UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE REGIONAL HEALTH FY14 COMMUNITY BENEFIT REPORT

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:
UMC at Easton 112	7,542	21601, 21613, 21629, 21632, 21655, 21639, 21643	Anne Arundel Medical Center UMC at Dorchester	**CAROLINE** 0.6% **DORCHESTER** 0.3% **KENT** 0.0% **QUEEN ANNES** 0.2% **TALBOT** 0.6% **TOTAL** 1.7%	**CAROLINE** 6.6% **DORCHESTER** 3.9% **KENT** 0.5% **QUEEN ANNES** 2.4% **TALBOT** 8.8% **TOTAL** 22.1%
UMC at Dorchester 39	1,785	21613, 21643, 21631	UMC at Easton Peninsula Regional Medical Center	**CAROLINE** 1.5% **DORCHESTER** 3.6% **KENT** 0.3% **QUEEN ANNES** 0.5% **TALBOT** 0.8% **TOTAL** 6.8%	**CAROLINE** 1.8% **DORCHESTER** 18.5% **KENT** 0.4% **QUEEN ANNES** .8% **TALBOT** 1.8% **TOTAL** 23.3%
UMC at Chestertown 31	1,880	21620, 21661, 21651, 21678	UMC at Easton Anne Arundel Medical Center Union Hospital	**KENT** 4.1%	**KENT** 11.3%

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.) This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

Description of the community University of Maryland Shore Regional Health serves:

Situated on Maryland's Eastern Shore, Shore Regional Health's three hospitals, University of Maryland Medical Center at Easton (UMC at Easton), University of Maryland Medical Center at Dorchester (UMC at Dorchester), University of Maryland Medical Center at Chestertown (UMC at Chestertown) are not for profit hospitals offering a complete range of inpatient and outpatient services to over 175,000 people throughout the Mid-Shore of Maryland.

Shore Regional Health's service area is defined as the Maryland counties of Caroline, Dorchester, Talbot, Queen Anne's and Kent.

UMC at Easton is situated at the center of the mid-shore area and thus serves a large rural geographical area (all 5 counties of the mid-shore). UMC at Dorchester is located approximately 18 miles from Easton and primarily serves Dorchester County and portions of Caroline County. UMC at Chestertown located in Chestertown, in Kent County merged with Shore Regional Health in July 2013. UMC at Chestertown serves the residents of Kent County, portions of Queen Anne's and Caroline Counties and the surrounding areas.

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 – 9.62% adults have less than a 9th grade education and another 9.62% have an education at the 9th -12th grade level but do not have a high school diploma.

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.

While steady progress is being made, the Mid-Shore economy still faces a myriad of challenges that include: limited access to affordable high speed broadband services; a shortage of affordable housing; an inadequate supply of skilled workers; low per capita income; and higher unemployment (declining manufacturing sector).

The lack of affordable and accessible high speed internet service is a major barrier to diversifying the Eastern Shore economy. The Yankee Group recommended that a wireless back bone and last mile network are a viable solution to meet our growing broadband demands. Eventually a fiber backbone will be required to handle bandwidth demand on the eastern shore.

The natural environment has been one of the region's greatest assets in terms of quality of life and potential for developing natural resource based industry clusters. Ironically, this factor also limits the development of the area. A significant percentage of the population lives within the 100-year floodplain and the Critical Area and limits the amount of developable lands. Forty-seven percent of Dorchester County's total acreage is in the Critical Area. Twelve percent of Caroline County's acreage is in the Critical Area, and forty percent of Talbot County's acreage is in the Critical Area.

In the Mid Shore Region there are hundreds of thousands of acres of farm land that make a significant contribution to the local economy and play an important role in the local ecology. Innovative and traditional approaches to farming will continue to preserve this valuable resource and protect the region's quality of life.

The level of economic distress in the region is immediately evident when compared with the state figure especially for Caroline, Dorchester, and Kent Counties. 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. According to the Maryland Department of Labor, Licensing and Regulation and the Bureau of Labor Statistics as of December 2013, the State unemployment rate was 6.1%. The average unemployment rate for Caroline County's was 7.5%, Dorchester County's was 9.7%. Talbot County's was 6.8%, Kent County's was 7.1%.
Source:http://dllr.maryland.gov/lmi/laus/; http://www.dllr.state.md.us/lmi/emppay/

Shore Regional Health's service area has a higher percentage of population aged 65 and older as compared to Maryland overall. Talbot County has a 23.7 % rate for this age group and Kent County has 21.8% of its residents age 65 years or older. These rates are 65% higher than Maryland's percentage, and higher than other rural areas in the state by almost a quarter. Today, more than two-thirds of all health care costs are for treating chronic illnesses. Among health care costs for older Americans, 95% are for chronic diseases. The cost of providing health care for one person aged 65 or older is three to five times higher than the cost for someone younger than 65.
Source: http://www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf.
Hoffman C, Rice D, Sung HY. Persons with chronic conditions: their prevalence and costs. JAMA. 1996;276(18):1473-1479

County Health Rankings for the Mid-Shore counties also reveal the large disparities between counties for health outcomes in the service area. The Mid-Shore Region has 26,203 minority persons, representing 25.3% of the total population. In terms of

healthcare, large disparities exist between Blacks and Whites as reported by the Office of Minority Health and Health Disparities, DHMH. For emergency department (ED) visit rates for diabetes, asthma and hypertension, the Black rates are typically 3- to 5 fold higher than White rates. Adults at a healthy weight is lower (worse) for Blacks in all three counties where Black data could be reported. Heart disease mortality Black rates are variously higher or lower compared to White rates in individual counties. In Caroline, the Black rate is lower than the White rates not because the Black rate is particularly low, but because the White rate is unusually high. For cancer mortality, Black rates exceed White rates in Dorchester, Kent, Queen Anne's and Talbot. In Caroline, Black rates are lower, again because of a rather high White rate. The Black rates and White rates are below the State Health Improvement Process (SHIP) goals.
Source: http://www.dhmh.maryland.gov/ship.

County ranking (out of 24 counties including Baltimore City)								
County	**Health Outcomes**	**Mortality**	**Morbidity**	**Health Factors**	**Health Behaviors**	**Clinical Care**	**Social & Economic Factors**	**Physical Environment**
Queen Anne	4	4	3	8	10	8	7	4
Talbot	6	9	7	4	3	3	11	2
Caroline	23	23	20	21	23	24	19	10
Dorchester	21	22	21	22	21	19	22	7
Kent	16	16	17	13	13	11	16	1

Key characteristics, information and statistics about Mid-Shore source:
http://www.countyhealthrankings.org/app/maryland/2014/county/snapshots/
Mid Shore Comprehensive Economic Development Strategy (CEDS) (revised March 2032)
http://www.midshore.org/reports/
Maryland State Health Improvement Process, http://dhmh.maryland.gov/ship and its County Health Profiles 2013, http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx; SAHIE-State and County by Demographics and Income Characteristics/http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; CDC;and U.S. Census 2010, American Community Survey, 2005-2009.)
http://www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf.
Hoffman C, Rice D, Sung HY. Persons with chronic conditions: their prevalence and costs. JAMA. 1996;276(18):1473-1479
Key characteristics, information and statistics about Kent County sourced: Kent County Community Needs Assessment, 2012; U.S. Census Data 2010; U.S. Census Bureau, Small Area Income & Poverty Estimates, 2009;

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, education and environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Table II

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

	Total Population	White	Black	Native American	Asian	Hispanic or Latino origin
Talbot	37,782	81.4%	12.8%	0.2%	1.2%	5.5%
Dorchester	32,618	67.6%	27.7%	0.3%	0.9%	3.5%
Caroline	33,066	79.8%	13.9%	0.4%	0.6%	5.5%
Queen Anne's	47,793	88.7%	6.9%	0.3%	1.0%	3.0%
Kent	20,197	80.1%	15.1%	0.2%	0.8%	4.5%

	Median Age	Under 5 Years	Under 18 Years	65 Years and Older	Female	Male
Talbot	43.3	4.9%	19.5%	23.7%	52.3%	47.7%
Dorchester	40.7	6.2%	21.7%	17.7%	52.3%	47.7%
Caroline	37.0	7.0%	25.2%	13.3%	51.2%	48.8%
Queen Anne's	38.8	5.7%	23.8%	14.9%	50.3%	49.7%
Kent	45.6	4.6%	18.7%	26.0%	52.3%	47.7%

Source: http://dhmh.maryland.gov/ship/ *and its County Health Profiles 2012*

Median Household Income within the CBSA

	Median Household Income
Talbot	$62,942
Dorchester	$46,199
Caroline	$60,735
Queen Anne's	$86,013
Kent	$54,614

Source*: http://quickfacts.census.gov/qfd/states/24/24041.html (2008-2012)*

Percentage of households with incomes below the federal poverty guidelines within the CBSA	Talbot 7.6% Dorchester 15.9% Caroline 12.9% Queen Anne's 7.4% Kent 10.8% *Source: http://quickfacts.census.gov/qfd/states/24/24041.html (2008-2012)*

Please estimate the percentage of uninsured people by County within the CBSA	Talbot 13% Dorchester 14% Caroline 15% Queen Anne's 10% Kent 14% *Source: http://www.countyhealthrankings.org/app/maryland/2014/county/snapshots/041*
Percentage of Medicaid recipients by County within the CBSA.	Talbot 17% Dorchester 31% Caroline 27% Queen Anne's 16% Kent 20% *Source: http://www.chpdm-ehealth.org/mco*

Life Expectancy by County within the CBSA

Life Expectancy	All Races	White	Black
Talbot	80.5	81.2	77.1
Dorchester	77.6	79.1	73.7
Caroline	76.5	76.8	74.7
Queen Anne's	79.7	80.0	75.2
Kent	78.4	78.9	75.6

Source: http://dhmh.maryland.gov

Mortality Rates by County within the CBSA

NUMBER OF DEATHS BY RACE

		White		Black				
	All Races*	Total	Non-Hispanic	Total	Non-Hispanic	American Indian	Asian or Pacific Islander	Hispanic **
Talbot	413	358	358	54	54	0	0	6
Dorchester	361	264	263	95	95	0	2	1
Caroline	311	261	261	49	49	0	1	0
Queen Anne's	390	351	349	39	39	0	0	2
Kent	219	185	182	34	34	0	0	3

Source: http://dhmh.maryland.gov/vsa/Documents/11annual.pdf

* INCLUDES RACES CATEGORIZED AS 'UNKNOWN' OR 'OTHER'.

** INCLUDES ALL DEATHS TO PERSONS OF HISPANIC ORIGIN OF ANY RACE.

Source: http://dhmh.maryland.gov/vsa/Documents/11annual.pdf

*INCLUDES RACES CATEGORIZED AS 'UNKNOWN' OR 'OTHER'.

DEATH RATES BY RACE, 2011

	All Races	White	Black
Talbot	1086.1	1118	1015
Dorchester	1106	1163.3	1008.4
Caroline	942.9	955.3	980.6
Queen Anne's	806.6	800.3	1077.9
Kent	1083.9	1109.9	1038.8

**RATES BASED ON <5 EVENTS IN THE NUMERATOR ARE NOT PRESENTED SINCE SUCH RATES ARE SUBJECT TO INSTABILITY.

***INCLUDES ALL PERSONS OF HISPANIC ORIGIN OF ANY RACE.

Access to healthy Food

	Population that is Food Insecure	County Ranking	Population Living in a USDA Food Desert	County Ranking
Talbot	9.4%	14	23.72%	12
Dorchester	15%	4	41.26%	5
Caroline	11.1%	10	24.09%	11
Queen Anne's	6.7%	22	0%	22
Kent	10.8%	11	28.59%	9

Source: http://mdfoodsystemmap.org/wp-content/uploads/2014/01/

Quality of housing

County	Home Ownership Rate
Caroline	72.2%
Dorchester	68.3%
Talbot	73.8%
Queen Anne's	84.9%
Kent	72.8%

Source: http://quickfacts.census.gov/qfd/states/

	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. **Total Housing units 13,459** **Homeownership rate, 2008-2012 72.2%** **Housing units in multi-unit structures, 9.9%** **Median value of owner-occupied housing units, $233,400** **Kent County.** There is a need to provide housing for the homeless, as well as residents who have special needs and require group home or assisted living facilities. **Total Housing units 10,612** **Homeownership rate, 2008-2012 72.2%** **Housing units in multi-unit structures, 13.5%** **Median value of owner-occupied housing units, $267,600** **Queen Anne's County.** There is a widening gap in the number of homeowners versus renters as incomes exceed the $60,000 threshold. Need for affordable housing for low income households. **Total Housing units 20,521** **Homeownership rate, 2008-2012 84.9%** **Housing units in multi-unit structures, 6.1%** **Median value of owner-occupied housing units, $356,800** **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. The lack of move-up housing in the County is seen as a deterrent to attracting business. Dorchester County has a relatively weak housing market linked to the weak economy. In addition, the disproportionate amount of the County's elderly population dictates the need for more modest priced homes for the persons in this age category. County-wide, just over 31.5 percent of housing was renter occupied in 2010 with a renter rate for incorporated towns nearing 50 percent. In 2010, 18.3 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 **Total Housing units 16,646** **Homeownership rate, 2008-2012 68.3%** **Housing units in multi-unit structures, 15.4%** **Median value of owner-occupied housing units, $200,000**

	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 home ownership. Habitat for Humanity and new Easton Town Council initiatives now require developers to address low to moderate income, affordable home ownership 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 countywide 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. **Total Housing units 19,975** **Homeownership rate, 2008-2012 73.8%** **Housing units in multi-unit structures, 13.1%** **Median value of owner-occupied housing units, $343,800** Source :*http://quickfacts.census.gov/qfd/states/* Source: Mid Shore Comprehensive Economic Development Strategy CEDS Source: *http://www.midshore.org/reports/*

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 (operated by the county) and Delmarva Community Transit (DCT), a private company under contract to the counties. 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. ***Source: Mid Shore Comprehensive Economic Development Strategy CEDS*** *(revised March 2013)* *http://www.midshore.org/reports/*

Unemployment Rate by County within the CBSA

County	Unemployment Rate June 2014
Talbot	6.1%
Dorchester	8.5%
Caroline	7.0%
Queen Anne's	5.1%
Kent	6.4%

Source: *http://www.dllr.state.md.us/lmi/laus/maryland.shtml*

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

   __X__ Yes
   ____ No

   Provide date here. 5/22/2013

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

   http://umms.org/shore-health/about/~/media/systemhospitals/shore/pdfs/about/chna.pdf

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

   _ X_Yes
   ____No

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

   http://umms.org/shore-health/about/~/media/systemhospitals/shore/pdfs/about/chna.pdf
   See **Appendix 2 in the CHNA** in link provided above

Shore Regional Health (SRH) conducted a Community Health Needs Assessment (CHNA) for the five counties of Maryland's Mid-Shore: Talbot, Caroline, Queen Anne's, Dorchester, and Kent. The health needs of our community were identified through a process which included collecting and analyzing primary and secondary data. In particular, the CHNA includes primary data from Talbot, Caroline, Dorchester, Kent, Queen Anne's Health Departments and the community at large. Additionally, Shore Regional Health, is a participating member of the Mid-Shore SHIP coalition, where we are partnering with other community stakeholders invested in improving the community's overall health. Members of the Mid-Shore SHIP coalition include community leaders, county government representatives, local non-profit organizations, local health providers, and members of the business community. Feedback from customers includes data collected from surveys, advisory groups and from our community outreach and education sessions. Secondary data resources referenced to identify community health needs include County Health Rankings (http://www.countyhealthrankings.org), Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/), the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf

Shore Regional Health participates on the University of Maryland Medical System (UMMS) Community Benefits Workgroup to study demographics, assess community

health disparities, inventory resources and establish community benefit goals for both Shore Regional Health System and UMMS.

Shore Regional Health consulted with community partners and organizations to discuss community needs related to health improvement and access to care. The following list of partner agencies meets on a monthly basis as members of the Mid-Shore SHIP coalition (below is membership roster, representative vary depending upon topic/agenda and availability) :

- Choptank Community Health Systems, Dr. Jonathan Moss, CMO
- Caroline County Minority Outreach Technical Assistance, Janet Fountain. Program Manager
- Talbot County Local Management Board Donna Hacker, Executive Director
- Partnership for Drug Free Dorchester, Sandy Wilson, Program Director
- Caroline County Community Representative,Margaret Jopp, Family Nurse Practitioner
- Eastern Shore Area Health Education Center, Jake Frego, Executive Director
- Kent County Minority Outreach Technical Assistance, Dora Best, Program Coordinator
- YMCA of the Chesapeake, Deanna Harrell, Executive Director
- University of MD Extension, Sara Rich, Executive Director
- Kent County Local Management Board, Hope Clark, Executive Director
- Kent County Department of Juvenile Services, William Clark, Director
- Coalition Against Tobacco Use, Carolyn Brooks, Member
- Mt. Olive AME Church, Rev. Mary Walker
- Mid- Shore Mental Health Systems, Holly Ireland LCSW-C, Executive Director
- Associated Black Charities, Ashyria Dotson, Program Director
- Queen Anne County Housing and Family Services,Mike Clark, Executive Director
- Queen Anne County Health Department, Joseph Ciotola MD
- Dorchester County Health Department, Roger L. Harrell, Health Officer
- Talbot County Health Department,Thomas McCarty, Health Officer
- Caroline County Health Department, Dr. Leland Spencer, House Officer
- UMC at Easton, Kathleen McGrath, Regional Director of Outreach
- UMC at Chestertown, Cindy Bach, Director Transitions in Care

Shore Regional Health hosted a series of community listening forums to gather community input for a regionalization study that explores the benefits of a regional approach to providing health care for Caroline, Dorchester, Kent, Queen Anne's and Talbot counties. In addition, Shore Regional Health meets quarterly with members of the local health departments and community leaders, including:

- Choptank Community Health System: Joseph Sheehan, CEO, Jonathan Moss, CMO

- Health Departments Health Officers:
  Leland Spencer, M.D. Kent County and Caroline County
  Roger L. Harrell, MHA, Dorchester County Health Department
  Joseph Ciotola MD -DHMH Queen Anne’s County
  Thomas McCarty, Talbot County Health Department

- Mid Shore Mental Health Systems, Holly Ireland, Executive Director

- Eastern Shore Hospital Center: Randy Bradford, CEO

In addition, the following agencies/organizations are referenced in gathering information and data.

- Maryland Department of Health and Mental Hygiene
- Maryland Department of Planning
- Maryland Vital Statistics Administration
- HealthStream, Inc.
- County Health Rankings
- Mid Shore Comprehensive Economic Development Strategy CEDS

Our CHNA identified the following priorities for our community:

1. Cancer
2. Obesity
3. Access to Care
4. Behavioral Health
5. Diabetes

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

__X_Yes
___ 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)
   CMO
   Board of Directors

ii. Clinical Leadership

1. _X__Physician
2. _X__Nurse
3. _X_Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. _X__Individual (please specify FTE)
   Director, Outreach and Business Development (1FTE)

2. _X_Committee (please list members)

- Patti Willis – Regional Senior Vice President, Strategy and Communications
- Kathleen McGrath - Director of Outreach & Business Development
- Chris Parker - Senior Vice President-Patient Care Services, Chief Nursing Officer
- Chris Pettit – Planning Analyst
- Brian Leutner – Director of Oncology Services
- Iris Lynn Giraudo RN,BSN, Readmissions Care Coordinator
- Linda Porter, Patient Access Manager
- Patricia Plaskon - PhD, LCSW-C, OSW-C, Coordinator of Oncology Social Work
- Rita Holley MS, BSN, RN Director of Shore Home Care
- Ruth Ann Jones EdD, MSN, RN, NEA-BC, Director Acute Care
- Sharon Stagg RN, DNP, MPH, FNP-BC, Director of Shore Wellness Partners
- Susan Siford, PharmD, MBA, Director of Pharmacy
- Trish Rosenberry, BSN, RN, Manager of Outpatient Services
- Bee Fish – Director IT, Site Executive
- Gary Jones, Director, Cardiovascular & Pulmonary Services
- Jackie Weston, BSN, RN-BC, Nurse Manager for Shore Behavioral Health Services
- Terri Ross - Director of Care Coordination
- Bill Roth - Senior Director, Comprehensive Rehab Care

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 FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet	__X___yes	_____no
Narrative	__X___yes	_____no

If you answered no to this question, please explain why.

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES This Information should come from the implementation strategy developed through the CHNA process.

1. **Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached examples of how to report.**

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

a. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.

b. Name of Initiative: insert name of initiative.

c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (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. How 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 to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?

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

i. Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.

. Initiative 1- Chronic Disease

Identified Need	**CHRONIC DISEASE—SHIP OBJECTIVES #27, 28, 17** Reduce diabetes - related emergency department visits. Reduce hypertension related - emergency department visits. Reduce emergency department visits from asthma. Reduce complications for conditions such as HF, COPD, CKD and asthma
Hospital Initiative	Shore Wellness Partners (SWP)
Primary Objective	Shore 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 reduce emergency department visits and readmissions.** Designed for at-risk families and individuals who do not 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 Regional Health 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
Single or Multi-Year Initiative Time Period	Ongoing; currently in third year
Key Partners in Development and/or Implementation	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 (sometimes care is provided in the patient's home). Shore Wellness Partners is a partner in the HEZ for Dorchester and Caroline Counties. Detailed information for the HEZ model, Competent Care Connections can be found at: *http://dhmh.maryland.gov/healthenterprisezones/SitePages/Updates. aspx*
How were the outcomes evaluated?	1. # of referrals to service 2. # of patients on service with Shore Wellness Partners 3. Comparison of **ALL CAUSE** readmissions for patients on service, FY14
Outcomes (Include process and impact measures)	1. Number of referrals = 305 2. Number of active patients=232 There was a 52% reduction in hospital admissions for clients on service with SWP for 0-6 months, which represented 84% of the SWP clients in FY 2014. This admission reduction is similar to the Glendening-Napoli, Dowling, Pulvion, Baillargeon and Raimer (2012) study that found a 53% decrease in hospital admissions. Based on FY 2014 history, there was an 8% mean ED visit and a 30% mean hospital visit rate decrease for clients with SWP greater than 6 months. FY14 satisfaction survey, which had a 29% response rate, SWP clients were highly satisfied with the program. One hundred percent of the clients surveyed rated the program 10 on a 0 – 10 scale with 0 being the worst service possible and 10 representing the best service possible. Medication management, vital signs monitoring, and emotional support were highly rated aspects of the program.

Continuation of Initiative	Ongoing, multiyear Expansion of SWP as part of the HEZ grant	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $467,268 (includes staff salary and supplies Does not include indirect overhead)	B. Direct offsetting revenue from Restricted Grants HEZ Grant: $35,289

Table III A. Initiative 2- Cardiovascular

Identified Need	**Cardiovascular** Critical Care Access to emergency medications prevents terminal outcomes for patients	
Hospital Initiative	Anti-thrombosis Clinic	
Primary Objective	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	
Single or Multi-Year Initiative Time Period	Multi-year/ongoing	
Key Partners in Development and/or Implementation	Shore Regional Health Pharmacy Services	
How were the outcomes evaluated?	1. # of patients enrolled 2. Time to therapeutic international normalized ratio (INR) 3. % of time with therapeutic INR's 4. # unexpected Adverse Events associated with oral anticoagulation	
Outcomes (Include process and impact measures)	Clinic manages greater than 1,000 patients UMC at Easton 11,684 patient encounters UMC at Easton average # of patients served, 932 Average time to therapeutic INR is 4.3 days (national average is 5.8 days) 76.15% patients were maintained with therapeutic range >90% time (national average is 58%) 4.7% incidence of Major Hemorrhagic Events (Literature reports rate of 5-8.1%) UMC at Chestertown 4,285 encounters UMC at Chestertown average # of patients served,259 Average time to therapeutic INR is 4.5 days (national average is 5.8 days) 68.9% patients were maintained with therapeutic range >90% time (national average is 58%) 2.5% averse events	
Continuation of Initiative	The initiative is continuing	
C. Total Cost of Initiative for Current Fiscal Year D. What amount is Restricted Grants/Direct offsetting revenue	C. Total Cost of Initiative UMC at Easton $185,918 UMC at Chestertown $100,509 (includes staff salary and supplies Does not include indirect overhead)	D. Direct offsetting revenue from Restricted Grants

Table III A. Initiative 3 – Medication Program

Identified Need	Critical Care Access to emergency medications prevents terminal outcomes for patients	
Hospital Initiative	EMS Medication Programs	
Primary Objective	Shore Regional Health provides emergency management medications to the local Ambulance Services so that Advanced Cardiac Life Support that may be initiated in the field	
Single or Multi-Year Initiative Time Period	Multi-year/ongoing	
Key Partners in Development and/or Implementation	Shore Regional Health Pharmacy, Local EMS units and the State of Maryland Institute for Emergency Medical Services System	
How were the outcomes evaluated?	Decrease death and disability related to critical illnesses where early intervention is possible and proven to be of benefit • UMC at Easton and Dorchester # of patients served, 10,000 • UMC at Chestertown # of patients served, 2,500	
Outcomes (Include process and impact measures)	Early interventions by EMS, served 12,500 persons. Successful field resuscitation and treatment of patients through early intervention as encountered by local EMS services. Providing access to emergency medication is an essential component of the early intervention protocols.	
Continuation of Initiative	The initiative is continuing	
E. Total Cost of Initiative for Current Fiscal Year F. What amount is Restricted Grants/Direct offsetting revenue	E. Total Cost of Initiative UMC at Easton and Dorchester $121,553 UMC at Chestertown $36,554	F. Direct offsetting revenue from Restricted Grants

Table III A. Initiative 4 – Cancer Program

Identified Need	**CANCER SHIP OBJECTIVE #26** Reduce overall cancer death rate	
Hospital Initiative	Shore Regional Breast Outreach	
Primary Objective	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 and Hispanic 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.	
Single or Multi-Year Initiative Time Period	Multi-year/ongoing	
Key Partners in Development and/or Implementation	Health Departments for five Counties	
How were the outcomes evaluated?	1. # of women educated through screenings and outreach programs 2. Correlation of tumor registry data with outreach events, screenings	
Outcomes (Include process and impact measures)	Increased the community's awareness of breast cancer prevention, detection and treatments. Served 2,421 person at 74 community events, 17 professional presentations 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	
Continuation of Initiative	The initiative is continuing	
G. Total Cost of Initiative for Current Fiscal Year H. What amount is Restricted Grants/Direct offsetting revenue	G. Total Cost of Initiative $25,000 (includes staff salary and supplies Does not include indirect overhead)	H. Direct offsetting revenue from Restricted Grants

Table III A. Initiative 5 – Cancer Program

Identified Need	**CANCER SHIP OBJECTIVE #26** Reduce overall cancer death rate	
Hospital Initiative	Shore Regional Breast Center Wellness for Women Program	
Primary Objective	The program serves as a point of access into care for age and risk specific mammography screening, clinical breast exam, and genetic testing for breast cancer Offers no cost mammograms to eligible women: those under the age of 40 and over 65who have no insurance and Latina women of all ages who will be screened annually thereafter. Those women needing further diagnostic tests or who need treatment for breast cancer will be enrolled in the State of Maryland Diagnosis and Treatment Program through the case manager.	
Single or Multi-Year Initiative Time Period	Multi-year/ongoing	
Key Partners in Development and/or Implementation	Health Departments	
How were the outcomes evaluated?	1. Ongoing data collection reported monthly to capture total number seen with breakdown by race. 2. Increase breast screening levels among uninsured and underinsured women.	

Outcomes (Include process and impact measures)	WFW Screenings:
	177 patients
	• African American new patients seen, 9, volume down 12%
	• Hispanic new patients seen, 24, volume up 37.5%
	• Caucasian new patients seen, 7, volume down 42%
	
	Shore Regional Breast Center Case Worker
	1,552 patient visits.
	• 37 were diagnosed with breast cancer
	• 264 total of patients case managed.
	  • 2 of 37 (5%) case managed with new diagnosis
	  • 24 of 264 with ongoing breast cancer (9%)
	  • 25 of 264 with negative diagnostic evaluation (9%)	

Continuation of Initiative	The initiative is continuing	
I. Total Cost of Initiative for Current Fiscal Year J. What amount is Restricted Grants/Direct offsetting revenue	I. Total Cost of Initiative: $45,543 (includes staff salary and supplies. Does not include indirect overhead)	J. Direct offsetting revenue from Restricted Grants

Table III A. Initiative 6 – Cancer Program

Identified Need	**CANCER SHIP OBJECTIVE #26** Reduce overall cancer death rate	
Hospital Initiative	Prostate Cancer Screening	
Primary Objective	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. This initiative is open to all men, but focused outreach is on areas of county with a high percentage of African American /Black population. Spiritual leaders and churches are contacted and engaged, and requested to encourage their congregations and communities to participate.	
Single or Multi-Year Initiative Time Period	Multi-year/ongoing	
Key Partners in Development and/or Implementation	Shore Comprehensive Urology Talbot County NAACP MOTA	
How were the outcomes evaluated?	# of screenings and exams provided	
Outcomes (Include process and impact measures)	• Increased awareness and detection of prostate cancer Provided access to screenings to underserved persons of community • 81 men were screened. All results are reviewed by the screening physician. Results are mailed to the participant.	
Continuation of Initiative	ongoing	
K. Total Cost of Initiative for Current Fiscal Year L. What amount is Restricted Grants/Direct offsetting revenue	K. Total Cost of Initiative $1,400 (includes staff salary and supplies Does not include indirect overhead)	L. Direct offsetting revenue from Restricted Grants

Table III A. Initiative 7- Chronic Disease Diabetes

Identified Need	**CHRONIC DISEASE SHIP OBJECTIVE # 27** Reduce ED visits from diabetes Improve management of diabetes Reduce incidence of diabetes	
Hospital Initiative	**Diabetes Education Programs** • Diabetes 101 • Diabetes Support Group • Education on Diabetes for High School Students	
Primary Objective	**The primary objectives of the Diabetes education programs are:** • Improve health through better management of diabetes • Increase knowledge of risk factors for diabetes, heart disease and stroke and how to improve health with regular exercise and nutrition • Provide support for diabetes patients and their families	
Single or Multi-Year Initiative Time Period	Multi-year/ongoing	
Key Partners in Development and/or Implementation	Grasonville Community Senior Center UM Center for Diabetes and Endocrinology Caroline County Schools	
How were the outcomes evaluated?	# of patient goal plans written. # of participants who reach goals # of Participants Pre and Post seminar survey	
Outcomes (Include process and impact measures)	**Diabetes 101**: 25 Participants attended 2 hour session to increase their knowledge on managing their diabetes. All participants made progress on developing management strategies. **Diabetes Support Group:** 8-10 patients attend monthly Diabetes support group. Attendees and their friends and family meet to discuss diabetes: concerns, problems, and challenges. Facilitator provides health education and accurate information. **Education on Diabetes for High School Students:** 150 Students attended educational seminars. Quiz given to assess awareness of sugar in foods. 95% not aware prior to seminar. Education on reading food labels and making healthy choices provided to attendees.	
Continuation of Initiative	ongoing	
M. Total Cost of Initiative for Current Fiscal Year N. What amount is Restricted Grants/Direct offsetting revenue	M. Total Cost of Initiative $3,493 (includes staff salary and supplies Does not include indirect overhead)	N. Direct offsetting revenue from Restricted Grants

Table III A. Initiative 8- Chronic Disease Diabetes

Identified Need	Chronic Disease Management: Diabetes and Asthma	
Hospital Initiative	Shore Kids Camp	
Primary Objective	This is a 4 day camp for children with diabetes or asthma. Children range in age from 8 to 13. • Provide children with learning and networking experience who have diabetes or asthma • Prevent hospitalization of children attending the camp	
Single or Multi-Year Initiative Time Period	Multi-year/ongoing	
Key Partners in Development and/or Implementation	American Diabetes Association Talbot, Caroline, QA Health Departments	
How were the outcomes evaluated?	Track the attendees for one year after attending camp for hospitalizations due to complications from diabetes or asthma	
Outcomes (Include process and impact measures)	10 children attended, Only 1 child hospitalized with diabetes complications in following year	
Continuation of Initiative	Yes, yearly	
O. Total Cost of Initiative for Current Fiscal Year P. What amount is Restricted Grants/Direct offsetting revenue	O. Total Cost of Initiative P. $9,600 (includes staff salary and supplies Does not include indirect overhead)	Q. Direct offsetting revenue from Restricted Grants $804

Table III A. Initiative 9- Chronic Disease Diabetes

Identified Need	Pre-diabetes and Diabetes Awareness, Prevention, and Management **SHIP Objective: Chronic Disease #27** Reduce ED visits from diabetes Reduce incidence of diabetes Improve management of diabetes
Hospital Initiative	Annual education initiative for American Diabetes Month, held each year in November. Support Groups July 2013 –June 2014; 10-15 attendees each month Grocery StoreTour – April 23, 2014;10 participants Radio Show - October 7, 2013; 200+ listeners
Primary Objective	The primary objective of this annual educational initiative is to educate the community about diabetes, including risk factors and to raise awareness about lifestyle changes that can prevent onset of type 2 diabetes. Kent County has a high incidence of diabetes, especially in the African American/Black community. SRH diabetes nurse/CDE provides community outreach to church groups and other community organizations about diabetes. SRH has a comprehensive educational and lifestyle-change program called "Managing Your Diabetes," which is led by the diabetes nurse/educator. SRH diabetes nurse/educator also facilitates the free monthly diabetes support group.
Single or Multi-Year Initiative Time Period	Multi-year and ongoing
Key Partners in Development and/or Implementation	Shore Medical Center at Chestertown, University of Maryland Center for Diabetes and Endocrinology hosts/sponsors this yearly program MOTA (Minority Outreach Technical Assistance) for annual community health fair (September 28, 2013). Local grocery stores, churches and community groups.
How were the outcomes evaluated?	Outcomes are evaluated by reviewing number of participants and all participants are provided with opportunity for pre-diabetes screening and access to glucose screening, as well as opportunity to participate in support groups
Outcomes (Include process and impact measures)	The annual event on November 26, 2013 had 20 attendees. Each participant provided with: educational materials about diabetes, nutrition and weight management information; free glucose screening vouchers provided. Partnering with the local grocery stores, the CDE and Dietician offered three "Healthy Eating Options and Nutrition Tips" on April 23, 2014; 10 community members participated. Free glucose screening vouchers provided. Lifestyle screenings were provided at educational events and health fairs, including: -Community Health Fair, Worton Community Center, Worton, Maryland; September 28, 2013

	-Senior Summit Health Fair, Centreville, Maryland; May 16, 2014 -Homeports Aging Symposium, Chestertown, Maryland; April 15, 2014	
Continuation of Initiative	Yes, all listed initiatives are continuing.	
Q. Total Cost of Initiative for Current Fiscal Year R. What amount is Restricted Grants/Direct offsetting revenue	R. Total Cost of Initiative $2,400 (includes staff salary and supplies Does not include indirect overhead)	S. Direct offsetting revenue from Restricted Grants

Table III A. Initiative 10- Program for Aging Population

Identified Need	Resources, Health Care Programs, Access to Care for Aging Population
Hospital Initiative	Lead Sponsor and Partner in local "Home Ports Annual Aging Symposium" an event that focused on aging issues and trends, and promoting aging in place.
Primary Objective	Kent County is unique in that 22% of its residents are 65 years or older, which is 65% higher than the state of Maryland's percentage, making Kent County one of the oldest, aging populations in the Maryland. As people live longer, aging well is a challenge and hospitals need to be prepared. Shore Medical Center at Chestertown has made it a priority to meet the growing needs of an aging adult population by supporting and participating in the annual HomePorts Aging Symposium, as well as other health fairs and community activities aimed at educating the underserved and diverse adult population. The Aging Sympsium, "Healthy Aging- A Community Perspective" on April 15, 2014, presented strategies that promote a healthier senior population, interventions for protecting older adults from financial exploitation, estate planning, aging in place, long term care options, resources and support services available for caregivers, and more. Shore Medical Center at Chestertown will continue to participate in programs that focus on the aging population and plans to explore and develop new aging service delivery models to improve pathways between hospitals and post-discharge and/or specialty care. ***Additional Health Fairs and Aging-related Events including:*** • Community Health Fair, September 28, 2013; 150 attendees • Queen Anne's County Annual Senior Summit, May 16, 2014; 300 attendees The following educational materials, information and free screenings on the topics were provided, including: • High blood pressure and heart disease • Diabetes • Cancer • Hospice services and palliative care • obesity, exercise and nutrition • Free Blood pressure screenings
Single or Multi-Year Initiative Time Period	Multi-year initiative and ongoing
Key Partners in Development and/or Implementation	Shore Regional Health System/UM Shore Medical Center at Chestertown (local Hospital in Kent County Maryland) • UM Chester River Home Care & Hospice • Kent County's HomePorts • Kent County Health Depart • Upper Shore Aging

	• Kent County Commission on Aging • University of Maryland Medical System/University of Maryland School of Medicine	
How were the outcomes evaluated?	Outcomes are evaluated by number of community members attending the annual event. All attendees are provided with educational materials on a variety of appropriate topics related to the aging population. Opportunities for free health screenings are provided.	
Outcomes (Include process and impact measures)	Shore Medical Center at Chestertown supported and participated in the 2014 Aging Symposium and provided: • $3500 of sponsorship support • Clinical staff and experts for presentations and outbreak sessions on a variety of health care topics and trends • Displays and educational materials on high blood pressure, heart disease, diabetes, cancer, urological issues, hospice services, palliative care, long term care, sleep hygiene, obesity, exercise and nutrition; wound care • Free Blood pressure screenings; BMI screenings; Bone Density screenings There were 100 attendees. Participants were provided with a survey and data/ feedback was collected on the presentations, displays, educational materials and the breakout sessions.	
Continuation of Initiative	Yes, all listed initiatives are continuing.	
S. Total Cost of Initiative for Current Fiscal Year T. What amount is Restricted Grants/Direct offsetting revenue	T. Total Cost of Initiative $9,580	U. Direct offsetting revenue from Restricted Grants

Table III A. Initiative 11- Chronic Diseases: Heart Disease/Hypertension/Obesity Program

Identified Need	Heart Disease, High Blood Pressure, Hypertension, Obesity SHIP Objectives: Chronic Disease - #25, #28 and #30 Reduce deaths from heart disease Reduce hypertension-related emergency department visits Increase the % of adults who are at a healthy weight
Hospital Initiative	***Free Annual heart disease education event: February 24, 2014.*** This program occurs every February in honor of American Heart Month. Support Groups: Mended Hearts meeting, February 24, 2014; 50 attendees at special meeting. Radio Shows on February 7, 2014; 200+ listeners ***Transitions Care Program - CHF (congestive heart failure) Free Clinic*** Formerly known as (for FY 12 and FY13; renamed in FY14): Chester River Hospital "Taking Charge of Your Heart" CHF Free Outpatient Clinic
Primary Objective	***Free Annual heart disease education event: February 24, 2014.*** The annual heart disease education event for FY14 focused on educating the community about what is heart disease with special emphasis on identifying cardiac risk factors. The event is free and features speakers that include a community Cardiac Rehab Nurse; and hospital dietician. This year's speaker discussed heart disease and cardiac risk factors; healthier lifestyle choices were emphasized. The discussion also touched on congestive heart failure (CHF). Members of Mended Hearts support group were in attendance. Discussion topics and educational materials include heart disease, high cholesterol, high blood pressure, and obesity/lifestyle choices. Special attention is given to educating about preventative measures, including a healthy diet and exercise. Free blood pressure screenings provided at events and throughout the community during the year, including the following: -Community Health Fair, Worton Community Center, Worton, Maryland; September 28, 2013 -Senior Summit Health Fair, Centreville, Maryland; May 16, 2014 -Homeports Aging Symposium, Chestertown, Maryland; April 15, 2014 Mended Hearts Support Group information provided. ***Transitions Care Program - CHF (congestive heart failure) Free Clinic*** Congestive Heart Failure (CHF) is a very serious problem and is one of the medical conditions responsible for the highest rates of hospitalizations in the US.

	The Medical Center at Chestertown's approach to dealing with CHF is to improve the management of this chronic disease, with an overarching goal to increase patients' quality of life, lower readmissions and other health complications, while increasing patients' understanding and knowledge. The program is managed by a nurse, in collaboration with the health system's home health group. Patients with CHF are evaluated, managed and treated in a comfortable and friendly environment. Progress is tracked. Each patient enrolled in the program receives: • Patient/family focused education • Individual binder • Scale to track weight Nutrition counseling
Single or Multi-Year Initiative Time Period	Multi-year and ongoing
Key Partners in Development and/or Implementation	***Free Annual heart disease education event: February 24, 2014.*** The UM Shore Medical Center at Chestertown is the host/sponsor of this annual initiative. Hospital's Cardiac Rehab nurses provide additional health and exercise information and free blood pressure screenings. Hospital's Dietician provides information on heart healthy eating. The Mended Hearts Support Group exhibits at event. Local grocery stores (for grocery store tours; offered April 23, 2014). ***Transitions Care Program - CHF (congestive heart failure) Free Clinic*** The Medical Center at Chestertown's Cardiac Rehab Department, Dietary Department and Home Health Department.
How were the outcomes evaluated?	***Free Annual heart disease education event: February 24, 2014.*** Attendees are provided with educational materials and information, as well as opportunity to participate in free educational programs and support groups and free blood pressure screenings to help assess/ identify cardiac risk factors. ***Transitions Care Program - CHF (congestive heart failure) Free Clinic*** Outcomes are evaluated by reviewing number of patients enrolled in the program and number of patients who complete the program.
Outcomes (Include process and impact measures)	***Free Annual heart disease education event: February 24, 2014.*** The Annual Heart Disease Event provided: • A total of 50 community members attended the February 24, 2014 event. • Participants were provided with educational materials about heart disease and healthy lifestyle choices, with emphasis on healthy weight management. • Free blood pressure screenings provided. • Heart-healthy snacks and refreshments provided, along with heart healthy recipes. Information about free, grocery store tours included (offered in April 2014).

	Transitions Care Program - CHF (congestive heart failure) Free Clinic The Medical Center at Chestertown's Transitions Care CHF Free Outpatient Clinic operates within the Cardiac Rehab Center. The program was launched in FY12 and has continued through FY14. • There are currently 6 patients in the program, seen three times each week. • The intermediate term outcome, to be tracked and measured over 1-5 years, is the overall decrease of patients' hospitalizations and readmissions. The short term outcome indicator, to be tracked and measured, is participation in heart failure program, as well as attendance of exercise and /or education class.	
Continuation of Initiative	Yes, all listed initiatives are continuing.	
U. Total Cost of Initiative for Current Fiscal Year V. What amount is Restricted Grants/Direct offsetting revenue	V. Total Cost of Initiative $5,600	W. Direct offsetting revenue from Restricted Grants

Table III A. Initiative 12- Pediatric Dental Program

Identified Need	Lack of Dental Care/Access for Pediatric Population SHIP Objective: Increase the proportion of individuals receiving dental care
Hospital Initiative	UMC at Chestertown became part of the Children's Regional Oral Health Consortium (CROC) in 2010 to provide services to children of low-income families and racial/ethnic minority children, who require general anesthesia for their dental care
Primary Objective	The primary objective for the Pediatric Dental Program at Chester River Hospital is to provide and improve access to Maryland rural oral health services. The program provides dental care to children of low-income families, as well as adults who have special needs and pregnant women. Dental disease is one of the most common unmet health treatment need in children on the Eastern Shore of Maryland. Children in Maryland have three times the national average of untreated tooth decay, with children on the Eastern Shore having the highest percentage in the state. The majority of the Eastern Shore is considered dentally underserved, with barriers to access dental care for low-income families and racial/ethnic minorities. As part of CROC, Chester River Hospital provides surgical facilities and equipment for hospital-based pediatric dental cases to Kent and Queen Anne's County residents. Transportation is a barrier, so transportation is provided by Chester River Hospital's Pediatric Program passenger van.
Single or Multi-Year Initiative Time Period	Multi-year and ongoing
Key Partners in Development and/or Implementation	• Chester River Health/Hospital • Eastern Shore Area Health Education Center • Choptank Community Health System • Shore Health System • Kent County Health Department • Maryland DHMH • Maryland Healthy Smiles • Dr. Margaret McGrath • Dr. Jean Carlson
How were the outcomes evaluated?	Outcomes are evaluated by number of patients served by this program.
Outcomes (Include process and impact measures)	The Pediatric Dental Program at Chester River Hospital provided restorative care, both minor and major, to 60 pediatric patients for 740 total teeth treated
Continuation of Initiative	Yes, all listed initiatives are continuing.

W. Total Cost of Initiative for Current Fiscal Year X. What amount is Restricted Grants/Direct offsetting revenue	X. Total Cost of Initiative $22,111 (Does not include indirect overhead)	Y. Direct offsetting revenue from Restricted Grants

Table III A. Initiative 13-Healthy Social Environments: RESET Program

Identified Need	Underage Drinking and Binge Drinking and Drug/ Substance abuse Distracted driving SHIP Objective: Healthy Social Environments #9 and #1 Increase life expectancy; reduce alcohol-impaired driving fatalities
Hospital Initiative	Partnership with local RESET Program, which serves the 5-county area, including Shore Regional Medical Center at Chestertown's PSA of Kent County
Primary Objective	The primary objective of this initiative is to provide the youth of our community with information about the risks of underage consumption of alcohol, binge drinking and drug/substance abuse, as well as distracted driving and not practicing safe driving (ie: texting, cell phone use, wearing seatbelts). The RESET Program is an early intervention/alternative sentencing education program targeted at "at-risk" teens and young adults, aged 13-24 years. Shore Medical Center at Chestertown is an annual partner and sponsor. The RESET Program utilizes the hospital's Emergency Department and ED Clinical staff to assist with educational instruction and emergency simulation, and includes presentations/lectures from physicians and emergency department staff. This interactive educational program shows youth the consequences of poor choices and risky behaviors. The RESET Program occurs monthly. RESET Program: http://terryober.weebly.com/reset-program.html
Single or Multi-Year Initiative Time Period	Multi-year initiative and ongoing
Key Partners in Development and/or Implementation	Emergency Department, Emergency Department Staff at Shore Medical Center at Chestertown. Community Physicians Terry Ober, RESET Program coordinator. Shore Medical Center at Chestertown supplied the use of its ED and clinical staff for the educational instruction, along with the use of its Conference Center and Education Center.

How were the outcomes evaluated?	Outcomes are evaluated by reviewing number of students enrolled and participating in program.	
Outcomes (Include process and impact measures)	Each year 75-100 RESET Program "students" participate from Mid-Shore counties, including Kent. The program provides: • Interactive and educational instruction to show youth consequences of poor choices and risky behaviors • Addresses alcohol, binge drinking, drug/substance abuse and distracted driving (texting, cell phone use, seatbelts) • Students participate in mock accident and show what a person experiences form ambulance through Emergency Department and then life post-rehab and/or death. • Recidivism Rate 10% among students who successfully complete program	
Continuation of Initiative	Yes, all listed initiatives are continuing.	
Y. Total Cost of Initiative for Current Fiscal Year Z. What amount is Restricted Grants/Direct offsetting revenue	Z. Total Cost of Initiative $2,066	AA. Direct offsetting revenue from Restricted Grants

2. **Were there any primary community health needs that were identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.**

   Needs Identified not addressed:

All primary health needs are being addressed to the extent that available resources and clinical expertise allow. The community benefits plan is able to adequately address heart disease, cancer, diabetes, hypertension, high cholesterol, issues associated with aging population. Nutrition, weight management/obesity is addressed through educational classes and/or seminars. Tobacco use/smoking and alcohol/binge drinking/underage drinking are being addressed by other county agencies and organizations and through partnerships, including the County Health Departments.

Shore Regional Health hospitals do not possess the resources and expertise required for environmental health concerns and issues. Mental Health is being addressed through the Mid-shore Mental Health Systems, Inc, which is a private, not-for-profit organization serving the five mid-shore counties: Caroline Dorchester, Kent, Queen Anne's and Talbot.

Several additional topic areas were identified by the CHNA Steering Committee including: safe housing, transportation, and substance abuse. The unmet needs not addressed by UMC at Eaton, UMC at Dorchester, UMC at Chestertown will continue to be addressed by key governmental agencies and existing community- based organizations. While Shore Regional Health hospitals will focus the majority of our efforts on the identified priorities outlined in the CHNA Action Plan, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through other health care organizations with our assistance as available.

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

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.**

   Shore Regional Health System and its Medical Staff require that physician coverage through on call arrangements meets the needs of the communities we serve. There are occasions when certain specialists are not available. Patient care needs are met by transfer of the patient to an appropriate facility where those needs can be met.

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.**

   Physician Subsidies: As a result of the prevailing physician shortage, Shore Health has an insufficient number of specialists on staff. Subsidies and/or employment for the following specialties are necessary to meet patient demand, including the uninsured and underinsured.

   Hospitalist
   Orthopedics
   Psychiatric Services
   Gastroenterology
   Pediatrics
   Anesthesia
   Emergency Medicine

   Physician Recruitment: Shore Regional Health continues to experience a high percentage of physician shortage for specialists. To address the shortage, ongoing recruitment for the following areas occurred for FY14.

   Psychiatry
   Neurology
   Internal Medicine
   Family Medicine
   Obstetrics

VI. APPENDICES

To Be Attached as Appendices:

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

For *example*, state whether the hospital:

- **Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):**
  - **in a culturally sensitive manner,**
  - **at a reading comprehension level appropriate to the CBSA's population, and**
  - **in non-English languages that are prevalent in the CBSA.**
- **posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;**
- **provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;**
- **provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;**
- **includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or**
- **discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.**

b. Include a copy of your hospital's FAP (label appendix II).

c. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).

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

Appendix I

Description of Shore Regional Health's Financial Assistance Policy (FAP):

It is the policy of Shore Regional Health 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 Regional 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 Regional Health offers our financial assistance program. Shore Regional Health posts notices of our policy in conspicuous places throughout the hospitals- including the emergency department, 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 Regional Health has a dedicated Financial Assistance Liaison to work with our patients to assist them with this process and expedite the decision process.

Shore Regional 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 (services at reduced cost) yearly as well.

- Shore Regional Health prepares its FAP in a culturally sensitive manner, at a reading comprehension level appropriate to the CBSA's population, and in Spanish.
- Shore Regional Health posts its FAP and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
- Shore Regional Health provides a copy of the FAP and financial assistance contact information to patients or their families as part of the intake process;
- Shore Regional Health provides a copy of the FAP and financial assistance contact information to patients with discharge materials.
- A copy of Shore Regional Health's FAP along with financial assistance contact information, is provided in patient bills; and/or
- Shore Regional Health 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.
- An abbreviated statement referencing Shore Regional Health's financial assistance policy, including a phone number to call for more information, is run annually in the local newspaper (*Star Democrat*)

Appendix II: Financial Policy

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-34
		REVISED:	8/28/13
	FINANCIAL ASSISTANCE	PAGE #:	1 of 10
		SUPERSEDES	8/12

1.0 POLICY

1.1 This policy applies to Shore Regional Health (SRH). Shore Regional Health 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:

- University of Maryland Shore Medical Center at Easton
- University of Maryland Shore Medical Center at Dorchester
- University of Maryland Shore Medical Center at Chestertown

1.2 It is the policy of SRH 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 SRH 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 SRH 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, SRH strives to ensure that the financial capacity

of people who need health care services does not prevent them from seeking or receiving 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 SRH (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 the SRH 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 SRH 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 SRH.

2.3.5 Failure to make appropriate arrangements on past payment obligations owed to SRH (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 A.

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, SRH 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 SRH 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

SRH applies the State established income, medical debt and timeframe 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 A.

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 SRH 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, SRH is to apply the greater of the two discounts.

4.7 Patient is required to notify SRH 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 in writing.

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 JUDGMENTS

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, SRH 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 SRH 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 Determination of Probable Eligibility will be made within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

9.5 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 SRH 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.

9.5.1 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.

9.5.2 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.

9.6 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.

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

9.7.1 Post-approval discovery of an ability to pay.

9.7.2 Changes to the patient's income, assets, expenses or family status which are expected to be communicated to SRH.

9.8 SRH 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.

9.9 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
Revised	08/12 (Minor Changes)
SRH Administrative Policy	
Effective	08/13
Approved	SRH Board of Directors: 08/28/13
Policy Owner	Walter Zajac, Vice President, Finance & Budget

ATTACHMENT:

- Attachment A - Sliding Scale

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Appendix III

SHORE REGIONAL HEALTH SYSTEM PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy

Shore Regional Health System is committed to ensuring that uninsured patients within its service area who lack financial resources have access to medically necessary hospital services. If you are unable to pay for medical care, you may qualify for Free or Reduced Cost Medically Necessary Care if you have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability.

Shore Regional Health System meets or exceeds the legal requirements by providing financial assistance to those individuals in households below 200% of the federal poverty level

and reduced cost-care up to 300% of the federal poverty level.

Patients' Rights

Shore Regional Health System will work with their uninsured patients to gain an understanding of each patient's financial resources.

- They will provide assistance with enrollment in publicly-funded entitlement programs (e.g. Medicaid) or other considerations of funding that may be available from other charitable organizations.
- If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.
- If you believe you have been wrongly referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

Patients' Obligations

Shore Regional Health System believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

- Cooperate at all times by providing complete and accurate insurance & financial information
- Provide requested data to complete Medicaid applications in a timely manner.
- Maintain compliance with established payment plan terms.
- Notify us immediately at the number listed below of any changes in circumstances.

Contacts:

Call 410-822-1000 x1020 or toll free 1-800-876-5534 with questions concerning:

- Your hospital bill
- Your rights and obligations with regards to your hospital bill
- How to apply for Maryland Medicaid
- How to apply for free or reduced care

For information about Maryland Medical Assistance

Contact your local department of Social Services
1-800-332-6347 TTY 1-800-925-4434
Or visit: www.dhr.state.md.us

Physician charges are not included in hospitals bills and are billed separately by the physician.

MHE/DGH/01/12

HOJA INFORMATIVA PARA LOS PACIENTES DE SHORE REGIONAL HEALTH SYSTEM

POLIZA DEL HOSPITAL PARA AYUDA FINANCIERA:

SHORE REGIONAL HEALTH SYSTEM está avocada para garantizar a los pacientes que residen dentro de su área y que no cuentan con seguro o recursos financieros, acceso a los servicios de atención médica necesarios.

Si Ud. no puede pagar la atención médica, puede aplicar por Atención Médica gratuita o con un costo reducido, en el caso de que no tenga ningún tipo de seguro o recursos para el pago que incluya atención médica, litigio o forma de pago por un tercero.

SHORE REGIONAL HEALTH SYSTEM reúne o excede los requisitos legales para proporcionar ayuda financiera a aquellos individuos con ingresos por debajo del 200% del nivel de pobreza determinado por el Gobierno, así como reducir el pago por atención médica hasta por encima del
300% del nivel de pobreza determinado por el Gobierno.

DERECHOS PARA LOS PACIENTES:

SHORE REGIONAL HEALTH SYSTEM encontrará la forma de llegar a un acuerdo con cada paciente que no cuente con un Seguro, de acuerdo a los ingresos económicos de cada paciente.

- Asimismo, proporcionará asistencia para afiliación a programas que cuentan con fondos solventados por el Gobierno, tales como Medicaid o afiliación a otras organizaciones que pueden ayudar económicamente.

- Si Ud. no califica para recibir ayuda Médica o financiera, puede optar por un plan de pagos a largo plazo, para pagar su cuenta del hospital.

- Si Ud. considera que erróneamente lo han referido a una agencia de recaudación de dinero, tiene el derecho de contactar al hospital para solicitar ayuda. (ver información para contactarse, en la parte inferior de la hoja)

OBLIGACIONES PARA LOS PACIENTES:

SHORE REGIONAL HEALTH SYSTEM considera que sus pacientes tienen responsabilidades con el pago por atención médica recibida. Se espera que los pacientes:

1. Colaboren proporcionando información sobre su compañía aseguradora así como información financiera.

2. Provean la información requerida para llenar las solicitudes de Medicaid en el menor tiempo possible.

3. Cumplan con los términos establecidos para el pago.

4. Nos notifiquen inmediatamente al teléfono indicado en la parte inferior de la hoja sobre algún cambio habido en la información que haya sido proporcionada.

INFORMACION PARA CONTACTARSE:

1. Llame al teléfono 410-822-1000, Anexo 1020 o al teléfono gratuito 1-800-876-5534, en caso de tener preguntas relativas a:
   - Su cuenta de hospital
   - Sus derechos y obligaciones con respecto a su cuenta
   - Cómo aplicar a Medicaid en Maryland
   - Cómo aplicar para la atención gratuita o con un costo reducido.

2. Para información acerca de la Ayuda Médica en Maryland:
   - Contacte al Departamento de Servicios Sociales de su Area, llamando al teléfono 1-800-332-6347 TTY 1-800-925-4434
   - O visite la Página Web: www.dhr.state.md.us

El pago por los servicios del médico no están incluídos en la cuenta del hospital. El médico cobra sus servicios por separado.

Appendix IV

SHORE REGIONAL HEALTH SYSTEM

Vision Statement

"To be the region's leader in patient centered health care"

MISSION

Creating Healthier Communities Together

Goal

To provide quality health care services that are comprehensive, accessible, and convenient, and that address the needs of our patients, their families and our wider communities.

VALUES

- Respect
- Integrity
- Teamwork
- Excellence
- Service