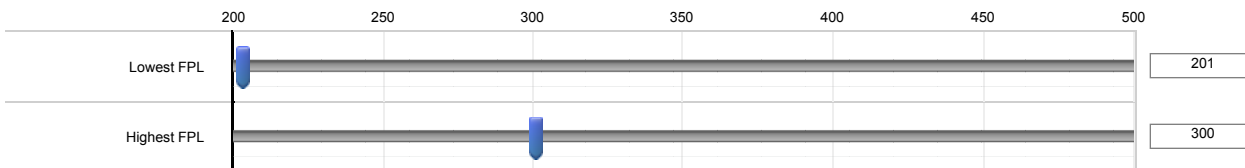
Q150. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.

100	200	300	400	500	600	700
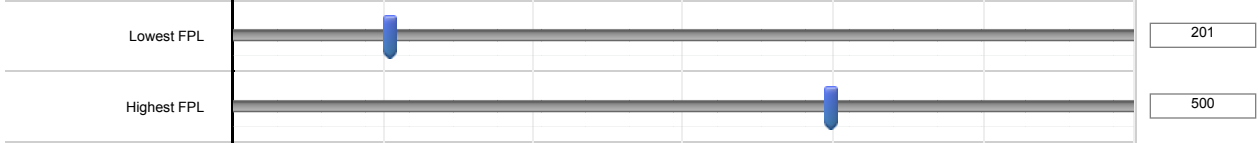
Lowest FPL			201
Highest FPL			500

Q151. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.

	0	10	20	30	40	50	60	70	80	90	100	
Debt as Percentage of Income												25

Q152. Has your FAP changed within the last year? If so, please describe the change.

- ⦿ No, the FAP has not changed.
- ○ Yes, the FAP has changed. Please describe: _____

Q153. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

[   ]

Q154. (Optional) Please attach any files containing further information about your hospital's FAP.

2020 AGH FA Income Guidelines.pdf
10.7KB
application/pdf

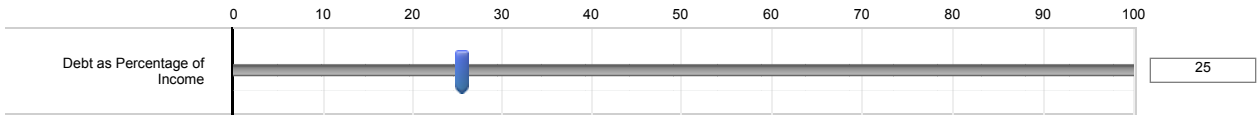Q155. Summary & Report Submission

Q156.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (38.345993041992, -75.183296203613)

Source: GeoIP Estimation

In order to prepare the statewide community benefit report for FY 2020, we must finalize the narrative responses. Could you please provide the clarifications requested below by Friday, July 16, 2021?

Thank you very much

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Wednesday, May 26, 2021 9:50 AM
To: mtodd@atlanticgeneral.org
Cc: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: HCB Narrative Report Clarification Request - Atlantic General

Thank you for submitting Atlantic General Hospital's FY 2020 Community Benefit Narrative Report. Upon reviewing your report, we require clarification of certain issues:

- In Question 135 on page 26 of the attached, no response is provided regarding whether all the needs identified in your CHNA were addressed by a hospital initiative. Please provide a response.

Please provide your clarifying answers as a response to this message.

Table III – FY 2020 Community Benefits Narrative Report – Access to Care

A. 1. Identified Need:	Access to Care
A. 2. How was the need identified:	The 2019-2021 CHNA combined population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH used Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs. Access to care was identified as a community health concern and the number one prioritized health need in the 2019-21 CHNA. Prioritization was based on the following criteria: • Size and severity of the problem determined by what percentage of the population is affected by risks • Health system's ability to impact the need • Availability of resources Atlantic General Hospital is the only hospital in Worcester County, a DHMH federally-designated medically-underserved area, a state-designated rural community, and a HRSA-designated Health Professional Shortage Area for primary care, mental health, and dental health. In AGH's service area, the top reasons for patients not seeking health care in our communities are cost, transportation, and lack of providers. According to the Community Health Needs Assessment (CHNA) FY2019, the community rated the follow as the top barriers to access health care: **Top Barriers to Healthcare** **What do you think are the problems that keep you or other community members from getting healthcare they neeed?** <table><tr><td>Too expensive/can't afford it</td><td>29.31%</td></tr><tr><td>No health insurance</td><td>23.53%</td></tr><tr><td>Couldn't get an appointment with my doctor</td><td>14.06%</td></tr><tr><td>No transportation</td><td>12.26%</td></tr><tr><td>Service is not available in our community</td><td>8.28%</td></tr><tr><td>Local doctors are not on my insurance plan</td><td>7.08%</td></tr><tr><td>Doctor is too far away from my home</td><td>5.48%</td></tr></table>

	Worcester County, MD	Sussex County, DE	MD Value	MD SHIP 2017	HP 2020
People with usual PCP	78.3% (2016)	NA	84.8%	83.9%	NA
Uninsured ED visits	7.6% (2014)	NA	11.0%	14.7%	NA
Adults with	91.1% (2017)	91.6% (2017)	NA	NA	100%

Table III – FY 2020 Community Benefits Narrative Report – Access to Care

	health insurance				
	Child with health insurance	95.6% (2017)	96.4% (2017)	NA	NA	100%
	People with health insurance	92.2% (2017)	NA	NA	NA	100%
	Source: https://www.atlanticgeneral.org/community-health-wellness/creating-healthy-communities/					

B: Name of hospital initiative	Initiative: Increase community access to comprehensive, quality health care services. (Healthy People 2020 Goal: Improve access to comprehensive, quality health care services) Clinical Screenings CPAP Fittings Community Meetings/Coalitions Flu Clinics Health Fairs Health Literacy HTN Clinics Living Well Workshops Provider Recruitment Speaker's Bureau Wellness Van Support Groups Rural Health Service Grants Grant Writing Disaster Readiness Community Education Walk With a Doc
C: Total number of people within target population	The population of the Worcester County resort destination, Ocean City, increases to near 300,000 during the tourist season. Lower Sussex County has similar characteristics of seasonality and retirees. Frankford and Dagsboro, DE have similar demographic profiles as Worcester County, MD. Selbyville, DE has some differing characteristics. Population estimates, July 1, 2018, (V2018) 51,823, Worcester County, MD Population estimates, July 1, 2018, (V2018) 229,286 Sussex County, DE (US Census Bureau Quickfacts https://www.census.gov/quickfacts/fact/table/US/PST045218)

Table III – FY 2020 Community Benefits Narrative Report – Access to Care

Population by Race	County: Worcester, MD		State: Maryland	
	Persons	% of Population	Persons	% of Population
White	42,342	81.76%	3,326,265	54.54%
Black/African American	6,694	12.93%	1,842,763	30.22%
American Indian/Alaskan Native	158	0.31%	23,550	0.39%
Asian	780	1.51%	413,172	6.78%
Native Hawaiian/Pacific Islander	20	0.04%	3,973	0.07%
Some Other Race	719	1.39%	276,169	4.53%
2+ Races	1,072	2.07%	212,528	3.48%

Population by Ethnicity	County: Worcester, MD		State: Maryland	
	Persons	% of Population	Persons	% of Population
Hispanic/Latino	1,876	3.62%	639,709	10.49%
Non-Hispanic/Latino	49,909	96.38%	5,458,711	89.51%

Population by Race	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
White	8,131	84.41%	181,858	78.30%	642,569	65.87%
Black/African American	638	6.62%	28,459	12.25%	217,440	22.29%
American Indian/Alaskan Native	79	0.82%	1,831	0.79%	4,751	0.49%
Asian	135	1.40%	2,980	1.28%	40,188	4.12%
Native Hawaiian/Pacific Islander	0	0.00%	196	0.08%	589	0.06%
Some Other Race	455	4.72%	10,810	4.65%	38,822	3.98%
2+ Races	195	2.02%	6,114	2.63%	31,133	3.19%

Population by Ethnicity	Zip Code: 19975		County: Sussex, DE		State: Delaware	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
Hispanic/Latino	1,163	12.07%	22,540	9.71%	94,055	9.64%
Non-Hispanic/Latino	8,470	87.93%	209,708	90.29%	881,437	90.36%

Median Age
County: Worcester, MD
50.1 Years

State: Maryland 39.2 Years

Median Age
Zip Code: 19975
55.9 Years

County:
Sussex, DE
48.7 Years

State:
Delaware
40.7 Years

Population Age 5+ by Language Spoken at Home	County: Worcester, MD		State: Maryland	
	Persons	% of Population Age 5+	Persons	% of Population Age 5+
Speak Only English	46,862	94.77%	4,684,915	81.74%
Speak Spanish	905	1.83%	450,637	7.86%
Speak Asian/Pac Islander Lang	278	0.56%	215,250	3.76%
Speak Indo-European Lang	1,098	2.22%	255,992	4.47%
Speak Other Lang	305	0.62%	124,390	2.17%

Table III – FY 2020 Community Benefits Narrative Report – Access to Care

(Source: AGH Community Needs Assessment FY19 – 21 https://www.atlanticgeneral.org/documents/AGH-9313-CHNA-Report-2019-21-booklet-form-050319.pdf)

3500:1 Worcester County
2060:1 Somerset County
1870:1 Wicomico County
1165:1 Sussex County
(Data: Healthy Communities Institute, 2016) |
| D: Total number of people reached by the initiative | 23,008 Encounters |
| E: Primary objective of initiative: | 1)   Reduce unnecessary healthcare costs and reduction in hospital admissions and readmissions during FY20
a)   Description: Through AGH's initiative to improve access to care reduction in unnecessary healthcare costs would be an impact of objectives improving access to care, educating the community on ED appropriate use, chronic illness self-management, and collaboration efforts with community organizations with a shared vision.
b)   Metrics: Hospital readmission rate

2)   Increase in awareness and self-management of chronic disease during FY20
a)   Description: Utilize Faith-based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management
b)   Metrics: Community Survey
        Track Wellness Workshops
        Track Health Fairs and Community Education Events

3)   Reduce health disparities during FY20
a)   Description:
Strategy #1-.Participate on AGH's Health Equity Steering Committee to promote health equity and reduce disparities
Strategy #2-Provide community health events to target minority populations by increasing relationships with faith-based partnerships, local businesses and cultural/ethnic community events.
Strategy #3-Educate community on financial assistance options to improve affordability of care and reduce delay in care.
Strategy #4-Promote patient engagement through adult health literacy initiative
Strategy #5-Pilot School based telehealth program
        b)   Metrics: AGH Database
                Track committee participation and partnerships
                Community Survey
                Track Health Fairs and Community Education Events |

Table III – FY 2020 Community Benefits Narrative Report – Access to Care

	4) Increase community capacity and collaboration for shared responsibility to address unmet health needs during FY20
	a) Description: Partnering with community organizations and participation on committees that address access to care and health disparities:
	-Partner with homeless shelters and food pantries to promote wellness
	      -Refer community to local agencies such as Shore Transit and Worcester County Health Department for transportation assistance
	      -Participate on Tri County Health Planning Council
	      -Participate on Worcester County LHIC
	      -Participate on Homelessness Committee and HOT
	      b) Metrics: Track committee participation and partnerships
	
	5) Increase number of practicing primary care providers and specialists to community during FY20
	a) Description: Provider recruitment
	b) Metrics: Track provider recruitment
	      Community Survey

F: Single or multi-year plan:	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY19 – FY21. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
G: Key collaborators in delivery:	Hospital Resources: • Population Health Department • AGH/HS • Human Resources • Registration/Billing Services • Emergency Department • Executive Care Coordination Team Community Resources: • Faith-based Partnership • Homelessness Committee • Worcester County Healthy Planning Advisory Council • Worcester County Health Department • Worcester County Public Schools • Diakonia • Samaritan Shelter • MD Food Bank and local pantries/soup kitchens • Shore Transit • Tri County Health Planning Council • LHIC • United Way

H: Impact of hospital initiative:	Objective 1: Reduce unnecessary healthcare costs and reduction in hospital admissions and readmissions during FY20
	Metrics: Hospital readmission rate
	
	Outcome:
	May 2020 (HSCRC) Inpatient readmission risk adjusted rate (MD only) – attainment Jan-Mar 2020 7.66% (Target 8.94%)
	
	Objective 2:Increase in awareness and self-management of chronic disease during FY20
	Metrics: Community Survey
	      Track Wellness Workshops
	      Track Health Fairs and Community Education Occurrences

Table III – FY 2020 Community Benefits Narrative Report – Access to Care

| | Outcomes-Population Health met frequently with MAC regarding wellness workshops for FY20. Unable to fill workshops due to Covid latter part of the fiscal year. Population Health Dept has worked to transition community education offerings to virtual events and will continue the discussion with MAC in FY21.
-Community Education Events/Health Fairs: 322 occurrences

Objective 3: <u>Reduce health disparities during FY20</u>
Metrics: AGH Database
        Track committee participation and partnerships
        Community Survey
        Track Health Fairs and Community Education Occurrences
        Maryland SHIP
        Healthy People 2020

Outcome:
Strategy #1- Participate on AGH's Health Equity Steering Committee to promote health equity and reduce disparities

-AGH Health Equity Steering Committee previously became chartered committee as part of MHA Health Equity Campaign. Community education on campaign x 1 community article in Care.giver. Goal of committee reduce health disparities tracking demographic data; diversity in leadership; and increase expand cultural awareness and competency across the organization. Associate education completed as part of an expanded cultural competence training. SOGI data collection and educational materials throughout organization. Will continue to monitor activity as initiatives create community outreach opportunities FY21.

Strategy #2 -Screenings during FY20:

-Community health education events during FY20 targeting minority population: 33 events; topics included free health screenings, kidney health, stroke and heart health, colon cancer, hypertension, diabetes, covid testing, etc.

Strategy #3 -Community health education events that educated community on financial assistance options to improve affordability of care and reduce delay in care.

- During FY20: 1 events – Ocean Pines Health Fair. The Ocean City Healthy Fair was cancelled due to Covid.

Strategy #4-Promote patient engagement through adult health literacy initiative

-AGH Health Equity Steering Committee working on adult health literacy campaign utilizing tools such as Ask ME 3 for health system and shared at community outreach activities in order to promote patient engagement and communication with providers. Will continue to monitor through affiliation with United Way – community health literacy strategic planning and interventions

Strategy #5-Pilot School based telehealth program

-In FY19 discussions and early planning for school based telehealth program partnership with WCPS. Equipment purchased with partial funding through a CFES grant. Participated in regular planning meetings in FY20. FY20 Spring program launch was delayed due to school closures in response to Covid. Schools transitioned to online learning. Continuing to work with WCBOE, |

Table III – FY 2020 Community Benefits Narrative Report – Access to Care

	MDH, and MSDE on program approval. Will continue to monitor FY21 for implementation of program and steering committee efforts. Objective 4:Increase community capacity and collaboration for shared responsibility to address unmet health needs during FY20 Metrics: Track committee participation and partnerships Outcome: --Continued relationship with local shelters and food pantries through Faith-Based Partnership to explore and assess need for opportunities to promote wellness via community education events and access to screenings. Will continue to promote relationship efforts FY20 pending Covid restrictions. Continuation of HSCRC Regional Grant partnership with PRMC Wellness Van outreach project FY2017 – FY2020. -Director Community Health active participation on the following committees FY20 to promote care coordination and community collaboration: Tri County Health Planning Council, Worcester County Healthy Planning Advisory Council LHIC, and Homelessness Committee (HOT). Objective 5: Increase number of practicing primary care providers and specialists to community during FY20 Metrics: Track provider recruitment Community Survey Outcome: - Community Survey completed as part of CHNA FY19-21 -During FY20 the following providers were recruited to address medical underserved area needs: One Physician Psychiatry, One Urologist, Two NP Urgent Care, Two Physician Primary Care, One Physician General Surgery, One Physician Gastroenterology, Three NP Primary Care, One PA Primary Care, One Part-time NP Psychiatry, One NP Gynecology, One NP Gastroenterology, One LSCW Psychiatry Will continue to monitor as multiple provider recruitment came to fruition in FY21.
I: Evaluation of outcome	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements include: Community Survey to be completed as part of CHNA FY22-24 Maryland SHIP Healthy People 2030
J: Continuation of initiative:	We will continue to monitor connections made to community programming for access to care programs in FY21.

K: Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	a. Total Cost of Initiative for Current Fiscal Year $163,412.00	b. Restricted Grants/Direct offsetting revenue CFES Grant for School Based Telehealth $4,278 for telehealth equipment HSCRC Regional Grant wellness van $4,225.00

Table III – FY 2020 Community Benefits Narrative Report - Initiative 3 Decrease incidence of diabetes in the community

<table>
<tr>
<td>A. 1. Identified Need:
A. 2. How was the need identified:</td>
<td>

<u>Diabetes</u>
The 2019-2021 CHNA combined population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH used Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs.

Diabetes was identified as a community health concern and the number three prioritized health need in the 2019-21 CHNA. Prioritization was based on the following criteria:
• Size and severity of the problem determined by what percentage of the population is affected by risks
• Health system's ability to impact the need
• Availability of resources

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

	Worcester County, MD	Sussex County, DE	MD Value	MD SHIP 2017	HP 2020
Age adjusted ER rate due to Diabetes per 100,000 visits	310.5 (2017)	NA	243.7	186.3	NA

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<tr>
<td>B: Name of hospital initiative</td>
<td>

<u>Initiative:</u>
Decrease incidence of diabetes in the community.
(Healthy People 2020 Goal: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.)
Clinical Screening
Heath Fairs
Support Group
Chronic Disease Self-Management Program (evidence based)
Speaker's Bureau
Community Education

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<tr>
<td>C: Total number of people within target population</td>
<td>

Worcester County 14% Diabetes Prevalence
Sussex County 13% Diabetes Prevalence
(Data: County Health Rankings 2019)

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<tr>
<td>D: Total number of people reached by the initiative</td>
<td>995 encounters through community education, health fairs, clinical screenings, Living Well Workshops, and support groups</td>
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<tr>
<td>E: Primary objective</td>
<td>

1)   <u>Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions</u>
a)   Description: Through AGH's initiative to improve access to care reduction in unnecessary healthcare costs would be an impact of objectives improving access to care, educating the

</td>
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</table>

of initiative:	community on ED appropriate use, Diabetes chronic illness self-management, Diabetes prevention, and collaboration efforts with community organizations with a shared vision. b) Metric: Track hospital admissions ED and inpatient FY20 2) Increase awareness around importance of prevention of diabetes and early detection a) Description: Strategy #1 -Provide diabetes screenings in community via health fairs and clinical screening events Strategy #2 - Increase prevention behaviors in persons at high risk for diabetes with prediabetes through community education opportunities and support groups. b) Metric: Strategy #1 - Track Diabetic community screening opportunities and support groups. Strategy #2 - Track community education opportunities that highlight Diabetes and pre-Diabetes. 3) Increase patient engagement in self-management of chronic conditions a) Description: AGH partners with MAC, local senior centers and faith-based partnerships to bring Stanford self-management workshops to the community to increase patient engagement and self-management of chronic disease b) Metric: Track DSMP wellness workshops 4) Increase provider services in community to provide for diabetes related treatment a) Description: Strategy #1 – Explore Diabetes Education opportunities via telehealth b) Metric: Strategy #1 -Track Diabetes Education telehealth opportunities 6) Increase community capacity and collaboration for shared responsibility to address unmet health needs a) Description: -Partner with local health agencies to facilitate grant applications to fund diabetes programs -DPP for associates b) Metric: -Track partnerships with local health agencies
F: Single or multi-year plan:	Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY19 – FY21. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
G: Key collaborators in delivery:	Hospital Resources: •Diabetes Outpatient Education Program •Diabetes Support Group •Population Health Department •Emergency Department •Foundation •Endocrinology •Outpatient Lab Services Community Resources: •Worcester County Health Department •MAC, Inc.
H: Impact of hospital initiative:	Objective #1 -Reduce unnecessary healthcare costs and decrease hospital admissions and readmissions Metric: Track hospital admissions IP and ED FY20

• Outcome:

AGH Internal Data: Diabetes (top 3 diagnosis codes)

	ER	IP	Total
FY20 AGH Visits	852	241	1,093

-AGH Database

Diabetes-ED pts with E08-E13 Primary DX codes to NCHS Postcensal Population Estimates

√ Initial Visit to the ED with Diabetes as a Primary DX   ■ ED Visits with Diabetes DX as Primary and returned to ED within 30 days

■ ED Visits with Diabetes DX as Primary and returned to ED outside of 30 days

-MD SHIP/Healthy People 2020

County: Worcester, MD 👥

310.5

ER Visits/ 100,000 population

Source: Maryland Department of Health
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: May 2019
Filter(s) for this location: State: Maryland

COMPARED TO

| MD Counties | MD Value (243.7) | Prior Value (326.4) |

| Trend | Maryland SHIP 2017 (186.3) | Maryland SHIP 2014 (300.2) |

atlanticgeneral.thehcn.net

Age–Adjusted ER Rate due to Diabetes

Maryland SHIP 2017: 186.3

Source: Maryland Department of Health (2017)

ADULTS WITH DIABETES

County: Worcester, MD

8.0%

COMPARED TO

Source: Maryland Behavioral Risk
Factor Surveillance System
Measurement period: 2017
Maintained by: Conduent Healthy
Communities Institute
Last update: May 2019
Filter(s) for this location: State:
Maryland

| MD Counties | MD Value (9.6%) | US Value (10.5%) |
| Prior Value (12.9%) | Trend |

County: Sussex, DE

12.6%

COMPARED TO

Source: Behavioral Risk Factor
Surveillance System
Measurement period: 2017
Maintained by: Conduent Healthy
Communities Institute
Last update: October 2018
Filter(s) for this location: State:
Delaware

| DE Value (11.3%) | US Value (10.5%) | Prior Value (13.1%) |
| Trend |

atlanticgeneral.trends.net

Adults with Diabetes

percent

County

Source: Maryland Behavioral Risk Factor Surveillance System, Behavioral Risk Factor Surveillance System (2017)

Objective #2 -Increase awareness around importance of prevention of diabetes and early detection

Metric:

Strategy #1 - Track Diabetic community screening opportunities and support groups FY20

Strategy #2 - Track community education opportunities that highlight
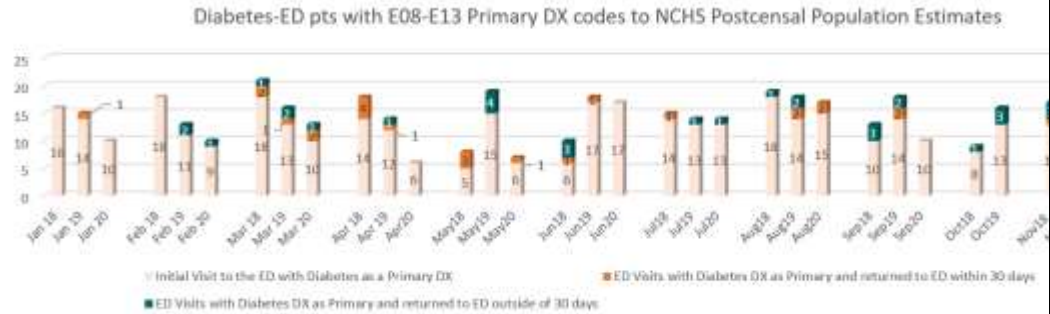Diabetes and pre-Diabetes during FY20

• Outcome:

Table III – FY 2020 Community Benefits Narrative Report - Initiative 3 Decrease incidence of diabetes in the community
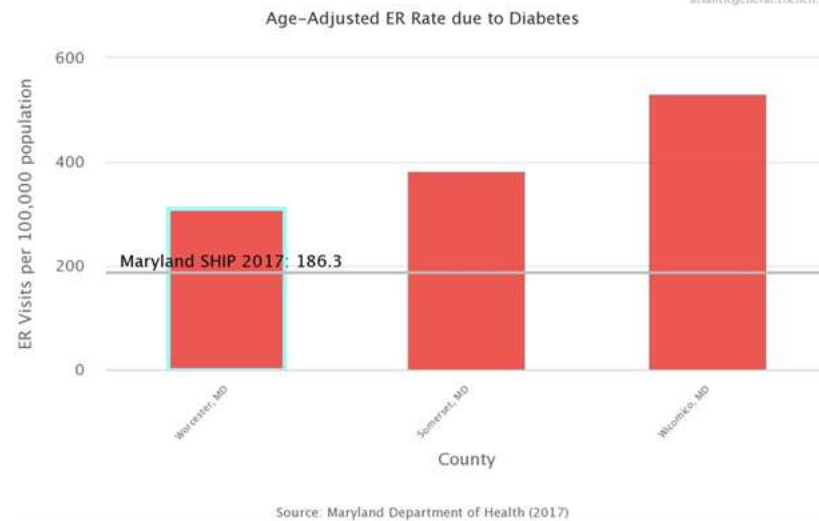
	Strategy #1 and Strategy #2 combined– South Bethany Library Diakonia Snow Hill Elementary School Worcester County Parks and Recreation Captain's Cove Health Fair UMES Ocean Pines Health Fair Multiple Faith-based Partnership Church Health Fairs Diabetes Support Group x 12 TOPS Objective #3 - <u>Increase patient engagement in self-management of chronic conditions</u> Metric: Track DSMP wellness workshops during FY20 • Outcome: DSMP zero enrollment in workshops offered to the community FY20 due to Covid. Will continue to monitor FY21 and seek workshop opportunities with MAC. Objective #4 -<u>Increase provider services in community to provide for diabetes related treatment</u> b) Metric: Strategy #1 -Track Diabetes Education telehealth opportunities • Outcome: Strategy #1- No data to track for FY20. Will continue to monitor FY21. Objective #6 - Increase community capacity and collaboration for shared responsibility to address unmet health needs Metric: Track partnerships with local health agencies FY20 • Outcome: AGH continues to partner with the following: -MD Diabetes Action Plan community workgroups -Referral process in place with local health departments -Area Agencies on Aging/MAC -Faith-based partnerships -AGH continues to partner with local health agencies to facilitate grant applications to fund Diabetes Programs. Will continue to track FY21. -AGH and WCHD partnership which provided DPP training to expand services in Worcester targeting AGH employees and family members.
I: Evaluation of outcome	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Primary Objectives Long Term Measurements: -Healthy People 2030 Objectives https://www.healthypeople.gov/2020/topics--objectives/topic/diabetes/objectives -Incidence of adult diabetes -Decrease ED visits due to acute episodes related to diabetes condition -County Health Rankings -MD SHIP
J: Continuati	We will continue to monitor connections made to community programming for diabetes in to FY21.

Table III – FY 2020 Community Benefits Narrative Report - Initiative 3 Decrease incidence of diabetes in the community

on of initiative:		
K: Expense: A. T otal Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Dir ect offsetting revenue	a. Total Cost of Initiative for Current Fiscal Year $7,510.00 community education, screenings, health fairs and support groups	b. Restricted Grants/Direct offsetting revenue None related to community education, screenings, health fairs and support groups activities tracked in cost for initiative.

Table III – FY 2020 Community Benefits Narrative Report - Initiative 2 Decrease the incidence of advanced breast, lung, colon and skin cancer in the community

|	
A. 1. Identified Need: A. 2. How was the need identified:	<u>Cancer</u> The 2019-2021 CHNA combined population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH used Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs. Cancer was identified as a community health concern and the number two prioritized health need in the 2019-21 CHNA. Prioritization was based on the following criteria: • Size and severity of the problem determined by what percentage of the population is affected by risks • Health system's ability to impact the need • Availability of resources According to Healthy People 2020, continued advances in cancer detection, research and cancer treatment have decreased cancer incidences and death rates in the United States. Despite continued advances, cancer remains a leading cause of death second to heart disease in the United States. (Healthy People 2020) <table><tr><th>Age adjusted Death Rate (deaths per 100,000 population)</th><th>Worcester County, MD</th><th>Sussex County, DE</th><th>MD Value</th><th>MD SHIP 2017</th><th>HP 2020</th></tr><tr><td>Cancer</td><td>179.7 (2011-2015)</td><td></td><td>162.3</td><td>147.4</td><td>161.4</td></tr></table>
B: Name of hospital initiative	Initiative: Decrease the incidence of advanced breast, lung, colon, and skin cancer in community. (Healthy People 2020 Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.) Community Education Clinical Screenings Grant Writing Speakers Bureau Support Groups
C: Total number of people within target population	Worcester County 533/100,000 persons Sussex County 548.8/100,000 persons Rate if all new cancer cases (2012-2016) https://gis.cdc.gov/Cancer/USCS/DataViz.html
D: Total number of people reached by the initiative	1586 encounters through community education, speaker's bureau, support group, health fairs and community clinical screening events. Due to size of initiative, these events are the only accurate tracking record for number of encounters.

E: Primary objective of initiative:	1) <u>Increase awareness around importance of prevention and early detection and reduce health disparities</u>
	a) Description:
	-Improve proportion of minorities receiving women's preventative health services
	-Improve proportion of minorities participating in community health screenings
	b) Metrics: Healthy People 2020
	           MD SHIP
	           AGH databases

<table>
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AGH CHNA
Vital Statistics

<u>2)   Increase provider services in community to provide for cancer related treatment</u>
a)   Description: Recruit proper professionals in community to provide for cancer related treatment
b)   Metrics: Track provider recruitment FY20

<u>3)   Improve access and referrals to community resources resulting in better outcomes</u>
a)   Description: Partner with local health agencies to facilitate grant application to fund cancer programs
b)   Metrics: Track grant opportunities and formal partnerships FY20

<u>4)   Increase support to patients and caregivers</u>
a)   Description: Patients and caregivers need support throughout the cancer treatment process. Patients experience the physical and emotional stressors undergoing treatment while caregivers fulfill a prominent and unique role supporting cancer patients and multitude of services such as home support, medical tasks support, communication with healthcare providers and patient advocate. AGH community education opportunities provide support and promote an informed patient and caregiver.

b)   Metrics:
Track cancer prevention and educational opportunities FY20

<u>5)   Increase participation in community cancer screenings – especially at-risk and vulnerable populations</u>
a)   Description:
-Provide community health screenings:
-Improve proportion of minorities receiving colonoscopy screenings
-Improve proportion of minorities receiving LDCT screenings
-Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn through melanoma education and skin cancer screenings
b)   Metrics: Track community screening events and persons screened FY20

</td></tr>
<tr><td>F: Single or multi-year plan:</td><td>Multi-Year – Atlantic General Hospital is looking at data over the three year cycle that is consistent with the CHNA cycle FY19 – FY21. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</td></tr>
<tr><td>G: Key collaborators in delivery:</td><td>

Hospital Resources:
•   Population Health Department
•   Human Resources
•   Foundation
•   Women's Diagnostic Center
•   Endoscopy
•   Imaging
•   Respiratory Therapy Department
•   Regional Cancer Care Center
•   AGH Cancer Committee

Community Resources:
•   Worcester County Health Department
•   Komen Consortium
•   Relay for Life
•   Women Supporting Women

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</table>

Table III – FY 2020 Community Benefits Narrative Report - Initiative 2 Decrease the incidence of advanced breast, lung, colon and skin cancer in the community

H: Impact of hospital initiative:	Objective 1: Increase awareness around importance of prevention and early detection and reduce health disparities
	Metrics: HP 2020 MD SHIP AGH database AGH CHNA Vital Statistics Outcome: AGH Regional Cancer Care, ED, IP Volumes CANCER ED/IP VOLUMES (First 3 Dx Codes)

FY	ED	IP	Totals
FY2019	287	189	476
FY2020	247	130	377

Cancer-Visit Count of RCC pts

■ RCC Visits with Cancer Care DX

County: Worcester, MD

176.1

deaths/ 100,000 population

Source: National Cancer Institute

Measurement period: 2012-2016
Maintained by: Conduent Healthy Communities Institute
Last update: October 2019
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value (160.3)
US Value (161.0)	Prior Value (179.7)	Trend
Maryland SHIP 2017 (147.4)	Maryland SHIP 2014 (169.2)	HP 2020 Target (161.4)

County: Sussex, DE

167.7

deaths/ 100,000 population

Source: National Cancer Institute

Measurement period: 2012-2016
Maintained by: Conduent Healthy Communities Institute
Last update: October 2019
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties

DE Value (169.6)

US Value (161.0)

Prior Value (165.9)

Trend

Maryland SHIP 2017 (147.4)

Maryland SHIP 2014 (169.2)

HP 2020 Target (161.4)

Objective 2: Increase provider services in community to provide for cancer related treatment

Metrics: Track provider recruitment FY20

• Outcome:
Regional Cancer Care Center grand opening FY18 and second full fiscal year of operation FY20 promoting rural community access to state of the art cancer treatment services. The Burbage Regional Cancer Care Center continues to offer genetic counseling services through its telehealth partnership with the University of Maryland Medical Center's Greenebaum Cancer Center. Telegenetics is available for individual with a family history of cancer and for patient sin treatment who are concern about their family's risk. Zero providers were hired in FY20 for RCCC. Will continue to monitor in FY21.

Objective 3: Improve access and referrals to community resources resulting in better outcomes

Metrics: Track grant opportunities and formal partnerships FY20

• Outcome:
There were zero grant awards for RCCC FY20.

Formal partnerships during FY20 include:
Komen
Local Health Departments
Women Supporting Women Support Group

Objective 4: Increase support to patients and caregivers

Metrics:
Track cancer prevention and educational opportunities FY20

• Outcome:
The following community education activities were tracked in FY20:
Increase awareness around importance of prevention and early detection and reduce health disparities – 26 occurrences
Improve proportion of minorities receiving women's preventative health services – 1 event at the Ocean Pines Health Fair. A Hope In Bloom event was planned for April 2020 but postponed to Sept 2020 due to Covid.

Table III – FY 2020 Community Benefits Narrative Report - Initiative 2 Decrease the incidence of advanced breast, lung, colon and skin cancer in the community

	Objective 5: Increase participation in community cancer screenings – especially at-risk and vulnerable populations Metrics: Track community screening events and persons screened FY20 • Outcome: Screenings provided at health fairs and clinical screening events FY20: Zero Prostate Screenings in FY20. One event planned but cancelled due to Covid. One Respiratory Screening event in FY 20, 19% referred to follow-up. AGH provided 2 screening events which were aimed to improve proportion of minorities participating in community health screenings. Decline in events offered due to Covid restrictions. Provided community via social media information on raising screening awareness and linkage to providers. No community data available at this time to report on the proportion of minorities receiving colonoscopy screenings. Will continue to track FY21.	
I: Evaluation of outcome	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above. Long term measurements: AGH CHNA AGH databases Healthy People 2030 SHIP Measures Vital Statistics	
J: Continuation of initiative:	We will continue to monitor connections made to community programming for access to cancer prevention and screenings FY20.	
K: Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	a. Total Cost of Initiative for Current Fiscal Year $2,905.00 Community education, free screening events, Speaker's Bureau, and Support Groups	b. Restricted Grants/Direct offsetting revenue Zero revenue for community education, speakers, groups and community clinical screening events

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

TITLE:	**FINANCIAL ASSISTANCE POLICY**
DEPARTMENT:	**PATIENT FINANCIAL SERVICES**

Effective Date: 7/1/16   Number:

Revised: 8/18   Pages: Five (5)

Reviewed: 8/18   Approval Date: 9/6/18

Signature:

_____   Director, Patient Financial Services
Vice President, Finance   Author

APPROVAL DATES:

_____9/6/18_____   _____
Board of Trustees   Finance Committee

POLICY:

It is the policy of Atlantic General Hospital/Health System (AGH/HS) to provide medically necessary services without charge or at a reduced cost to all eligible patients who lack healthcare coverage or whose healthcare coverage does not pay the full cost of their bill for AGH/HS services. The intent of this policy is to ensure access to AGH/HS services regardless of an individual's ability to pay, and to provide those services on a charitable basis to qualified indigent persons consistent with this policy. Financial Assistance (FA) is granted after all other avenues have been exhausted, including, but not limited to Medical Assistance, private funding, grant programs, credit cards, and/or payment arrangements. FA applies only to bills related to services provided by the AGH/HS. Fees for healthcare and professional services that are not provided by AGH/HS are not included in this policy. Emergent and urgent services, including those services provided at the AGH ambulatory surgery facility, may be considered for FA. All hospital regulated services will be charged consistently as established by the Health Services Cost Review Commission (HSCRC), and the amounts generally billed (AGB). All patients requesting charity care services from an AGHS provider in an unregulated area will be charged the fee schedule plus the

standard mark-up, unless a final determination of eligibility for FA is made for services provided to a qualified indigent individual consistent with the procedures set forth below. A roster of providers that deliver emergent, urgent, and other medically necessary care is updated quarterly and available on the hospital website at www.atlanticgeneral.org, indicating which providers are covered and which are not under the FA policy. This information is also available by calling a Financial Counselor at (410) 629-6025. The patient must have a valid social security number, valid green card or valid visa. A patient's payment for reduced-cost care for AGH shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission (HSCRC).

Definitions:

Emergent Care: An emergency accident, meaning a sudden external event resulting in bodily injury, or an emergency illness, meaning the sudden onset of acute symptoms of such severity that the absence of immediate attention may result in serious medical consequences.

Medical Necessity: Inpatient or outpatient healthcare services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms, which otherwise left untreated, would pose a threat to the ongoing health status. Services must:

- Be clinically appropriate and within generally accepted medical practice standards

- Represent the most appropriate and cost effective supply, device or service that can be safely provided and readily available with a primary purpose other than patient or provider convenience.

Immediate Family: A family unit is defined as all 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 must be submitted.

Post-Discharge Billing Statement: The first billing statement after the discharge date of an Inpatient or the service date of an outpatient.

Medical Hardship: Medical debt incurred by a family over the course of the previous twelve months that exceeds 25% of the family's income. Medical debt is defined as out of pocket expenses for medical costs billed by the health system. The hospital will provide reduced-cost, medically necessary care to patients with family income at or below 500% of the Federal Poverty Level.

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.

Medical Debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs for medical costs by AGH/HS.

Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

Plain Language Summary: A summary of the Financial Assistance Policy which includes information on how to apply and how to obtain additional information.

Income: The amount of income as defined on the tax returns, pay stubs, social security award letter, unemployment report, etc.

Procedures:

The Maryland State Uniform FA application, (Attachment 1) the AGH/HS FA policy, Collection policy and the Plain Language Summary (PLS) are available in English and Spanish. No other language constitutes a group that is 5% or more of the hospital service area based on Worcester County population demographics as listed by the U.S. Census Bureau. The policies, application, and PLS can be obtained free of charge in English and in Spanish by one of the following ways:

1. Available upon request by calling (410) 629-6025.

2. Are located in the registration areas and AGHS Offices

3. Downloaded from the hospital website;

    www.atlanticgeneral.org/FAP

4. The PLS is inserted in the Admission packet

5. FA language is included on all the patient's statement and includes the telephone number to call and request a copy and the website address where copies may be obtained.

6.   FA notification signs are posted in the main registration areas

7.   An annual notification is posted in the local newspaper

8. Patients who have difficulty in completing the application can orally provide the information

9. The PLS is on the third patient statement

No ECA will be taken within 120 days of the first post-discharge billing statement. A message will be on the statement thirty days prior to initiating ECA notifying the patient. During the 120 day period, the patient will be reminded of the FA program during normal collection calls. If the application is ineligible, normal collection actions will resume, which includes notifying the agency if applicable to proceed with ECA efforts. 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. A list of approved ECA actions may be found in the Credit and Collection Policy. The patient may appeal a denied application by submitting a letter to the Director of Patient Financial Services indicating the reason for the request.

If the FA application is submitted incomplete, any ECA efforts that have been taken will be suspended for 30 calendar days and assistance will be provided to the patient in order to get the application completed. A written notice that describes the additional information and/or documentation required will be mailed which includes a phone contact to call for assistance.

Approved FA applies to all applicable open balances at the time the application is approved, and shall remain in effect for future medically necessary services for 6 months.   For patients that have paid $5.00 or more, and within a two-year period was found to be eligible for FA at 100%, any amount paid exceeding $5.00 shall be refunded.

Within two business days following a patient's request for charity care services, application for medical assistance, or both, AGH/HS shall make a determination of probable eligibility and communicate the determination to the patient and/or the patient's representative. The determination of probable eligibility will be made on the basis of an interview with the patient and/or the patient's representative. The interview will cover family size, insurance and income. The determination of probable eligibility will be made based on the information provided in the interview. No application form, verification or documentation of eligibility will be requested or required for the determination of probable eligibility to be made. A final eligibility determination for charity care for qualified indigent persons will be provided in writing within 2 business days of receipt of a completed application for FA.

Automatic Eligibility:

If the patient is enrolled in a means-tested program, the application is approved for 100% FA on a presumptive basis, not requiring supporting financial data.   Examples of a means-tested program are reduced/free school lunches, food stamps, energy and housing assistance, out of state Medicaid, WIC, and the Specified Low Income Beneficiary Program.   The patient is responsible for providing proof of eligibility.

FA will be granted for a deceased patient with no estate.

Patients approved under any Federal or State Grant are eligible for FA for the balance over the grant payment.

FA may be approved based on their propensity to pay credit scoring.

Eligibility Consideration:

Generally only income and family size will be considered in approving applications for FA.   Liquid assets such as rental properties, stocks, bonds, CD's, and money market funds will be considered if one of the following scenarios occurs:

1. The amount requested is greater than $20,000

2. The tax return shows a significant amount of interest income

3. The patient has a savings or checking account greater than $10,000

4. If the patient/guarantor is self-employed, a current tax return may be required

The following assets are excluded:

1. The first $10,000 of monetary assets

2. Up to $150,000 in a primary residence

3. Certain retirement benefits such as a 401K where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans where the patient potentially could pay taxes and/or penalties by cashing in the benefit.

FA approval is based on the following income level:

- 0% to 200% of the Federal Poverty Guideline – 100% reduction for Medically Necessary care

- Between 201% and 225% of the Federal Poverty Guidelines – Reduced cost Medically Necessary care at 75%

- Between 226% and 250% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 50%

- Between 251% and 300% of the Federal Poverty Guidelines - Reduced cost care Medically Necessary care at 25%

Medical Hardship is based on the following income level:

- 0% to 200% of the Federal Poverty Guideline – 100% reduction for Medically Necessary care

- Between 201% and 300% of the Federal Poverty Guidelines – Reduced cost Medically Necessary care at 75%

- Between 301% and 400% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 50%

- Between 401% and 500% of the Federal Poverty Guidelines - Reduced cost care Medically Necessary care at 25%

If the patient qualifies for both reduced cost-care and Medical Hardship, the reduction that is most favorable to the patient will be applied. The Federal Poverty Guideline, family size, and income level can be referenced on Attachment 2.

This policy may not be changed without the approval of the Board of Trustees. Furthermore, this policy must be reviewed by the Board and re-approved at least every two years.

Financial Assistance Summary
Plain Language Summary

Patient's Obligations and Rights regarding Hospital bills

For patients with the ability to pay, it is their obligation to pay their bill in a timely manner. If they fail to meet this obligation, they may be referred to a collection agency. If a patient believes they have been wrongly referred to a collection agency, they have the right to contact the hospital for more information at 410-641-9101. If a patient is uninsured or underinsured, financial assistance (FA) may be available. There are certain criteria that must be met in order to qualify for FA. If a patient applies for FA, it is their responsibility to provide all required information and supporting documents to the hospital so that their eligibility can be determined. Partial or full financial assistance will be granted based on the patient's ability to pay the billed charges. The information below summarizes Atlantic General Hospital's Financial Assistance Policy. For more information regarding FA, please call 410-629-6025 or visit the AGH website: http://www.atlanticgeneral.org/fap

Overview

It is the policy of Atlantic General Hospital/Health System to provide medically necessary services without charge or at a reduced cost to all eligible persons, who are unable to pay, according to the Hospital's guidelines. Atlantic General Hospital defines all emergency room care as medically necessary even though decisions by insurance companies may be in conflict with this decision.

A FA eligible individual may not be charged more than the Amounts Generally Billed (AGB) for emergency or other medically necessary care. Eligibility for financial assistance is based on several factors, including income (see Federal Poverty Level guidelines below), household size, assets and any special consideration that the patient would like to have considered.

Patients may be eligible for Medical Assistance or other public assistance. Patients can apply at their local Department of Social Services or online. Information and applications can be obtained from the following state websites: https://mmcp.dhmh.maryland.gov (MD), http://dhss.delaware.gov (DE), http://www.dmas.virginia.gov (VA). Maryland residents might be able to apply for assistance with MD Children's Health Program if the assistance is for a child or a pregnant woman. Patients may also apply for Qualified Medicare Beneficiary (QMB) or Specified Low Income Medicare (SLMB) programs if they need assistance with Medicare premiums.

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement.

Am I eligible?

AGH bases Financial Assistance on the patient's income level falling within these ranges:
- 0% to 200% of the Federal Poverty Guideline - 100% reduction for Medically Necessary care
- Between 201% and 225% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 75%
- Between 226% and 250% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 50%
- Between 251% and 300% of the Federal Poverty Guidelines - Reduced cost care Medically Necessary care at 25%

An application is deemed eligible for 100% Financial Assistance if a patient is enrolled in a means tested program such as:
- Reduced/free school lunches
- SNAP (food stamps)
- MEAP (energy assistance)
- WIC

There are other circumstances where Financial Assistance may automatically apply. Please contact 410-629-6025 for more information.

How can I apply?

The uniform financial assistance application can be found online at: http://www.atlanticgeneral.org/fap. This application can also be obtained at any Atlantic General Hospital Registration area (9733 Healthway Drive, Berlin, MD 21811) or the Patient Accounting Office (10026 Old Ocean City Blvd, Unit 6, Berlin, Maryland 21811). This form, the FA application and FA policy are available upon request and free of charge. These forms are also available in Spanish and Large Print.