I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
Memorial at Easton 116	10,454	21601 21629 21613 21632 21655 21643 21639	Anne Arundel Medical Center Dorchester General Hospital	**CAROLINE** 0.7% **DORCHESTER** 0.4% **KENT** 0.1% **QUEEN ANNES** 0.2% **TALBOT** 1.1% **TOTAL** 2.5%	**CAROLINE** 8.6% **DORCHESTER** 5.6% **KENT** 0.3% **QUEEN ANNES** 1.7% **TALBOT** 6.1% **TOTAL** 22.3%
Dorchester General Hospital 54	3,458	21613 21643 21631	Memorial Hospital at Easton Peninsula Regional Medical Center	**CAROLINE** 1.3% **DORCHESTER** 4.4% **KENT** 0.5% **QUEEN ANNES** 0.3% **TALBOT** 0.8% **TOTAL** 7.3%	**CAROLINE** 2.5% **DORCHESTER** 11.0% **KENT** 0.9% **QUEEN ANNES** 0.7% **TALBOT** 2.3% **TOTAL** 17.3%

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

a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1. Please describe in detail.)

Description of the community Shore Health System serves:

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

Shore Health System's service area is defined as the Maryland counties of Caroline, Dorchester, Talbot (primary service area); Queen Anne's and Kent (secondary service area). A map showing the service area counties is shown in Figure 1: Map of Shore Health System Service Area and surrounding area.

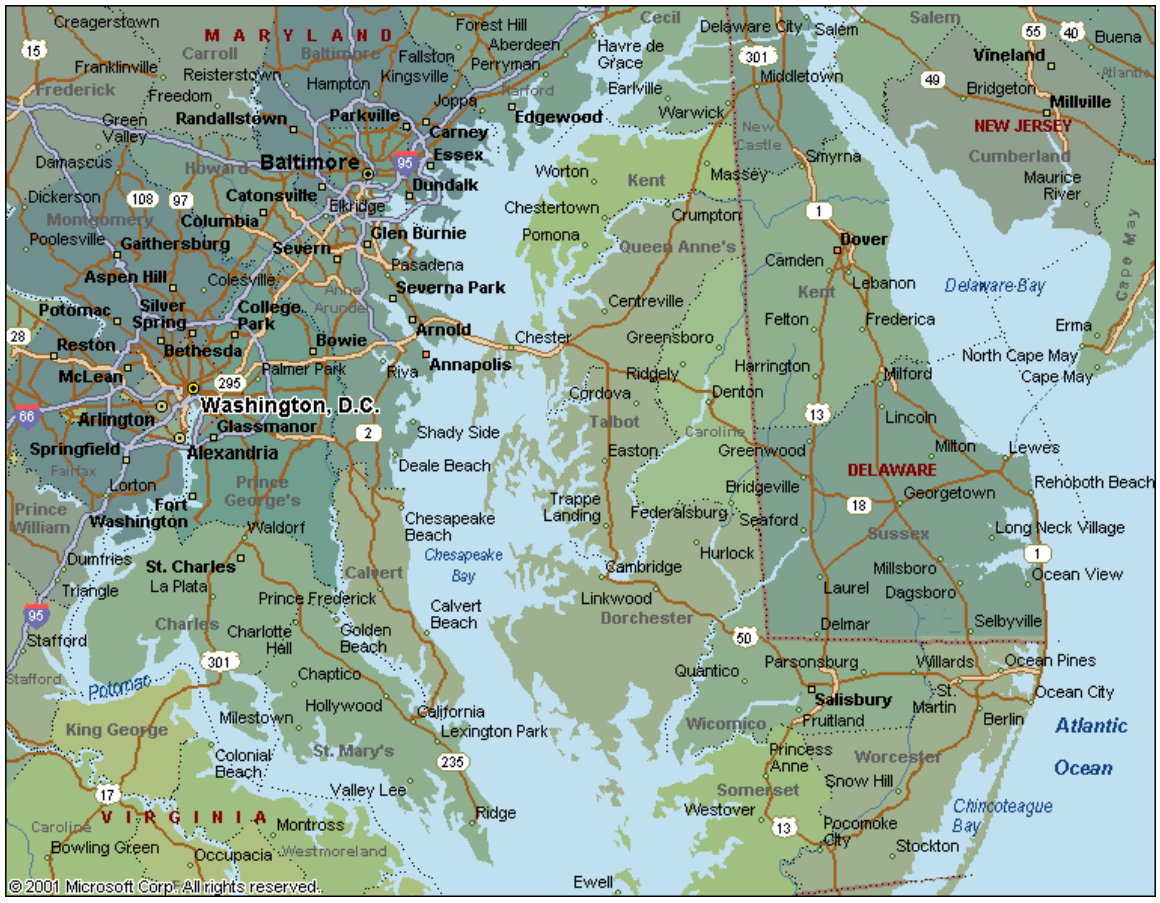

Figure 1

Memorial Hospital at Easton is situated at the center of the mid-shore area and thus serves a large geographical area. MHE is a single jurisdiction hospital located in a rural area. Dorchester General Hospital,

also a single jurisdiction hospital, is located approximately 18 miles from MHE. MHE is located approximately 44 miles from Chester River Hospital and approximately 42 miles from Anne Arundel Medical Center.

Memorial Hospital's service area has a higher percentage of population aged 65 and older as compared to Maryland overall. Talbot County has a 20.4 percent rate for this age group. This concentration is due mainly to influx of retirees.

The five counties of the Mid-Shore comprise 20% of the landmass of the State of Maryland and 2% of the population. The population of the five counties is just over 170,000 -- 16,485 adults have less than a 9th grade education and 16,356 have education at the 9th -12th grade level but do not have a high school diploma. (See Table 1)

Table 1: Income & Education Levels by County*

County	# of People in County All ages**	# of Hispanic Origin**	Less than 9th grade Education	9th-12th Grade– No Diploma	Percent Below Poverty**
Caroline	33,367	1,965	1,401	3,482	13.2%
Dorchester	32,043	791	1,944	3,583	15.4%
Kent	19,197	546	837	1,942	10.7%
Queen Anne's	47,958	1,069	1,182	3,258	7.3%
Talbot	36,262	1,322	1,067	2,795	8.8%

***Source: 2000 Census Data.**

****Source:** U. S. Census Bureau, Small Area Income & Poverty Estimates for states and counties (2009)

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

In the past year, the Mid-Shore region, has significantly higher unemployment rates as compared to state and national levels. Like many other rural communities in the country, the area has suffered a significant loss of jobs. Manufacturers such as Airpax, Black & Decker and Hi-Tech Plastics have moved production work out of the country, leaving local residents with few options. Well over 1,000 workers have been dislocated and often need to upgrade their skills in order to find work in more technical fields or even just to do the jobs now available in the workplace.

Source: Mid Shore Comprehensive Economic Development Strategy CEDS
http://www.midshore.org/reports/CEDS%20Full%20Document%20update%202-18-11%20-%20FINAL.pdf

Although minority populations are significant throughout the Eastern Shore, Dorchester has the highest percentages of African-American and Hispanic residents and the highest level of unemployment at 11%. Of the five counties comprising the Mid-Shore, Kent, Caroline and Dorchester have the highest percentage of low-income families. A look at Effective Buying Income (Table 2) for these counties shows the range of income differences:

Table 2: Effective Buying Income

Distribution	Caroline	Kent	Dorchester
Under $15,000	26.7%	24.1%	29%
$15,000-$24,999	20.3%	17.4%	21%
$25,000-$49,999	38.2%	35.3%	34.5%

Source: Maryland Department of Business & Economic Development

Furthermore, these three counties are among the top quartile of jurisdictions in Maryland where significant percentages of families are considered at-risk. Some examples include:

· Teen mothers account for 63 of every 1,000 births in Caroline County; in Dorchester County, the ratio is 75 over 1,000.

· The child poverty rate in Dorchester County is 25%.

· School dropout rates are also significant in Caroline County (6%) and in Dorchester County (5.2%).

Source: Census Bureau and Maryland Vital Statistics MID SHORE CEDS 2011

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

Some statistics may be accessed from the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), and the Maryland State Health Improvement Plan (http://dhmh.maryland.gov/ship/).

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)

Community Benefit Service Area (CBSA):

	Estimated Population, July 1, 2009							
		White		Black				
	All Races	Total	Non-Hispanic	Total	Non-Hispanic	American Indian	Asian or Pacific Islander	Hispanic2
Talbot	36,262	30,680	29,577	5,051	4,954	73	458	1,322
Dorchester	32,043	22,611	21,946	9,041	8,920	77	314	791
Caroline	33,367	27,974	26,244	4,912	4,802	202	279	1,965
Queen Annes	47,958	43,135	42,136	4,090	4,040	100	633	1,069

Population Statistics for the State of Maryland
Population Estimate Year: 2009*

Age	0-19	20-44	45-64	65-85+	Median Age	%Female	%Male
CAROLINE	**9,074**	**10,830**	**9,145**	**4,318**	**37.0**	0.512	0.488
DORCHESTER	**7,606**	**9,189**	**9,306**	**5,942**	**40.7**	0.523	0.477
QUEEN ANNES	**12,450**	**14,077**	**14,565**	**6,866**	**38.8**	0.503	0.497
TALBOT	**7,930**	**9,056**	**10,679**	**8,597**	**43.3**	0.523	0.477
TOTAL	**37,060**	**43,152**	**43,695**	**25,723**	**149,630**		

*source: Maryland Assessement Tool for Community Health, http://www.matchstats.org/

Median Household Income within the CBSA	**Community Benefit Service Area (CBSA):** — Median Household Income (2009)* Talbot — $59,633 Dorchester — $43,751 Caroline — $49,050 Queen Annes — $75,146 *source: MD Assessment Tool for Community Health and Bureau of Labor Statistics **source:SAHIE//State and County by Demographic and Income Characteristics/2007, US Census Bureau The level of economic distress in the region is immediately evident when compared with the state figures. It should be noted that Talbot County appears to have a significantly higher median income than Caroline and Dorchester, however, a large percentage of the population has incomes in line with those of Caroline and Dorchester. The figures for Talbot are somewhat skewed due to large incomes of a few individual families and high net worth individuals.
Percentage of households with incomes below the federal poverty guidelines within the CBSA	**Talbot 8.80%** **Dorchester 15.40%** **Caroline 13.20%** **Queen Anne's 7.30%** **Source:** U. S. Census Bureau, Small Area Income & Poverty Estimates for states and counties (2009) **Note:** Families and persons are classified as **below poverty** if their total family income or unrelated individual income was less than the poverty threshold specified for the applicable family size, age of householder, and number of related children under 18 present . The Census Bureau uses the federal government's official poverty definition.
Estimate of the percentage of uninsured people by County within the CBSA	**Talbot 19%** **Dorchester 16%** **Caroline 20%** **Queen Anne's 16%** source:http://countyhealthrankings.org/maryland
Percentage of Medicaid recipients by County within the CBSA.	**Talbot 27.05%** **Dorchester 30.17%** **Caroline 14.53%** **Queen Anne's 16.53%** source: http://chpdm-ehealth.org/eligibility/index.cfm

Life Expectancy by County within the CBSA.	**Talbot 80.1** **Dorchester 76.5** **Caroline 75.7** **Queen Anne's 80.1** source: MD Assessment Tool for Community Health and Bureau of Labor Statistics
Mortality Rates by County within the CBSA.	**Talbot 1,213.4** *per 1000,000* **Dorchester 1,154.7** *per 1000,000* **Caroline 983** *per 1000,000* **Queen Anne's 715.2** *per 1000,000* source: MD Assessment Tool for Community Health and Bureau of Labor Statistics

Access to healthy food,

Talbot 25%
Dorchester 21%
Caroline 75%
Queen Anne's 60%

Source:http://www.countyhealthrankings.org/maryland

Note: Access to healthy foods- Healthy food outlets include grocery stores and produce stands/farmer's markets

Quality of housing

County	Housing units	Home Ownership Rate
Caroline	13,600	74.1%
Dorchester	16,570	70.1%
Talbot	20,215	71.6%

Source: Housing Characteristics for the Region (2000 Census-State & County Quick facts 2008**)**

Primary Service area:

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

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

County-wide, just over 25.9 percent of housing was renter occupied in 2000 with a renter rate for incorporated towns nearing 50 percent. In 2000, 13.5 percent of the County's housing units were vacant. This is a much higher percentage than for adjoining counties. Problems associated with Dorchester County housing include the following:

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

	Talbot County The housing issues in Talbot County are complex primarily because of the extreme disparity of income levels in the County. Limited entrepreneurial and job opportunities keep the moderate income wage earners from homeownership. Habitat for Humanities and new Easton Town Council initiatives now require developers to address low to moderate income, affordable homeownership opportunities as part of any new housing development strategy. The net effect will not be known for several years. There is no shortage of high end housing options. Middle income affordable housing remains a county wide issue. Talbot County had the fourth smallest number of persons per household in the State in 2000 (2.32) however 40% of public housing remains inexplicably vacant. Rental property is exorbitant and often requires unrelated families to share space. Apartments represent 85% of the rental property. Failure of code enforcement allows rentals to remain in a state of disrepair. Much of the substandard housing is in small rural pockets. The Talbot County Housing Roundtable, a coalition of organizations and individuals formed to assess and recommend affordable housing policy for Talbot County, and the local and county councils are exploring avenues to significantly address quality of life issues through better housing options. On the drawing board are zoning and design standards that increase the mix of uses and housing types; mandated moderately priced dwellings as part of all new developments; employer- assisted housing, creation of housing trust funds solely to build affordable homes in low, moderate and middle income brackets and creating nonprofit, semi-public developers and other financers of affordable housing. **Source: Mid Shore Comprehensive Economic Development Strategy CEDS** http://www.midshore.org/reports/CEDS%20Full%20Document%20update%202-18-11%20-%20FINAL.pdf
Transportation by County within the CBSA	Transit services in the three county areas are provided under contract by Delmarva Community Transit. Services include medical and senior citizen demand services and fixed route county and regional service. While most of the region is served by the fixed routes, there are gaps in coverage in the less populated areas of the counties. The regional system, Maryland Upper Shore Transit (MUST), provides low cost and seamless service for the general public from Kent Island to Ocean City with convenient free transfer points at key locations on the shore. MUST is a coordinated effort of several Upper Shore agencies and governments to provide a regional transit system for Kent, Queen Anne's, Talbot, Caroline, and Dorchester Counties. Transit services are provided by Queen Anne's County Ride and Delmarva Community Transit (DCT). DCT is a private company under contract to the counties and County Ride is operated by Queen Anne's County. The system also includes Shore Transit, which provides scheduled routes on the lower shore. The MTA and the Maryland Department of Human Resources have provided funding. Overall management of the regional system is the responsibility of the Transportation Advisory Group (TAG). The County Commissioners of the five Upper Shore counties appoint the members of the TAG. In January 2002 the TAG began a pilot program to determine the feasibility and cost effectiveness of a regional transit system. MUST began operations in August 2002 and the MSRC assumed administration of the pilot project in July 2003 **Source: Mid Shore Comprehensive Economic Development Strategy CEDS** http://www.midshore.org/reports/CEDS%20Full%20Document%20update%202-18-11%20-%20FINAL.pdf

Population growth by county

Service Area Population Demographics

	Census	Census	Projection	Projection	Projected Population Change, 2000 to 2005		Projected Population Change, 2000 to 2010	
	1995	2000	2005	2010	Persons	Percent	Persons	Percent
Caroline	28,900	29,772	30,950	32,050	1,100	3.7%	2,278	7.7%
Dorchester	30,001	30,674	30,900	31,100	200	0.7%	426	1.4%
Talbot	32,325	33,812	34,800	35,800	1,000	3.0%	1,988	5.9%
Queen Anne's	37,451	40,563	44,600	48,500	3,900	9.6%	7,937	19.6%
Kent	18,771	19,197	19,650	20,050	400	2.1%	853	4.4%
5-County	147,448	154,018	160,900	167,500	6,600	4.3%	13,482	8.8%
Prepared by the Maryland Department of Planning, Planning Data Services.								
Based on Rnd 5C (Baltimore) and Rnd 6.2 (Washington) changes applied to Census 2000 base.								

Figure 1 Projected Population and Rates of Population Growth for Service Area.

Primary and Secondary Service Area Population Trends by Age Cohort								
Caroline, Dorchester, Talbot, Queen Anne's, and Kent County Population								
Age Cohorts	1995		2000		2005		2010	
	Population	%	Population	%	Population	%	Population	%
0 to 14	30,248	20.5%	30,376	19.7%	28,779	17.9%	27,880	16.6%
15 to 44	59,148	40.1%	59,124	38.4%	59,110	36.7%	58,048	34.7%
45 to 64	33,688	22.8%	39,232	25.5%	46,734	29.0%	52,205	31.2%
65 and Over	24,364	16.5%	25,286	16.4%	26,264	16.3%	29,376	17.5%
Total	147,448	100.0%	154,018	100.0%	160,887	100.0%	167,509	100.0%

Figure 2 Historic Trends in Age Cohorts for the Service Area.

Figure 2 presents the historic and estimated population by age cohort for MHE's service area. The fastest growth in population is occurring in the age cohorts of 45 to 64 and 65 and over, reflecting the aging of the "baby boom" generation. The older age segments are increasing in both people and percent of total population. The population 65 and older, generally uses healthcare services four times as often as the population overall.

Four-County Service Area Population Analysis, form MOP based on US Census 2000										Change, from 2000 to 2015	
County	**Age Group**	**2000**	**Percent**	**2005**	**Percent**	**2010**	**Percent**	**2015**	**Percent**	**Population**	**Percent**
Caroline	Under Age 65	25,741	86.5%	26,861	86.8%	27,625	86.2%	27,914	84.6%	2,173	8.4%
	65 and Older	4,031	13.5%	4,083	13.2%	4,426	13.8%	5,085	15.4%	1,054	26.1%
Caroline Co. Total		29,772	100.0%	30,944	100.0%	32,051	100.0%	32,999	100.0%	3,227	10.8%
Dorchester	Under Age 65	25,251	82.3%	25,430	82.3%	25,358	81.5%	25,061	79.9%	-190	-0.8%
	65 and Older	5,423	17.7%	5,468	17.7%	5,745	18.5%	6,286	20.1%	863	15.9%
Dorchester Co. Total		30,674	100.0%	30,898	100.0%	31,103	100.0%	31,347	100.0%	673	2.2%
Queen Anne's	Under Age 65	35,336	87.1%	38,702	86.8%	41,227	85.0%	43,405	82.8%	8,069	22.8%
	65 and Older	5,227	12.9%	5,899	13.2%	7,274	15.0%	8,998	17.2%	3,771	72.1%
Queen Anne's Co. Total		40,563	100.0%	44,601	100.0%	48,501	100.0%	52,403	100.0%	11,840	29.2%
Talbot	Under Age 65	26,915	79.6%	27,574	79.2%	27,839	77.8%	27,719	75.5%	804	3.0%
	65 and Older	6,897	20.4%	7,222	20.8%	7,964	22.2%	8,979	24.5%	2,082	30.2%
Talbot Co. Total		33,812	100.0%	34,796	100.0%	35,803	100.0%	36,698	100.0%	2,886	8.5%
4-County	Under Age 65	113,243	84.0%	118,567	83.9%	122,049	82.8%	124,099	80.9%	10,856	9.6%
	65 and Older	21,578	16.0%	22,672	16.1%	25,409	17.2%	29,348	19.1%	7,770	36.0%
Population Total, 4-County Service Ar		134,821	100.0%	141,239	100.0%	147,458	100.0%	153,447	100.0%	18,626	13.8%

Figure 3

As can be seen from the information in Figure 3 above, MDP projects the service area to have more substantial growth in the senior population, growing at 2.4% per year. The overall population is projected to grow less than 1% per year according to MDP.

Unemployment rate by county

Maryland 7.2%

Caroline 8.8%

Dorchester 10.0%

Queen Anne's 6.4%

Talbot 7.3%

Source: U.S. Bureau of Labor Statistics | www.bls.gov/ro3

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following:

(1) A description of the process used to conduct the assessment
(2) With whom the hospital has worked
(3) How the hospital took into account input from community members and public health experts
(4) A description of the community served
(5) A description of the health needs identified through the assessment process.

Shore Health did not perform a community health needs assessment as defined by the federal reform bill in FY11. Such an assessment is currently being conducted in FY12 and will be fully implemented in FY13. The information included below reflects the standard assessment process which Shore Health System has typically conducted each year as part of strategic planning.

1. **Identification of Community Health Needs:**
   Describe in detail the process(s) your hospital used for identifying the health needs in your community and the resource(s) used.

   Shore Health identifies community needs through analysis of the current needs assessments and health plans developed by the local health departments for Talbot, Dorchester, Caroline, and Queen Anne's counties. The needs assessments include data compiled by county, state, and federal government and identifies health needs by county.

   Additional resources reviewed in FY11 to identify community needs: the *Healthy People 2020* guidelines established by the Maryland DHHS and the Maryland Department of Health and Mental Hygiene's State Improvement Plan (SHIP, Http://dhmh.maryland.gov./ship). These comprehensive sets of heath objectives serve as the framework to develop community health initiatives and activities that address major public health concern

   Currently SHS uses statistical data gathered by local health departments along with internal documentation/evaluation to assess effectiveness of community benefit initiatives. SHS tracks encounters for all health screenings, community outreach programs, and educational based programs offered. The program initiatives are evaluated to ensure the goals of the program are met. Thorough documentation and tracking is accomplished through completion of: Activity Forms; Occurrence Forms;

Outcomes Forms; and Leadership Journal Forms for all community benefit activities. This tracking system provides the stakeholders with the ability to determine the effectiveness of individual activities and for year-to-year comparison analysis.

SHS is continuing to work towards the incorporation of an electronic data collection process to improve tracking effectiveness of activities.

2. In seeking information about community health needs, what organizations or individuals outside the hospital were consulted?

Shore Health maintains open communication with the local health departments for Talbot, Dorchester, Caroline, and Queen Anne's counties; Public School Systems and church leaders. Shore Health system programs serve the needs of a diverse population through senior centers, schools, churches, and community centers throughout the Mid Shore.

Leadership of Shore Health are members of committees, advisory boards, community workgroups identifying the region's health care needs. Many factors, such as population growth projections, the aging of the regional population, emerging trends in health care delivery, physician recruitment needs, changes in the region's transportation network are examined.

3. When was the most recent needs identification process or community health needs assessment completed?
Provide date here. 5/1 /2010

4. Although not required by federal law until 2013, has your hospital conducted a community health needs assessment that conforms to the definition on the previous page within the past three fiscal years?
___Yes
_X_No

If you answered yes to this question, please provide a link to the document or attach a PDF of the document with your electronic submission.

III. COMMUNITY BENEFIT ADMINISTRATION

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

a. Does your hospital have a CB strategic plan?

___ Yes
_X_ No

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

i. Senior Leadership

1. _X_CEO
2. _X_CFO
3. _X_Other (please specify)-CNO, VP of Strategic Planning, Board of Directors

ii. Clinical Leadership

1. ___Physician
2. _X_Nurse
3. _X_Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. _X_ Individuals-
   - Planning Data Analyst
   - Financial Shared Services Analyst
   - Director of Marketing and Business Development,
2. _X_ Committee
   - Walter Zajac, Chief Financial Officer, SHS
   - Michael Silgen, Vice President, Marketing and Strategic Planning
   - Donna Jacobs, Senior Vice President Government and Regulatory Affairs, University of Maryland Medical System
3. ___Other (please describe)

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

Spreadsheet X yes _____no
Narrative X yes _____no

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

Spreadsheet _X__ yes _____no
Narrative _X__ yes _____no

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

1. Please use Table III (see attachment) to provide a clear and concise description of the needs identified in the process described above, the initiative undertaken to address the identified need, the amount of time allocated to the initiative, the key partners involved in the planning and implementation of the initiative, the date and outcome of any evaluation of the initiative, and whether the initiative will be continued. Use at least one page for each initiative (at 10 point type).

***For example*: for each major initiative where data is available, provide the following:**

a. Identified need: This includes the community needs identified in your most recent community health needs assessment.

b. Name of Initiative: insert name of initiative.

c. Primary Objective of the Initiative: This is a detailed description of the initiative and how it is intended to address the identified need. (Use several pages if necessary)

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

e. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.

f. Date of Evaluation: When were the outcomes of the initiative evaluated?

g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data when available).

h. Continuation of Initiative: Will the initiative be continued based on the outcome?

See attachment, labeled Table III.

Table III

Initiative 1.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Chronic Disease Asthma and Diabetes	Shore Kids Camp	Provide children ages 8-13 with diabetes and/or asthma, access to educators and resources to manage chronic conditions	Multi-year /ongoing	Talbot County Schools	7/10	24 attendees: • Provision of education, decreased admissions to hospital • Less complications in attendees/children due to uncontrolled disease process	The initiative is continuing
Community Education	Diabetes Update	Educate seniors on diabetes management to prevent adverse outcomes, reduction of hospital encounters related to over diabetes	Multi-year /ongoing	Community Senior Center	10/11	70 attendees able to identify behaviors that improve diabetes management resulting in fewer complications due to uncontrolled disease process	The initiative is continuing
Physical Activity	Diabetes Self help Series	Increase knowledge of risk factors for heart disease and stroke and how to improve health with regular exercise	Multi-year /ongoing	UM Center for Diabetes and Endocrinology	7/10-6/11	Ongoing monthly education series improved health of regular attendees. 86 attendees, participated in program and were successfully able to identify benefit of management of diabetes through regular exercise	The initiative is continuing
Heart disease mortality	Heart-walk	Participate and sponsor event to raise awareness of origins and symptoms of heart disease and stroke	Multi-year /ongoing	American Heart Association	5/11	Improved health and awareness through education and participation in AHA event for Mid-Shore community. 100 participants 7 cholesterol screenings	The initiative is continuing

Table III

Nutrition And Obesity							
Increase the proportion of adults who are at healthy weight	Nutrition Life Style Modification	Provide nutrition recommendations as part of life style changes necessary to maintain healthy weight	Multi-year /ongoing	Shore Health Department of Neuroscience	1/11	70 attendees learned how to support healthy lifestyle choices to manage weight by: • mastering nutrition basics • understanding the food groups • Increased awareness of calories and roles that specific nutrients play in a healthy diet.	The initiative is continuing
Maternal and Children Health	Women and Feeding	Educate children and women on healthy eating to improve overall health and reduce obesity	Multi-year /ongoing	St. Martin's Shelter	5/9/11	15 attendees educated on how to support healthy lifestyle choices to manage weight	The initiative is continuing
Diabetes	Pre-Diabetes Seminars	Educate individuals at risk for diabetes providing information on how to prevent and/or delay the onset of type 2 diabetes	Multi-year /ongoing	UM Center for Diabetes and Endocrinology	7/10-6/11	28 attendees educated on prevention of obesity by promoting activity and healthy nutrition.	The initiative is continuing

Table III

Initiative 2.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Reduce overall cancer death rate	Shore Regional Breast Outreach	1. Increase the number of women surviving breast cancer by diagnosing them at an earlier stage through education and promotion of preventative measures and early detection. 2. Diagnose African American women at earlier stages of breast cancer, equivalent to Caucasian women. 3. Educate Latina women in breast self examination with the assistance of a translator.	Multi-year /ongoing	Susan G. Koken for the Cure	7/10-6/11	• 1,750 encounters • Increased the community's awareness of breast cancer prevention, detection and treatments. • The stage at diagnosis as reported by the Tumor Registry for the Cancer Center indicates women are being diagnosed at early stages of the disease, and that there is no distinction between the ethnic groups in our community	The initiative is continuing
	Prostate Cancer Screening	Provide men in the mid shore, the opportunity to obtain a free prostate cancer screening which includes blood test and exam by a competent physician.	Multi-year /ongoing	Shore Comprehensive Urology Talbot County Health Dept. Talbot County NAACP	9/2010	Increased awareness and detection of prostate cancer Provided access to screenings to underserved persons of community	The initiative is continuing

Table III

	Shore Regional Breast Center/ Wellness for Women Program	1. Increase breast cancer screening levels among uninsured and underinsured women 2. Provide followup diagnosis treatment when needed 3. Provide education with a focus on underserved women	Multi-year /ongoing	Susan G. Koken for the Cure	7/10-6/11	All patients, 205, presently enrolled receive annual mammograms. Approximately 10% increase in Latina women enrolled in the program	The initiative is continuing
	Outpatient Oncology Social Work Services	Provide services by social workers at no cost, including crisis intervention, linking to resources, counseling and advocacy, and public education.	Multi-year /ongoing	ACS, NCI, LLS, Cancer Care Inc.	7/10-6/11	All patients, 889, receive services at no charge to support cancer treatment	The initiative is continuing

Table III

Initiative 3.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Access to care	Anti-thrombo-sis Clinic	Provide anticoagulated patients (no charge) with close monitoring, educational resources and dedicated expertise to prevent adverse outcomes, reduction of hospital encounters related to over anticoagulation or under anticoagulation	Multi-year /ongoing	Shore Health Pharmacy	7/10-6/11	Clinic manages greater than 1,000 patients enrolled Average time to therapeutic INR is 4.1 days compared to national average of 5.6 days 75% of patients spend greater than 90% of time in therapeutic range 1.2% adverse event requiring hospitalization	The initiative is continuing
Prescrip-tion drugs for uninsured	ER Urgent "To Go" Meds	Provide continued patient care for uninsured. Program designed to reduce readmissions to ER for same/like illnesses due to lack of followup care.	Multi-year /ongoing	Shore Health Pharmacy		Quality patient care with decreased recidivism rate for same/like illness	

Table III

Initiative 4.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Stroke Preven-tion	Stroke Aware-ness/ preventio n	Stroke Awareness and Prevention program is designed to raise awareness of risk factors, and warning signs of stroke –along with EMS activation in an effort to decrease the incidence of stroke	Multi-year /ongoing	Community organizations	7/10-6/11	125 attendees, after series of five seminar presentations able to: • Identify what a stroke is • Identify risk factors for stroke • Identify ways to modify risk factors • Identify stroke warning signs • Identify importance of EMS activation	
Stroke Support	Stroke Support Group	Educate stroke survivors or recovery and health maintenance to reduce risk of recurrent stroke Provide support by building relationships and emotional support for survivors and caregivers	Multi-year /ongoing	Talbot County Stroke Support Group	7/10-6/11	Provide resources for stroke survivors, 35-45 monthly, to establish and promote healthy recovery.	

Table III

Initiative 5.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Chronic Disese manage-ment Reduce complica-tions for conditions such as HF, COPD, CKD and asthma	Shore Wellness Partners	Well Partners is a unique program that provides a continuum of care, focusing on preventive care to improve the ability of patients and families to work together to manage chronic disease. Designed for at-risk families and individuals who don't have sufficient resources and are not eligible for other in-home services. Wellness Partners helps patients with disease management and life skills so that they can continue to live in their own homes. The service is provided by Shore Health System at no charge for those who qualify. Objectives: • Managing physical health problems • Connection with other community services • Dietary education • Home safety evaluations • Safe medicine use • Education on specific illness and treatments • Emotional support • Monitoring client progress through home visits or phone calls	Multi-year /ongoing	Members of the Shore Wellness Partners team include advanced practice nurses and medical social workers. These specialists work with patients, caregivers, and primary care providers.	7/11- through current date	FY11 was the first year for the Wellness Program. Outcome includes • Organization and development of program • Hiring team • Program Admission Criteria defined • Communication and education of primary care network about program • Admissions into the program, year one equals (6 months) on track, 30 patients.	The initiative is continuing

2 Were there any primary community health needs that were identified through a community needs assessment that were not addressed by the hospital? If so, why not?

Major Needs Identified:

The top ten areas/needs that have the greatest impact on overall health in our communities are:

- Access to quality health services
- Cancer
- Heart Disease and Stroke
- Physical Activity and Fitness
- Educational & Community-based Programs
- Diabetes
- Maternal, Infant and Child Health
- Nutrition and Obesity
- Mental Health and Mental Disorders
- Environmental Health

Needs Identified not addressed:

- Environmental Health requires expertise and resources beyond the capabilities of Shore Health System.
- Mental Health and Mental Disorders is being addressed through the Mid-Shore Mental Health Systems, Inc., a Private Not for Profit 501(C)(3) Organization, serving Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties. The mission of MSMHS is to continually improve the provision of mental health services for residents of the Mid-Shore through effective coordination of services in collaboration with consumers, family members, providers and community leaders.

Attachment, Table III, describes initiative undertaken to address the identified needs.

V. PHYSICIANS

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

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

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

Stipend to Tidewater Anesthesia and Maryland Emergency Medicine paid to provide evening, weekend, and holiday call at Dorchester General Hospital in order to provide emergency Surgical Services 24/7. Consistent to prior years, the report reflects the expense for ER and Anesthesiology physicians, offset by any other revenue (the CFO refers to as rebate of expenses received).

I. APPENDICES

To Be Attached as Appendices:

1. **Describe your Charity Care policy:**
   a. **Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's charity care policy. (label appendix 1)**

For *example*, state whether the hospital:

- **posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;**
- **provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;**
- **provides a copy of the policy, or summary thereof, and financial assistance contact information to patients with discharge materials;**
- **includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; and/or**
- **discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.**

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

System works with a business partner who will work with our patients to assist them with the state assistance programs, which is free to our patients.

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

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

b. Include a copy of your hospital's charity care policy (label appendix 2).

Shore Health System Policy LD-34, Patient Financial Services – Financial Assistance Program attached.

2. Attach the hospital's mission, vision, and value statement(s) (label appendix 3).

1. **Describe your Charity Care policy:**
    a. **Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's charity care policy. (label appendix 1)**

For *example*, state whether the hospital:

- **posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;**
- **provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;**
- **provides a copy of the policy, or summary thereof, and financial assistance contact information to patients with discharge materials;**
- **includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; and/or**
- **discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.**

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

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information sheet is mailed to patients with all statements and/or handed to them if needed. Notices are sent regarding our Hill Burton program yearly as well.

1.0 POLICY

1.1 This policy applies to Shore Health System ("SHS"). Shore Health System is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. The hospitals covered by this policy include:

- The Memorial Hospital at Easton
- Dorchester General Hospital

1.2 It is the policy of SHS to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility and the steps for processing applications.

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

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

1.5 SHS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent services, applications to the Financial Assistance Program will be completed, received and evaluated retrospectively and will not delay patients from receiving care.

2.0 PROGRAM ELIGIBILITY

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

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

2.2.1 Services provided by healthcare providers not affiliated with SHS (e.g., home health services).

2.2.2 Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, Workers Compensation or Medicaid), are not eligible for the Financial Assistance Program. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made considering medical and programmatic implications.

2.2.3 Unpaid balances resulting from cosmetic or other non-medically necessary services.

2.2.4 Patient convenience items.

2.2.5 Patient meals and lodging.

2.2.6 Physician charges related to the date of service are excluded from SHS' Financial Assistance Policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.

2.3 Patients may become ineligible for Financial Assistance for the following reasons:

2.3.1 Refusal to provide requested documentation or providing incomplete information.

2.3.2 Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid or other insurance programs that deny access to SHS due to insurance plan restrictions/limits.

2.3.3 Failure to pay co-payments as required by the Financial Assistance Program.

2.3.4 Failure to keep current on existing payment arrangements with SHS.

2.3.5 Failure to make appropriate arrangements on past payment obligations owed to SHS (including those patients who were referred to an outside collection agency for a previous debt).

2.3.6 Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.

2.4 Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

2.5 Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section 3 below). If patient qualifies for COBRA coverage, patient's financial

ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services and for their overall personal health.

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

3.0 PRESUMPTIVE FINANCIAL ASSISTANCE

3.1 Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance form and/or supporting documentation on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with Financial Assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, SHS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining Financial Assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only Financial Assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

3.1.1 Active Medical Assistance pharmacy coverage.

3.1.2 Qualified Medicare Beneficiary (“QMB”) coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary (“SLMB”) coverage (covers Medicare Part B premiums).

3.1.3 Primary Adult Care (“PAC”) coverage.

3.1.4 Homelessness.

3.1.5 Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs.

3.1.6 Maryland Public Health System Emergency Petition patients.

3.1.7 Participation in Women, Infants and Children Programs (“WIC”).

3.1.8 Food Stamp eligibility.

3.1.9 Eligibility for other state or local assistance programs.

3.1.10 Patient is deceased with no known estate.

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

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

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

3.2.2 Lack health insurance coverage.

3.2.3 Not enrolled in Medical Assistance for date of service.

3.2.4 Indicate an inability to pay for their care.

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

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

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

3.3.2 Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive Financial Assistance Program until the Maryland Medicaid Psych Program has been billed.

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

4.0 MEDICAL HARDSHIP

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

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

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

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

4.2 Patient Balance after Insurance

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

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

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

4.5 Individual patient situation consideration:

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

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

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

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

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

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

5.0 ASSET CONSIDERATION

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

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

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

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

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

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

6.0 APPEALS

6.1 Patients whose financial assistance applications are denied have the option to appeal the decision.

6.2 Appeals can be initiated verbally or written.

6.3 Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

6.4 Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.

6.5 If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.

6.6 The escalation can progress up to the Chief Financial Officer who will render a final decision.

6.7 A letter of final determination will be submitted to each patient who has formally submitted an appeal.

7.0 PATIENT REFUND

7.1 Patients applying for Financial Assistance up to 2 years after the service date who have made account payment(s) greater than $25 are eligible for refund consideration.

7.2 Collector notes, and any other relevant information, are deliberated as part of the final refund decision. In general, refunds are issued based on when the patient was determined unable to pay compared to when the payments were made.

7.3 Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for refund.

8.0 JUDGEMENTS

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

9.0 PROCEDURES

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

9.2 Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

9.2.1 Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.

9.2.2 Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.

9.2.3 SHS will not require documentation beyond that necessary to validate the information on the Maryland State Uniform Financial Assistance Application.

9.2.4 Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.

9.2.5 Patients will have thirty (30) days to submit required documentation to be considered for eligibility. If no data is received within 20 days, a reminder letter will be sent notifying that the case will be closed for inactivity and the account referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.

9.3 In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:

9.3.1 A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable).

9.3.2 A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.

9.3.3 Proof of Social Security income (if applicable).

9.3.4 A Medical Assistance Notice of Determination (if applicable).

9.3.5 Proof of U.S. citizenship or lawful permanent residence status (green card).

9.3.6 Reasonable proof of other declared expenses.

9.3.7 If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

9.4 A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on SHS guidelines. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.

9.4.1 If the patient does qualify for financial clearance, appropriate personnel will notify the treating department who may then schedule the patient for the appropriate service.

9.4.2 If the patient does not qualify for financial clearance, appropriate personnel will notify the clinical staff of the determination and the non-emergent/urgent services will not be scheduled. A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.

9.5 Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.

9.6 The following may result in the reconsideration of Financial Assistance approval:

9.6.1 Post-approval discovery of an ability to pay.

9.6.2 Changes to the patient’s income, assets, expenses or family status which are expected to be communicated to SHS.

9.7 SHS will track patients with 6 or 12 month certification periods utilizing either eligibility coverage cards and/or a unique insurance plan code(s). However, it is ultimately the responsibility of the patient or guarantor to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

9.8 If patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

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

ATTACHMENTS:

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

ZIP CODES FOR COVERAGE AREAS

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

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

SHORE HEALTH SYSTEM UNIVERSITY OF MARYLAND MEDICAL SYSTEM	SLIDING SCALE	POLICY NO:	LD-34
		REVISED:	02/11
	ATTACHMENT B TO FINANCIAL ASSISTANCE POLICY	PAGE #:	1 of 1
		SUPERSEDES	04/05

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

Patient Income and Eligibility Examples:

Example #1	Example #2	Example #3
- Patient earns $53,000 per year - There are 5 people in the patient's family - The % of potential Financial Assistance coverage would equal 90% (they earn more than $51,580 but less than $54,159)	- Patient earns $37,000 per year - There are 2 people in the patient's family - The % of potential Financial Assistance coverage would equal 40% (they earn more than $36,425 but less than $37,882)	- Patient earns $54,000 per year - There is 1 person in the family - The balance owed is $20,000 - This patient qualifies for Hardship coverage, owes$13,500 (25% of $54,000)

Notes: FPL = Federal Poverty Levels

SHORE HEALTH SYSTEM

Vision Statement

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

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

MISSION STATEMENT

"TO EXCEL IN QUALITY CARE AND PATIENT SATISFACTION"

STRATEGIC PRINCIPLE

"EXCEPTIONAL CARE EVERYDAY"

VALUES STATEMENT

"EVERY INTERACTION WITH ANOTHER IS AN OPPORTUNITY TO CARE"