UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE REGIONAL HEALTH FY15 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 acute care hospitals by the HSCRC. (Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

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	7,544	21601, 21613, 21629, 21632, 21655, 21639, 21643	Anne Arundel Medical Center UMC at Dorchester	**CAROLINE** 0.2% **DORCHESTER** 0.1% **KENT** 0.0% **QUEEN ANNES** 0.1% **TALBOT** 0.3% **TOTAL** 0.7%	**CAROLINE** 6.5% **DORCHESTER** 4.1% **KENT** 0.6% **QUEEN ANNES** 2.4% **TALBOT** 9.3% **TOTAL** 23%
UMC at Dorchester 39	1,836	21613, 21643, 21631	UMC at Easton Peninsula Regional Medical Center	**CAROLINE** 0.1% **DORCHESTER** 0.8% **KENT** 0.0% **QUEEN ANNES** 0.0% **TALBOT** 0.1% **TOTAL** 1.0%	**CAROLINE** 1.5% **DORCHESTER** 19.7% **KENT** 0.6% **QUEEN ANNES** .8% **TALBOT** 1.9% **TOTAL** 24.5%
UMC at Chestertown 31	1,866	21620, 21661, 21651, 21678	UMC at Easton Anne Arundel Medical Center Union Hospital	**CAROLINE** 0.0% **DORCHESTER** 0.0% **KENT** 0.5% **QUEEN ANNES** 0.1% **TALBOT** 0.0% **TOTAL** 0.6%	**CAROLINE** 0.3% **DORCHESTER** 0.0% **KENT** 9.8% **QUEEN ANNES** 1.9% **TALBOT** 0.0% **TOTAL** 12.1%

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. Based on findings from the CHNA, provide a list of the Community Benefit Service Area (CBSA) zip codes. These CBSA zip codes should reflect the geographic areas where the most vulnerable populations reside. Describe how the CBSA was determined, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the 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 175,000 – 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 June 2015, the State unemployment rate was 7.2%. The unemployment rate for Caroline County's was 5.7%, Dorchester County's was 9.7%. Talbot County's was 5.2%, Kent County's was 5.6%, Queen Anne's was 4.9%.
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	6	4	3	9	10	8	6	3
Talbot	7	9	7	5	3	3	11	7
Caroline	23	23	20	21	23	19	19	9
Dorchester	19	22	21	22	21	22	22	15
Kent	18	16	17	12	13	14	16	2

Key characteristics, information and statistics about Mid-Shore source: http://www.countyhealthrankings.org/app/maryland/2015/county/snapshots/
Mid Shore Comprehensive Economic Development Strategy (CEDS) (revised March 2013) http://www.midshore.org
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 the population within the CBSA, including 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, transportation, education and healthy 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	37,643	83.3%	13.2%	0.3%	1.5%	6.3%
Dorchester	32,578	68%	28.3%	0.5%	1.1%	4.6%
Caroline	32.538	81.5%	14.3%	0.4%	0.6%	6.4%
Queen Anne's	48,804	89.8%	6.9%	0.3%	1.1%	3.0%
Kent	19,820	81.8%	15.1%	0.3%	1.0%	3.4%

	Median Age	Under 5 Years	Under 18 Years	65 Years and Older	Female	Male
Talbot	43.3	4.6%	18.6%	26.6%	52.6%	47.4%
Dorchester	40.7	6.2%	21.4%	19.7%	52.5%	47.5%
Caroline	37.0	6.0%	24%	15.4%	51.2%	48.8%
Queen Anne's	38.8	5.3%	22.3%	17.3%	50.3%	49.7%
Kent	45.6	4.5%	17%	24.4%	52.1%	47.9%

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

Median Household Income within the CBSA

Median Household Income	
Talbot	$61,597
Dorchester	$46,361
Caroline	$58.632
Queen Anne's	$87,256
Kent	$56,259

Source: *http://quickfacts.census.gov/qfd/states/24/24041.html*

Percentage of households with incomes below the federal poverty guidelines within the CBSA	Talbot 8.6% Dorchester 16.5% Caroline 14.4% Queen Anne's 8.1% Kent 13.2% *Source: http://quickfacts.census.gov/qfd/states/24/24041.html*

Please estimate the percentage of uninsured people by County within the CBSA	Talbot 13% Dorchester 13% Caroline 14% Queen Anne's 10% Kent 13% *Source: http://www.countyhealthrankings.org/app/maryland/2015/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	81	81.9	76.2
Dorchester	78.1	79.1	75.2
Caroline	76.9	77.1	75.7
Queen Anne's	79.4	79.7	74.3
Kent	80.3	81.2	75.8

Source: http://dhmh.maryland.gov(2010-2012)

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	436	387	385	49	49	0	0	2
Dorchester	352	254	253	96	96	0	2	1
Caroline	322	273	271	45	45	0	1	4
Queen Anne's	397	365	364	29	29	0	3	1
Kent	248	202	202	43	42	0	2	1

Source: http://dhmh.maryland.gov/vsa/Documents/15annual.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/15annual.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/13annual.pdf

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

DEATH RATES BY RACE, 2013

	All Races	White	Black
Talbot	1149.5	1209.6	938.7
Dorchester	1077.8	1122.9	1015.4
Caroline	984.9	1012.0	901.6
Queen Anne's	818.3	828.0	822.5
Kent	1243.5	1224.6	1364.2

**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	Population participating in Supplemental Nutrition Assistance Program (SNAP)	Percent of Eligible Population participating (SNAP)	Percent of Eligible K- 12 eligible for free and reduced price meals
Talbot	10.5%	12%	56%	39%
Dorchester	15.8%	29%	88%	62%
Caroline	12.1%	21%	74%	58%
Queen Anne's	7.5%	10%	64%	26%
Kent	11.5%	16%	59%	52%

Source: http://mdfoodsystemmap.org/glossary

Quality of housing

County	Home Ownership Rate
Caroline	72.3%
Dorchester	65.9%
Talbot	72.5%
Queen Anne's	84.5%
Kent	71.4%

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 13,514** **Homeownership rate, 2009-2013 72.3%** **Housing units in multi-unit structures, 9.7%** **Median value of owner-occupied housing units, $212,800** **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 10,662** **Homeownership rate, 2009-2013 71.4%** **Housing units in multi-unit structures, 12.8%** **Median value of owner-occupied housing units, $258,200** **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 20,765** **Homeownership rate, 2009-2013 84.5%** **Housing units in multi-unit structures, 6.4%** **Median value of owner-occupied housing units, $348,100** **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 16,702** **Homeownership rate, 2009-2013 65.9%** **Housing units in multi-unit structures, 16.8%** **Median value of owner-occupied housing units, $191,000**

	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 expensive 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. **Total Housing units 20,230** **Homeownership rate, 2009-2013 72.5%** **Housing units in multi-unit structures, 13.6%** **Median value of owner-occupied housing units, $327,400** 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 2015)* *http://www.midshore.org/reports/*
Unemployment Rate by County within the CBSA	

County	**Unemployment Rate June 2015**
Talbot	5.2%
Dorchester	7.2%
Caroline	5.7%
Queen Anne's	4.9%
Kent	5.6%

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?

   √ Yes
   __No

   Provide date here. 5/22/2013

   If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

   http://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?

   √ 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 Health Improvement Committee 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 quarterly basis as members of the Mid-Shore SHIP coalition (below is membership roster, representative varies 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
- SRH, Kathleen McGrath, Regional Director of Outreach
- SRH, Cindy Bach, Regional 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

Shore Regional Health CHNA 2013:
Analysis of all quantitative and qualitative data, identified these top six areas of need within the Mid-Shore Counties. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths and mission.

1. Obesity
2. Diabetes
3. Heart Disease/Stroke
4. Cancer
5. Behavioral Health
6. Access to Care/Prevention

Shore Regional Health is in the process of conducting the CHNA to be completed by June 2016.

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital? **(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b,)**

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

_√_ Yes
___ No

If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

Shore Regional Health's organization's mission and vision statements set the framework for the community benefit program. As University of Maryland Shore Regional Health expands the regional health care network, we have explored and renewed our mission, vision and values to reflect a changing health care environment and our communities' needs. With input from physicians, team members, patients, health officers, community leaders, volunteers and other stakeholders, the Board of UM Shore Regional Health has adopted a new, five-year Strategic Plan.

The Strategic Plan supports our **Mission**, **Creating Healthier Communities Together**, and our **Vision**, to be the **region's leader in patient centered health care**. Our goal is 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.

Link to Strategic Plan:
http://umshoreregional.org/~/media/systemhospitals/shore/pdfs/about/srm-4014-handoutmech.pdf?la=en

Shore Regional Health has established a process of determining which needs in the community are to be addressed through establishment of the Community Health Needs Steering Committee (CHNSC). CHNSC is a multidisciplinary team that fulfills several functions which include: facilitating and supporting community and health care partnerships; providing leadership in advocating community-wide responses to health care needs; identifying unmet health needs; promoting universal access to health care; and guiding new community benefit opportunities. Ultimately the CHNSC determines the community benefit activities to be delivered by Shore Regional Health to the community based on best use of resources and areas of expertise.

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. √ **CEO**-Appoints qualified person(s) to lead and staff community benefits operations.
    - Assures that all entities affiliated with Shore Regional Health share community benefit goals and related policies.
    - Holds key staff accountable for participation in community benefit.
    - Reports to the governing body about community need and Shore Regional Health's response to those needs.
    - Key advocate for community benefit within and outside the organization.
2. √ **CFO** -Advises on budget implications of community benefit proposals/plans.
    - Develops/oversees implementation of financial assistance policies and procedures
    - Develops long-range strategic financial plans that include community benefit targets
3. √ Other (please specify)
   Regional Senior Vice President, Strategy and Communications-Member of CHNSC
    - Includes/integrates community benefit goals, objectives, and strategy into Shore Regional Health plans.
    - Understands/communicates local, regional and national health priorities

- Uses community assessment information in the organization's strategic/operational plans.
- Tells the community benefits story

CMO- Member of the CHNSC
- Leadership in moving Shore Regional Health to value-based care and population health
- Recruits primary care and specialty services to improve access to care

ii. Clinical Leadership

1. √ Physician
   Member of the CHNSC
   Advises on best practices for the health of populations and prevention strategies

2. √ Nurse
   Member of the CHNSC
   - Advises on best practices for the health of populations and prevention strategies; including activities for: diabetes, cancer, behavioral health, cardiovascular disease

3. √ Social Worker
   Member of the CHNSC
   - Advises on best practices for the health of populations, prevention strategies, referral processes for support, wrap around services for: diabetes, cancer, behavioral health patients.

4. √ Other (please specify)

Pharmacist,
Member of the CHNSC
- Advises on best practices for the health of populations and prevention strategies; including medication management activities

Case Management
Member of the CHNSC
- Advises on best practices for transitions in care and readmission prevention programs.

iii. Community Benefit Department/Team

1. √ Individual (please specify FTE)

Director, Outreach and Business Development (1FTE)
- Facilitator of CHNSC
- Oversees community health needs assessment

- Coordinates community benefits planning and participates in integrating it into Shore Regional Health's strategic planning process.
- Involves executive and board leaders with community benefit program: keep them informed of needs, program successes, issues and collaboration.
- Oversees implementation of community benefit programs and activities. Manage community benefits operations.
- Responsible for evaluating organization's overall approach and strategy as well evaluating individual programs.
- Works with finance staff to budget for community benefit and track programs and costs.
- Works with communications staff t prepare reports and tell community benefit story.

2. √ Committee (please list members) Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

- Patti Willis – Regional Senior Vice President, Strategy and Communications
  - Includes/integrates community benefit goals, objectives, and strategy into Shore Regional Health plans.
  - Understands/communicates local, regional and national health priorities
  - Uses community assessment information in the organization's strategic/operational plans.
  - Tells the community benefits story

- Kathleen McGrath - Director of Outreach & Business Development
  - Facilitator of CHNSC
  - Oversees community health needs assessment
  - Coordinates community benefits planning and participates in integrating it into Shore Regional Health's strategic planning process.
  - Involves executive and board leaders with community benefit program: keep them informed of needs, program successes, issues and collaboration.
  - Oversees implementation of community benefit programs and activities. Manage community benefits operations.
  - Responsible for evaluating organization's overall approach and strategy as well evaluating individual programs.
  - Works with finance staff to budget for community benefit and track programs and costs.
  - Works with communications staff to prepare reports and tell community benefit story.

- Chris Parker - Senior Vice President-Patient Care Services, Chief Nursing Officer
  - Leadership in moving Shore Regional Health to value-based care and population health

- William Huffner, MD, MBA, FACEP, FACHE, Chief Medical Officer
  - Leadership in moving Shore Regional Health to value-based care and population health

  - Recruits primary care and specialty services to improve access to care

- Chris Pettit – Planning Analyst
  - Contributes statistical data and other information

- Brian Leutner – Director of Oncology Services
  - Advises on best practices for the health of populations and prevention strategies for cancer

- Iris Lynn Giraudo RN,BSN, Readmissions Care Coordinator
  - Advises on best practices for transitions in care and readmission prevention programs.

- Linda Porter, Patient Access Manager
  - Helps oversee implementation of financial assistance policies and procedures

- Patricia Plaskon - PhD, LCSW-C, OSW-C, Coordinator of Oncology Social Work
  - Advises on best practices for the health of populations, prevention strategies, referral processes for support, wrap-around services for cancer patients.

- Rita Holley MS, BSN, RN Director of Shore Home Care
  - Advises on best practices for the health of populations referral processes for community case management and home care services to prevent readmissions

- Ruth Ann Jones EdD, MSN, RN, NEA-BC, Director Acute Care
  - Advises on community utilization of emergency services, and inpatient population.

- Sharon Stagg RN, DNP, MPH, FNP-BC, Director of Palliative Care Program
  - Advises on best practices for the health of populations and the referral processes for palliative care services.

- Susan Siford, PharmD, MBA, Director of Pharmacy
  - Advises on best practices for the health of populations and prevention strategies; including medication management activities, chronic disease management

- Trish Rosenberry, BSN, RN, Manager of Outpatient Services, Diabetes Center
  - Advises on best practices for the health of populations and prevention and management strategies for diabetes.

- Elizabeth Fish – Director IT, Site Executive
  - Contributes statistical data and other information

- Gary Jones, Director, Cardiovascular & Pulmonary Services
  - Advises on best practices for the health of populations and prevention and management strategies for cardiovascular and pulmonary disease.

- Jackie Weston, BSN, RN-BC, Nurse Manager for Shore Behavioral Health Services
  - Advises on best practices for management and support services for the behavioral health.

- Terri Ross - Director of Care Coordination
  - Advises on best practices for the health of populations referral processes for community case management to prevent readmissions. Identifies high risk/utilizer of inpatient and ED.

- Bill Roth - Senior Director, Comprehensive Rehab Care
  - Leadership in moving Shore Regional Health to value-based care and population health

- Cindy Bach – Regional Director of Care Transitions
  - Advises on best practices for the health of populations referral processes for community case management to prevent readmissions. Identifies high risk/utilizer of inpatient and ED.

- Mary Jo Keefe - Mary Jo Keefe RN,BSN, MSM Director of Nursing
  - Advises on community utilization of emergency services, and inpatient population

- Walter Zajac – Vice President, Finance
  - Advises on budget implications of community benefit proposals/plans.
  -
- Anna D'Acunzi Manager, Financial Decision Support
  - Advises on budget implications of community benefit proposals/plans.

- Greg Vasas - Decision Support Senior Analyst
  - Advises on budget implications of community benefit proposals/plans.

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

Spreadsheet	√ yes	_____no
Narrative	√ yes	_____no

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

Spreadsheet	√ yes	_____no
Narrative	√ yes	_____no

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

Shore Regional Health submits one narrative report, which reflects activities/initiatives delivered throughout the Mid-Shore. Shore Regional Health prepares three inventory spreadsheets, one for each hospital, as required by the HSCRC. This results in a number of regional initiatives being accounted for under the UMC at Easton, in order to capture the cost of the program.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

√ Other hospital organizations
√ Local Health Department
√ Local health improvement coalitions (LHICs)
√ Schools
√ Behavioral health organizations
√ Faith based community organizations
√ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

Organization	Name of Key Collaborator	Title	Collaboration Description
Mid-Shore Mental Health System	Holly Ireland	Executive Director	Consulted with partner and organization to discuss community needs related to behavioral health, access to care, and share data, SRH is a member of the Behavioral Health Integration Workgroup.
Dorchester County Health Dept.	Roger Harrell	Health Officer	Consulted with partners to discuss community needs related to health improvement, access to care, share Data, and partner in HEZ
Talbot County Health Dept.	Thomas McCarty	Health Officer	Consulted with partner to discuss community needs related to health improvement, access to care, and share data
Caroline County Health Dept.	Dr. Leland Spencer	Health Officer	Consulted with partner to discuss community needs related to health

			improvement, access to care, and share data, member of Caroline County Taskforce
Queen Anne's County Health Dept.	Joseph Ciotola, MD	Health Officer	Consulted with partner to discuss community needs related to health improvement, access to care, and share data partner in Mobile Integrated Community Health Program, Geriatric medication management program.
Kent County Health Dept.	Dr. Leland Spencer	Health Officer	Consulted with partner to discuss community needs related to health improvement, access to care, and share data.
Home Ports	Muriel Cole	Board, Executive	Shore Regional Health consulted with ABC to discuss community needs and sponsor of Home Ports health related events
Associated Black Charities	Ashyria Dotson	Program Director	Shore Regional Health consulted with ABC to discuss community needs related to health to disparities, partner in HEZ
Recovery for Shore	Sharon Dundon	Founder	Discuss community needs related to health improvement, access to care
Choptank Community Health Systems	Dr. Jonathan Moss	CMO	Consulted with partners to discuss community needs related to health improvement, access to care, and share data as well as work on transitions in care and as a member of LHIC
Caroline County Minority Outreach Technical Assistance	Janet Fountain	Program Manager	Consulted with partners to discuss community needs related to health improvement, access to care, share data, and as a member of LHIC
Partnership for Drug Free Dorchester	Sandy Wilson	Program Director	Consulted with partners to discuss community needs related to health improvement, access to care, share data, and as a member of LHIC
Eastern Shore Area Health Education Center	Jake Frego	Executive Director	Consulted with partners to discuss community needs related to health improvement, access to care, share data, and as a member of LHIC
Local Schools	representative varies depending upon topic/agenda and availability	representative varies depending upon topic/agenda and availability	School based Wellness Committee's and participation in education on health topics and careers
Kent County Minority Outreach Technical Assistance	Dora Best	Program Coordinator	Consulted with partners to discuss community needs related to health improvement, access to care, share data, and as a member of LHIC
YMCA of the Chesapeake	Deanna Harrell	Executive Director	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC

University of MD Extension	Sara Rich	Executive Director	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC
Kent County Local Management	Hope Clark	Board, Executive	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC
Kent County Department of Juvenile Services	William Clark	Director	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC
Coalition Against Tobacco Use	Carolyn Brooks	Member	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC
Mt. Olive AME Church	Rev. Mary Walker		Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC
Queen Anne County Housing and Family Services	Mike Clark	Executive Director	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?

____yes √ no

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

√ yes _____no

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

This Information should come from the implementation strategy developed through the CHNA process.

1. Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached example of how to report.

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

a. 1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.
   2. Please indicate whether the need was identified through the most recent CHNA process.
b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following link: http://www.thecommunityguide.org/)
   (Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)
c. Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?
d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?
e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results.
f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?
g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.
h. Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.
   - What were the measurable results of the initiative?
   - For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health

targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.

j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:
A. What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
B. Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

Table III –Initiative 1 -Chronic Disease	
a. 1. Identified Need 2. Was this identified through the CHNA process?	**CHRONIC DISEASE—SHIP OBJECTIVES #27, 28, 17** **Reduce diabetes - related emergency department visits.** Emergency department visits for diabetes-related complications may signify that the disease is uncontrolled. **Reduce hypertension related - emergency department visits.** In Maryland, 30% of all deaths were attributed to heart disease and stroke. Heart disease and stroke can be prevented by control of high blood pressure. **Reduce emergency department visits from asthma.** Asthma is a chronic health condition which causes very serious breathing problems. When properly controlled through close outpatient medical supervision, individuals and families can manage their asthma without costly emergency intervention. **Reduce complications for conditions such as HF, COPD, CKD and asthma** Residents of Talbot, Caroline, Dorchester, Kent have a higher rate than the HP 2020 goal rate of related emergency department visits for these chronic diseases http://dhmh.maryland.gov/ship/SitePages/Home Yes this was identified through the CHNA process.
b. Hospital Initiative	Shore Wellness Partners (SWP) provides community case management, at no charge, to community members who meet the eligibility criteria
c. Total Number of People Within the Target Population	The number of clients serviced depends on the complexity and needs of the client. FY15, 400 people identified as approved for referral.
d. Total Number of People Reached by the Initiative Within the Target Population	1. New clients = 115 2. Number of patient visits = 3,954
e. Primary Objective of the Initiative	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
f. Single or Multi-Year Initiative – Time Period	Multi-year 2011-present

g. Key Collaborators in Delivery of the Initiative	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/Home*.	
h. Impact/Outcome of Hospital Initiative?	There was a 48% reduction in hospital admissions for clients on service with SWP for 0-6 months, which represented 84% of the SWP clients in FY 2015. This admission reduction is similar to the Glendening-Napoli, Dowling, Pulvion, Baillargeon and Raimer (2012) study that found a 53% decrease in hospital admissions.	
i. Evaluation of Outcomes:	Based on FY 2015 history, readmissions to the hospital, SWP had a 4.6% 30 day readmission rate for clients served. Improved management of chronic disease has resulted in fewer ED visits and readmissions for the target population.	
j. Continuation of Initiative?	Yes, there has been a reduction in the readmissions rate for clients on service with SWP.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 582,158 (includes staff salary and supplies Does not include indirect overhead)	B. Direct Offsetting Revenue from Restricted Grants $35,000

Table III –Initiative 2 -Cardiovascular	
a. 1. Identified Need 2. Was this identified through the CHNA process?	**Cardiovascular** **The Antithrombosis Clinic** is designed to provide dedicated health care monitoring for those patient receiving chronic warfarin therapy. Warfarin therapy is reported widely in the medical literature as having significant morbidities associated with long-term therapy. Vigilant monitoring is necessary to avoid these complications. This clinic provides close monitoring of these patients with dedicated, knowledgeable staff. Through close monitoring, education, and continuous follow-up, the risks associated with long term anticoagulation are greatly reduced. Yes this was identified through the CHNA process.
b. Hospital Initiative	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
c. Total Number of People Within the Target Population	All anticoagulated patients who require close monitoring, educational resources and dedicated expertise to prevent adverse outcomes, reduction of hospital encounters related to over anticoagulation or under anticoagulation
d. Total Number of People Reached by the Initiative Within the Target Population	UMC at Chestertown • 4,445 patient encounters occurred during this period UMC at Easton • 15,792 patient encounters occurred during this period
e. Primary Objective of the Initiative	Provide safe anticoagulation management, provide extensive patient education regarding anticoagulation therapy, prevent adverse events related to anticoagulation therapy.
f. Single or Multi-Year Initiative – Time Period	Multi Year 2008-present
g. Key Collaborators in Delivery of the Initiative	Participating Hospital Staff, Shore Regional Health Pharmacy Services
h. Impact/Outcome of Hospital Initiative?	UMC at Easton • 15,792 patient encounters occurred during this period • Average # patients served 1211.8 patients • Average time to therapeutic INR is 4.3 days (national average is 5.8 days) • 76.15% patients were maintained within 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 • 4,445 patient encounters occurred during this period • Average # patients served 268 patients • Average time to therapeutic INR is 4.5 days (national average is 5.8 days) • 68.9% patients were maintained within therapeutic range >90% time (national average is 58%) • 2.5% averse events noted requiring hospitalization

i. Evaluation of Outcomes:	Indicators show a better than national average therapeutic range for patients in the program and better than average time to therapeutic INR than national average leading to a reduction of hospital encounters related to over anticoagulation or under anticoagulation	
j. Continuation of Initiative?	Yes, the initiative is continuing	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative UMC at Easton $265,345 UMC at Chestertown $89,636 (includes staff salary and supplies Does not include indirect overhead)	B. Direct Offsetting Revenue from Restricted Grants N/A

Table III –Initiative 3 -Cardiovascular		
a. 1. Identified Need 2. Was this identified through the CHNA process?	**Cardiovascular** Critical Care Access to emergency medications prevents terminal outcomes for patients Yes this was identified through the CHNA process.	
b. Hospital Initiative	Local EMS units and the State of Maryland Institute for Emergency Medical Services System collaborate to **determine medication protocols** appropriate for field administration as well as necessary PAR levels per ambulance crew.	
c. Total Number of People Within the Target Population	Early interventions by EMS, served 12,500 persons.	
d. Total Number of People Reached by the Initiative Within the Target Population	• UMC at Easton and Dorchester # of patients served: 10,000 • UMC at Chestertown # of patients served: 2,500	
e. Primary Objective of the Initiative	Decrease death and disability related to critical illnesses where early intervention is possible and proven to be of benefit, i.e., cardiac illnesses	
f. Single or Multi-Year Initiative – Time Period	Multi Year 2008-present	
g. Key Collaborators in Delivery of the Initiative	Shore Regional Health Pharmacy, Local EMS units and the State of Maryland Institute for Emergency Medical Services System	
h. Impact/Outcome of Hospital Initiative?	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 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. 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.	
i. Evaluation of Outcomes:	EMS providers provided emergency medical care to residents of our surrounding communities. SRH's active participation in this system through the provision of emergency medications needed to care for these critically ill patients in the field, have demonstrated that early intervention saves lives. http://www.ncbi.nlm.nih.gov/pubmed/8323592	
j. Continuation of Initiative?	This initiative may not continue due to cost	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative UMC at Easton and Dorchester $167,742 UMC at Chestertown $46,055	B. Direct Offsetting Revenue from Restricted Grants N/A

Table III –Initiative 4 Cancer

a. 1. Identified Need 2. Was this identified through the CHNA process?	**CANCER SHIP OBJECTIVE #26** **Reduce overall cancer death rate** Yes this was identified through the CHNA process.
b. Hospital Initiative	Shore Regional Breast Outreach
c. Total Number of People Within the Target Population	All patients who qualify for program in five counties who are uninsured or underinsured
d. Total Number of People Reached by the Initiative Within the Target Population	3,324 lives touched (some events included both community and professional audiences) • 62 Community events • 9 Professional Presentations
e. Primary Objective of the Initiative	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.
f. Single or Multi-Year Initiative – Time Period	Multi Year 2008-present
g. Key Collaborators in Delivery of the Initiative	Participating Hospital Staff; Talbot, QA, Kent, Dorchester, Caroline Counties Health Departments for five Counties
h. Impact/Outcome of Hospital Initiative?	Increased the community's awareness of breast cancer prevention, detection and treatments. 3,324 lives touched (some events included both community and professional audiences) • 62 Community events • 9 Professional Presentations Correlation with Outreach:

County	# of Events	# of Breast Cancer Diagnose	Cauc	AA	Other	Stages	
Tal	40	44	40	2	2	3	St 3-4
Dor	2	37	27	9	1	4	St 3-4
Kent	5	19	15	4	0	2	St 3-4
QA	9	14	13	1	0	1	St 3-

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The stage at diagnosis as reported by the Tumor Registry for the Cancer Center indicates disparity for women in Caroline and Dorchester County. For those counties women are being diagnosed at later stages with higher percentage for African American women.
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<tr><td>i. Evaluation of Outcomes:</td><td colspan="2">Indicators show improved access to care and referral for treatment</td></tr>
<tr><td>j. Continuation of Initiative?</td><td colspan="2">Yes, the initiative is continuing</td></tr>
<tr><td>k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue</td><td>A. Total Cost of Initiative
$181,646</td><td>B. Direct Offsetting Revenue from Restricted Grants N/A</td></tr>
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Table III Initiative 5- Cancer

a. 1. Identified Need 2. Was this identified through the CHNA process?	**CANCER SHIP OBJECTIVE #26** Reduce overall cancer death rate Yes this was identified through the CHNA process.	
b. Hospital Initiative	Shore Regional Breast Center Wellness for Women Program	
c. Total Number of People Within the Target Population	All patients who qualify for program in five counties who are uninsured or underinsured	
d. Total Number of People Reached by the Initiative Within the Target Population	207 patients seen (24% increase)	
e. 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 65 who 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.	
f. Single or Multi-Year Initiative Time Period	Multi Year 2008-present	
g. Key Collaborators in Delivery of the Initiative	Health Departments, Talbot, Caroline, Dorchester, Kent, Queen Anne's	
h. Impact/Outcome of Hospital Initiative?	WFW Screenings: 207 patients seen (24% increase) • New AA volume up 13% • New Hispanic volume up 49% • New Caucasian volume up 54% Shore Regional Breast Center Case Worker • 1706 patient visits • 32 diagnosed with Breast Cancer • 284 patient's case managed ◦ 5 of 32 (16%) case managed (new diagnosis) ◦ 23 of 284 with ongoing breast cancer (8%) 23 of 284 with negative diagnostic evaluation (8%)	
i. Evaluation of Outcomes:	1. Ongoing data collection reported monthly to capture total number seen with breakdown by race. 2. Increased breast screening levels among uninsured and underinsured women.	
j. Continuation of Initiative?	The initiative is continuing	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative: $33,595 (includes staff salary and supplies. Does not include indirect overhead)	B. Direct offsetting revenue from Restricted Grants $33,595

Table III Initiative 6 – Cancer Program		
a. 1. Identified Need 2. Was this identified through the CHNA process?	**CANCER SHIP OBJECTIVE #26** Reduce overall cancer death rate Yes this was identified through the CHNA process.	
b. Hospital Initiative	Prostate Cancer Screening	
c. Total Number of People Within the Target Population	All patients men who qualify for program in five counties who are uninsured or underinsured	
d. Total Number of People Reached by the Initiative Within the Target Population	98 men were screened	
e. 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.	
f. Single or Multi-Year Initiative Time Period	Multi Year 2006-present	
g. Key Collaborators in Delivery of the Initiative	Shore Comprehensive Urology Talbot County NAACP MOTA	
h. Impact/Outcome of Hospital Initiative?	98 men were screened. 10 men had PSA elevated, 2 had abnormal DRE and one had both.The man with both was biopsied and was negative for cancer	
i. Evaluation of Outcomes:	• Increased awareness and detection of prostate cancer Provided access to screenings to underserved persons of community • All results are reviewed by the screening physician. Results are mailed to the participant.	
j. Continuation of Initiative?	The initiative is continuing	
k. Total Cost of Initiative for Current Fiscal Year and What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $486 (includes staff salary and supplies Does not include indirect overhead)	B. Direct offsetting revenue from Restricted Grants N/A

Table III Initiatives 7- Diabetes		
a. 1. Identified Need 2. Was this identified through the CHNA process?	**CHRONIC DISEASE SHIP OBJECTIVE # 27** Reduce ED visits from diabetes Improve management of diabetes Reduce incidence of diabetes Yes this was identified through the CHNA process.	
b. Hospital Initiative	**Diabetes Education Programs** • Diabetes Education Series • Diabetes Support Group • Radio Broadcasts - 200+ listeners	
c. Total Number of People Within the Target Population	Five County Region	
d. Total Number of People Reached by the Initiative Within the Target Population	Radio Broadcasts - 200+ listeners for health show **Diabetes Support Group:** 8-10 patients attend monthly **Diabetes Education Series "Ask the Dietitian"**: 30 Participants	
e. 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	
f. Single or Multi-Year Initiative Time Period	Multi Year 2008-present	
g. Key Collaborators in Delivery of the Initiative	• Community Senior Centers • UM Center for Diabetes and Endocrinology • Health Departments	
h. Impact/Outcome of Hospital Initiative?	**Diabetes Education Series "Ask the Dietitian":** 30 Participants attended 1 hour session to increase their knowledge on managing their diabetes. All participants made progress on developing strategies to improve nutritional health and healthy lifestyles **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.	
i. Evaluation of Outcomes:	Through Pre and Post seminar survey, population demonstrated improved knowledge of risk factors. Support groups reported better management of diabetes	
j. Continuation of Initiative?	Multi Year 2006-present	
k. Total Cost of Initiative for Current Fiscal Year and What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $4,834 (includes staff salary and supplies Does not include indirect overhead)	B. Direct offsetting revenue from Restricted Grants N/A

Table III Initiatives 8- Chronic Disease		
a. 1. Identified Need 2. Was this identified through the CHNA process?	Chronic Disease Management: Diabetes and Asthma **Reduce diabetes - related emergency department visits.** Emergency department visits for diabetes-related complications may signify that the disease is uncontrolled. **Reduce emergency department visits from asthma.** Asthma is a chronic health condition which causes very serious breathing problems. When properly controlled through close outpatient medical supervision, individuals and families can manage their asthma without costly emergency intervention. Yes this was identified through the CHNA process.	
b. Hospital Initiative	Shore Kids Camp	
c. Total Number of People Within the Target Population	Children with diabetes or asthma	
d. Total Number of People Reached by the Initiative Within the Target Population	This is a 4 day camp for children with diabetes or asthma. Children range in age from 8 to 13.	
e. Primary Objective	• Provide children with learning and networking experience who have diabetes or asthma • Prevent hospitalization of children attending the camp • Promote development of self-management skills for children with diabetes or asthma	
f. Single or Multi-Year Initiative Time Period	Multi-year/ongoing 2008-present	
g. Key Collaborators in Delivery of the Initiative	American Diabetes Association Talbot, Caroline, QA Health Departments	
h. Impact/Outcome of Hospital Initiative?	Track the attendees for one year after attending camp for hospitalizations due to complications from diabetes or asthma	
i. Evaluation of Outcomes:	9 children attended, None of the children who attended camp were reported to be hospitalized with diabetes complications in following year Children who attend camp report feeling “less alone” in their management of their disease. Parents report a feeling of relief to have this time that their child can be having fun while under the professional care of nurses.	
j. Continuation of Initiative?	Yes, yearly 2006-present	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $5,872 (includes staff salary and supplies Does not include indirect overhead)	B. Direct offsetting revenue from Restricted Grants $2,600

Table III Initiative 9- Programs for Aging Population	
a. 1. Identified Need 2. Was this identified through the CHNA process?	Resources, Health Care Programs, Access to Care for Aging Population Yes this was identified through the CHNA process.
b. Hospital Initiative	Lead Sponsor: • Partner in local "Home Ports Annual Aging Symposium" an event that focused on aging issues and trends, and promoting aging in place. • Queen Anne's County Annual Senior Summit, a health fair and aging-related event
c. Total Number of People Within the Target Population	Senior population of QA, Kent, Caroline County
d. Total Number of People Reached by the Initiative Within the Target Population	200-300 participants at each event
e. 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 Symposium, "Healthy Aging- A Community Perspective" on April 2, 2015, 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:*** • Queen Anne's County Annual Senior Summit, May 2015; 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

f. Single or Multi-Year Initiative Time Period	Multi-year initiative and ongoing	
g. Key Collaborators in Delivery of the Initiative	• Shore Regional Health System • 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	
h. Impact/Outcome of Hospital Initiative?	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.	
i. Evaluation of Outcomes:	Shore Regional Health lead sponsor, supported and participated in the 2015 Aging Symposium and provided: • 28 Clinical staff and experts from SRH for presentations and breakout 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, Pulmonary Lung Function screenings There were 200 attendees. Participants were provided with a survey and data/ feedback was collected on the presentations, displays, educational materials and the breakout sessions. <u>Survey Question</u>: Do you plan any changes in the things you normally do as a result of anything you learned or participated in at the Health Fair, such as taking a class or stopping smoking? Yes 66% (29) No 34% (15) How would you rate the Health Fair overall? Excellent 71% (35) Good 29% (16) Fair 0 Poor 0	
j. Continuation of Initiative?	Yes, all listed initiatives are continuing.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $9,580	B. Direct offsetting revenue from Restricted Grants N/A

Table III Initiative 10- Mobile Integrated Community Health Program	
a. 1. Identified Need 2. Was this identified through the CHNA process?	Address the issue of fragmentation of access to health care among medically fragile residents who frequently call 911 for non-life threatening medical reasons.
b. Hospital Initiative	Mobile Integrated Community Health Program http://phpa.dhmh.maryland.gov/cdp/SiteAssets/SitePages/Maryland%20Chronic%20Disease%20Conference/Breakout%201_Health%20Systems_Smith.pdf
c. Total Number of People Within the Target Population	The MICH program focuses on individuals who have utilized 911 services five instances or more within a six-month period. Individuals who qualify for the program can participate voluntarily at no cost, giving them access to a health care team who provide a scheduled home visit.
d. Total Number of People Reached by the Initiative Within the Target Population	26 enrolled individuals in MICH program • First Phase – Frequent 911 Callers • Second Phase – EMS Referrals • Third Phase – Emergency Department Referrals from Free-Standing Emergency Center in Queenstown • Fourth Phase – Shore Regional Health Post-Hospital Discharge
e. Primary Objective	• To improve health outcomes among citizens of the county through multi-agency, integrated, and intervention-based healthcare • To provide mechanisms for citizens to have better access to healthcare and to enhance individual health outcomes
f. Single or Multi-Year Initiative Time Period	Multi-year and ongoing. The program has been active since August 2014
g. Key Collaborators in Delivery of the Initiative	• Queen Anne's County Department of Emergency Services • Queen Anne's County Department of Health • Maryland Institute for Emergency Medical Services Systems (MIEMSS) • University of Maryland Shore Regional Health • Queen Anne's County Commissioners • Queen Anne's County Addictions & Prevention Services • Queen Anne's County Area Agency on Aging • Department of Health and Mental Hygiene • ZOLL Medical Corporation
h. Impact/Outcome of Hospital Initiative?	72 connections were made during 48 visits to enrolled participants in the program. Referrals to: • Home Care/Home Health • Specialty Care • Nutrition Assistance • Transportation Referrals • Informational Resources Provided • Safety Concerns Addressed • All Participants Linked with Primary Care. • All 26 enrolled patients have a primary care provider • 22% reduction in 911 transports to the hospital.

i. Evaluation of Outcomes:	The results of our satisfaction survey are as follows: Questions: 1. After the MICH visit, I feel better equipped to manage my personal health (64% Agree) and (28% Strongly Agree) 2. Did the MICH staff adequately explain the services (43% Agree) and (57% strongly agree) 3. Do you feel as though your quality of life improved after the MICH visit (71% Agree), (14% Disagree), (7% have no opinion) and (7% Strongly Agree) 4. Were the services referred appropriate for your needs (50% Agree), (7% Disagree) and (43% Strongly agree) 5. Would you recommend MICH to others (29% Agree) and (71% Strongly agree) Challenges Faced • Challenges faced with data collection • Dealing with declinations • Issues surrounding social isolation and mental health • Home safety issues • Sustainability	
j. Continuation of Initiative?	Yes, Pilot MICH program continuing.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $50,000- SRH funding of program	B. Direct offsetting revenue from Restricted Grants $50,000- SRH funding of $100,000 program

Table III Initiative 11- Pediatric Dental Program	
a. 1. Identified Need 2. Was this identified through the CHNA process?	Lack of Dental Care/Access for Pediatric Population SHIP Objective: Increase the proportion of individuals receiving dental care
b. 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 esahec.org/services/croc
c. Total Number of People Within the Target Population	All children of low-income families and racial/ethnic minority children, who require general anesthesia for their dental care
d. Total Number of People Reached by the Initiative Within the Target Population	68 pediatric patients
e. 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. The oral health program's objectives are: •Increase access to oral healthcare •Provide oral healthcare services •Increase utilization of services •Improve oral health outcomes •Improve oral health literacy •Reduce barriers to accessing care •Raise awareness about oral health •Adapt and implement promising and evidence-based approaches •Build networks of oral health partners in communities
f. Single or Multi-Year Initiative Time Period	Multi-year and ongoing 2010-present
g. Key Collaborators in Delivery of the Initiative	• Chester River Health/Hospital • Eastern Shore Area Health Education Center • Choptank Community Health System • Shore Regional Health System • Kent County Health Department • Maryland DHMH • Maryland Healthy Smiles • Dr. Margaret McGrath • Dr. Jean Carlson

h. Impact/Outcome of Hospital Initiative?	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.	
i. Evaluation of Outcomes:	The Pediatric Dental Program at Chester River Hospital provided restorative care, both minor and major, to 68 pediatric patients	
j. Continuation of Initiative?	Yes, initiative is continuing.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $3,234 (Does not include indirect overhead)	B. Direct offsetting revenue from Restricted Grants N/A

Table III Initiative 12-Healthy Social Environments: Recovery for Shore	
a. 1. Identified Need 2. Was this identified through the CHNA process?	Drug/ Substance abuse SHIP Objective: Healthy Social Environments #9 and #1 http://dhmh.maryland.gov/data/Documents/Annual%20OD%20Report%202014_merged%20file%20final.pdf
b. Hospital Initiative	UM SRH partnership with Recovery for Shore (RFS) Program, promotes recovery through advocacy, education and support
c. Total Number of People Within the Target Population	Population in recovery
d. Total Number of People Reached by the Initiative Within the Target Population	Participation in community events varies by activity and program. Participation in 15-20 community events attended by over 500 people
e. Primary Objective	The primary objective of this initiative is to: • Raise the awareness about addiction and recovery • Reduce the stigma about addiction and mental disorders • Advocacy for those in recovery • Engage in community activities that celebrate recovery and wellness
f. Single or Multi-Year Initiative Time Period	Multi-year initiative and ongoing 2010-present
g. Key Collaborators in Delivery of the Initiative	• Caroline Counseling Center • Caroline County Prevention Services • Chesapeake Treatment Services • Chesapeake Voyagers, Inc. • Circuit Court of Talbot County, Problem Solving Court • Community Newspaper Project (Chestertown Spy and Talbot Spy) • Dorchester County Addictions Program • Dri-Dock Recovery and Wellness Center • Kent County Department of Health Addiction Services • Mid Shore Mental Health Systems, Inc. • Queen Anne's County Department of Health - Addictions Treatment and Prevention Services • University of Maryland Shore Behavioral Health Outpatient Addictions • Talbot Association of Clergy and Laity • Talbot County Health Department Addictions Program (TCAP) and Prevention • Parole and Probation • Talbot Partnership for Alcohol and Other Drug Abuse Prevention • University of Maryland Shore Regional Health

	• Warwick Manor Behavioral Health	
h. Impact/Outcome of Hospital Initiative?	RFP events and programs: Participation in 15-20 community events raising awareness and providing support those affected by substance abuse, serving 5 counties of Mid-Shore, including: • Out of the Darkness, Suicide Prevention • Advocacy for naloxone, legislative forums in Centreville and Cambridge • Address alcohol, binge drinking, drug/substance abuse through partnerships listed above • Sponsor peer support programs	
i. Evaluation of Outcomes:	• Indicators suggest the quality of life for the target population of those in long-term recovery from alcohol or other drug addiction, improved as a result of the support and advocacy provided by RFS programs.	
j. Continuation of Initiative?	Yes, all listed initiatives are continuing.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $2,000	B. Direct offsetting revenue from Restricted Grants N/A

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

   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.

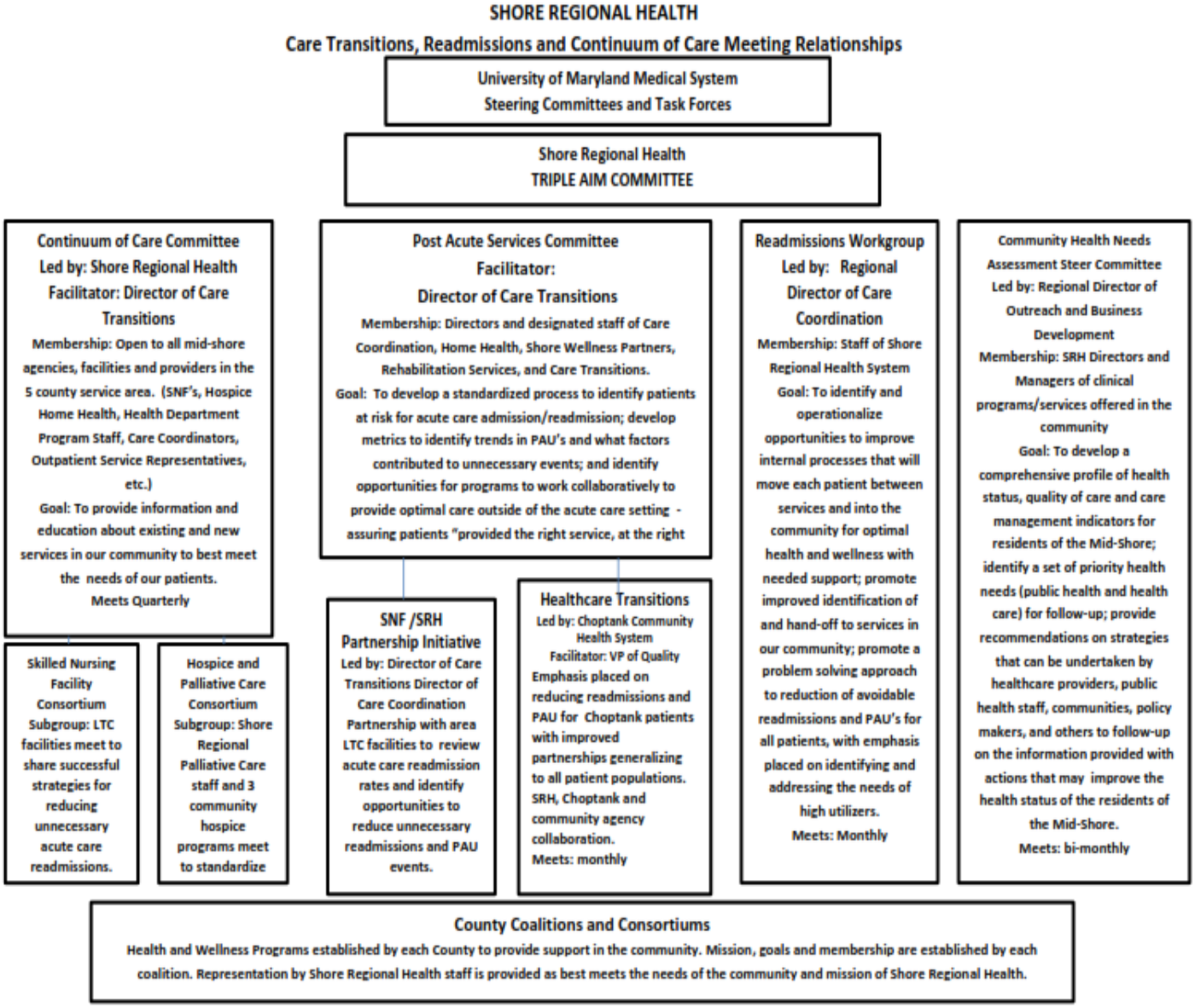
   Several additional topic areas were identified by the CHNA Steering Committee including: safe housing, transportation, and substance abuse. The unmet needs not addressed by UMC at Easton, UMC at Dorchester, UMC at Chestertown will continue to be addressed by key governmental agencies and existing community- 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.

3. **How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)**

   STATE INNOVATION MODEL (SIM) http://hsia.dhmh.maryland.gov/SitePages/sim.aspx
   MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
   http://dhmh.maryland.gov/ship/SitePages/Home.aspx
   HEALTH CARE INNOVATIONS IN MARYLAND
   http://www.dhmh.maryland.gov/innovations/SitePages/Home.aspx
   MARYLAND ALL-PAYER MODEL http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/
   COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

   Shore Regional Health Community Benefits operations/activities work toward the State's initiatives for improvement in population health through:

- Planning and promoting community-and population-based activities to enhance prevention
- Addressing specific health problems that are specific to Maryland State Health Improvement Process (SHIP)
- Expanding access to care for underserved populations, including ED diversion programs and community case management
- Participation in Local Health Improvement Coalitions
- Participation in Health Enterprise Zone for Dorchester and Caroline Counties.
- Partnering with community providers to reduce unnecessary 911 calls, emergency department visits, hospital admissions
- Establishment of the Triple Aim Committee



VI. PHYSICIANS

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

In 2014, Shore Regional Health engaged Southwind, a division of the Advisory Board Company, to conduct a physician needs assessment. The principal objective of the physician needs assessment was to find surpluses or deficits of physicians in the community and document community need. The assessment included development of a roster of every active physician in the community, detailing each physician's specialty or subspecialty, address, age, medical staff status and full-time equivalency (FTE) in the community. The assessment showed shortages in the following areas:

Internal Medicine
Obstetrics / Gynecology
General Surgery
Orthopedic Surgery
Neurology
Family Practice
Gastroenterology

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 FY15

Psychiatry
Neurology
Internal Medicine
Family Medicine
Obstetrics
GYN

VII. APPENDICES

To Be Attached as Appendices:

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

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

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

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

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

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

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

Appendix I and II

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 financial information 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*)

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

SHORE HEALTH SYSTEM UNIVERSITY OF MARYLAND MEDICAL SYSTEM	SLIDING SCALE	POLICY NO:	LD-34
		REVISED:	10/01/14
	ATTACHMENT A TO FINANCIAL ASSISTANCE POLICY	PAGE #:	1 of 1
		SUPERSEDES	08/12

Send to SS to get SSI & bills/ cancer

Size of Family Unit	FPL Income	Approved % of Financial Assistance										
		100%	90%	80%	70%	60%	50%	40%	30%	20%	25% of Income	
1	$11,670	$23,340	$24,507	$25,674	$26,841	$28,008	$29,175	$30,342	$31,509	$32,676	$35,010	$58,350
2	$15,730	$31,460	$33,033	$34,606	$36,179	$37,752	$39,325	$40,898	$42,471	$44,044	$47,190	$78,650
3	$19,790	$39,580	$41,559	$43,538	$45,517	$47,496	$49,475	$51,454	$53,433	$55,412	$59,370	$98,950
4	$23,850	$47,700	$50,085	$52,470	$54,855	$57,240	$59,625	$62,010	$64,395	$66,780	$71,550	$119,250
5	$27,910	$55,820	$58,611	$61,402	$64,193	$66,984	$69,775	$72,566	$75,357	$78,148	$83,730	$139,550
6	$31,970	$63,940	$67,137	$70,334	$73,531	$76,728	$79,925	$83,122	$86,319	$89,516	$95,910	$159,850
7	$36,030	$72,060	$75,663	$79,266	$82,869	$86,472	$90,075	$93,678	$97,281	$100,884	$108,090	$180,150
8	$40,090	$80,180	$84,189	$88,198	$92,207	$96,216	$100,225	$104,234	$108,243	$112,252	$120,270	$200,450

Patient Income and Eligibility Examples:

Example #1	Example #2	Example #3
- Patient earns $56,000 per year - There are 5 people in the patient's family - The % of potential Financial Assistance coverage would equal 90% (they earn more than $55,820 but less than $58,611)	- Patient earns $40,000 per year - There are 2 people in the patient's family - The % of potential Financial Assistance coverage would equal 40% (they earn more than $39,325 but less than $40,898)	- Patient earns $54,000 per year - There is 1 person in the family - The balance owed is $20,000 - This patient qualifies for Hardship coverage, owes$13,500 (25% of $54,000)

Notes: FPL = Federal Poverty Levels

Effective:	10/14

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Appendix IV

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

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 V

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