Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area zip codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of the Hospital's Patients who are Uninsured:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
Adults: 281 Newborn: 28	Adults: 17,237 Newborn: 1911	21804 21801 21853 21811 21851 21875 21826 21817 21842 21863	Atlantic General Hospital McCready Memorial Hospital	Review of Hospital Discharge Data: Wicomico 1.70% Worcester .88% Somerset 1.16%	Review of Hospital Discharge Data: Wicomico 31.64% Worcester 27.55% Somerset 34.95%	Review of Hospital Discharge Data: Wicomico Medicare 42.72% Medicare HMO .40% Worcester: Medicare 42.99% Medicare HMO .63% Somerset Medicare 43.75% Medicare HMO .34%

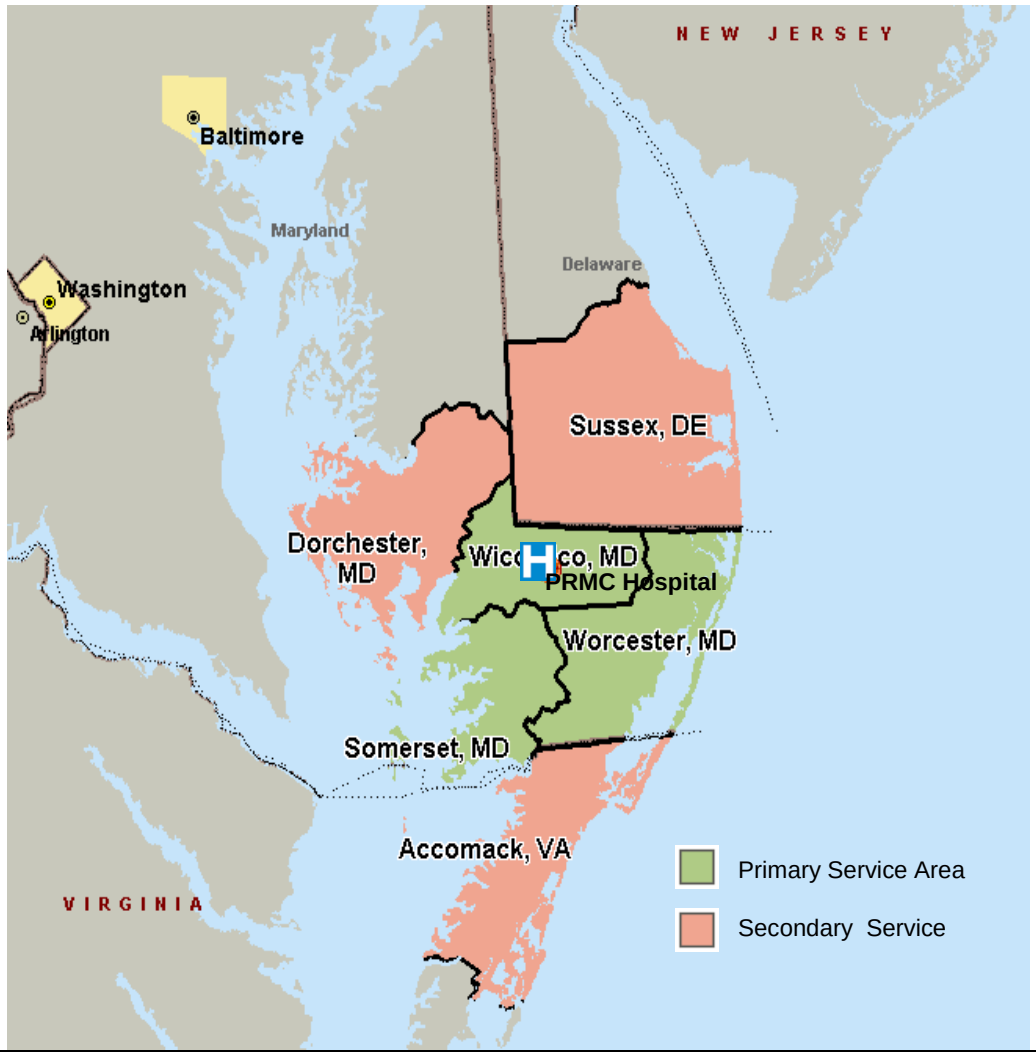
TABLE II	Demographic Characteristic

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

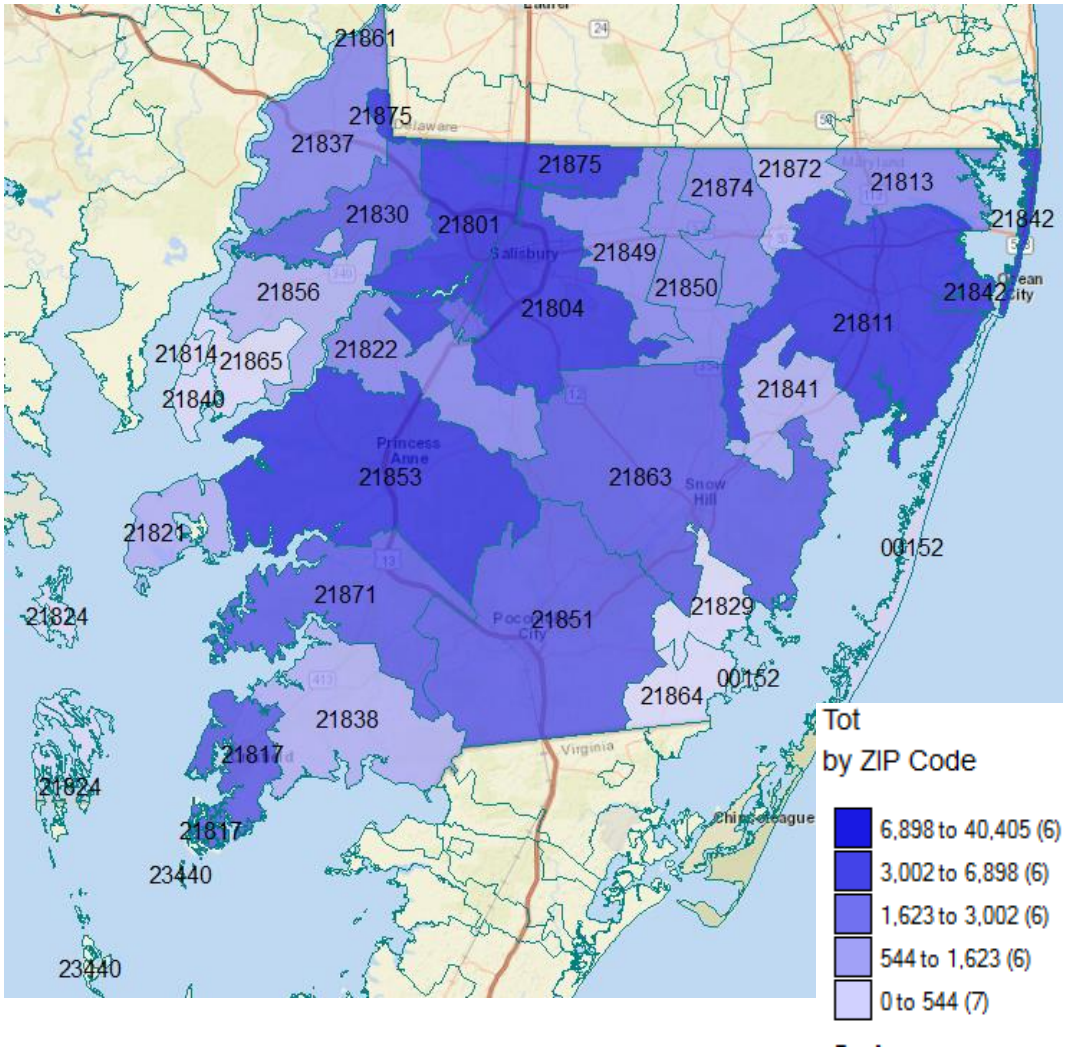
(i) A list of the zip codes included in the organization's CBSA

The Community We Serve

Peninsula Regional Medical Center functions as the primary Hospital provider for the rural southernmost three counties of the Eastern Shore of Maryland, which includes Wicomico, Worcester and Somerset Counties (highlighted in green). In FY 2017, approximately 77% of the patients discharged from the Medical Center were residents of the primary service area, which has an estimated population of approximately 180,533 in 2017 and is expected to increase to 184,828 in 2022, or by 2.4%. The primary service area population has grown by an estimated 5% since 2010. The fastest growing and largest age cohort in our primary service area is represented by those 55 and older. This seniors' age category represents 32% our population which is 4% higher than the national distribution rate of 28%. This age-cohort has a per capita consumption of health services 3 times more than younger adults. The older adults also have vastly different needs and nearly 80% of seniors have been diagnosed with 1 chronic condition, and half have been diagnosed with at least 2.



Peninsula Regional's CBSA consists of those zip codes within our primary service area. The majority of the population resides in Wicomico County (104,756) with Salisbury serving as the capital of the Eastern Shore. Salisbury is located on the headwaters of the Wicomico River and it is located at the crossroads of the Bay and the Ocean. The region is unique; the city of Salisbury has similar socio-economic and demographic characteristics of a large city, however, the area surrounding Salisbury is rural and has like-kind characteristics of small town America. Due to this dichotomy, serving both sometimes presents a challenge in delivering healthcare. The two other counties in Peninsula Regional's CBSA include Worcester County, with a population of 52,052 and Somerset County with a population of 23,881. The map below identifies Peninsula Regional's CBSA by zip codes by population density.



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

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

greater Salisbury area, the landscape and environment is considered rural, made up of small businesses and agriculture.

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

The three counties have a diversified economic base; however, it is predominately made up of small employers (companies with less than 50 employees). Major employers include local hospitals, the chicken industry, local colleges and teaching institutions. The median income in our Community Benefits Service Area is considerably less than $54,131, compared to Maryland's median income of $77,385. In addition, 2015 unemployment rates were higher for Maryland's most Eastern Shore counties. The unemployment rate in Maryland was 5.2%, the Nation 5.3% compared to Wicomico 6.0%; Worcester 8.6%; and Somerset 8.1%. Research indicates lower median incomes and higher unemployment rates contribute to a disparity in access to medical care and a prevalence of untreated chronic disease.

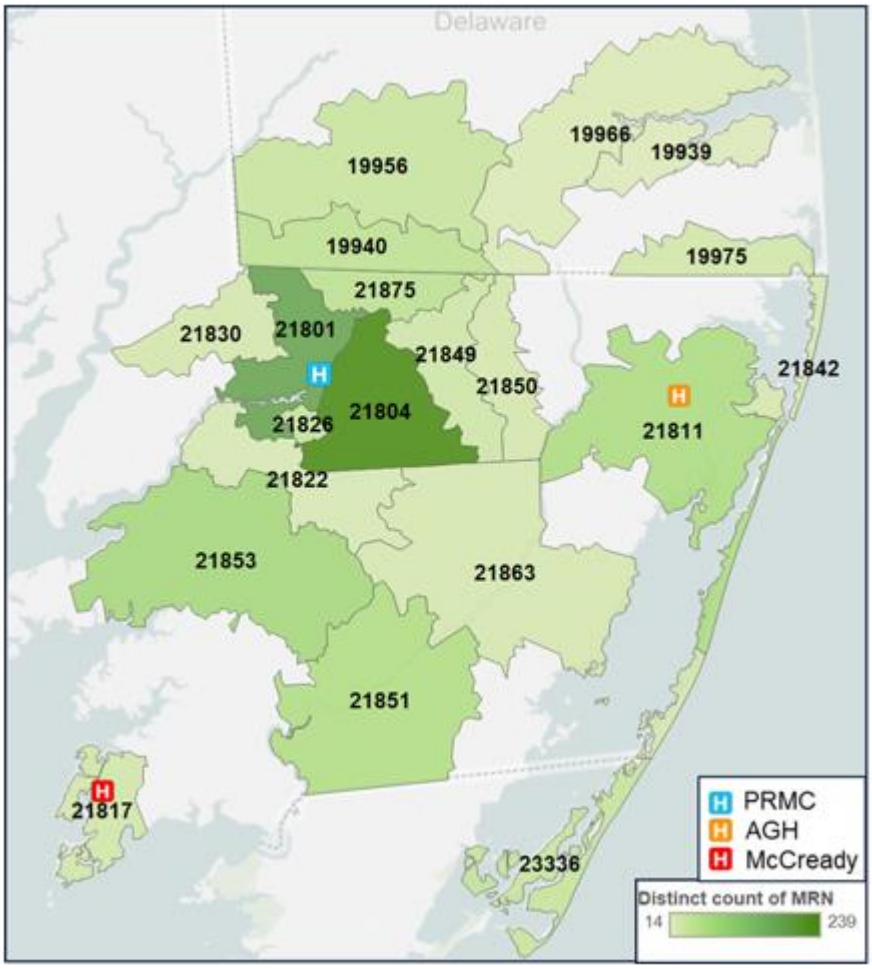
(iii) Describe how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the community definition section of the organization's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

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

- Demographics (block groups, zip codes)
- Race/Ethnicity
- Age-Cohorts
- Chronic Conditions
- Isolated and Disparate Communities that have Access Issues
- Underserved/Economically Depressed Block Group Populations

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

Medicare Proxy High Utilizers by Zip Code FY2015



Source: BRG Healthcare Consultants

Peninsula Regional is targeting CBSA zip codes based upon social and economic determinants of health to include the uninsured, indigent population, residents who lack transportation, lack of education and availability of healthy foods. Targeting this by cluster and block groups, we seek to impact the health by providing primary health services, education, access and more importantly by fostering relationships within the community we serve. For example, our Wagner Wellness Van travels locally to block groups where there was an identified need for basic health services, in addition to providing health services and education to local ethnic churches and civic organizations.

Peninsula Regional's Wellness Wagner Van in collaboration with Atlantic General Hospital (AGH) and McCready Hospital is delivering healthcare, education and support services to those in underserved and low income communities and neighborhoods.

- The Wagner Wellness Van is used to make "rounds" on patients in their communities.
- The van is targeting communities with high ED utilization and readmissions as well as isolated and disparate communities where access to primary care and/or transportation is problematic
- The van will assist patients in managing their chronic conditions who live remotely from

providers

- AGH and McCready will each provide a nurse to assist in staffing the Wagner Van. Each nurse will staff the van when the van is in locations that are primarily AGH or McCready. PRMC will supply the van, other staffing and equipment
- The Wagner Van staff will assist patients in accessing health insurance and by helping eligible patients enroll in appropriate insurance coverage.

Current population health efforts include:

- PRMC and AGH are each building large physician networks which are geared toward value-based care and care management models.
- PRMC and AGH have successfully integrated programs that include: High risk assessment tools for readmission identification for inpatients, and 'community plan of care'.
- PRMC physicians call on the care transitions teams employed by PRMC for post-discharge follow-up. Physicians also draw on community health workers employed by the Health Department, Maintaining Active Citizens (MAC), and Peninsula Home Care for extended patient management. Similarly, AGH places all current health system patients transitioning from acute care into the "transitions of care" for 30 days post-discharge.
- All three hospitals are learning about other resources that are available to the region, as well as learning that other resources such as a Network of Care are needed. Currently, each works closely with a network of health care and social service agencies - - including home health agencies, 3 county Health Departments, the YMCA, MAC, the local FQHC, and local churches.
- AGH and Berlin Nursing and Rehabilitation Center (BNRC) have put into place a telehealth partnership to prevent avoidable transfers, admissions and readmission to the acute care setting. Through this program, which also included comprehensive use of Interact care protocols, they were able to reduce readmissions for patients discharged from AGH to BNRC from 63% to < 20%, and sustain this gain for over six months. The expectation is that through this regional effort we will expand the use of this technology and of Interact tools to other facilities in the region.

PRMC CBSA

Race/Ethnicity	CBSA Primary Service Area		USA % of Total
White Non-Hispanic	119,583	66.5%	61.3%
Black Non-Hispanic	42,794	23.8%	12.3%
Hispanic	8,710	4.8%	17.8%
Asian & Pacific Non-Hisp.	4,087	2.3%	5.4%
All Others	4,578	2.5%	3.1%
Total	**179,752**	**100%**	**100.0%**

Source: Truven Health Analytics 2016

Within our CBSA, Wicomico has the highest Hispanic/Latino population at 6%, though all three counties have smaller percentages compared to Maryland. Worcester has the highest percentage of Whites (81%), whereas Somerset has the lowest percentage (52%). Somerset has the largest

proportion of Black/African Americans (43%), whereas Worcester has the lowest (14%). The other race groups comprise a tiny sliver of the tri-county population in comparison.

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

CBSA Population Age-Cohorts

Age Group	2016 Population	% of Total	USA 2016 % of Total
0-14	29,571	16.5%	19.0%
15-17	6,606	3.7%	4.0%
18-24	23,217	12.9%	9.8%
25-34	21,588	12.4%	13.3%
35-54	41,596	23.1%	26.3%
55-64	24,287	13.5%	12.8%
65+	32,887	18.3%	15.1%
Total	**179,752**	**100.0%**	**100.0%**

CBSA Population Sex

Population	Primary Service Area
Female Population	88,106
Male Population	91,646
Child Bearing	34,835

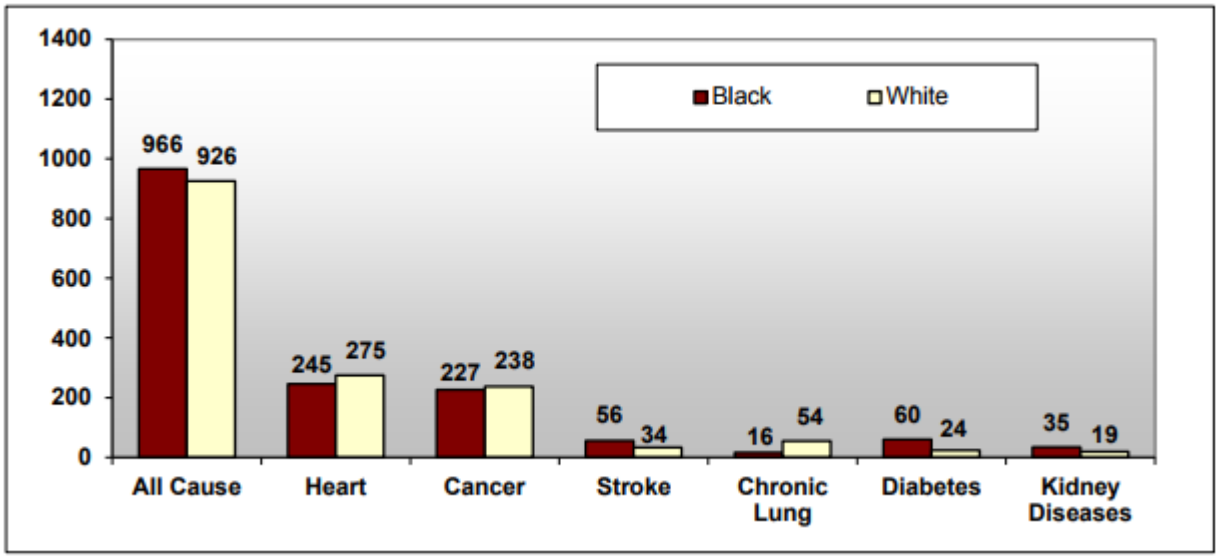
Source: Truven Health Analytics 2016

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

Wicomico County

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

Age-Adjusted Morality Rates (per 100,000), Selected Causes of Death for African American and Whites, Wicomico County most current data available.

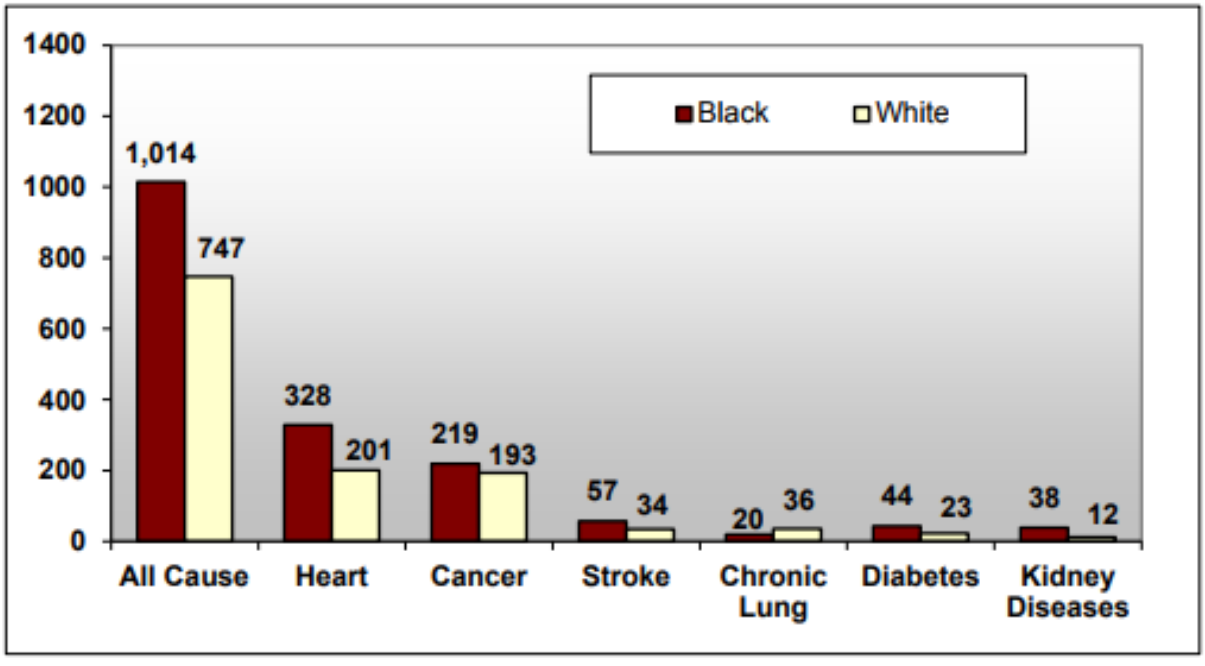


Source: CDC Wonder online database, Compressed Mortality files 2005-2009.

Worcester County

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

Age-Adjusted Mortality Rates (per 100,000), Selected Cause of Death for African Americans and Whites, Worcester County, Maryland 2005-2009 most current data available.

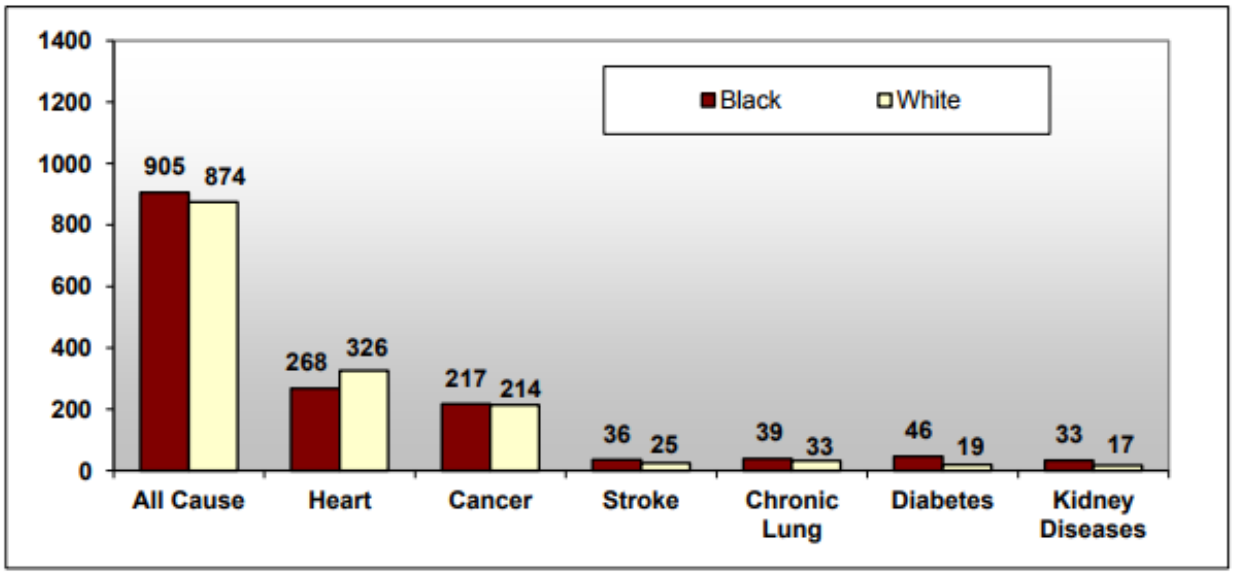


Source: CDC Wonder online database, Compressed Mortality files 2005-2009.

Somerset County

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

Age-Adjusted Mortality Rates (per 100,000), Selected Cause of Death for African Americans and Whites, Somerset County, Maryland 2005-2009 most current data available.



Source: CDC Wonder online database, Compressed Mortality files 2005-2009.

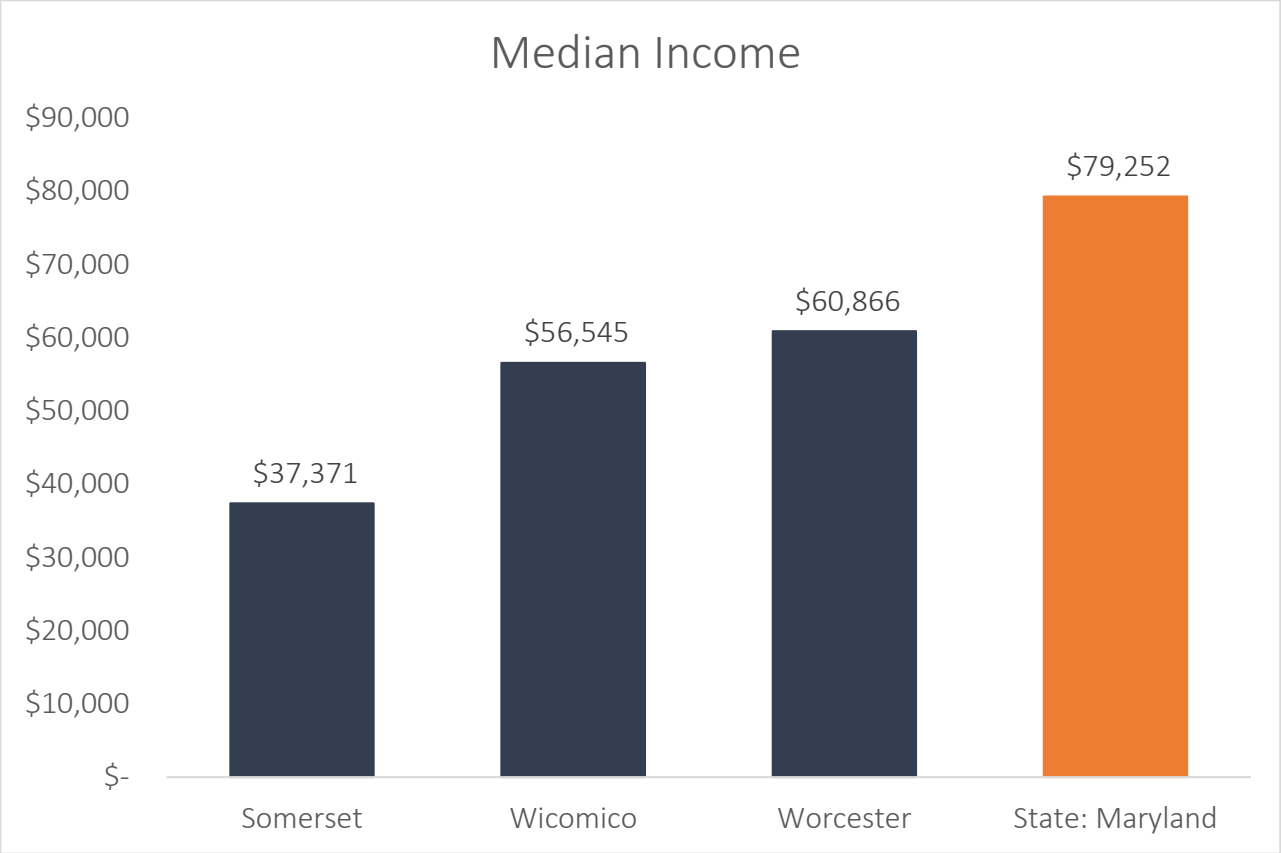
Chronic Disease Management

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

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

Median Household Income within the CBSA

The median household income values in all three counties are lower than that of Maryland. Somerset has the lowest median household income in the tri-county service area with a value that is $37,371 which is half that of the State of Maryland's median income. Worcester has the highest median household income in the service area at $60,866.



Source: HCI Healthy Communities Inc. 2017

Percentage of households in the CBSA with household income below the federal poverty guidelines

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

Somerset County is ranked one of the poorest counties in Maryland with children living below the poverty level at 39.7% compared to the Maryland value of 13.3%. Families living in poverty within Somerset County is very high at 20.3% compared to Maryland value of 7.0% Wicomico County has both children and families that are living in poverty that are substantially higher than Maryland.

Children Living Below Poverty Level

	VALUE	COMPARED TO:				
County: Somerset, MD	39.7% (2011-2015)	 MD Counties	 U.S. Counties	 MD Value (13.3%)	 US Value (21.7%)	 Prior Value (34.2%)	 Trend
County: Wicomico, MD	20.0% (2011-2015)	 MD Counties	 U.S. Counties	 MD Value (13.3%)	 US Value (21.7%)	 Prior Value (23.3%)	 Trend
County: Worcester, MD	15.5% (2011-2015)	 MD Counties	 U.S. Counties	 MD Value (13.3%)	 US Value (21.7%)	 Prior Value (15.3%)	 Trend

Families Living Below Poverty Level

	VALUE	COMPARED TO:		
County: Somerset, MD	20.3% (2011-2015)	 MD Counties	 U.S. Counties	 MD Value (7.0%)
		 US Value (11.3%)	= Prior Value (17.9%)	 Trend
County: Wicomico, MD	11.1% (2011-2015)	 MD Counties	 U.S. Counties	 MD Value (7.0%)
		 US Value (11.3%)	= Prior Value (11.5%)	 Trend
County: Worcester, MD	7.6% (2011-2015)	 MD Counties	 U.S. Counties	 MD Value (7.0%)
		 US Value (11.3%)	= Prior Value (7.1%)	 Trend

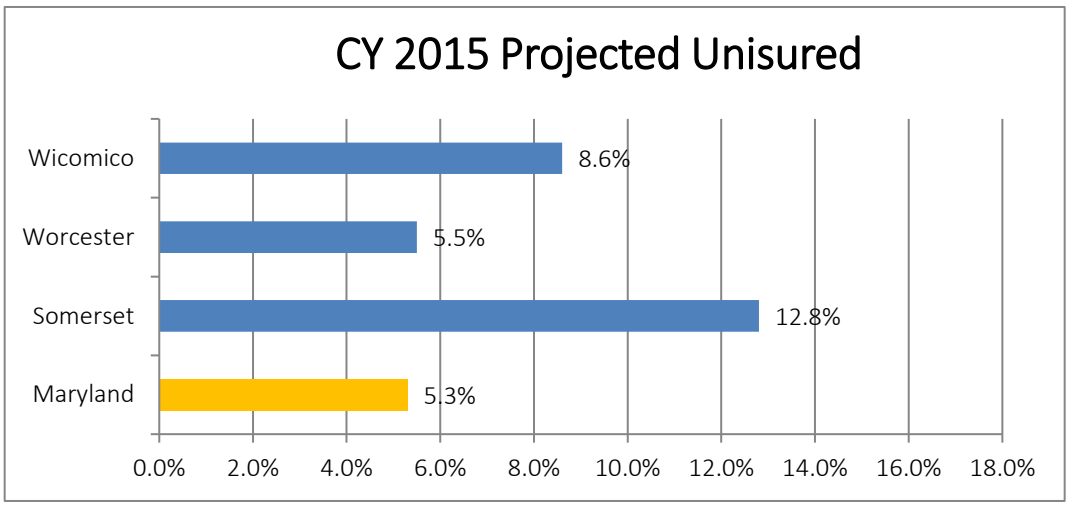
People 65+ Living Below Poverty Level

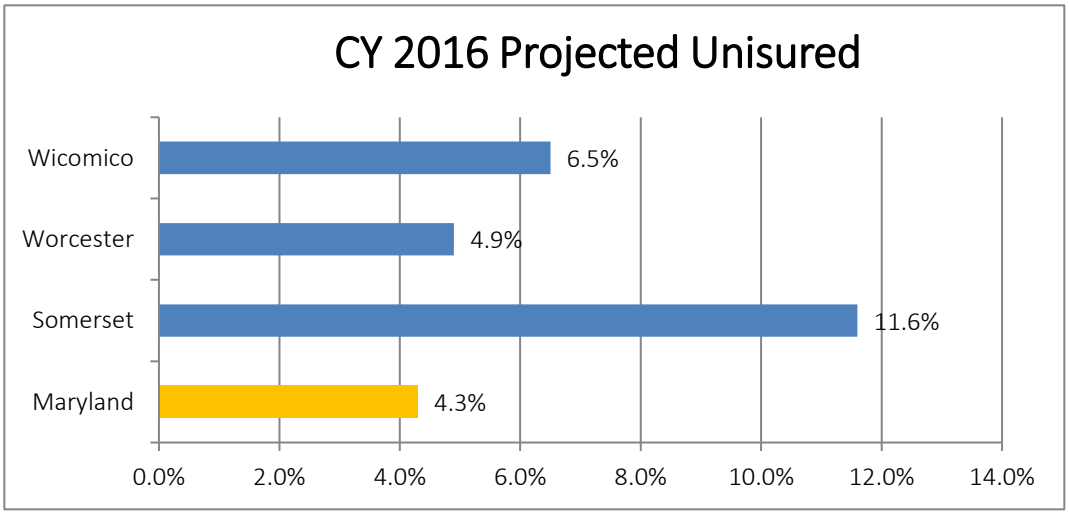
	VALUE	COMPARED TO:		
County: Somerset, MD	10.3% (2011-2015)	MD Counties	U.S. Counties	MD Value (7.5%)
		US Value (9.4%)	Prior Value (9.3%)	Trend
County: Wicomico, MD	7.4% (2011-2015)	MD Counties	U.S. Counties	MD Value (7.5%)
		US Value (9.4%)	Prior Value (8.2%)	Trend
County: Worcester, MD	6.4% (2011-2015)	MD Counties	U.S. Counties	MD Value (7.5%)
		US Value (9.4%)	Prior Value (6.3%)	Trend

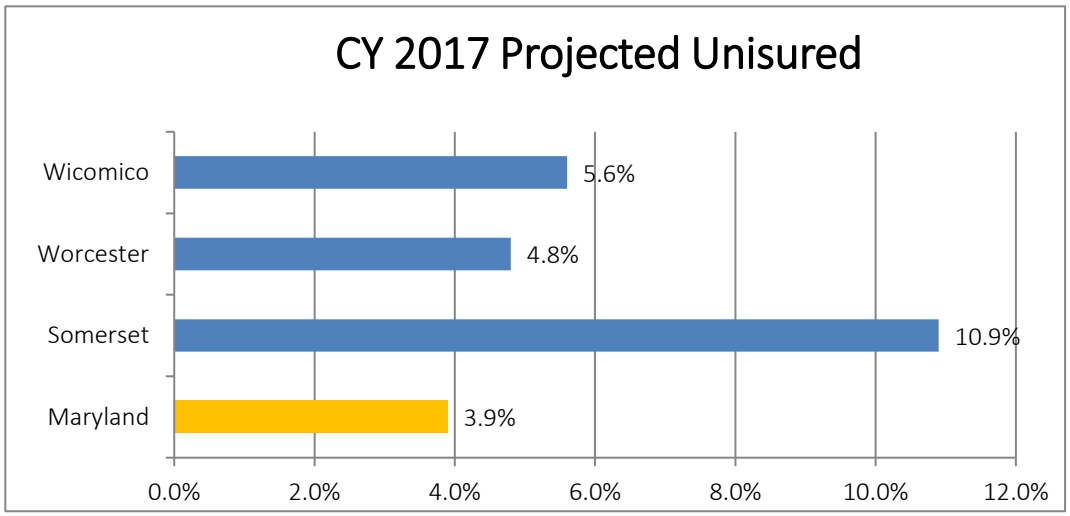
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links:

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

Over the most current three years the total number of projected uninsured continues to decrease, primarily due to an increase in Medicaid enrollees and enrollment in various private and public health exchanges. However, compared to Maryland, Peninsula Regional's CBSA, specifically Wicomico and Somerset County, still has a greater percentage of its population uninsured. Somerset County's uninsured is 10.9%- twice the amount of Maryland.



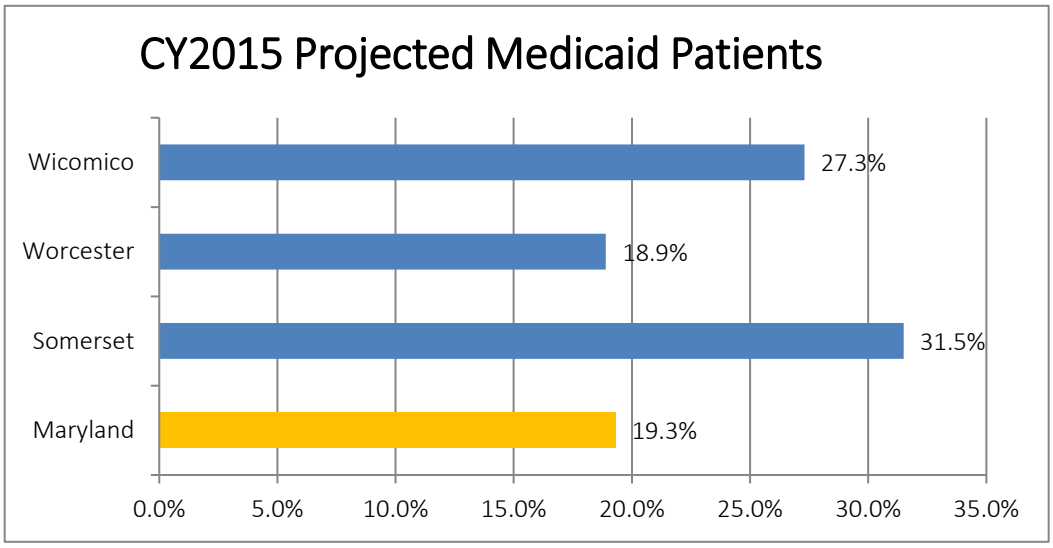


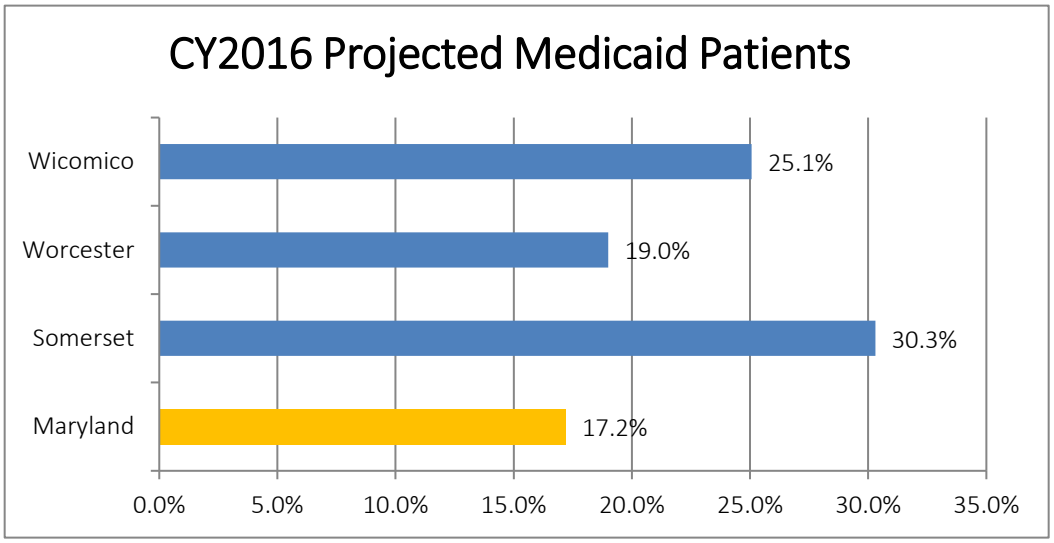


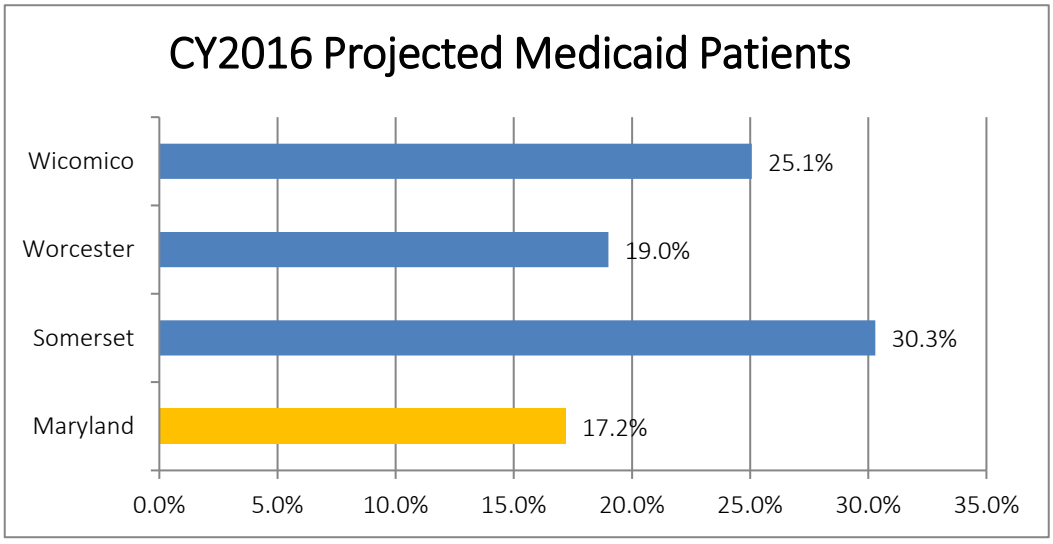
Source: Truven Health Analytics 2015, 2016, 2017

Percentage of Medicaid recipients by County within the CBSA.

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







Source: Truven Health Analytics 2015, 2016, 2017

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

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

The life expectancy in all three counties is 3-8% below the Maryland SHIP Target of 82.5 years. Worcester County is very close to meeting the SHIP target of 82.5 years; however, there is a gap of 5 years between Black/African Americans and White residents. Both Somerset and Worcester are 5 years behind in meeting the Maryland SHIP longevity target. The top leading causes of death in our CBSA area are heart-related and cancer-related diseases, which as a percentage are higher than other Maryland counties. Supporting social determinants indicate an underlying lack of healthy lifestyle adoption/education, poverty, and lack of chronic disease management/education.

County	Life Expectancy	Maryland SHIP Target
Wicomico All	77.4	82.5
Black	75.6	82.5
White	77.9	82.5
Worcester All	79.4	82.5
Black	74.5	82.5
White	80.2	82.5
Somerset All	76.3	82.5
Black	75.8	82.5
White	76.0	82.5

Source: Most current available Maryland Vital Statistic Report 2015

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

Crude Death Rate
The crude death rate for Wicomico County is 885.0, Worcester County 1,263.1, and Somerset County 958.6, all higher than Maryland at 786.4 deaths/100,000. The large crude death rates reflect multiple factors: specifically, a more aging 65+ population, in addition to healthcare access issues, cultural and lifestyle characteristics not conducive to healthy lifestyles, and lack of education regarding chronic disease management in rural areas.

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

Diseases of the Heart Age-Adjusted Death Rates (2013-2015)
For diseases of the heart, several counties' age-adjusted death rates are much higher than the Maryland average:
Wicomico: 46.4% higher heart age-adjusted death rate than MD.
Worcester: 6.8% higher heart age-adjusted death rate than MD.
Somerset: 88.4% higher heart age-adjusted death rate than MD.

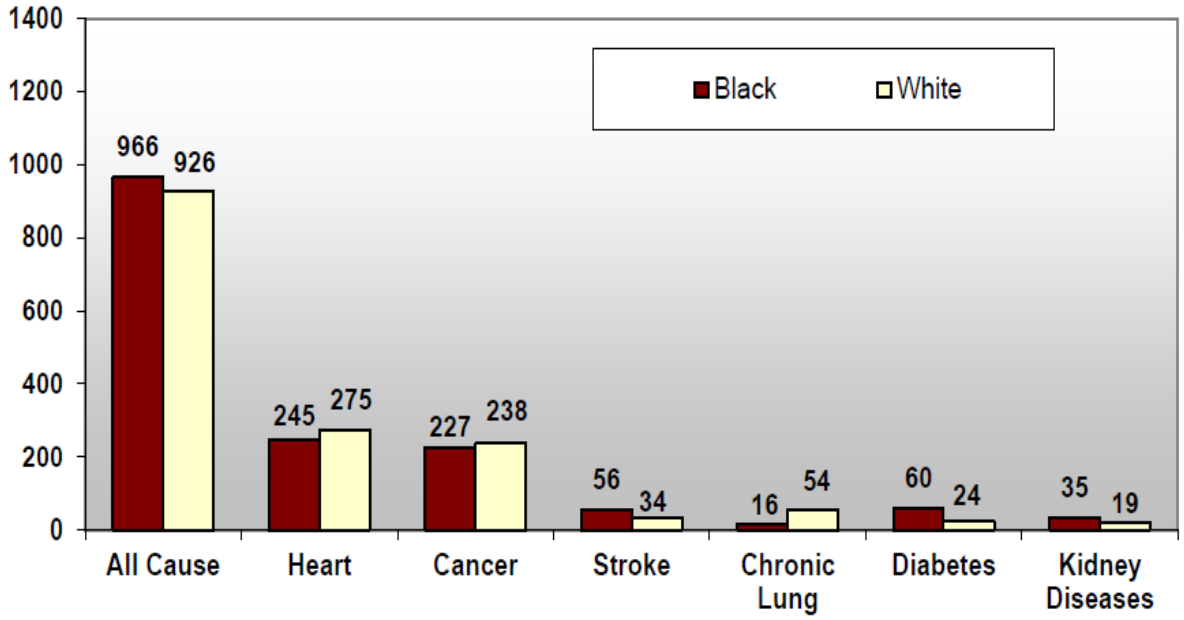
Malignant Neoplasms Age-Adjusted Death Rates (2013-2015)
For malignant neoplasms, all counties' age-adjusted death rates are higher than Maryland.
Wicomico: 27.7% higher malignant neoplasm age-adjusted death rate than MD.
Worcester: 13.2% higher malignant neoplasm age-adjusted death rate than MD.
Somerset: 19.1% higher malignant neoplasm age-adjusted death rate than MD.

Chronic Lower Respiratory Diseases Age-Adjusted Death Rates (2013-2015)
For chronic lower respiratory diseases, all counties' age-adjusted death rates are higher than Maryland:
Wicomico: 49.7% higher chronic lower respiratory diseases age-adjusted death rate than MD.
Worcester: 24.0% higher chronic lower respiratory age-adjusted death rate than MD.

Source: Most current available Maryland Vital Statistics Report 2015

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

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

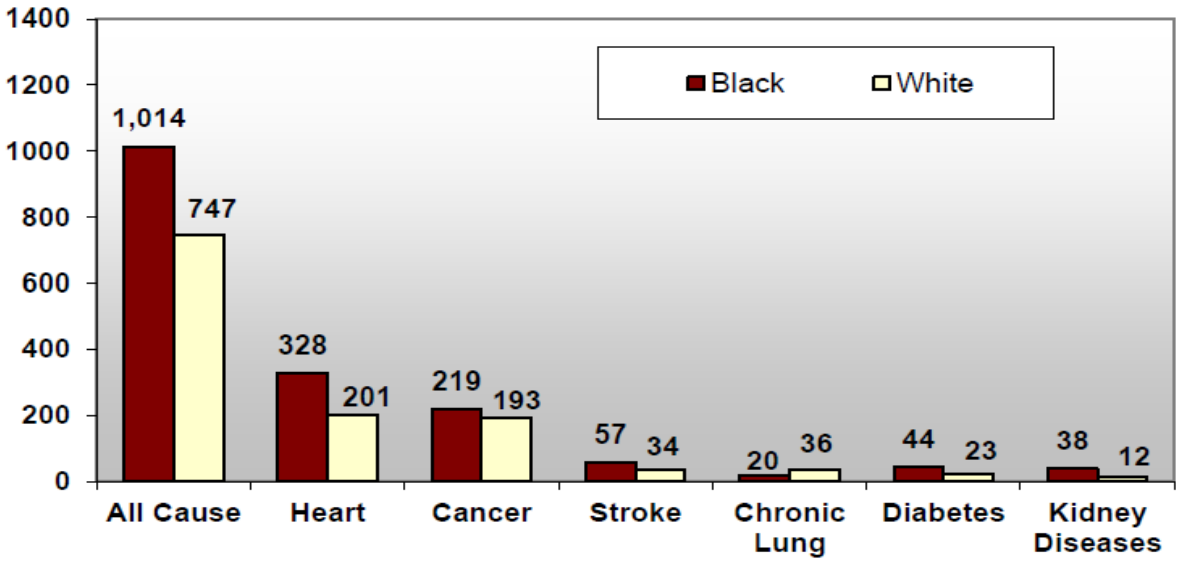


Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

Worcester County

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

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

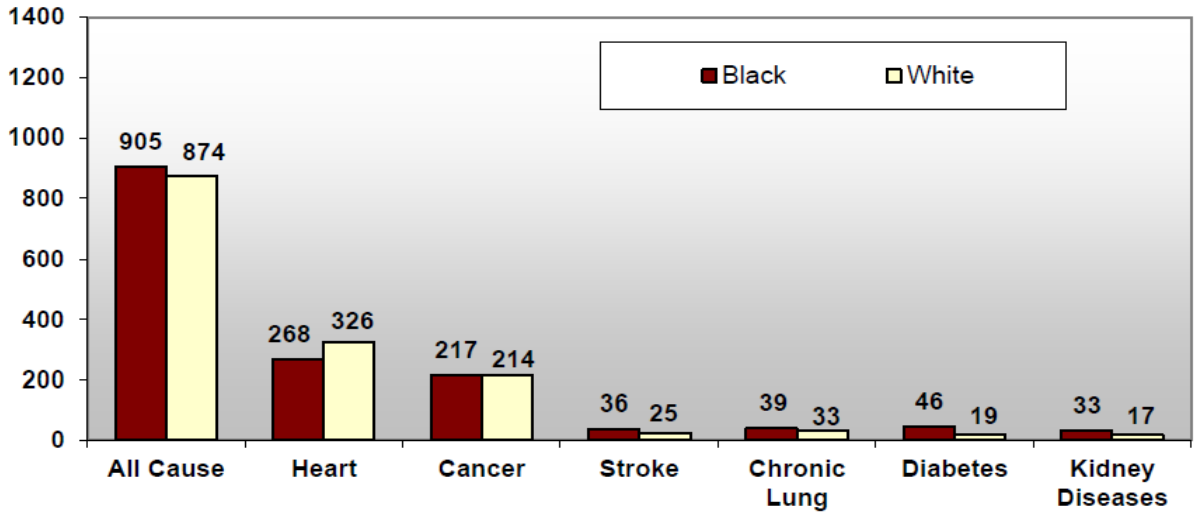


Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

Somerset County

Blacks or African Americans in Somerset County had higher mortality rates than Whites for all-cause mortality and for five of top six causes of death.

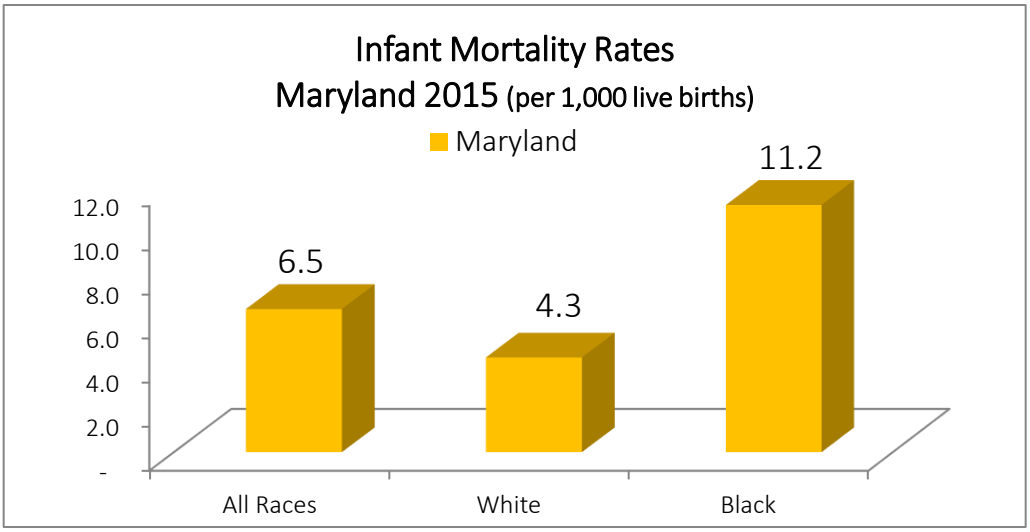
The diabetes mortality rate for Blacks or African Americans was 2.4 times higher than for Whites; and the kidney disease mortality rate was 1.9 times higher for Blacks or African Americans.



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

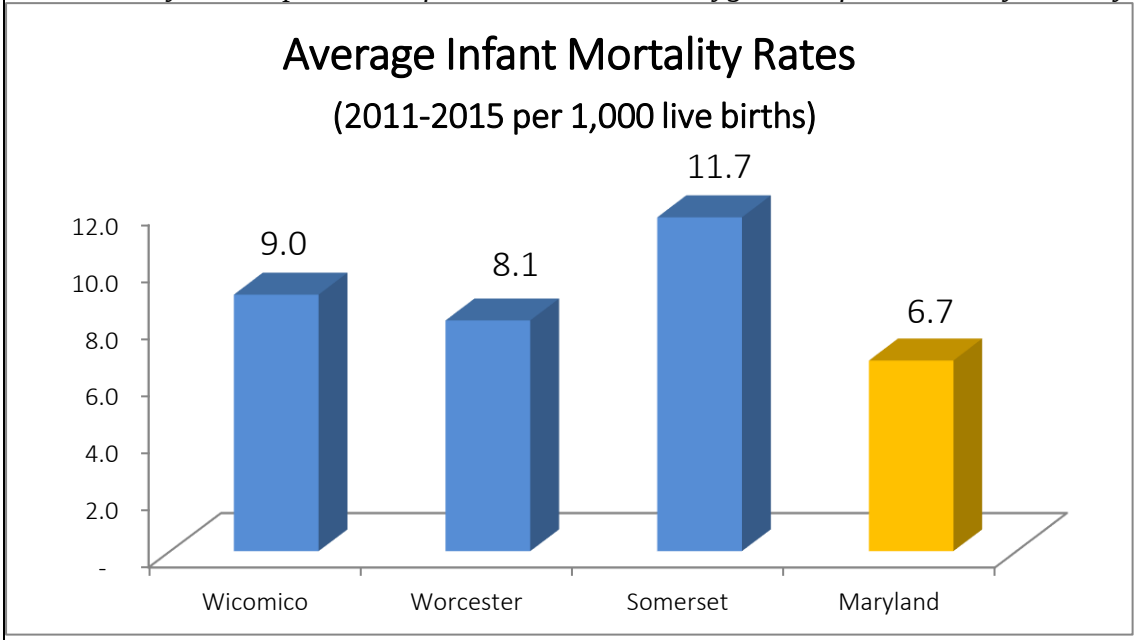
Source: Maryland Chartbook of Minority Heath and Minority Health Disparities Data 2012.

According to the 2015 Maryland Vital Statistics, the average infant mortality rate has fallen by 14% in Maryland over the past decade, with an 11% decline in the average rate among white infants and a 17% decline among black infants,



Despite the statewide decline in infant mortality rate over the past decade, the Lower Eastern Shore's average infant mortality rate has increased by 23% between 2006-2010 and 2011-2015.

Source: Maryland Department of Health and Mental Hygiene, Infant Mortality in Maryland, 2015

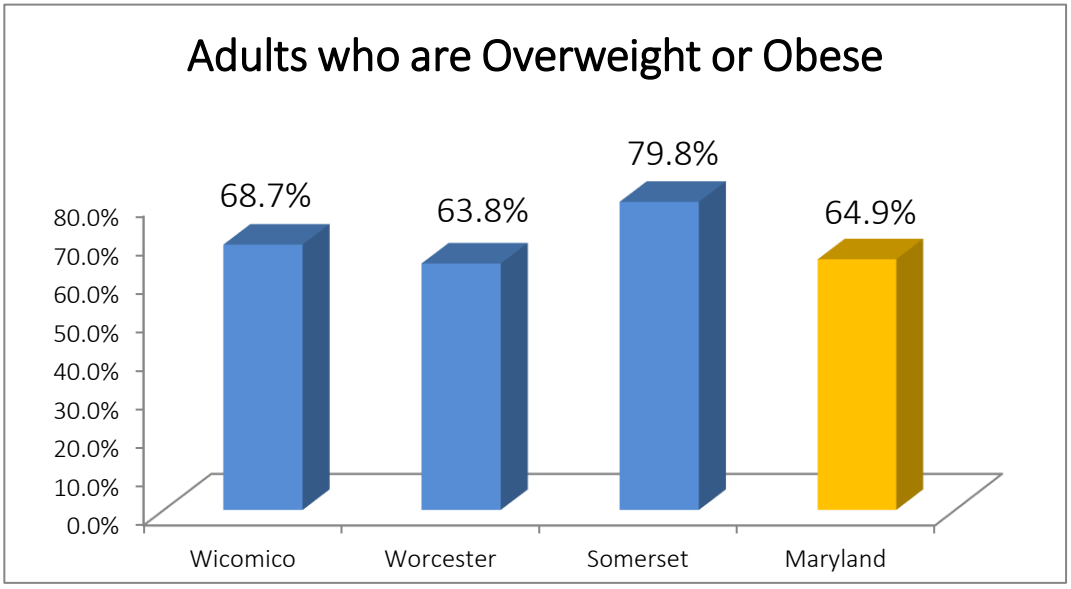


Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials,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

Access to Healthy Food
Healthy Food/Healthy Lifestyle Environmental Factors
Obesity continues to be a health issue in Wicomico, Worcester and Somerset Counties. Somerset County has a high percentage of adolescent obesity: 17.5% compared to the Maryland SHIP 2017

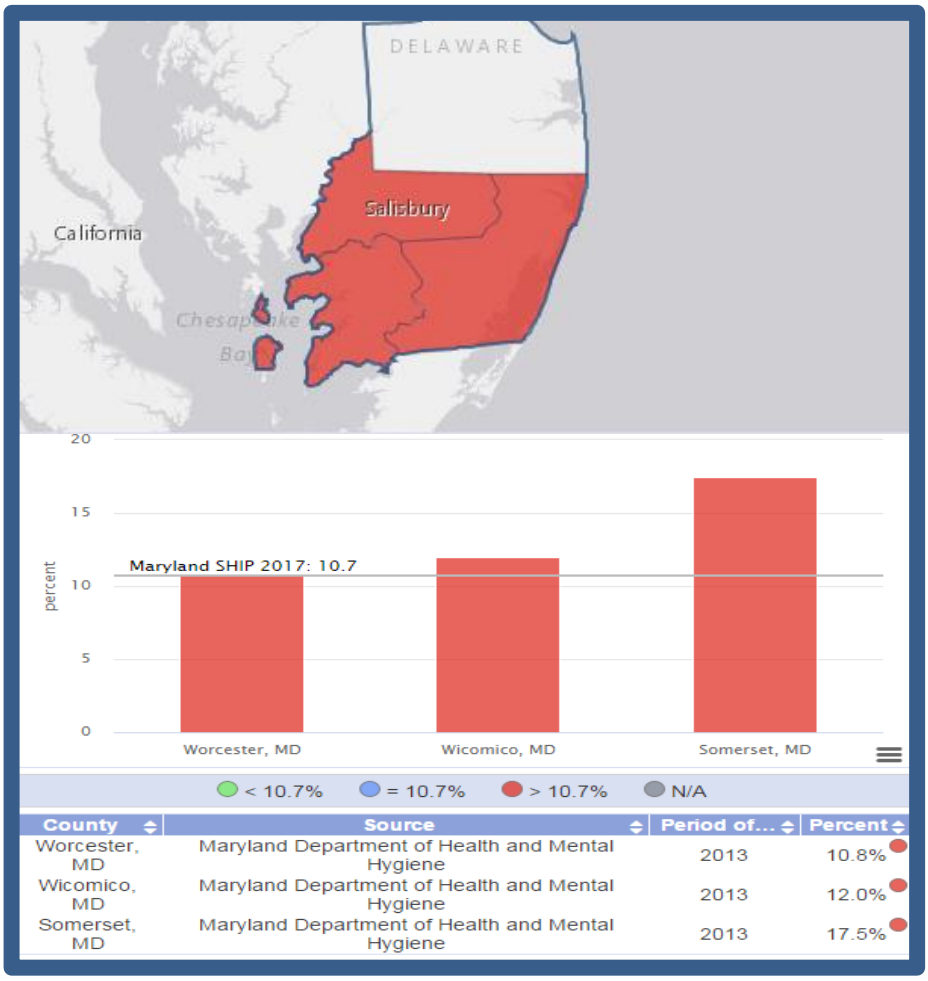
target of 10.7%. The tri-county area has a higher percentage of overweight or obese adults than Maryland, and is an indicator of general overall health. Additional weight and obesity increases the risk of many diseases and health conditions. These include type 2 diabetes, cancer, hypertension, stroke, liver, gallbladder and respiratory problems, all of which we are experiencing. Being obese also carries significant economic costs due to increased healthcare spending.

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



Source: HCI Healthy Communities Inc.

Adolescent Obesity



County	Source	Period of...	Percent
Worcester, MD	Maryland Department of Health and Mental Hygiene	2013	10.8%
Wicomico, MD	Maryland Department of Health and Mental Hygiene	2013	12.0%
Somerset, MD	Maryland Department of Health and Mental Hygiene	2013	17.5%

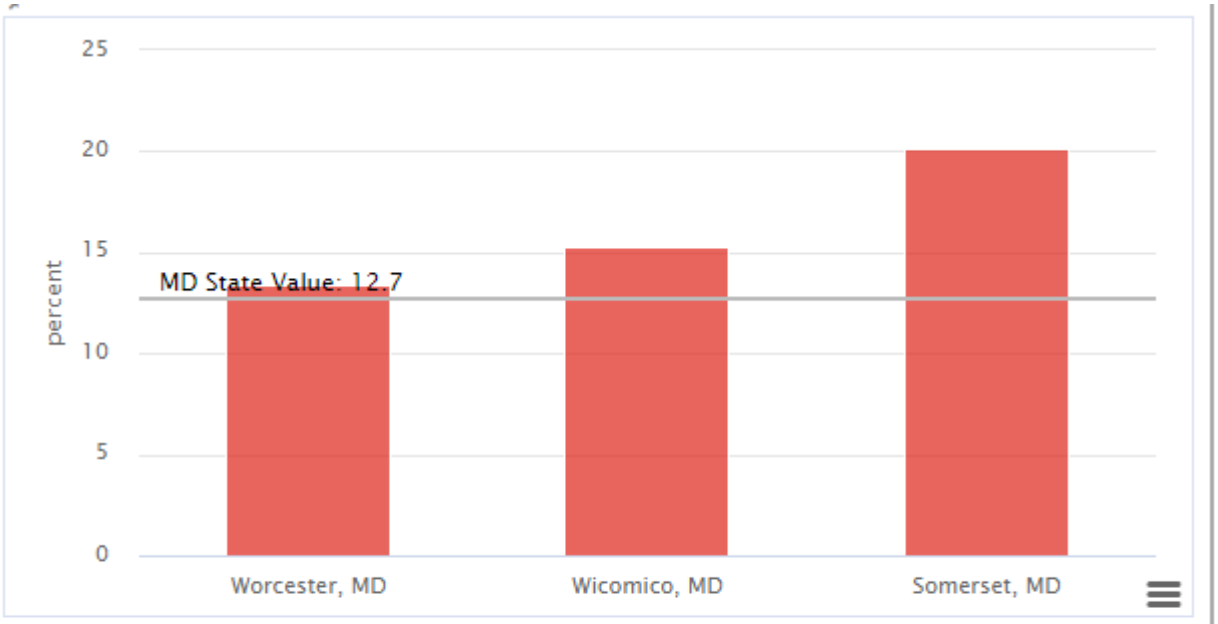
Source: HCI Healthy Communities Inc.

Food Insecurity

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

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

Food Insecurity Rate



County	Source	Period of Measu...	Percent
Worcester, MD	Feeding America	2014	13.4%
Wicomico, MD	Feeding America	2014	15.3%
Somerset, MD	Feeding America	2014	20.1%

Source: HCI Healthy Communities Inc.

Grocery Store Density

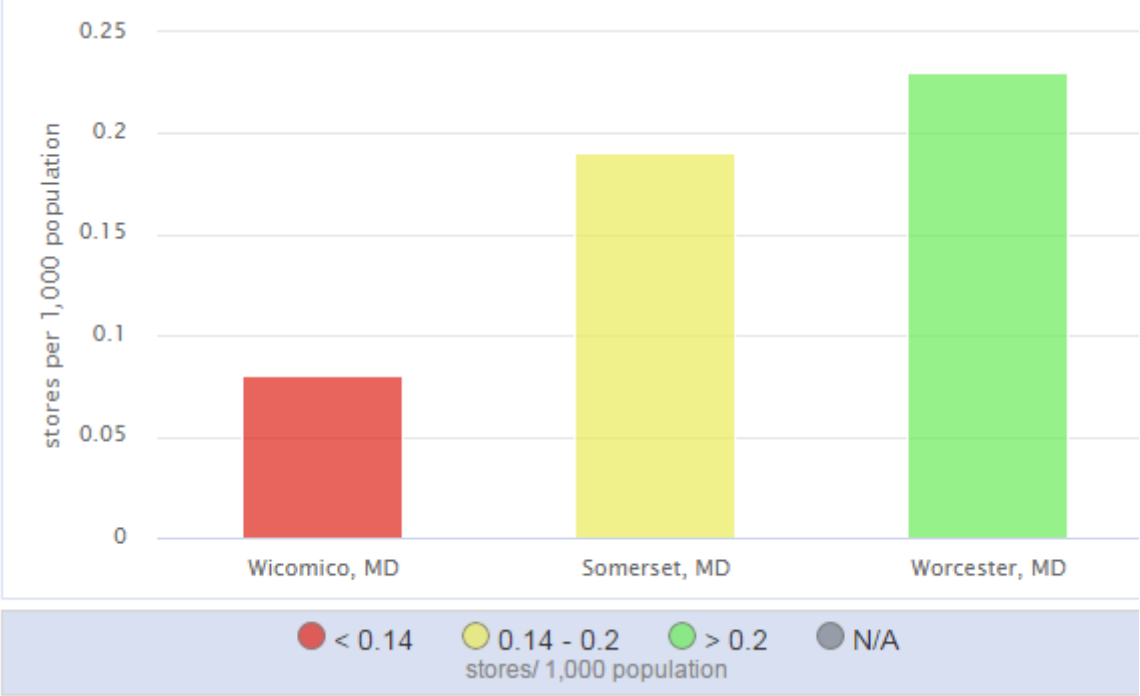
There are strong correlations between the density of grocery stores in a neighborhood and the nutrition and diet of its residents. The availability and affordability of healthy and varied food options in the community increase the likelihood that residents will have a balanced and nutritious diet.

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

Source: HCI Healthy Communities Inc.

Adult Fruit and Vegetable Consumption

Based upon Maryland's most recent Behavioral Risk Factor Surveillance System, adults living in Wicomico and Somerset counties are not consuming adequate amounts of fruits and vegetables in their diet. This statistic indicates that an opportunity exists for education about healthy lifestyle



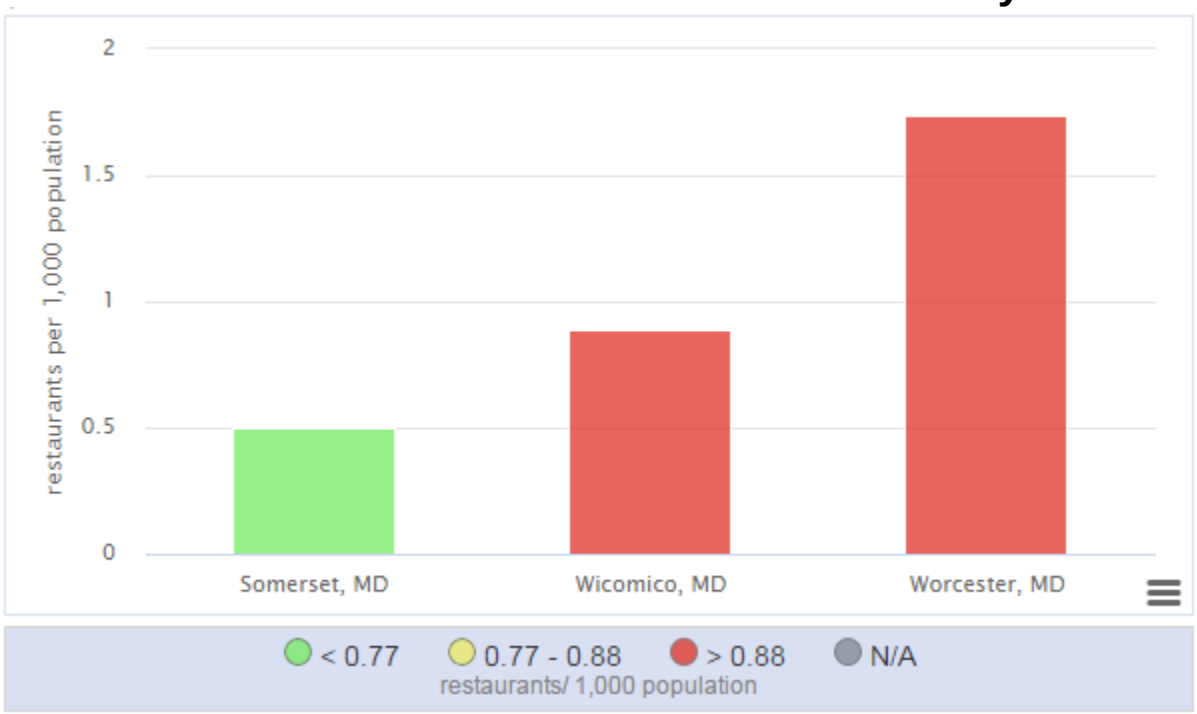
choices. Worcester County is a more affluent county and has a very positive grocery store density to population ratio.

Adult Fruit and Vegetable Consumption

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

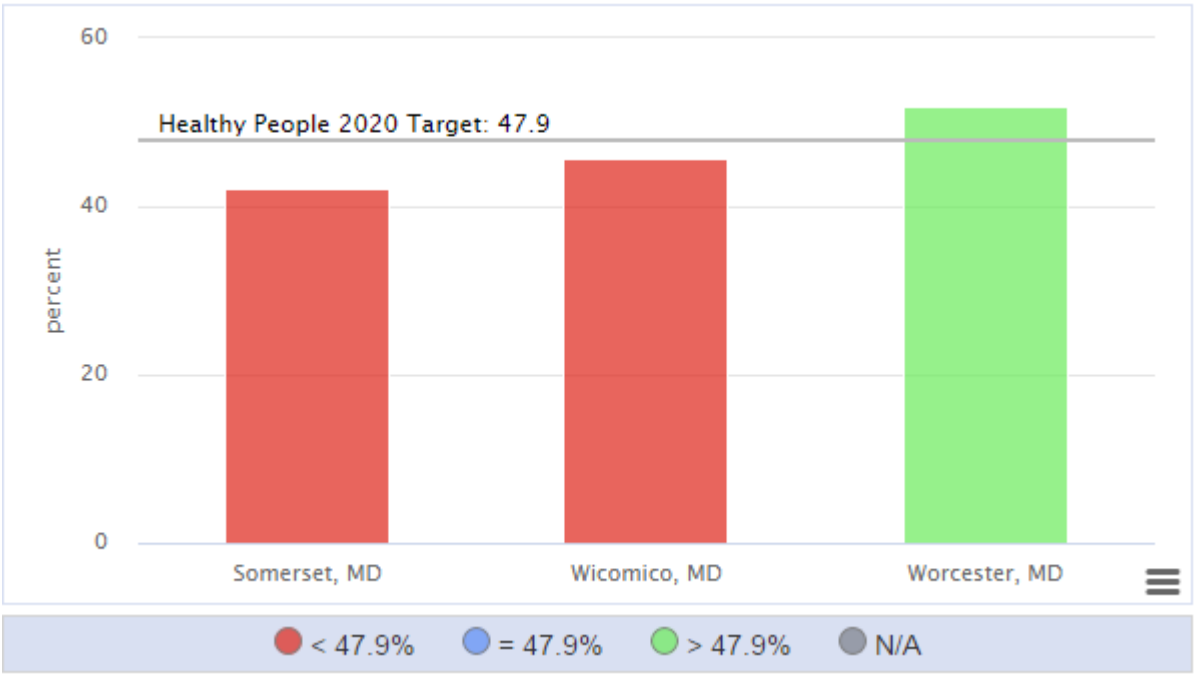
Source: HCI Healthy Communities Inc.

Fast Food Restaurant Density



Source: HCI Healthy Communities Inc.

Adults Engaging in Regular Physician Activity



Source: HCI Healthy Communities Inc.

The social determinants of health within our CBSA (as evidenced by the preceding charts) suggest that residents would benefit from a "Live Well" campaign. This campaign was designed to create awareness and provide a forum for becoming engaged and actively pursuing living a healthy lifestyle. Live Well Delmarva promotes healthy lifestyles and provides information and access to free screenings and healthy living tips. Although the campaign started in FY2015 and has since concluded, a number of programs have continued as a result:

These offerings include:

- Free skin cancer screenings
- Hypertension clinics
- Live Well HealthFest, an annual event with 35+ health screenings, exercise demonstrations and kids' activities
- Wagner Wellness Van local fair and festival live well presence
- Free women's and men's heart screenings (total cholesterol, HDL, risk ratio and glucose, ankle/brachial index, resting 12-lead EKG, pulse oximetry testing, strength and more)
- Drive-Thru Flu Clinic, a one-day event that results in the vaccination of more than community members

Transportation Services

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

Upon inpatient hospital discharge, the Institution also provides transportation for certain elderly patients who do not drive and/or those who may lack a caregiver. A bus tickets or a taxi fare is

provided for those patients who are indigent or may lack a vehicle. Our Patient Care Management Department manages these cases on a patient by patient basis.

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

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

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

Households without a Vehicle

	VALUE	COMPARED TO:
County: Somerset, MD	10.3% (2010-2014)	MD Counties
County: Wicomico, MD	7.5% (2010-2014)	MD Counties
County: Worcester, MD	6.1% (2010-2014)	MD Counties

Source: HCI Healthy Communities Inc.

Affordable Housing

Peninsula Regional's CBSA has exceptionally high household rent compared to other Maryland counties. Spending a high percentage of household income on rent can create financial hardship, especially for lower-income renters. Limited income due to high rent makes it difficult to access health care resources.

Renters Spending 30% or More of Household Income on Rent

	VALUE	COMPARED TO:
County: Somerset, MD	62.9% (2010-2014)	MD Counties
County: Wicomico, MD	55.5% (2010-2014)	MD Counties
County: Worcester, MD	53.3% (2010-2014)	MD Counties

Source: HCI Healthy Communities Inc.

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

Severe Housing Problems

	VALUE	COMPARED TO:
County: Somerset, MD	21.3% (2008-2012)	MD Counties
County: Wicomico, MD	20.5% (2008-2012)	MD Counties
County: Worcester, MD	16.2% (2008-2012)	MD Counties

Source: HCI Healthy Communities Inc.

Unemployment

Compared to other counties, the unemployment rate is high in Wicomico, Worcester and Somerset counties. Unemployment is a key indicator of the health of the local economy; in addition, high unemployment rates can be related to reduced access to health resources.

Unemployed Workers in Civilian Labor Force

	VALUE	COMPARED TO:
County: Somerset, MD	6.5% (July 2016)	MD Counties
County: Wicomico, MD	5.5% (July 2016)	MD Counties
County: Worcester, MD	5.6% (July 2016)	MD Counties

Source: HCI Healthy Communities Inc.

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

Available detail on race, ethnicity, and language within CBSA.
See SHIP County profiles for demographic information of Maryland jurisdictions.
http://ship.md.networkofcare.org/ph/county-indicators.aspx

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

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

Within our CBSA, all three counties' average household incomes are considerably less than Maryland's average. In addition, a smaller percentage of the population has a bachelor's degree or above. Wicomico County (13.3%) and Somerset County (19.7%) have a much higher high school drop-out rate than the state of Maryland (11.1%). Research indicates that education level is a social determinant and predictor of a healthy lifestyle and health literacy.

Wicomico has the highest Hispanic/Latino population in the tri-county area although all have smaller percentages compared to Maryland. Worcester has the higher percentage of white population at 64%, whereas Somerset has the lowest at 49.8%. Somerset has the largest proportion of Black/African Americans at 42.2%, whereas Worcester has the lowest at 13.8%.

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

Demographics	Wicomico County	Worcester County	Somerset County	Benchmark Maryland
Race/Ethnicity				
White Non-Hispanic	64.0%	79.2%	49.8%	**51.8%**
Black Non-Hispanic	24.6%	13.8%	42.2%	**29.2%**
Hispanic	5.6%	3.5%	4.4%	**9.7%**
Asian & Pacific	3.0%	1.5%	.9%	**6.4%**
All Others	2.8%	2.0%	2.7%	**2.9%**
Average Household Income	$67,745	$82,169	$50,547	**$98,950**
Pop. 25+ Without H.S. Diploma	13.3%	10.9%	19.7%	**10.9%**
Pop. 25+ With Bachelor's Degree or Above+	26.8%	27.9%	14.0%	**37.3%**
Demographics	**Wicomico County**	**Worcester County**	**Somerset County**	**Benchmark Maryland**
English Spoken at Home	89.6%	94.2%	92.7%	**83.1%**
Spanish Spoken at Home	4.5%	2.4%	3.0%	**7.0%**
Other Spoken at Home	5.9%	3.4%	4.3%	**9.9%**

Source: United States Census Bureau, Advisory Board 2016

Other

SocioNeeds Index

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

HCI SocioNeeds Index

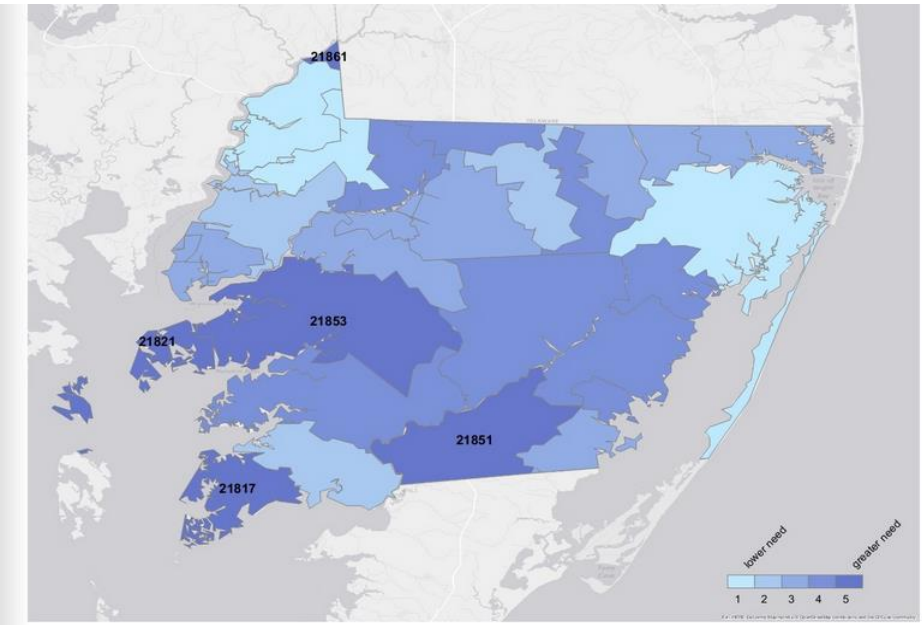


FIGURE 15: ZIP CODES WITH HIGHEST SOCIOECONOMIC NEED

Somerset	21817	21821	21853
Wicomico	21861		
Worcester	21851		

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

Social Environment

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

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

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

Economy

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

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

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

Education

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

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

Source: HCI Healthy Communities Inc.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. **Within the past three fiscal years, has your hospital conducted a Community Health Needs Assessment that conforms to the IRS requirements detailed on pages 1-2 of these Instructions?**

__X_ Yes **Provide date approved by the hospital's governing body or an authorized body thereof here: 06/28/2016 (mm/dd/yy)**

____No

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).

www.peninsula.org

Go to quick links Community

1. **Has your hospital adopted an implementation strategy that conforms to the IRS requirements detailed on pages 3-4?**

_X_ Yes **Enter date approved by governing body/authorized body thereof here: 11/02/2016 (mm/dd/yy)**

___No

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

www.peninsula.org

Go to quick links Community

III. COMMUNITY BENEFIT ADMINISTRATION

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

a. Are Community Benefits planning and investments part of your hospital's internal strategic plan?

_X_ Yes
___ No

If yes, please provide a specific description of how CB planning fits into the hospital's strategic plan. If this is a publicly available document, please provide a link here and indicate which sections apply to CB planning.

Community Benefits is woven throughout Peninsula Regional's ***Vision 2020 Strategic Plan*** and is an integral part of each of our Strategic Tenets, which encompass the following themes: patient-centered care, population health management and expanding access through growth of an ambulatory presence.

Peninsula Regional Vision 2020- Strategy 2.0

To deliver population-based care through health and wellness; medical and chronic disease management; clinically integrated networks and alliances; primary care development; physician integration; and research development

Peninsula Regional Vision 2020- Strategy 3.0

To expand access to care through the continued growth of an ambulatory presence; continued development of affiliations and partnerships; and the evaluation of medical education and training.

The Strategic Plan is a living document that interfaces with Community Benefit Initiatives, the Strategic Transformation Plan, Local County Health Departments, and dovetails with the State Health Improvement Plan (SHIP) goals. In addition, collaboration and partnerships with local civic organizations, faith-based institutions and community providers like the YMCA and MAC, etc., are now the norm instead of the exception.

As part of the preceding Strategic Tenet, Peninsula Regional continues to build the future care infrastructure for ongoing community health benefits by investing in patient-centered care, provider/care team innovations, health information systems reinvestment and employee/ family, *"Live Well"* initiatives. The synergy created by these incremental health building blocks has provided access to those most in need of health resources and chronic disease management in our community.

Peninsula Regional
Transformational Initiatives
Providing a Community Approach to Population

- SWIFT- Salisbury Wicomico Integrated Firstcare Team is a new initiative developed in October 2017 that delivers a partnership between Peninsula Regional, Wicomico County Health Department and the Salisbury Fire Department to Salisbury, Maryland residents who have utilized the 911 EMS system more than 5 times in the last 6 months. These three local organizations have joined forces to give the community the tools and support that's needed to manage their health and reduce unnecessary utilization of the 911 system. The team provides an EMT-P and RN who go directly to resident's homes to find out their healthcare needs and connect them with the right services. Participation is voluntary to those Salisbury residents who meet this "high utilizer" definition, the health visit is free to participants. Phone Number 410-548-3120.
- The Post–Acute Care Quality Committee constitutes local SNFs, HHAs, and Hospice in the region that meet with Peninsula Regional on a quarterly basis to have open discussion on how to provide appropriate cost effective processes to the transition of post-acute patients. The team identifies areas to improve: complex patient referrals, readmission and risk identification, process flow, education concerning advance directives and other items, challenges with dementia care and behavioral health issues.
- Chronic Disease Self-Management partnership with MAC (Maintaining Active Citizens) a program that provides evidence-based classes for those 18 and older supporting them with health literacy, and disease control of their health through education and goal setting to improve disease self-management.

  Classes include:
  - Diabetes Self-Management
  - Chronic Disease Self-Management
  - Stepping on Falls Reduction
  - Chronic Pain Self-Management
- Development of a Weight Loss and Wellness Center (2016) located in Salisbury MD, a multidisciplinary team that incorporates nutrition, weight loss, physical activity and support groups.
- Forged a new partnership in 2017 with CoreLife, a Maryland based company that specializes in providing a tailored and compassionate approach to weight loss and lifestyle modification through coordinated management of medical, nutrition, exercise and behavior disciplines. The future plan includes evaluating phasing in 3-5 lifestyle centers within the service area maximizing opportunities to provide medically evidence-based obesity and weight loss modification.
- Peninsula Regional's Wellness Van, the mobile clinic on wheels, travels to local targeted area community locations to provide clinic access, social work support, health resources and education to high-risk, underserved patients.
- Continuing to strengthen and develop the adult behavioral health "Partial Hospitalization Program" in addition to recently opening an outpatient child and adolescent behavioral health unit. In April of 2016 Peninsula Regional celebrated the opening of the Leighton

Moore Child and Adolescent Outpatient Behavioral Health Unit (seeing 62-72 patients weekly).

- PRCIN (Peninsula Regional Clinically Integrated Network) In FY2016, the Centers for Medicare & Medicaid Services approved Peninsula Regional Health System's clinically integrated network or ACO (Accountable Care Organization). This new Medicare network brings the Hospital, local physician, and providers together to provide higher-quality, coordinated care to patients. Peninsula Regional has embedded patient care coordination practice managers in local primary care physician offices.
- A "Renal Coach" who meets with patients in stage 4 and 5 to help reduce the rate of transitions to dialysis.
- This year, as part of our mission Peninsula Regional has initiated a "*community based advanced care planning outreach program."* Five of the largest local large employers have agreed to have their employees participate in educational sessions for end of life planning. Respecting Choices is an internationally acclaimed, evidence-based model of advance care planning (ACP) initiated by Gunderson Health of LaCrosse, Wisconsin. The program creates a healthcare culture of person-centered care that honors individual's goals and values for current and future healthcare. The model has been used with diverse socio-economic, racial, and religious groups around the globe to offer a standardized approach to advance care planning. In addition, we are sharing this information with a number of Faith Based and Civic Institutions within the CBSA.
- Partnering with Chesapeake Health Center a federally qualified health center to improve access to primary care appointments.
- Inpatient post-discharge chronic disease management through remote data collection and data management services.
- Provision of medication for indigent population to pay for meds to help prevent readmissions and develop a healthier community.
- Palliative care culture advancement whose focus on patients with complex chronic disease states with specialized care revolves around symptom control, counseling, family support and education/assistance with end-of-life decision making.
- RN coordinators to improve access to primary care appointments within 72 hours of discharge.
- Grant to local Department of Aging to support chronic disease self-management classes (Stanford Model) within the community
- Dedicated social worker (5 days a week) to connect ED high utilizers with community services, primary care physicians including helping to provide transportation and access to disease management education. *(Hiring an additional .6 FTE in FY 2017)*
- Community-Based Care Coordination Program focuses on patients at high risk of hospital readmissions. These complex, high-needs patients are supported by an RN and three community health workers. This year we have added several Chronic Care Coordination Specialists for telephonic follow-up.
- Community Health Workers at PRMC, provide in home support for chronic disease and improving social determinants of health, providing assistance with improving compliance with dietary and medication management.

- Endocrinology: Implementation of telemedicine/diabetes clinic for pediatric patients with a focus on accurate diagnosis/ treatment using family support and school nurse. Patient education and chronic disease management for diabetes and the co-morbidities associated diabetes, which is so prevalent in our region.
- Continued recruitment of primary care physicians that develop care models targeting high-risk patients, assigning them to specific care plans and care plan coordinators.
- HSCRC (Health Services Cost Review Commission) Transformational Grant to provide:
    - Multiple Bridge Clinics will provide localized services to those patients who do not have a primary care physician or need to see a primary care physician. Patients with high risk for readmission or revisit to the ED with limited access to a PCP who need access within 48-72 hours of discharge to a primary care physician will be referred and an appointment will be established by a transition RN.
    - Wagner Wellness Van is a medical van that will be targeting communities with high ED utilizations and readmissions as well as isolated and disparate communities where access to primary care and/or transportation is problematic.
    - Smith Island Telemedicine will be able to assess patients within the home setting and work with a PRMC hospitalist via telemedicine who need care but may not need to be admitted to the hospital.
    - Expand the Transitions of Care Team program

Peninsula Regional Community Integrator Population Health

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

Clinical Partnerships - with Adventist Healthcare, Johns Hopkins and Children's National Health System.

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

The program is the formation of a team of a SFD emergency medical technician and a PRMC registered nurse to conduct welfare checks, case management, safety planning, and referrals for

frequent utilizers of 911 EMS for nonemergency reasons. "Frequent utilizers" are defined as individuals calling 911 for medical reasons at least five times over a six month period. The SWIFT team will identify and contact these individuals to see if they are interested in enrollment into the program. Team members will conduct home visits with these patients to conduct vital signs checks, examination for signs of abuse or neglect, conduct safety assessments of the home, and refer patients to primary care physicians, medical specialists, and, if necessary, in-home care providers.

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

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

Health Information Systems

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

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

PRCIN (Peninsula Regional Clinically Integrated Network)

In FY2016, the Centers for Medicare & Medicaid Services approved Peninsula Regional Health System's clinically integrated network or ACO (Accountable Care Organization). This new Medicare network brings the Hospital, local physician, and providers together to provide higher-quality, coordinated care to patients. Ultimately, this is about delivering better care, spending dollars more wisely and having healthier people and communities. The PRCIN's mission is to drive health care progress by improving the coordination and integration of health

care, and improving the health of patients, with a priority placed on prevention and wellness. There are four domains of ACO quality measures and multiple metrics within each domain:

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

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

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

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

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

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

Care Wrap

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

"CareWrap is another of those absolutely essential pieces to the population health puzzle that we don't have to invent or reinvent. It's a proven approach to care that lets us touch some of our most at-risk patients, through one-on-one, face-to-face education and instruction," said Karen Poisker, PRMC's Vice President of Population Health. "We know that if we ingrain those good habits associated with properly managing chronic conditions, we can keep people healthier and out of our emergency department or hospital."

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

CARE SAGE

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

Wagner Wellness Van

The Wagner Wellness Van makes routine visits to shelters and local churches and is a population heath platform visiting locals with the van equipped as a clinic. We have established a presence at many locations throughout the tri-county area; the van conducts blood pressure screenings, height/weight and acts as a conduit for

education and access to other health care providers and facilities. On most Thursdays of every month the van visits Urban Ministries and it has impacted 156 health/wellness community programs.

Child and Adolescent Outpatient Behavioral Health Unit

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

Employee Family "Live Well" Campaign

Building on the externally focused "Live Well" marketing efforts, Peninsula Regional turned that inward to the new "Live Well" campaign that is directed at employees and their families. This campaign encourages/promotes healthy lifestyles through education, financial benefits, health care assessments, chronic disease management and other collective health activities.

A specific module associated with the "Live Well" campaign focuses on employees with diabetes as a diagnosis; the primary objective is to improve diabetes control and reduce A1C for individuals over time. Employees participating in the program receive a reduction in cost for their health care benefit and receive free testing and medications for their diabetes care. In addition, PRMC is currently developing a playbook to build ways to engage its employees and their families in a comprehensive "Live Well" lifestyle.

Population Health

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

Future Community Benefit Intent:

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

Peninsula Regional Ambulatory Access

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

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

The Peninsula Regional Health System officially dedicated its new, community-based **Peninsula Breast Center** in Salisbury last year. The Peninsula Breast Center provides women the most comprehensive breast health services on Delmarva with care plans individualized for each woman. The warm and caring staff believes in a team approach, and will offer 3D mammography, biopsies, physician consultations and surgical services all in a single location.

The Peninsula Weight Loss and Wellness Center is in the second year of existence located on Snow Hill Road in Salisbury at the MAC (Maintaining Active Citizens) pavilion. It provides clients with medically managed weight loss options and the support system they need to succeed. At the new center, clients are empowered to make decisions regarding their diet and overall health. The philosophy is not to swear off certain foods, but to learn about diet and nutrition to achieve a healthy balance. The Center give patients the tools they need to make healthy choices with resources that are easy to obtain. The ongoing delivery of information will lead to healthy lifelong habits and the maintenance of weight loss goals.

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

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

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

Reduce inappropriate Emergency Room Utilization

In FY2017 Peninsula Regional and Your Doc's In, established experts in the delivery of ambulatory urgent care created a partnership to provide urgent care on the Eastern Shore of Maryland. The new center will be the first urgent care center on Delmarva collaboratively owned and operated by the two local healthcare leaders. It will be located in the former Horner Honda building on South Salisbury Boulevard. The team there will provide cost-effective, high-quality urgent and occupational health services, giving residents of all ages a new healthcare option on the south side of Salisbury for acute illnesses and injuries that do not require an emergency room visit. This is a continuation of the

Peninsula Regional Health System's commitment to offer exceptional healthcare services for the entire Delmarva Peninsula in locations that provide people options close to their homes, in the most appropriate setting, and give them the greatest value for their care.

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

b. What stakeholders within 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. _X__CEO Dr. Peggy Naleppa

   CEO Designate Steve Leonard

2. _X__CFO Bruce Ritchie
3. _X__Other (please specify)

   COO- Cindy Lunsford

   CMO- Dr. Charles B. Silvia

   CNO- Sheri Matter

   VP Strategy CBO- Christopher Hall

   VP Safety and Compliance Officer- Tim Feist

   VP People- Mitzi Scott

   Executive Director Population Health- Kathryn Fiddler

Describe the role of Senior Leadership.

The Community Benefits Team at PRMC encompasses many departments and facets of the organization. Senior Leadership is responsible for defining the organization's population health objective and creating the infrastructure that delivers health services

to targeted populations. Other roles include creating business cases for population health management initiatives, providing leadership for future health information systems connectivity, targeting high-risk populations for chronic disease management/ interventions, identifying service line gaps, building partnerships and collaborations with other health care providers, and setting overall direction and goals.

ii. Clinical Leadership

1. _X_ Physician
2. _X_ Nurse
3. _X_ Social Worker
4. _X_ Other (please specify)

Describe the role of Clinical Leadership

iii. Population Health Leadership and Staff

1. _X_ Population health VP or equivalent (please list)

   Executive Director of Population Health- Kathryn Fiddler

   Director of Community Initiatives- Stephanie Elliott

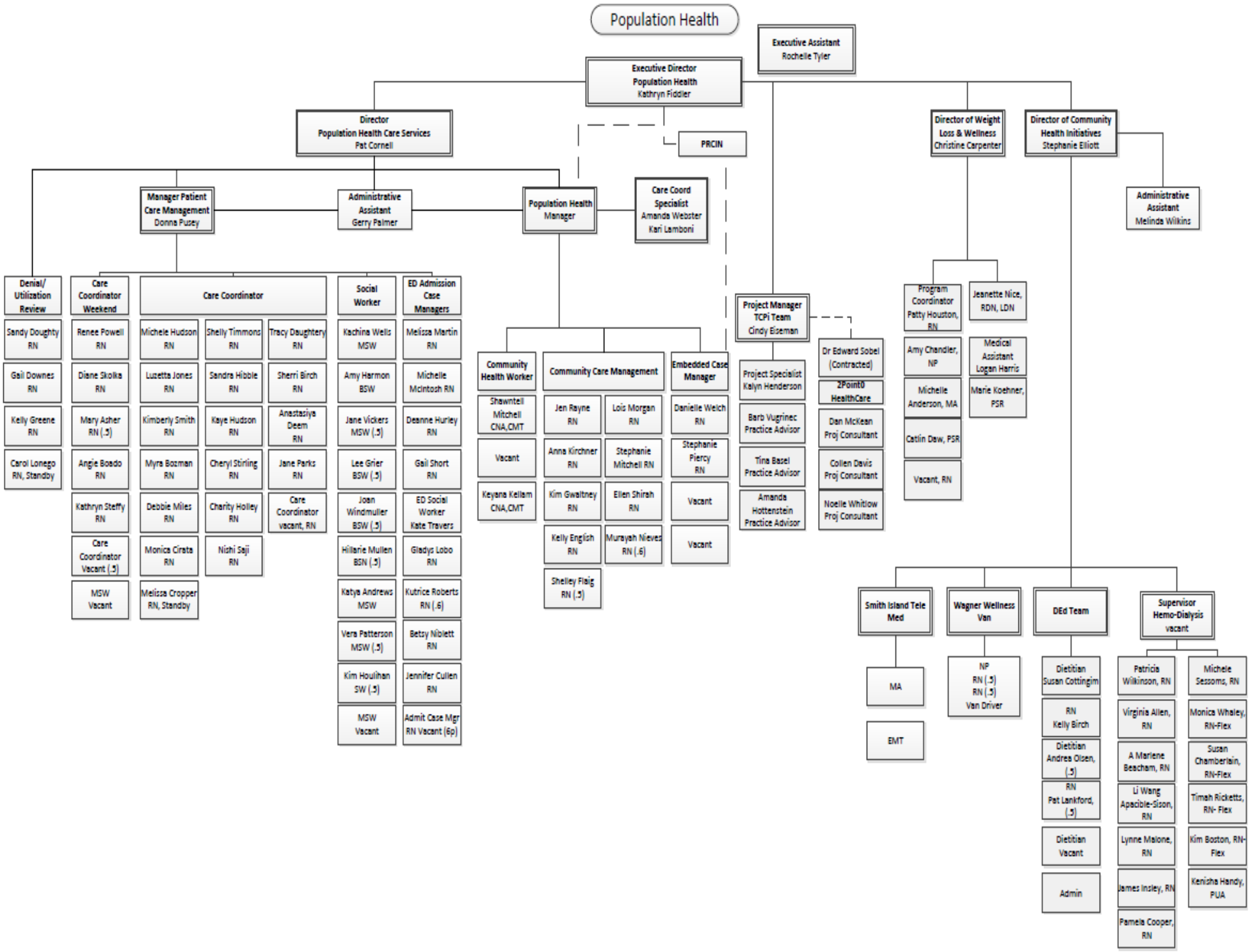
   Director of Population Health- Pat Cornell

2. _X_ Other population health staff (please list staff)

   a. Please see next page for organizational chart

Describe the role of population health leaders and staff in the community benefit process.

Clinical Leadership creates tactical action plans around population health initiatives that achieve the best health outcomes for residents. Their roles include designing care management processes, engaging targeted population with care and wellness plans, health education, follow-up, intervention, transportation, coordination of care along the continuum, health analytics/ metrics, and collaborating with other providers and local health departments.


Population Health
Executive Assistant
Rochelle Tyler
Executive Director
Population Health
Kathryn Fiddler
Director
Population Health Care Services
Pat Cornell
PRCIN
Director of Weight Loss & Wellness
Christine Carpenter
Director of Community Health Initiatives
Stephanie Elliott
Manager Patient Care Management
Donna Pusey
Administrative Assistant
Gerry Palmer
Population Health Manager
Care Coord Specialist
Amanda Webster
Kari Lamboni
Administrative Assistant
Melinda Wilkins
Denial/ Utilization Review
Sandy Doughty RN
Gail Downes RN
Kelly Greene RN
Carol Lonego RN, Standby
Care Coordinator Weekend
Renee Powell RN
Diane Skolka RN
Mary Asher RN (.5)
Angie Boado RN
Kathryn Steffy RN
Care Coordinator Vacant (.5)
MSW Vacant
Care Coordinator
Michele Hudson RN
Luzetta Jones RN
Kimberly Smith RN
Myra Bozman RN
Debbie Miles RN
Monica Cirata RN
Melissa Cropper RN, Standby
Shelly Timmons RN
Sandra Hibble RN
Kaye Hudson RN
Cheryl Stirling RN
Charity Holley RN
Nishi Saji RN
Tracy Daughtery RN
Sherri Birch RN
Anastasiya Deem RN
Jane Parks RN
Care Coordinator vacant, RN
Social Worker
Kachina Wells MSW
Amy Harmon BSW
Jane Vickers MSW (.5)
Lee Grier BSW (.5)
Joan Windmuller BSW (.5)
Hillarie Mullen BSN (.5)
Katya Andrews MSW
Vera Patterson MSW (.5)
Kim Houlihan SW (.5)
MSW Vacant
ED Admission Case Managers
Melissa Martin RN
Michelle McIntosh RN
Deanne Hurley RN
Gail Short RN
ED Social Worker Kate Travers
Gladys Lobo RN
Kutrice Roberts RN (.6)
Betsy Niblett RN
Jennifer Cullen RN
Admit Case Mgr RN Vacant (6p)
Community Health Worker
Shawntell Mitchell CNA,CMT
Vacant
Keyana Kellam CNA,CMT
Community Care Management
Jen Rayne RN
Lois Morgan RN
Anna Kirchner RN
Stephanie Mitchell RN
Kim Gwaltney RN
Ellen Shirah RN
Kelly English RN
Murayah Nieves RN (.6)
Shelley Fisig RN (.5)
Embedded Case Manager
Danielle Welch RN
Stephanie Piercy RN
Vacant
Vacant
Project Manager TCPi Team
Cindy Eiseman
Project Specialist
Kalyn Henderson
Barb Vugrinec Practice Advisor
Tina Basel Practice Advisor
Amanda Hottenstein Practice Advisor
Dr Edward Sobel (Contracted)
2Point0 HealthCare
Dan McKean Proj Consultant
Collen Davis Proj Consultant
Noelle Whitlow Proj Consultant
Program Coordinator
Patty Houston, RN
Amy Chandler, NP
Michelle Anderson, MA
Catlin Daw, PSR
Vacant, RN
Jeanette Nice, RDN, LDN
Medical Assistant
Logan Harris
Marie Koehner, PSR
Smith Island Tele Med
MA
EMT
Wagner Wellness Van
NP
RN (.5)
RN (.5)
Van Driver
DEd Team
Dietitian
Susan Cottingim
RN
Kelly Birch
Dietitian
Andrea Olsen, (.5)
RN
Pat Lankford, (.5)
Dietitian
Vacant
Admin
Supervisor Hemo-Dialysis
vacant
Patricia Wilkinson, RN
Virginia Allen, RN
A Marlene Beacham, RN
Li Wang Apacible-Sison, RN
Lynne Malone, RN
James Insley, RN
Pamela Cooper, RN
Michele Sessoms, RN
Monica Whaley, RN-Flex
Susan Chamberlain, RN-Flex
Timah Ricketts, RN- Flex
Kim Boston, RN-Flex
Kenisha Handy, PUA

iv. Community Benefit Operations

1. _X_ Title of Individual(s) (please specify FTE)

a. Administration and Coordination of Services- Rhonda Lasher

2. ___Committee (please list members)

a. Executive Director of Population Health- Katherine Fiddler
b. Community Health Initiatives- Stephanie Elliott
c. Exercise Physiologist and Nutritionist- Caroline Farrell
d. Coordinator of Community Benefits- Pattie Serkes
e. Communication and Messaging- Gwen Garland
f. Resource Allocation- Jon Mitchell
g. Strategic Guidance and Oversight- VP Chris Hall
h. Behavioral Health Leadership- Katherine Smith
i. Weight Loss and Wellness Center- Christine Carpenter
j. Diabetes Educator Coordinator- Susan Cottingim
k. Campaign Coordination and Administration- Laren Carmean
l. Pediatric Weight Loss/Diabetes and Nutrition- Flora Glasglow

3. _X_ Department (please list staff)

Population Health Department –Transition Coaches Community Care

(See Attached Org Chart)

Jen Rayne, Lois Morgan, Anna Kirchner, Stephanie Mitchell, Kim Gwaltney, Eilen Shirah, Kelly English, Shelley Flaig,

4. ___Task Force (please list members)

5. _X_ Other (please describe)

a. Pulmonary Diagnostics Supervisor- Tom Russ
b. Employee Health and Wellness- VP Mitzi Scott
c. Child Care Services- Linda Brannock

Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

The preceding Community Benefit Health & Wellness Committee and the Transitions Services/Population Health Department work in tandem identifying, targeting, developing and implementing action plans for community health. These stakeholders collaborate with local county health departments, civic organizations, faith based groups and other local providers.

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

Spreadsheet __X__ yes _____ no

Narrative __X__ yes _____ no

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

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

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

Spreadsheet ___X__ yes _____ no

Narrative ___X__ yes _____ no

If no, please explain why.

Each year, the Board of Trustees receives a copy of the Community Benefit report and a presentation at their monthly education session. Following the education session, the board fully accepts the community benefit report through the passing of a resolution.

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

__X__ Yes _____ No

If yes, please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

All three components- Peninsula Regional Health System's Strategic Plan, Community Benefits and our Transformational Plan work in unison creating synergy for advancing community health. It has been an entire cultural change from treating sick patients to being on the forefront, developing collaborative programs that contribute to improving our CBSA's health. The mission is to promote healthy lifestyles, avoiding hospital admissions/readmissions and potentially avoidable emergency room visits. Many of aforementioned initiatives implemented by the Health

System has addressed access issues, chronic disease identification and management, education/monitoring, appropriateness of care, EMS high utilizers, right-cost / right setting, embedded care management (patient care managers, social workers), network optimization, post-acute care transitions, prescription/medication help, advanced directives and EMT resource assessments. Using the Community Health Needs Assessment as a roadmap to prioritize community health, the integration of System Strategy, Community Benefits and the Transformational Plan has created a strong cooperative and focused approach to population health planning and execution.

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?

__X_Other hospital organizations

__X___Local Health Department

__X___Local health improvement coalitions (LHICs)

__X___ Schools

__X___Behavioral health organizations

__X___Faith based community organizations

__X___Social service organizations

__X__Post-acute care facilities

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct a CHNA. Provide a brief description of collaborative activities indicating the roles and responsibilities of each partner and indicating the approximate time period during which collaborative activities occurred (please add as many rows to the table as necessary to be complete).

Our core partners over the last decade have sponsored and supported CHNA reporting; individually and collectively the group has conducted, discussed and shared information the results. The participation has led to development of health and wellness programs and collaborations throughout the Tri-County region:

- Peninsula Regional Health System
- Atlantic General Hospital
- McCready Health/Hospital
- Wicomico Health Department
- Worcester Health Department
- Somerset Health Department

New IRS regulations required Peninsula Regional Health System to conduct a **2016 Community Health Needs Assessment (CHNA).** This CHNA report was developed to provide an overview of the health needs in the PRMC tri-county service area, including Somerset, Wicomico, and Worcester counties in Maryland, our Community Benefit CBSA. PRMC partnered with Healthy Communities Institute (HCI), a Xerox Company, to conduct the CHNA. The goal of this report is to offer a meaningful understanding of the greatest health needs across the PRMC service area, as well as to guide planning efforts to address those needs. Special attention has been given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community. Members of the community are invited to provide feedback and comments on this report through multiple avenues. First, the report will be published on PRMC's website (www.Peninsula.org); when opening the report, a pop-up survey box will be there asking for feedback. In addition, community members are able to send emails to the community relations department via community.relations@peninsula.org.

Over the years the collective outcome of CHNA participation has led to collaborations and partnerships with some of the following key organizations:

Organization/ Key Partners	Name of Key Collaborator	Title	Collaboration Description
Tri-County Diabetes Alliance	PRMC-Susan Cottingim- Clinic Coordinator	Worcester County Chronic Disease Prevention	General Diabetes Awareness, Education & Disease Self-Management Classes to include Obesity and Hypertension Wagner Wellness Van- Screenings Education Resource Referrals Primary Care
Hospitals Atlantic General	Colleen Wareing	VP of Patient Care Services	
McCready	Lori Dize	Outpatient Coordinator	
PRMC	Susan Cottongim Kathryn Fiddler	Clinical Cord. Nutrition & Diabetes Exc. Dir. Pop. Hlth.	
Health Departments			
Somerset County	Craig Stofko Dawn Mills Sharon Lynch	Health Officer Exec Dir. Wellness	
Wicomico County	Lori Brewster Jennifer Johnson James A. Cockey MD	Health Officer Chronic Disease Deputy Health Officer	
Worcester County	Rebecca L. Jones Mimi Dean Maureen Sharkey	Health Officer Dir of Plan & Pop	
Chesapeake Health FQHC	Sue Gray	CEO	
Peninsula Regional Weight Loss And Wellness Center	Christine Carpenter Stephanie Elliott	Director Wgt. Loss /Wellness Center Dir of Comm. Health	
UMES	Cathy Ferraro		
Salisbury Urban Ministries	Debbie Donaway	Executive Director	
PRMC Parents & Teens	Susan Cottongim Parents & Teens	Manages Diabetes Education	Diabetes Support Group for Teens

Children's National Medical Center	Physicians		
PRMC CNMC- Children's National Medical Center YMCA Delmarva	Diane Hitchens & Flora Glasgow Chris Hall Robbie Gill Amy Sorg	Executive Director of Women's & Children's Services Nurse Practitioner VP PRMC YMCA Exec Dir. Wellness Director	Pediatric Weight Management Program
PRMC Parents & Children	PRMC Health Day Care Program- Linda Brannock	Director of Child Care	Pediatric Weight Management: PRMC Healthy Day Care Program
Health Fest PRMC Wicomico County Board of Education- James M. Bennett High School	PRMC Health and Wellness Committee Amy Eskridge	See Section III. iii. Community Benefit Operations 2. Principal	Obesity-Reduce the Proportion of Children and Adolescents Who are Considered Obese- General Awareness Campaign
University of Maryland MAC- Maintaining Active Citizens Peninsula Regional Home Care **Local Churches** New Dimensions Church Crisfield Church of God	 Pattie Tingle Leigh Ann Eagle Nancy Bagwell Jesse Abbott Harvey Tyler Alana Tyler	 Executive Director Health & Wellness Project Director Branch Director Director of Operations Bishop Pastor Pastor	Chronic Disease Management Partners Flu Shots, Chronic Disease Management

Shelters HOPE inc. HALO Hope and Life Outreach Salisbury Ministries	 Donna Clark Celeste Savage Debbie Donaway	 RN Executive Director Executive Director	
SWIFT- (Salisbury Wicomico Integrated FirstCare Team) Wicomico Health Dept. Salisbury Fire Dept. Peninsula Regional	Lori Brewster – Health Officer Dennis Phippin- SWIFT Coordinator Kathryn Fiddler- Executive Director of Population Health	Wicomico County Health Department Salisbury Fire Department PRMC	Addressing a range of community health issues including high utilizers of 911 including accessibility, affordability and referrals to appropriate services
PRMC Adventist Behavioral Health	Kathryn Fiddler Katherine Smith	Exec. Dir. Pop. Health Adventist Behavioral Health	Partnered with Adventist Health to Provide Behavioral Health Services in the Emergency Department including outpatient Child and Adolescent Behavioral Health
Lower Shore Health Clinic Go-Getters	Richard Bearman	Clinic Director	Behavioral Health Services
Atlantic General McCready Health Emergency Service Associates			ED Care Management for High Utilizers
Salisbury Genesis Anchorage Coastal Hospice Aurora Nursing Home Berlin Nursing Home White Oak SNF Harrison House Hartley Hall Deers Head Center	Rob Stofer Evelyn Sadler Bob Miller Marsha Strauss	Administrator CNO	Partnering with 7 SNFs for Post-Acute Transitions of Care

EMT Services Crisfield Clinic			Partnering with EMT Services and the Crisfield Clinic to provide Care Management and Telemedicine Services to High Utilizes of Smith Island
Independent and Employed Providers within Primary and Secondary Service Areas	PRMC & Peninsula Regional Medical Group Three Lower Counties Community Services Dr. Jonathan Patrowicz Dr. Alon Davis Dr. Chris Huddleston Dr. Vel Natesan	Physicians Physicians	PRMC Clinically Integrated Network: Develop Clinical Integration Including Physician Alignment And New Partnerships

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

__X__yes _____no

If the response to the question above is yes, please list the counties for which a member of the hospital organization co-chairs the LHIC.

Stephanie Elliott- Peninsula Regional Health System (Director of Community Initiatives)

Co-Chair for the Maryland Wicomico County LHIC.

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

__X__yes _____no

If the response to the question above is yes, please list the counties in which a member of the hospital organization attends meetings or is a member of the LHIC.

Historically Peninsula Regional has facilitated involvement with health improvement organizations to identify, assess, and create aggregate action plans to address local emerging and chronic CBSA healthcare issues. Kathryn Fiddler (Executive Director of Population Health) and Stephanie Elliot (Director of Community Services Health) attend the following LHIC's including some of the front-line care management coordinators and physicians.

- Wicomico County LHIC
- Worcester County HRSA
- Healthy Somerset Coalition
- Worcester County LHIC
- Tri County Health Improvement Planning
- Tri County Alliance for the Homeless
- Project Living Well Advisory Committee – MAC (Maintaining Active Citizens)

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Please use Table III to provide a clear and concise description of the primary need identified for inclusion in this report, 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.

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

a. **1. Identified need: This may have been identified through a CHNA, a documented request from a public health agency or community group, or other generally accepted practice for developing community benefit programs. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include a description of the collaborative process used to identify common priority areas and alignment with other public and private organizations.**

   2. Please indicate how the community's need for the initiative was identified.

b. **Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based community health improvement initiatives may be found on the CDC's website using the following links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/), or from the County Health Rankings and Roadmaps website, here: http://tinyurl.com/mmea7nw.**
   (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 or other negative health factor 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,**

f. **Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)**

g. **Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.**

h. **Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.**

   Describe here the measure(s)/health indicator(s) that the hospital will use to evaluate the initiative's impact. The hospital shall evaluate the initiative's impact by reporting (in item "i. Evaluation of Outcome"):

(i) Statistical evidence of measurable improvement in health status of the target population. If the hospital is unable to provide statistical evidence of measurable improvement in health status of the target population, then it may substitute:

(ii) Statistical evidence of measureable improvement in the health status of individuals served by the initiative. If the hospital is unable to provide statistical evidence of measureable improvement in the health status of individuals served by the initiative, then it may substitute:

(iii) The number of people served by the initiative.

Please include short-term, mid-term, and long-term population health targets for each measure/health indicator. These should be monitored and tracked by the hospital organization, preferably in collaboration with appropriate community partners.

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? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)

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? If not, why? 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, and grants associated with the fiscal year being reported.
B. Of the total costs associated with the initiative, what amount, if any, was provided through a restricted grant or donation?

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples: the fact that another nearby hospital is focusing on that identified community need, or that the hospital does not have adequate resources to address it.) This information may be copied directly from the section of the CHNA that refers to community health needs identified but unmet.

Priorities

On June 8, 2016, PRMC's Community Benefit team and other members from various departments in the hospital came together to prioritize the significant health needs in a session led by consultants from HCI. The team reviewed the significant health needs using the following prioritization criteria:

- Importance of problem to the community
- Alignment with 2017 MD SHIP objectives
- Opportunity for partnership
- Addresses disparities of subgroups
- Existing resources/programs to address the problem

Using the Prioritization Matrix method, the following three topics were identified as priorities to address:

- Diabetes

- Exercise, Nutrition, and Weight
- Behavioral Health (focusing on the topic areas of Mental Health and Mental Disorders as well as Substance Abuse)

Other significant health needs not chosen were: Access to Health Services, Cancer, Heart Disease and Stroke, and Prevention and Safety. These needs were not selected because they did not meet the prioritization criteria as strongly as the selected topics. PRMC has other programs in these areas, but they are not the focus of this report.

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)

As part of Maryland's SHIP (State Health Improvement Process) initiative, the Tri-County Health Improvement Plan (T-CHIP) is adopting SHIP objective 27: reduce diabetes complications and reduce diabetes-related emergency department visits; and SHIP objective 31: reduce the proportion of children and adolescents who are considered obese or overweight. Peninsula Regional will continue to partner with T-CHIP and Wicomico County Health Department to create strategies and tactics around SHIP objectives 27 and 31. By adopting the same health improvement objectives, we create alignment, synergy and efficient resource allocation for establishing and promoting these community healthcare improvement objectives.

Some of the goals and initiatives include: reducing the number of diabetes related emergency room visits; tracking the number of tri-county diabetes risk assessment tests administered; and increasing community participation in diabetes management and education programs. In response to SHIP objective 31, Peninsula Regional established and offers a pediatric weight-loss clinic in addition to creating an education module on obesity for our Child Care Center. Peninsula Regional is an active participant and member of the Tri-County Diabetes Alliance, which was created to identify and educate individuals at risk of developing diabetes and to develop programs that will help individual with diabetes reduce their risk of developing medical complications associated with the disease. Peninsula Regionals cooperation with MAC (Maintaining Active Citizens) and their chronic disease management programs are an important component in improving the health of those members with diabetes, hypertension and weight management. Promoting and educating healthy lifestyles to make an impact in patients' health and to reduce unnecessary inpatient hospital utilization and emergency room visits.

A Maryland SHIP objective priority is to reduce the number of Emergency Room visits due to mental health conditions. Our strategy is to provide coordinated care for identified high utilizers of the hospital or the emergency room for mental/behavioral health issues. PRMC continues to strengthen the CareWrap program that identifies people with mental health issues and co-morbidiities led by a registered nurse and consisting of two medical assistants the team will closely follow newly discharged behavioral health patients who agree to participate. For up to three months, the team will: assist in filling prescriptions, see that discharge instructions are being followed, schedule appointments and ensure they are kept, provide instruction on maintaining a healthy lifestyle, and link to social supports, housing, and benefits as eligible. If clients do not have a primary health care provider, they will be offered care at a 'Bridge Clinic' for primary and preventive care.

The second program COAT (Community Outreach Addictions Team) recently received an honor proclamation from the county for opioid outreach efforts, and has been recognized on a national

scale by the National Association of County and City Health Officials as a program of Promising Practice. Fifty-six percent of those reached by the COAT program enter treatment- the national average is 20 percent. COAT is a joint community program that provides transitions/treatment/education and recovery services to individuals with opioid addiction. Many of these individuals have behavioral health issues that the COAT team addresses through their recovery services.

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) **http://dhmh.maryland.gov/ship/SitePages/Home.aspx**
COMMUNITY HEALTH RESOURCES COMMISSION **http://dhmh.maryland.gov/mchrc/sitepages/home.aspx**

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.**

Peninsula Regional is contracting with ECG in FY 2018 to conduct a new medical staff development plan & physician demand environmental scan; conducted every three years the data from this research is used to develop strategies to meet the unique rural healthcare needs of the region.

In 2015 ECG was engaged by Peninsula Regional to assist in the development of a medical staff development plan based upon the healthcare needs of its medical service area. The report included both analysis of PRMC service area and specific recommendations regarding appropriate staffing levels in a variety of medical specialties. The plan serves as a guide for strategic staff planning and contributes to an effort to document community need for physicians,

In 2017 Peninsula Regional recruited three much needed Family Medicine Physicians and recruited Specialists for underserved service lines.

Recent Recruitment

July
Sophia Shakur, MD - Neurosurgery

August
Angela DeRidder, MD – Hem/Onc
Justin Kucinski, MD – Hem/Onc
Pushpjeet Kanwar, MD – GI
Pooja Srikanth, MD – Snow Hill Family Med

September
Zach Baker, MD – CT Surgical
Tammy Donoway, MD – Ocean Pines Family Med
Courtney Pearson, MD – Ocean Pines Family Med

November
Bothwell Lee, MD - Neurosurgery

The approach to evaluating physician need is based upon the following elements:

- Defining the demographic profile and payor mix of the client's service area
- Researching unique service area factors that might influence the demand for healthcare services within the area
- Identifying the total number of physicians by specialty in the defined service area
- Developing a profile of the current medical staff using quantitative data and qualitative data from the medical staff survey and physician focus interviews
- Developing a profile of the patient market, including demographic data
- Utilizing six established physician needs assessment models to identify potential physician surpluses or deficits in each medical specialty
- Evaluating results of the above efforts in the context of our medical staffing and consulting experience

Deficiencies and surpluses in the current supply of physicians was determined by reviewing physician-to-population ratios, physician patient volumes, population data, and other factors.

The consultant ECG noted that PRMC may be vulnerable in the specialty area for which succession planning may be prudent. Within each of the following specialties, at least half of the PRMC active medical staff are 55 or older.

- Cardiac/Thoracic Surgery
- Dermatology
- Gastroenterology
- Hematology/Oncology (recruited several this year)
- Infectious Disease
- Medical Genetics
- Neurology
- Oral/Maxillofacial Surgery
- Otolaryngology
- Psychiatry
- Rheumatology

These specialties are considered to be" significant risk" by ECG and recommends the Hospital adopt a formal succession and/or contingency plan for these specialties over the next several years.

Conservative estimates of primary care physicians needed within the service area suggest a slight shortage in supply of primary care providers. Qualitative data indicates access problems for some patients with lengthy wait times for new patient appointments.

ECG currently projects the following recruitment needs for Primary Care:

	Current Community-Wide Need for Physician	**PRMC Succession Planning Need**	**Total Need to Evaluate for Gaps**
Primary Care- Family Medicine	11.0	2.0	13.0
Primary Care-Internal Medicine	11.0	5.5	16.5
Primary Care-Pediatrics	3.00	2.8	5.8
Total	**25.0**	**10.3**	**35.3**

2. **If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to 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.**

3. **If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to 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.**

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	In FY 2018 ECG Management Consultants will be conducting a new Medical Staff Development Plan. ECG Management Consultants was engaged by Peninsula Regional to assist in developing a "Medical Staff Development Plan" based on the healthcare needs of our medical service area. The current Plan *(11/11/2015)* includes an analysis of PRMC's service area and specific recommendations regarding appropriate staffing levels in a variety of medical specialties. Peninsula Regional feels it is important to continually monitor specialties where a significant amount of patient care within the service area is provided by older physicians, as a sudden or unexpected loss of coverage could have an adverse effect on provision of medical services to the community. Succession planning and recruitment go hand-in-hand, as does socio-demographics and governmental initiatives all which must be considered to assess appropriate physician recruitment. Key findings according to the most recent Medical Staff Development Plan indicate an immediate need for recruitment of 4 Primary Care Physicians to engage in

chronic disease management as part of our population health initiatives. Succession planning is a key objective as 10 primary care physicians are above the age of 55 which will leave a void in an already underserved area. Demographics also play a key role as the Medicare population is growing at a faster rate than the State of Maryland and the Nation. As a growing retirement community, there is an increased need for additional primary care physicians and certain specialties. There will be a 22.7% growth of those between the ages of 65 to 74 over the next 5 years.

Deficiencies and surpluses in the current supply of physicians were determined by reviewing physician to-population ratios, physician patient volumes, population data, and other data. ECG Management Consultants recommend evaluating potential recruitment of the following over the next several years:

Primary Care Recruitment

Primary Care Family Medicine	11 FTEs
Primary Care Internal Medicine	11 FTEs
Primary Care Pediatrics	3 FTEs

Other key findings according to the most recent Medical Staff Development Report indicate that certain specialties have long wait times:

Peer Reported Wait Times

Dermatology- 133 days
Endocrinology- 74 days
Neurology- 50 days
Pulmonology- 54 days
Rheumatology- 56 days
Psychiatry- 41 days
Pain Management- 61 days

Medical specialty needs are driven by the overall market supply, wait times for new patient appointments, and call coverage and inpatient consultation needs. Current medical specialty recommendations

	include recruitment of the following physicians a recruiting for the following specialties due to community needs assessment, market demand and retirement: Allergy/immunology, Dermatology, Endocrinology, Infectious Disease, Neurology, OB/GYN, Pain Management, Psychiatry and Rheumatology. Of the medical staff, 32% is either at or above the age of 55, which poses succession risk. Peninsula Regional a rural hospital, and other like-kind rural communities are typically challenged in both recruitment and retention of physicians due to numerous factors. Some of these challenges are due to the location and geography of the area and availability of healthcare resources. Retaining and recruiting resources in sub-specialties can be hard for regional rural hospitals and Peninsula Regional Medical Center is no exception. To address specific community healthcare needs the Medical Center has had to recruit, retain, employ and subsidize some of the following sub-specialties; Pulmonary, Neuro-Hospitalist, Neurosurgery, Medical Oncology & Hematology, Gastroenterology, Pediatric Specialties, Endocrinology, Cardiology, Cardiovascular Surgery, and Pain Management . Rural communities lack the cultural and educational resources that larger urban centers provide making it harder to retain and recruit these physicians, the spouse/significant other and children. Low population patterns by geography make it more costly and harder for communities and businesses to provide various types of services especially specialty physician services. Overall our local economy is not as robust as the urban centers as acknowledged by our low average household income in the Tri-County area: Wicomico $67,745

	Worcester $82,169 Somerset $50,547 Compared to Maryland $98,950 *Source: Truven Health Analytics* Lower average household income, higher unemployment rates, lower educational attainment, fewer higher paying job opportunities and many other factors may put rural communities at a disadvantage in providing some of these specialty healthcare services that metropolitan centers more readily provide.
Non-Resident House Staff and Hospitalists	N/A
Coverage of Emergency Department Call	As the only Level III trauma center that serves the region and an emergency room with close to 90,000 visits annually, Peninsula Regional must have certain specialties on-call and exclusive contracts with provider groups to guarantee coverage and meet patient demand for these services. Peninsula Regional is the 6th most busy Emergency Room in the State and also receives emergency patients from Sussex County, Delaware and Accomack County, Virginia. The regulatory requirements and benefits of having exclusive arrangements for a large rural tertiary hospital include some of the following: ➢ On-call Trauma Surgeon within 30 minutes of call ➢ On-call Anesthesiologists with CRNA who is in the hospital ➢ On-call Orthopedic Surgeon within 30 minutes of call ➢ On-call Neurosurgeon within 30 minutes of call ➢ Enhances providers' response time to critical care patients in a rural setting ➢ Assures competent coverage and availability of services ➢ Aids in supervision, administration, training and scheduling of coverage

	In order to maintain an adequate number of sub-specialties, sufficient response times and be available to over 450,000 residents in our primary and secondary service area we must provide for Emergency Department Call Coverage. The Medical Center's challenge as a large rural regional tertiary care provider has been to recruit and retain for underserved specialties, and to create comprehensive succession planning that supports the diverse medical needs of the region spread throughout a large geographical area ECG Management Consultants recommends the recruitment of the following medical specialties: **Medical Specialties** Dermatology- 1 FTE OB/GYN- 4 FTEs Infectious Dis 1 FTE Neurology 1 FTE Rheumatology 1 FTE Psychiatry 4 FTEs **Surgical Specialties** Neurosurgery 1 FTE Oral/maxilla. 1 FTE Otolaryngology 1 FTE Plastics 1 FTE Urology 1 FTE Vascular Surgery 1 FTE
Physician Provision of Financial Assistance	N/A
Physician Recruitment to Meet Community Need	There is a very high demand for hospitalist recruitment and other physician recruitment on the Delmarva Peninsula. The implementation of the ACA and Medicare reforms has helped hospitals improve patient satisfaction, reduce length of stay and prevent readmissions. Somerset County is designated as a HPSA (Health Professional Shortage Area) for primary care and certain census tracks around the city of Salisbury located in Wicomico County are also designated.

	A clear advantage is that the addition of hospitalists has reduced the patient load of overburdened community-based primary care physicians. Freeing up community based physicians effectively allows them more time to provide patient visits/care to our patients in rural underserved locations. Another issue is that the Delmarva Peninsula is a very rural area and does not attract everyone. Millennials desire a metro location and many times have to be "sold" on the area. This requires a more direct and personal approach in contacting candidates individually through many forms of communication. Our recruiter attends physician conferences and represents PRMC and its services in attempt to recruit physicians to work here.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	**Mission Driven Statement** Behavioral health and substance abuse services ranked very high as part the latest Community Health Needs Assessment. Eleven community-based key informants discussed both addiction and mental health issues more than any other topic, making this a significant health issue in the region. Due to increasing demand for behavioral health and addiction services, coupled with behavioral health provider shortages, ECG Management Consultants made recommendations that Peninsula Regional recruit 4 Psychiatrists immediately. In 2015, Peninsula Regional and Adventist Behavioral Health and Wellness Services entered into a partnership that will lead the behavioral health service line for the Salisbury-based Peninsula Regional Medical Center's behavioral health unit. They will bring their knowledge and expertise to help enhance and expand behavioral health services to the underserved Tri-County Area. A community assessment for gaps in behavioral health services for the region

	has led to the establishment of a Partial Hospitalization Program at Peninsula Regional. The program is directed towards adults needing to step down from the twelve-bed inpatient psychiatric unit. The transition into the community is an important step and provides more intensive therapy than a primary practice setting could provide, but yet does not need to continue as an inpatient. Peninsula Regional also dedicated a new Rebecca & Leighton Moore Child and Adolescent Outpatient Behavioral Health Unit. Prior to this program being developed there were very limited adolescent services available in the community and to some extent non-existent. To access child behavioral health services, many families would have to travel outside of the area for treatment, inconvenient at best and for some impractical due to time and job constraints. Addressing these issues at the onset and treating at an earlier stage the hope is to lessen the effects of long-term behavioral health issues The goal is to make this convenient and accessible to families in the area. In addition Lower Shore Clinic and Peninsula Regional are collaborating on a 'CareWrap' initiative establishing an outreach team of health professionals, called CareWrap, whose goal will be to enhance access to community based primary and mental health care by targeting people at risk of thirty-day readmission. Thirty-day readmission refers to a patient returning to the hospital within thirty days of discharge, which is an expensive and undesirable outcome for both patient and hospital. ***Conclusion:*** Rural providers and rural residents have issues unlike other more metropolitan areas of our State. Over the next three years, Peninsula Regional is committed to working on a Regional approach with our Tri-County Health Care Partners and

	several local hospitals on the selected identified State Healthcare Improvement Processes objectives (Diabetes, Obesity, Behavioral Health/Addiction). We will continue to work with our other local and national healthcare organizations to promote our third initiative, healthy lifestyles. Peninsula Regional will continue to strengthen its community education & screening initiatives as it relates to diabetes, obesity and living a healthy lifestyle. We continually strive to meet the needs of the underserved/underinsured by providing free wellness screenings at local festivals, churches, civic organization and health fairs in the three lower counties, Wicomico, Worcester and Somerset.

A. 1. Identified Need:
A. 2. How was the need identified:
	Priority Area - Behavioral Health
	In support of Maryland State Health Improvement Process
	SHIP Objective 35: Reduce drug-induced deaths
	SHIP Objective 36: Reduce emergency department visits related to mental health conditions (new measure)
	SHIP Objective 37: Reduce emergency department visits for addictions-related conditions (new measure)
	
	In primary data, mental health was specifically brought up by key informants, being mentioned by nine out of twelve people. Informants repeatedly discussed the growing issue and concerns around lack of resources and services available to address mental health in their community. The following key themes arose out of the key informant interviews:
	• Rising issue with mental health as it relates to drug abuse
	• Lack of support for teens/adolescents with mental health issues
	• Stigma and fear associated with mental health/seeking care for mental illness
	• Lack of resources and services in the community
	• Lost opportunities for those ready to seek care with no place to go
	
	In Wicomico County, indicators of concern included:
	• ER Rate due to Mental Health — the Wicomico County value of 6207.9 ER visits/100,000 population in 2014 was almost double the Maryland state value (3442.6) and the Maryland SHIP 2017 value (3152.6), fell into the worst quartile of Maryland counties, and has been worsening over time
	• Suicide Death Rate — the Wicomico County value of 12.2 deaths/100,000 population in 2012-2014 is higher than the Maryland state value of 9.2, the Maryland SHIP 2017 target of 9.1, and the HP2020 target value of 10.2
	• These indicators also had some poor comparisons:
	  • Self-Reported Good Mental Health
	  • Frequent Mental Distress
	  • Poor Mental Health Days
	
	In Worcester County, the following indicator had multiple poor comparisons:
	• Suicide Death Rate — the Worcester County value of 12 deaths/100,000 population in 2011-2013 is higher than the

	Maryland state value of 9, the Maryland SHIP 2017 target of 9.1, and the HP2020 target value of 10.2 In Somerset County, the indicators of concern included: • ER Rate due to Mental Health — the Somerset County value of 5665.2 ER visits/100,000 population in 2014 was much higher than the Maryland state value (3442.6) and the Maryland SHIP 2017 value (3152.6), and has been worsening over time • Frequent Mental Distress — the Somerset County value of 12.6% in 2014 was higher than the Maryland state value of 10 and fell into the worst quartile of U.S. and Maryland counties • Poor Mental Health Days — the Somerset County value of 12.4 days/previous 30 days in 2014 was higher than the Maryland state value of 3.3 days/previous 30 days and fell into the worst quartile of U.S. and Maryland counties Yes, this was identified through the 2016 CHNA (Community Health Needs Assessment) Report.
B: Name of hospital initiative	**CareWrap** CareWrap is hospital-community collaboration between PRMC and Lower Shore Clinic. The model is based on the Pathways model used by Family Services, Inc., partnering with Washington Adventist and Shady Grove Hospitals to decrease thirty-day readmissions. Program education was provided to PRMC physicians, social workers and RN case managers to identify and refer high-risk patients with dual diagnosis in need of community support. A centralized email process was developed to facilitate ease of referral and clinical review determines appropriateness of referral prior to assignment. The Community Health Workers link patients to community resources and access to the healthcare system to eliminate and/or minimize social determinants of health. Examples include: obtaining housing, medications, transportation and linking to entitled financial assistance or helping find employment. The CareWrap team provides weekly status updates on all patients. This team discusses participant progress as well as identifying barriers and works toward solutions.

C: Total number of people within target population	Located in Salisbury, Maryland, CareWrap is a partnership between Lower Shore Clinic and Peninsula Regional that provides residents of Wicomico County with care coordination, medication compliance and help in accessing and scheduling primary care physician appointments. Predominantly Targets the Salisbury Population: 71,582 The "Transitions Team" at Peninsula Regional targets patients that have a high risk for returning to the hospital within 30 days of discharge. Once identified, those individuals are referred to the CareWrap program. The goal is to reduce hospital readmissions by helping patients access primary care and behavioral health services, and to help fill other social determinants of health gaps to ensure a smooth transition to health stabilization.
D: Total number of people reached by the initiative	The total number of intensive high risk patients reached by the initiative was 55.
E: Primary objective of initiative:	The goal of the initiative is to improve access to and coordination of care for people with mental health and/or substance abuse issues. With the additional purpose of education, chronic disease management, medication adherence and primary care physician access to facilitate healthy lifestyles. The outcome is a reduction in emergency room visits and hospital readmissions.
F: Single or multi-year plan:	Multi-year plan
G: Key collaborators in delivery:	• Peninsula Regional Health System • Lower Shore Clinic of Salisbury, MD • Tri-County PCPs
H: Impact of hospital initiative:	CareWrap has contributed to stabilizing patient's chronic exacerbations of medical and psychological conditions by providing support, encouragement and assistance with problem-solving skills as they transition the patient to an independent status. **CareWrap - creating a program to provide health maintenance for those most at risk in our community through:**

	• Educate doctors, nurses, social workers who could refer participants about CareWrap program • Identify and refer people with mental health issues and medical co-morbidities to program through doctors, nurses and social workers • Connect individuals to resources, drive them to appointments, assist with coordinating medication and therapy resources • Hold weekly team meetings to discuss participant progress as well as identify gaps and work towards solutions	
I: Evaluation of outcome	The CareWrap team will spend an average of about three months with their patients but never releases anyone until they are sure that the person is ready to venture out on their own and with everything needed to obtain the additional resources available to them to help keep them healthy. To see the healthy change in a person is the real measure, we have achieved our main goal if we can improve their quality of life. To date the team has been successful in stabilizing discharged patients at high risk for readmission through one-on-one, face-to-face education and instruction. Ingraining good habits associated with properly managing chronic conditions has helped this at-risk population by keeping them healthier so they do not require our emergency department and hospitalization. The CareWrap team, led by a registered nurse, medical assistants and a benefits coordinator closely follow newly discharged inpatients who agree to participate. For up to three months, the team will: assist in filling prescriptions, see that discharge instructions are being followed, schedule appointments and ensure they are kept, provide instruction on maintaining a healthy lifestyle, and link to social supports, housing, and benefits as eligible. If clients do not have a primary health care provider, they will be offered care at a 'Bridge Clinic' for primary and preventive care.	
J: Continuation of initiative:	Initiative will continue for at least 2 more years and possibly beyond.	
K: Expense:	a. $74,733	b.

A. 1. Identified Need:
A. 2. How was the need identified:
	Priority Area- Behavioral Health
	In support of Maryland State Health Improvement Process
	SHIP Objective 35: Reduce drug-induced deaths
	SHIP Objective 36: Reduce emergency department visits related to mental health conditions (new measure)
	SHIP Objective 37: Reduce emergency department visits for addictions-related conditions (new measure)
	
	In primary data, mental health was specifically brought up by key informants, being mentioned by nine out of twelve people. Informants repeatedly discussed the growing issue and concerns around lack of resources and services available to address mental health in their community. The following key themes arose out of the key informant interviews:
	• Rising issue with mental health as it relates to drug abuse
	• Lack of support for teens/adolescents with mental health issues
	• Stigma and fear associated with mental health/seeking care for mental illness
	• Lack of resources and services in the community
	• Lost opportunities for those ready to seek care with no place to go
	
	In Wicomico County, indicators of concern included:
	• ER Rate due to Mental Health — the Wicomico County value of 6207.9 ER visits/100,000 population in 2014 was almost double the Maryland state value (3442.6) and the Maryland SHIP 2017 value (3152.6), fell into the worst quartile of Maryland counties, and has been worsening over time
	• Suicide Death Rate — the Wicomico County value of 12.2 deaths/100,000 population in 2012-2014 is higher than the Maryland state value of 9.2, the Maryland SHIP 2017 target of 9.1, and the HP2020 target value of 10.2
	• These indicators also had some poor comparisons:
	  • Self-Reported Good Mental Health
	  • Frequent Mental Distress
	  • Poor Mental Health Days
	
	In Worcester County, the following indicator had multiple poor comparisons:
	• Suicide Death Rate — the Worcester County value of 12 deaths/100,000 population in 2011-2013 is higher than the

	Maryland state value of 9, the Maryland SHIP 2017 target of 9.1, and the HP2020 target value of 10.2 In Somerset County, the indicators of concern included: • ER Rate due to Mental Health — the Somerset County value of 5665.2 ER visits/100,000 population in 2014 was much higher than the Maryland state value (3442.6) and the Maryland SHIP 2017 value (3152.6), and has been worsening over time • Frequent Mental Distress — the Somerset County value of 12.6% in 2014 was higher than the Maryland state value of 10 and fell into the worst quartile of U.S. and Maryland counties • Poor Mental Health Days — the Somerset County value of 12.4 days/previous 30 days in 2014 was higher than the Maryland state value of 3.3 days/previous 30 days and fell into the worst quartile of U.S. and Maryland counties Yes, this was identified through the 2016 CHNA (Community Health Needs Assessment) Report.
B: Name of hospital initiative	**COAT Program - Community Outreach Addictions Team** Provides peer support for people who have overdosed or sought help for drug and mental health issues. Created in June of 2016, COAT is a collaboration between Peninsula Regional's Emergency Department, law enforcement, local health departments and others to provide resources and help to residents fighting addiction. In May 2017, Wicomico County announced that the COAT project had been recognized on a national scale by the National Association of County and City Health Officials as a Program of Promising Practice. Fifty-six percent of those reached by the COAT program enter treatment – the national average is 20 percent.
C: Total number of people within target population	The total number of residents within the tri-county area – Wicomico, Worcester and Somerset counties – is 180,533. The target population are those overdose patients who have touchpoints through Wicomico County emergency services, law enforcement or Peninsula Regional emergency room visits. The total number of contacts in FY2017 was approximately 1,000.

D: Total number of people reached by the initiative	The total number of residents who have addictions and behavioral health issues served through the newly established COAT collaborative is as follows: **COAT TEAM STATISTICS** • Outreach through community calls: 976 • Addicts & behavioral health served: 256 • Enrolled in treatment programs: 146 • Attempted contacts for follow-up: 944 COAT has been responsible for linking over 50% of the individuals served to treatment; this is well above the national average of about 20% of individuals accessing treatment.
E: Primary objective of initiative:	• To improve clinical outcomes, overall health and quality of life for our community's residents with diabetes • Teach self-care behaviors that support educated decision-making for healthy lifestyles. • Provide chronic disease management referrals, outreach and collaboration with the local health care team providers. • Provision of resources
F: Single or multi-year plan:	Multi-year plan
G: Key collaborators in delivery:	• Peninsula Regional Health System • Lower Shore Clinic of Salisbury, MD • Wicomico County Health Department • Wicomico County Sheriff's Department • Salisbury City Government- Law Enforcement, EMS, Office of the State's Attorney • Tri-county community PCPs
H: Impact of hospital initiative:	The COAT program is having a dramatic impact in our community providing hope to those that have addiction and behavioral health issues. The program has provided a coordination of care within local EMS, law enforcement, Wicomico County Health

	Department, and Peninsula Regional Emergency Room. After referral of patients, there is phone and in-person support to help provide linkages to resources and to provide the continuity of longitudinal follow-up to prevent recidivism. **The COAT program provides the following:** • Educate doctors, nurses, social workers, law enforcement who could refer participants to COAT program • Train peer support specialists • Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction • Provide linkages to resources, including treatment options • Provide peer outreach to high-risk areas of the community • Maintain ongoing communications about metrics between PRMC and COAT team • Monitor ED recidivism for opioid overdose/addictive needs • Explore ability to expand program outside of Wicomico County	
I: Evaluation of outcome	The program has been well received in the community and has substantially impacted the lifestyle and health of those that have entered treatment. COAT has been responsible for linking over 50% of the individuals served to treatments, far above the national average of 20%. • Explore the possibility of expanding the program • Review the efficacy of implementing a tele-health program for behavioral health in the coming year.	
J: Continuation of initiative:	Initiative will continue for at least 2 more years and possibly beyond.	
K: Expense:	a. $84,387	b.

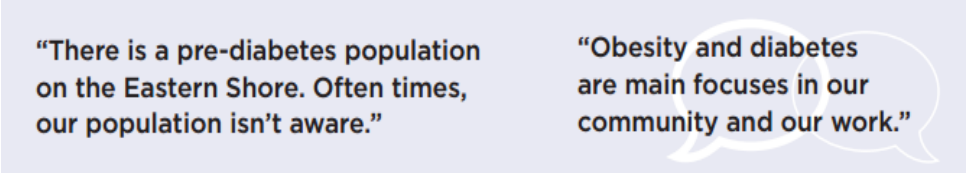
A. 1. Identified Need: A. 2. How was the need identified:	Reduce diabetes complications as measured by SHIP 27. Reduce diabetes-related emergency department visits. We need to raise the level of diabetes awareness, education and diabetes management in the community. *Peninsula Regional engaged HCI (Healthy Communities Institute) to conduct a Community Health Needs Assessment Survey (2016). The CHNA findings were drawn from analysis of primary data interviewing community health leaders and organizations that serve the community at large.* ***The secondary data analysis for diabetes resulted in a score that ranked in the top ten in the list of health concerns for the tri-county area.*** *There are specific diabetes-related indicators of concern across the three counties:* • *Adults with Diabetes (highest in Worcester County)* • *ER Rate due to Diabetes (highest in Wicomico County)* • *Diabetes Death Rate (highest in Somerset County)* • *Diabetes in the Medicare Population (highest in Somerset County)* ***In Wicomico County, which has the largest population of the tri-county area, three indicators had multiple extremely poor comparisons:*** • *Diabetes in the Medicare Population — the Wicomico County value of 31.3% in 2014 was higher than the U.S. value of 26.7% and fell in the bottom quartile of U.S. counties* • *Adults with Diabetes — the Wicomico County value of 12.9% in 2014 was much higher than the Maryland value of 10.2% and the U.S. value of 10%* • *ER Rate Due to Diabetes — the Wicomico County value of 372.7 ER visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties* ***In Worcester County, one indicator had multiple extremely poor comparisons:*** • *Adults with Diabetes — the Worcester County value of 18.2% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland Counties* ***In Somerset County, four indicators had multiple extremely poor comparisons:***

- *Diabetes in the Medicare Population — the Somerset County value of 34% in 2014 was higher than the U.S. value of 26.7%, the Maryland value of 29%, and fell in the bottom quartile of both U.S. counties and Maryland counties*
- *Age-Adjusted Death Rate Due to Diabetes — the Somerset County value of 25.2 deaths/100,000 population in 2010-2012 was higher than the U.S. value of 21.2, the Maryland value of 19.9, and fell in the bottom quartile of Maryland counties*
- *Adults with Diabetes — the Somerset County value of 13.3% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland counties*
- *ER Rate Due to Diabetes — the Somerset County value of 253.8 ER visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties*

Prevalence of diabetes is high in this community – higher than average within both Maryland and the country. Management of the disease among those with diabetes is inadequate, as evidenced by the high ER and death rates.

When looking at sub-populations disproportionately impacted by diabetes, the Black community has a greater burden of the disease, almost double the prevalence of the White community. Of adults, in Wicomico County 16.9% of Black adults have diabetes, compared to 9.8% of White adults. In Somerset County, 28.8% of Black adults have diabetes, compared to 9.9% of White adults. There are also disparities for women in Somerset County with almost triple the diabetes prevalence of men — 20.6% of women have diabetes, compared to 7.5% of men. Asian and Other Race groups are also disproportionately affected in Wicomico County, with 17.9% of Asian adults and 33.1% of Other Race adults impacted by diabetes.

The figure below indicates some direct quotes from key informants regarding diabetes and related health issues in their community and the populations most impacted.



Yes, this was identified through the CHNA process.

B: Name of hospital initiative	**Chronic Disease Self-Management Classes (CDSM) To Be Offered** Provide awareness, education and diabetes management to the community. The goals and initiatives include: reducing the number of diabetes-related emergency room visits; tracking the number of tri-county diabetes patients that have completed the self-management program; offer classes in English and Spanish; offer six-week classes weekly; and continue to increase community participation in diabetes management and education programs. **Peninsula Regional has partnered with MAC (Maintaining Active Citizens) to provide evidence-based classes.** Point of entry into these ongoing programs at the MAC Center originates from many different providers and other outreach programs that are working locally in unison. Peninsula Regional's Wagner Wellness Van, SWIFT, Peninsula Regional Weight Loss and Wellness Center, local churches, physicians and civic organizations are aware of the program and are referring patients. **Evidence-Based Classes Offered at MAC** **Diabetes Self-Management:** Diabetes is associated with an increased risk for a number of serious, even life-threatening, complications. Good diabetes control can help reduce the risk of these complications. Topics include nutrition, exercise, stress management, foot care and more. This class is also available in Spanish. **Chronic Pain Self-Management:** Chronic pain can be debilitating and may lead to isolation and depression. Better management of chronic pain can help participants feel better, move better and improve quality of life. **Chronic Disease Self-Management:** Chronic disease, such as heart disease, stroke, cancer and arthritis, are leading causes of disability in the U.S. Participants will learn to cope with the fatigue, frustration and pain that accompany chronic disease, and exercises for improving strength and endurance, all which have been shown to improve health and decrease hospital stays. **Living Well With Hypertension:** Untreated hypertension is the leading cause of kidney disease and failure, and can lead to stroke and heart attacks. Participants will learn blood pressure management strategies. **Diabetes Prevention Program:** This lifestyle change intervention program is designed to help participants make lasting changes to

	reduce their risk of developing Type 2 Diabetes. Developed by the Centers for Disease Control & Prevention, this program offers participants the skills they need to lose weight, be more physically active and manage stress. They have a trained lifestyle coach to guide and encourage participants, as well as support from other participants, and six monthly follow-up sessions to help participants maintain healthy lifestyle changes. *Must be pre-diabetic or demonstrate a high risk of developing Type 2 diabetes.* **PEARLS:** There are many losses associated with aging – loss of health, loved ones, and independence – and these losses can lead to feelings of loneliness, frustration, anxiousness and restlessness. Left unattended, these feelings can lead to depression, and affect quality of life. PEARLS (Program to Encourage Active Rewarding Lives) is a free one-on-one counseling program designed to help those age 60 and older learn how to manage these feelings and improve their quality of life (*Funding provided by The Women's Fund*) **Walk with Ease:** This new exercise program seeks to help reduce pain and improve health for those living with different types of arthritis and other related conditions that cause pain and stiffness in the joints. This program will help participants walk safely and comfortably, improve flexibility, strength and stamina, and reduce pain.
C: Total number of people within target population	The total number of residents within the tri-county area – Wicomico, Worcester and Somerset counties – is 180,533. Within the CBSA, it is projected that more than 20,000 have the chronic disease diabetes. Projected residents with diabetes: Wicomico - 10,838 Worcester - 6,601 Somerset - 3,521 Targeted patients include those with uncontrolled diabetes identified through multiple emergency room visits, indigent patients who have been screened on the Wagner Wellness Van, and patients who have been identified as at risk for diabetes from other providers.
D: Total number of people reached by the initiative	The total number of participants in the Chronic Disease Self-Management Classes at the MAC Center for Peninsula Regional was 311, with 92 attending the diabetes program. **Chronic Disease Management**

Number of workshops: 28

Average participants per workshop: 11.1
Number of participants: 311
Participants with attendance data: 311
Completers: 248 of 311 (80%)
Number who are caregivers: 65 of 274 (24%)

Gender	Count	Percent
Female	220	73%
Male	81	27%
Unknown	10	

Ethnicity/Race	Count	Percent
White/Caucasian	118	47%
Black or African American	90	36%
Hispanic/Latino	63	25%
American Indian or AK Native	5	2%
Asian or Asian American	4	2%
Hawaiian Native or Pacific Islander	3	1%
Unknown	59	

Age	Count	Percent
0—44	30	14%
44—49	13	6%
50—54	14	6%
55—59	32	15%
60—64	19	9%
65—69	23	11%
70—74	21	10%
75—79	22	10%
80—84	25	11%
85—89	11	5%
90+	8	4%
Unknown	93	

People in Household	Count	Percent
1	42	34%
2	40	33%
3	14	11%
4	13	11%

5	6	5%
6	5	4%
7	2	2%
Unknown	189	

Lives Alone	Count	Percent
No	222	83%
Yes	47	17%
Unknown	42	

Chronic Condition	Count	Percent
Hypertension	120	60%
Diabetes	92	46%
Arthritis	86	43%
Chronic Pain	48	24%
Depression or Mental Illness	43	21%
Lung Disease	39	19%
Heart Disease	38	19%
Cancer	26	13%
Osteoporosis	19	9%
Stroke	14	7%
Obesity	13	6%
Kidney Disease	4	2%
Alzheimer's	3	1%
Schizophrenia	1	0%
Other	10	5%
Unknown	15	

Condition Count	Count	Percent
Multiple chronic conditions	152	51%
No chronic conditions	95	32%
One chronic condition	49	17%
Unknown	15	

Participant County	Count	Percent
Wicomico, MD	180	58%
Somerset, MD	47	15%
Worcester, MD	41	13%
Dorchester, MD	22	7%
Kent, MD	7	2%
Talbot, MD	7	2%
Caroline, MD	4	1%
Sussex, DE	2	1%
Accomack, VA	1	0%

Caregiver	Count	Percent
No	209	76%
Yes	65	24%
Unknown	37	

Education	Count	Percent
Completed High School	73	35%
Some College	67	32%
Some High School	41	20%
Completed College	26	13%
Unknown	104	

Organization	Count	Percent
MAC Inc	311	100%

Hearing Impaired	Count	Percent
No	156	96%
Yes	6	4%
Unknown	149	

Vision Impaired	Count	Percent
No	225	97%
Yes	8	3%
Unknown	78	

Activities Are Difficult	Count	Percent
No	208	98%
Yes	4	2%
Unknown	99	

Health	Count	Percent
Good	32	51%
Fair	18	29%
Very Good	8	13%
Excellent	3	5%
Poor	2	3%
Unknown	248	

Referred	Count	Percent
No	311	100%

Can Manage Condition	Count	Percent
10	10	26%
9	9	24%

8	9	24%
7	8	21%
5	1	3%
6	1	3%
Unknown	273	

Insurance	Count	Percent
Medicare	111	63%
Medicaid	38	22%
United	33	19%
BC/BS	30	17%
No Insurance	10	6%
Aetna	7	4%
Veterans Health	5	3%
Cigna	3	2%
TriCare	1	1%
Other	13	7%
Unknown	135	

Spanish DSMP
7/1/16 - 6/30/17
There is a contingency of Spanish-speaking residents in the community. This program was designed to provide outreach and assistance to this underserved population.

Number of workshops: 5

Average participants per workshop: 14.8
Number of participants: 74
Participants with attendance data: 74
Completers: 70 of 74 (95%)
Number who are caregivers: 11 of 45 (24%)

Gender	Count	Percent
Female	42	60%
Male	28	40%
Unknown	4	

Ethnicity/Race	Count	Percent

Hispanic/Latino	59	89%
White/Caucasian	25	38%
Hawaiian Native or Pacific Islander	2	3%
Black or African American	2	3%
Unknown	8	

Age	Count	Percent
0—44	15	45%
44—49	4	12%
50—54	5	15%
55—59	3	9%
60—64	1	3%
65—69	1	3%
75—79	4	12%
Unknown	41	

People in Household	Count	Percent
4	8	44%
5	4	22%
2	3	17%
1	2	11%
6	1	6%
Unknown	56	

Lives Alone	Count	Percent
No	37	95%
Yes	2	5%
Unknown	35	

Chronic Condition	Count	Percent
Diabetes	9	39%
Hypertension	9	39%
Arthritis	5	22%
Lung Disease	4	17%
Depression or Mental Illness	4	17%
Osteoporosis	2	9%
Heart Disease	2	9%
Obesity	2	9%
Cancer	1	4%
Kidney Disease	1	4%
Other	2	9%
Unknown	10	

Condition Count	Count	Percent
No chronic conditions	41	64%
One chronic condition	13	20%
Multiple chronic conditions	10	16%
Unknown	10	

Participant County	Count	Percent
Wicomico, MD	74	100%

Caregiver	Count	Percent
No	34	76%
Yes	11	24%
Unknown	29	

Education	Count	Percent
Completed High School	12	44%
Some High School	8	30%
Some College	6	22%
Completed College	1	4%
Unknown	47	

Organization	Count	Percent
MAC Inc	74	100%

Hearing Impaired	Count	Percent
No	48	100%
Unknown	26	

Vision Impaired	Count	Percent
No	48	100%
Unknown	26	

Activities Are Difficult	Count	Percent
No	33	100%
Unknown	41	

BP
7/1/16 - 6/30/17

Hypertension Chronic Disease Workshop
Number of workshops: 10

Average participants per workshop: 8.5
Number of participants: 85

Participants with attendance data: 0
Completers: 0 of 0
Number who are caregivers: 20 (24%)

Gender	Count	Percent
Female	62	73%
Male	23	27%

Ethnicity/Race	Count	Percent
Black or African American	40	50%
White/Caucasian	39	49%
Asian or Asian American	1	1%
Unknown	5	

Age	Count	Percent
0—44	6	8%
44—49	5	7%
50—54	9	12%
55—59	11	14%
60—64	8	11%
65—69	14	18%
70—74	9	12%
75—79	5	7%
80—84	6	8%
85—89	2	3%
90+	1	1%
Unknown	9	

People in Household	Count	Percent
2	19	39%
1	13	27%
3	11	22%
4	4	8%
5	1	2%
7	1	2%
Unknown	36	

Lives Alone	Count	Percent
No	72	85%
Yes	13	15%

Chronic Condition	Count	Percent

Hypertension	48	66%
Diabetes	45	62%
Arthritis	27	37%
Depression or Mental Illness	20	27%
Chronic Pain	16	22%
Heart Disease	14	19%
Lung Disease	12	16%
Osteoporosis	8	11%
Cancer	6	8%
Stroke	4	5%
Alzheimer's	1	1%
Kidney Disease	1	1%
Other	16	22%

Condition Count	Count	Percent
Multiple chronic conditions	63	74%
No chronic conditions	12	14%
One chronic condition	10	12%

Participant County	Count	Percent
Wicomico, MD	56	66%
Somerset, MD	25	29%
Worcester, MD	4	5%

Caregiver	Count	Percent
No	65	76%
Yes	20	24%

Education	Count	Percent
Some College	37	49%
Completed High School	17	22%
Some High School	12	16%
Completed College	10	13%
Unknown	9	

Organization	Count	Percent
MAC Inc	85	100%

Hearing Impaired	Count	Percent
No	80	98%
Yes	2	2%
Unknown	3	

Vision Impaired	Count	Percent

No	80	98%
Yes	2	2%
Unknown	3	

Stepping On
7/1/16 - 6/30/17
Falling can cause serious injury in the elderly and can result in an inpatient hospital admission
Stepping On is a fall-prevention program for those in the community-residing elderly. It is a seven-week workshop designed to lower the risk of falling. About 30% of older people who fall lose their self-confidence and start to go out less often. Inactivity leads to social isolation and loss of muscle strength and balance, increasing the risk of falling.

Number of workshops: 11

Average participants per workshop: 16.1
Number of participants: 177
Participants with attendance data: 177
Completers: 119 of 177 (67%)
Number who are caregivers: 0 of 147 (0%)

Gender	Count	Percent
Female	140	83%
Male	29	17%
Unknown	8	

Ethnicity/Race	Count	Percent
White/Caucasian	134	82%
Black or African American	27	17%
Hispanic/Latino	2	1%
American Indian or AK Native	1	1%
Asian or Asian American	1	1%
Unknown	14	

Age	Count	Percent
0—44	2	1%
50—54	1	1%
55—59	2	1%
60—64	9	7%

65—69	18	13%
70—74	20	15%
75—79	31	23%
80—84	28	20%
85—89	19	14%
90+	7	5%
Unknown	40	

People in Household	Count	Percent
1	6	100%
Unknown	171	

Lives Alone	Count	Percent
No	147	96%
Yes	6	4%
Unknown	24	

Chronic Condition	Count	Percent
Arthritis	98	70%
Diabetes	46	33%
Heart Disease	37	26%
Lung Disease	22	16%
Depression or Mental Illness	21	15%
Hypertension	16	11%
Kidney Disease	2	1%
Chronic Pain	1	1%
MS	1	1%
Cancer	1	1%
Osteoporosis	1	1%
Other	48	34%
Unknown	1	

Condition Count	Count	Percent
Multiple chronic conditions	93	53%
One chronic condition	48	27%
No chronic conditions	35	20%
Unknown	1	

Participant County	Count	Percent
Wicomico, MD	93	53%
Somerset, MD	42	24%
Dorchester, MD	28	16%
Worcester, MD	14	8%

Caregiver	Count	Percent
No	147	100%
Unknown	30	

Education	Count	Percent
Some College	57	36%
Completed High School	48	31%
Completed College	43	27%
Some High School	9	6%
Unknown	20	

Organization	Count	Percent
MAC Inc	177	100%

Hearing Impaired	Count	Percent
No	101	100%
Unknown	76	

Vision Impaired	Count	Percent
No	123	100%
Unknown	54	

E: Primary objective of initiative:	• To improve clinical outcomes, overall health and quality of life for our community's residents with diabetes • Teach self-care behaviors that support educated decision-making for healthy lifestyles. • Provide chronic disease management referrals, outreach and collaboration with the local health care team providers. • Provision of resources
F: Single or multi-year plan:	Multi-year plan
G: Key collaborators in delivery:	• PRMC • MAC, Inc. • Atlantic General Hospital (AGH) • McCready Health • Peninsula Regional Clinically Integrated Network (PRCIN)

<table>
<tr><td></td><td>

Local Health Departments in the tri-county area
Local community centers and churches

</td></tr>
<tr><td>H: Impact of hospital initiative:</td><td>

Increase access and referrals to chronic disease management classes.
Identification of health risks/behaviors through screenings
Development of a network of providers that positively impacts chronic disease health at a grassroots level.
Residents completing the program can better manage the disease, reducing ER visits and hospital admissions

</td></tr>
<tr><td>I: Evaluation of outcome</td><td>

Post Program Survey
Current monitoring of ED and Admissions data for reduction in utilization

Post Survey
Chronic Disease Management
Number of workshops: 28

<table>
<tr><th>My peer leaders made me feel welcome and a part of the group</th><th>Count</th><th>Percent</th></tr>
<tr><td>Strongly Agree (1)</td><td>133</td><td>79%</td></tr>
<tr><td>Agree (2)</td><td>33</td><td>20%</td></tr>
<tr><td>Disagree (3)</td><td>3</td><td>2%</td></tr>
<tr><td>Average Value</td><td>1.2</td><td></td></tr>
</table>

<table>
<tr><th>My peer leaders shared teaching responsibilities</th><th>Count</th><th>Percent</th></tr>
<tr><td>Strongly Agree (1)</td><td>128</td><td>76%</td></tr>
<tr><td>Agree (2)</td><td>40</td><td>24%</td></tr>
<tr><td>Disagree (3)</td><td>1</td><td>1%</td></tr>
<tr><td>Average Value</td><td>1.2</td><td></td></tr>
</table>

<table>
<tr><th>The peer leaders were prepared when they came to class</th><th>Count</th><th>Percent</th></tr>
<tr><td>Strongly Agree (1)</td><td>132</td><td>78%</td></tr>
<tr><td>Agree (2)</td><td>36</td><td>21%</td></tr>
<tr><td>Disagree (3)</td><td>1</td><td>1%</td></tr>
<tr><td>Average Value</td><td>1.2</td><td></td></tr>
</table>

<table>
<tr><th>I have more self-confidence in my ability to manage my</th><th>Count</th><th>Percent</th></tr>
</table>
</td></tr>
</table>

health than I did before taking this workshop		
Strongly Agree (1)	102	61%
Agree (2)	63	38%
Disagree (3)	2	1%
Average Value	1.4	

The book that we used for the workshop was very helpful	Count	Percent
Strongly Agree (1)	105	63%
Agree (2)	60	36%
Disagree (3)	1	1%
Strongly Disagree (4)	1	1%
Average Value	1.4	

I learned how to set an action plan and follow it	Count	Percent
Strongly Agree (1)	97	57%
Agree (2)	72	43%
Average Value	1.4	

I now have a better understanding of how to manage the symptoms of my chronic health conditions	Count	Percent
Strongly Agree (1)	96	58%
Agree (2)	69	42%
Disagree (3)	1	1%
Average Value	1.4	

The site used for the workshop was conducive to learning	Count	Percent
Strongly Agree (1)	115	69%
Agree (2)	49	29%
Disagree (3)	2	1%
Strongly Disagree (4)	1	1%
Average Value	1.3	

I felt my opinions and contributions to the group	Count	Percent

were valued by the other participants		
Strongly Agree (1)	110	66%
Agree (2)	57	34%
Average Value	1.3	

The peer leaders were able to manage the group very well	Count	Percent
Strongly Agree (1)	116	72%
Agree (2)	46	28%
Average Value	1.3	

I felt my opinions and contributions to the group were valued by the peer leaders	Count	Percent
Strongly Agree (1)	109	69%
Agree (2)	50	31%
Average Value	1.3	

My peer leaders got along well together	Count	Percent
Strongly Agree (1)	123	77%
Agree (2)	36	22%
Disagree (3)	1	1%
Average Value	1.2	

I valued the time to talk to other participants at break time	Count	Percent
Strongly Agree (1)	88	56%
Agree (2)	66	42%
Disagree (3)	3	2%
Strongly Disagree (4)	1	1%
Average Value	1.5	

I noticed that some participants did not come back to the workshop after the first week	Count	Percent
Strongly Agree (1)	42	28%
Agree (2)	59	39%
Disagree (3)	33	22%
Strongly Disagree (4)	17	11%
Average Value	2.2	

<table>
<tr><td></td><td colspan="2"><table>
<tr><th>I feel more motivated to take care of my health since I took this workshop</th><th>Count</th><th>Percent</th></tr>
<tr><td>Strongly Agree (1)</td><td>109</td><td>67%</td></tr>
<tr><td>Agree (2)</td><td>52</td><td>32%</td></tr>
<tr><td>Disagree (3)</td><td>1</td><td>1%</td></tr>
<tr><td>Average Value</td><td>1.3</td><td></td></tr>
</table></td></tr>
<tr><td>J: Continuation of initiative:</td><td colspan="2">Initiative will continue for at least 2 more years and possibly beyond.</td></tr>
<tr><td>K: Expense:</td><td>a. $119,500</td><td>b.</td></tr>
</table>

A. 1. Identified Need: A. 2. How was the need identified:	**OBESITY- EXERCISE, NUTRITION, and WEIGHT** SHIP 31. Reduce the proportion of children and adolescents who are considered obese. *The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included:* • *Adults who are Obese* • *Child Food Insecurity Rate* ***In Wicomico County, which has the largest population of the tri-county area, several indicators had multiple, extremely poor comparisons:*** • *Adults who are Obese — the Wicomico County value of 34.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%* • *Adults with a Healthy Weight — the Wicomico County value of 31.3% in 2014 was lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%* • *Other environmental indicators related to Nutrition and Exercise with poor comparisons included:* o *Child Food Insecurity Rate* o *Food Environment Index* o *Food Insecurity Rate* o *Grocery Store Density* o *Low-Income and Low Access to a Grocery Store* o *Fast Food Restaurant Density* o *Workers who Walk to Work* ***In Worcester County, several indicators had multiple extremely poor comparisons, mostly related to environment:*** • *Child Food Insecurity Rate* • *65+ with Low Access to a Grocery Store* • *Fast Food Restaurant Density* ***Somerset County had the most indicators with very poor comparisons:*** • *Adults who are Obese — the Somerset County value of 49.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%. Also, Somerset County fell in the bottom quartile of Maryland counties.*

	• *Adults with a Healthy Weight — the Somerset County value of 21.2% in 2014 was much lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adults who are overweight or obese — the Somerset County value of 79.8% in 2014 was much higher than the U.S. value of 65% and Maryland value of 64.9%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties* ***Other environmental indicators related to Nutrition and Exercise with poor comparisons included:*** • *Child Food Insecurity Rate* • *Food Insecurity Rate* • *Food Environment Index* • *Access to Exercise Opportunities* • *Low-Income and Access to a Grocery Store* *When looking at sub-populations with disparities for Exercise, Nutrition, and Weight, we see racial and ethnic disparities as well as gender. In Worcester County adults, Blacks (47%) are more obese than Whites (27.1%). In Somerset County adults, Blacks (74%) and Latinos (60.3%) are more obese than Whites (40.8%); women (62.4%) are more obese than men (39.9%).* ***COMMUNITY INPUT:** Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area.* ***COMMUNITY INPUT*** Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area. Yes, this was identified through the 2016 CHNA (Community Health Needs Assessment) process. Both the primary and secondary data supports the need to reduce obesity and to support healthy lifestyle programs.
B: Name of hospital initiative	Develop and implement improving Walkability in Wicomico County Program. The "*Walk Wicomico"* project brings community partners together to discuss creating walking trails and other venues to improve walkability in Wicomico County. Peninsula Regional's Weight Loss and

	Wellness Center is a participant in this project which emphasizes the importance of getting out and exercising.
C: Total number of people within target population	"Walk Wicomico" is primarily targeting those that reside in the county (pop. 104,756); however, it would also be an attraction for adjacent counties including visitors.
D: Total number of people reached by the initiative	This project is currently in the preliminary stages, including committee meetings, staging and identification of potential sites, gathering of GIS data mapping and review of signals, sidewalks, ADA requirements etc. The data and committee review will guide the project as the infrastructure is developed to provide safe walkability improvements in the County.
E: Primary objective of initiative:	The primary objective is to increase awareness of and engagement in healthy lifestyle behaviors promoting exercise to help with weight loss, increase energy, reduce risk of chronic disease and make people feel happier.
F: Single or multi-year plan:	This continues to be a multi-year initiative that will continue into the future.
G: Key collaborators in delivery:	• Peninsula Regional • Wicomico County Health Department • Eastern Shore Regional GIS Cooperative • Community Support • Other Local Partners
H: Impact of hospital initiative:	The Hospital is an active participant in transforming the communities' culture by providing education, guidance and resources towards promoting exercise through walkability as an integral part of a healthy lifestyle commitment. **Activities:** • Attend planning sessions of collaborative • Determine regions of focus within Wicomico County • Explore expansion to other counties • Create walkability maps for community members • Develop communications plan to message to community
I: Evaluation of outcome	The evaluation of outcomes are to be advanced after the preliminary work has been accomplished and the project has moved onto the next phase.
J: Continuation of initiative:	Initiative will continue for at least 2 more years and possibly beyond.

Table III – FY 2017 Community Benefits Narrative Report
Priority Area Exercise, Nutrition, and Weight- Develop & Improve Walkability in Wicomico County Program

K: Expense:	a.	b.

A. 1. Identified Need: A. 2. How was the need identified:	**OBESITY- EXERCISE, NUTRITION, and WEIGHT** SHIP 31. Reduce the proportion of children and adolescents who are considered obese. *The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included:* • *Adults who are Obese* • *Child Food Insecurity Rate* ***In Wicomico County, which has the largest population of the tri-county area, several indicators had multiple, extremely poor comparisons:*** • *Adults who are Obese — the Wicomico County value of 34.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%* • *Adults with a Healthy Weight — the Wicomico County value of 31.3% in 2014 was lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%* • *Other environmental indicators related to Nutrition and Exercise with poor comparisons included:* o *Child Food Insecurity Rate* o *Food Environment Index* o *Food Insecurity Rate* o *Grocery Store Density* o *Low-Income and Low Access to a Grocery Store* o *Fast Food Restaurant Density* o *Workers who Walk to Work* ***In Worcester County, several indicators had multiple extremely poor comparisons, mostly related to environment:*** • *Child Food Insecurity Rate* • *65+ with Low Access to a Grocery Store* • *Fast Food Restaurant Density* ***Somerset County had the most indicators with very poor comparisons:*** • *Adults who are Obese — the Somerset County value of 49.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of*

	30.5%. Also, Somerset County fell in the bottom quartile of Maryland counties. • *Adults with a Healthy Weight — the Somerset County value of 21.2% in 2014 was much lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adults who are overweight or obese — the Somerset County value of 79.8% in 2014 was much higher than the U.S. value of 65% and Maryland value of 64.9%. Also, Somerset County fell in the bottom quartile of Maryland counties* • *Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties* ***Other environmental indicators related to Nutrition and Exercise with poor comparisons included:*** • *Child Food Insecurity Rate* • *Food Insecurity Rate* • *Food Environment Index* • *Access to Exercise Opportunities* • *Low-Income and Access to a Grocery Store* *When looking at sub-populations with disparities for Exercise, Nutrition, and Weight, we see racial and ethnic disparities as well as gender. In Worcester County adults, Blacks (47%) are more obese than Whites (27.1%). In Somerset County adults, Blacks (74%) and Latinos (60.3%) are more obese than Whites (40.8%); women (62.4%) are more obese than men (39.9%). COMMUNITY INPUT Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area.* ***COMMUNITY INPUT*** Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area. Yes, this was identified through the CHNA process and the consensus was that the YMCA would make an appropriate partner since their mission parallels the community need. Working together clinicians and program coordinators to transition patients into a healthy lifestyle programs.
B: Name of hospital initiative	Reduce the # of child & adolescents/adults in Wicomico, Worcester and Somerset who are considered overweight and present a healthy lifestyle of nutrition and exercise opportunities.

The partnership with the YMCA seeks to establish monthly educational series on a number of health-related topics, participation by PRMC clinical teams in YMCA programs and services, health literacy programs for families, increased blood pressure and hypertension monitoring, enhanced diabetes education and a focused collaboration around the Y's successful Healthy Us initiative to combat **childhood obesity**.

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

HealthFest- An Annual Health Fair sponsored by Peninsula Regional for the residents of Salisbury (1,500+ attendance) which promotes health lifestyles through nutritional education and exercise- as it targets hypertension, and chronic disease among other screenings:

- Blood Pressure
- Height/Weight/Waist Measurement/ Nutritional Counseling
- Body Fat
- Kidney Health
- Mental Health Assessment
- Oral Cancer
- Colorectal Information
- Breast Education
- Bone Density
- Hearing /Vision
- Diabetes Assessment
- Glaucoma

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

Heart Smart Community Screenings are provided to the community to promote a healthy heart though understanding of lifestyle and risk factors that can help reduce the risk of heart disease. These are free and comprehensive screenings.

Screenings include:

- Cholesterol, HDL, triglycerides, fasting blood glucose
- Resting 12-lead EKG
- Body fat and body mass index
- Waist to hip ratio

<table>
<tr><td></td><td>

Blood pressure testing
Pulse oximetry testing
10-year risk analysis
Review of current medications
Follow-up care plan

Exercise/nutrition recommendations

Peninsula Regional Weight Loss and Wellness Center located in Salisbury Maryland offers a number of medically- monitored weight loss options to guide and support patients on their journey to a healthier you. The Center uses small support groups to keep patients on track along with an on-site gym, organic garden that supports both exercise and healthy eating.

See Appendix A for Strategy Implementation Plan
</td></tr>
<tr><td>C: Total number of people within target population</td><td>
PRMC services a rural population where the percentage of adults who are obese is very high. Compared to other Maryland counties both Somerset and Wicomico have an exceptionally high number of adults who are overweight or obese.

Peninsula Regional has partnered with the YMCA, the largest human services organization in the region with over 27,000 active members at 7 locations across the Maryland's Eastern Shore and in Chincoteague, VA.

Adults who are Overweight or Obese
<table>
<tr><th></th><th>VALUE</th><th>COMPARED TO:</th></tr>
<tr><td>County: Somerset, MD</td><td>79.8%
(2014)</td><td>MD Counties</td></tr>
<tr><td>County: Wicomico, MD</td><td>68.7%
(2014)</td><td>MD Counties</td></tr>
<tr><td>County: Worcester, MD</td><td>63.8%
(2014)</td><td>MD Counties</td></tr>
</table>
Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community wide health care initiative.

Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties
</td></tr>
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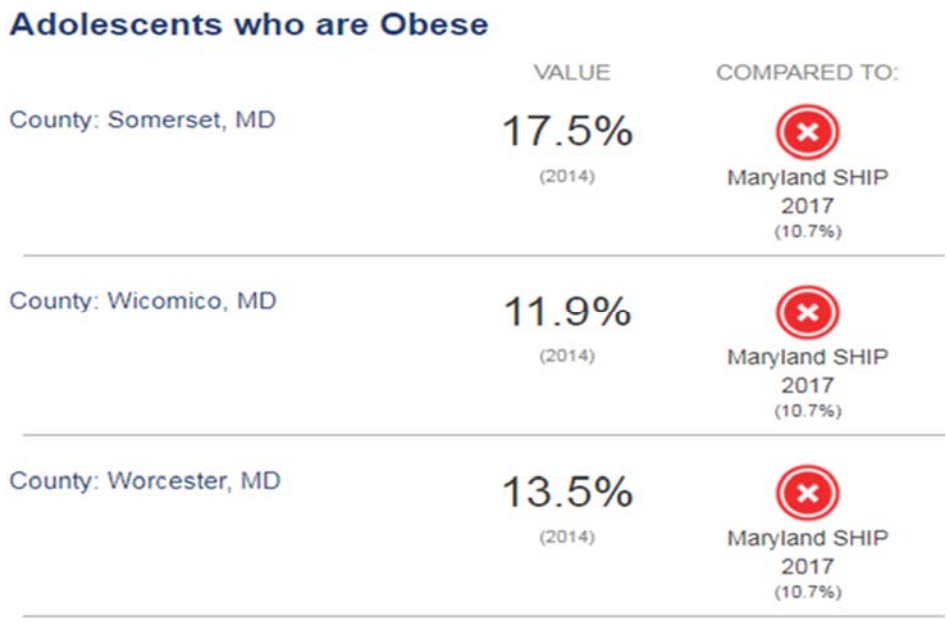
<tr><td></td><td> 

Source: 2017 HCI Community Health Needs Assessment</td></tr>
<tr><td>D: Total number of people reached by the initiative</td><td>Total Community Benefit nutritional and healthy lifestyle encounters or “touchpoints” in FY2017 exceeds over 8,000 residents. This is based upon the programs provided and through participation and interactions in community fairs and festivals.
We are continuing to explore and develop our relationship with the YMCA in support of healthy lifestyles which has the potential to reach over 27,000 residents.</td></tr>
<tr><td>E: Primary objective of initiative:</td><td>The primary objective is to increase awareness of and engagement in healthy lifestyle behaviors promoting healthy weight, nutrition and exercise.</td></tr>
<tr><td>F: Single or multi-year plan:</td><td>This continues to be a multi-year initiative that will continue into the future. In addition, there will be an expansion of the obesity-based initiative as a result of the most current 2016 CHNA. The priority area will be broadened to include Exercise, Nutrition and Weight which will encompass several new strategies with the goal of increasing awareness and engagement in healthy lifestyle behaviors.

Strategies
1. Implement an after-school program for weight loss in collaboration with the YMCA (Healthy Us).
Other future discussions and program development with the YMCA include:
- Healthy Lifestyles and Weight Loss Partnership
- Chronic Disease Management with Focus on Diabetes
- Therapy Pool Collaboration for Rehabilitation Patients</td></tr>
</table>

	- Cancer Rehabilitation and Exercise Program 2. Develop and implement Improving Walkability in Wicomico County program.
G: Key collaborators in delivery:	PRMC Health and Wellness Committee working with local employers, community groups and attends community events. • YMCA • Schools • Pediatric Referring Physicians • Wicomico County Health Department • Eastern Shore Regional GIS Cooperative
H: Impact of hospital initiative:	Track number of venues information was distributed. Peninsula Regional participated in over fifty health festivals and fairs at which 8,000+ encounters or "touch points" occurred where local residents were introduced to healthy lifestyles, health education and preventive screenings. Residents were matched with health resources based upon need, and as a consequence elevated the awareness of where and how to access care. The community is becoming better educated on what constitutes healthy living as the status quo culture is challenged by presenting alternatives that promote their well-being. Peninsula Regional is continuing to meet with and explore expansion and development of new healthy lifestyle programs with the YMCA. **Promo Sampling** 250 "Healthy Steamer Bowls" distributed for healthy eating 250 "Healthy Lifestyle Recipe Cards" shared with residents 250 "Healthy Lifestyle Coloring Books" passed out to children 1000 Know your medicine pill boxes distributed Over 1,000 beach balls, jump ropes, frisbees and airplanes distributed to children to promote outdoor physical activity. 100 Tooth brushes/paste and dental books passed out to children 800 Bottles of sunscreen distributed to promote smart sun exposure.

I: Evaluation of outcome	The outcomes are evaluated individually based upon response rate and participation and by the Community Benefits Task Force.	
J: Continuation of initiative:	Initiative will continue for at least 2 more years and possibly beyond.	
K: Expense:	a.	b.

Table III – FY 2017 Community Benefits Narrative Report
Priority Area Diabetes- Wagner Wellness Van

A. 1. Identified Need: A. 2. How was the need identified:	• Diabetes • Exercise, Nutrition, and Weight • Heart disease and stroke • Access to health services Identified through the CHNA, (Community Health Needs Assessment) 2016.
B: Name of hospital initiative	**Wagner Wellness Van Mobile Outreach Clinic** To address the identified needs, the Wagner Wellness Van was deployed to locations in all three counties to serve as a clinic on wheels. Primarily, the van staff, which includes an RN and a nurse practitioner, screens clients for diabetes, hypertension, and obesity. Other screenings, such as drug and alcohol misuse and depression, are also used when indicated. Screenings are completed using standardized screening tools used throughout our health system. Diabetes screenings can also include point-of-care A1C testing or random glucose testing. Patients are given the appropriate education, self-management class information, and referrals to community resources and services. The nurse practitioner is available for initiating diabetic and hypertension medications and provides follow-up on the van. Connection with primary care and financial counselors is a large part of our mission to help ensure patients have consistent management of their health and access to a payer source that matches their financial status. Additional connections to resources that address many of the social determinants are also accomplished through the mobile van outreach. Additionally, the van team partners with the Cardiac Rehab team to provide cardiac screenings one to two times per

	month in the tri-county area and beyond. Through these screenings, which include point-of-care cholesterol testing, patients who are at high risk for cardiac complications are identified and navigated appropriately to connect them to needed care.
C: Total number of people within target population	The Tri-County area of Maryland's lower Eastern Shore includes some of the unhealthiest counties in the State. It was recognized that there is much work to do to improve the overall health of the residents in this target area. The CHNA was very helpful in allowing us to narrow our focus to some of the most urgent needs present among the populations served. The total number of residents within the tri-county area – Wicomico, Worcester and Somerset counties – is 180,533. The Wagner Wellness Van visits high-traffic areas where the social determinants of health dictate the greatest need. The areas we focus on have a higher prevalence of emergency room visits, lower median incomes, an indigent population, access issues, communication barriers and overall poor health outcomes.
D: Total number of people reached by the initiative	A total of 681 clients have been reached to date. Efforts to increase our reach are underway. **(April-June)**

	Total number of patient encounters: 101 **Patients seen without primary care provider:** 49 **Patients seen for hypertension screening:** 101 • Those patients with hypertension are contacted by phone to make sure they are receiving follow-up care for their hypertension by a primary care provider or by the Wagner Wellness Van. **Patients seen for prediabetes screening: 31** • Of those patients screened for prediabetes: o 9 currently were diabetic. They were referred back to their primary care provider for continued followup, and diabetic education was provided. o 3 had positive prediabetes screening (not previously diagnosed). They were referred back to their primary care provider and diabetic education was provided. o 19 were negative for prediabetes. o Appropriate patients were referred to community educational resources.
E: Primary objective of initiative:	• To reduce ED utilization by increasing access to care for vulnerable and under-served populations. • To improve the health of the target population by providing screenings and education for chronic disease and behaviors that cause the disease

	The Wagner Wellness Van provides the following services to the community five days a week: • Provides outreach to communities utilizing a Nurse Practitioner (NP) to provide primary care services. Provide screenings for diabetes (other screenings provided as well) • Identify need for and make referrals to community resources for health education programs • Ensure those people identified as diabetic or pre-diabetic are referred for primary care follow-up • Track rate of successful PCP follow-up for all referrals • Identify barriers to accessing PCP follow-up and work towards future solutions
F: Single or multi-year plan:	Multi-year plan
G: Key collaborators in delivery:	• PRMC • Atlantic General Hospital • McCready Health
H: Impact of hospital initiative:	• Increase in access to care • Reduction in ED utilization • Identification of health risks / behaviors through screenings
I: Evaluation of outcome	• Pre- and post-implementation survey

	• Monitoring of ED data for reduction in utilization	
J: Continuation of initiative:	Initiative will continue for at least 2 more years and possibly beyond.	
K: Expense:	a. $106,527	b.

APPENDIX A – Expansion of Community Benefit Initiatives

This report summarizes the plans for PRMC to develop and collaborate on community benefit programs that address the prioritized needs identified in the 2016 CHNA. PRMC provides additional support for community benefit activities in the community, but those additional activities will not be covered in this report.

Community Health Needs Assessment (CHNA) (taken from CHNA exec summary)

In June 2016, Peninsula Regional Medical Center (PRMC) published their 2016 Community Health Needs Assessment (CHNA). This CHNA report was developed to provide an overview of the health needs in the PRMC tri-county service area, including Somerset, Wicomico, and Worcester counties. PRMC partnered with Healthy Communities Institute (HCI), a Xerox Company, to conduct the CHNA. The goal of this report was to offer a meaningful understanding of the greatest health needs across the PRMC service area, as well as to guide planning efforts to address those needs. Special attention was given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

Priorities

On June 8, 2016, PRMC's Community Benefit team and other members from various departments in the hospital came together to prioritize the significant health needs in a session led by consultants from HCI. The team reviewed the significant health needs using the following prioritization criteria:

- Importance of problem to the community
- Alignment with 2017 MD SHIP objectives
- Opportunity for partnership
- Addresses disparities of subgroups
- Existing resources/programs to address the problem

Using the Prioritization Matrix method, the following three topics were identified as priorities to address:

Priority Areas:

1. **Diabetes**
2. **Exercise, Nutrition, and Weight**
3. **Behavioral Health (focusing on the topic areas of Mental Health and Mental Disorders as well as Substance Abuse)**

Other significant health needs not chosen were: Access to Health Services, Cancer, Heart Disease and Stroke, and Prevention and Safety. These needs were not selected because they did not meet the prioritization criteria as strongly as the selected topics. PRMC has other programs in these areas, but they are not the focus of this report.

APPENDIX A- Future Expansion of Community Benefit Initiatives
Based upon 2016 Community Health Needs Assessment

1. Priority Area: Diabetes

Strategies

1. Offer Chronic Disease Self-Management Classes (CDSM) throughout the tri-county area
2. Expand Wagner Wellness Van mobile clinic services frequency and outreach

Goal *Improve health of people with diabetes or pre-diabetes in the tri-county area.*

Anticipated Impact

- **Objectives:**
  - By December, 2017, increase the number of 6 week educational classes with identified diabetic patients and their supporting caregivers from 26 to 52 per year
  - By December, 2017, PRMC will expand the Wagner Wellness Van mobile clinic services from monthly trips to Salisbury Urban Ministries to 5 days a week throughout the tri-county area

- **Evaluation Measures:**
  - # of participants educated
  - % completion rate
  - % knowledge change
  - # of community members reached
  - reduction in ED visits
  - patient survey used to track improved referral rate for local resources related to health education
  - patient satisfaction survey to track improved access to care for communities

Strategy 1: CDSM Classes

- **Activities:**
- Target and identify patients who have diabetes and their caregivers through self-referral or provider referral
- Train Community Peer Trainers and PRMC Community Health Workers to conduct classes
- Offer classes in English, Spanish and American Sign Language
- Explore the possibility to offer classes in Haitian-Creole, Korean and Mandarin languages
- Offer 6-week classes at least weekly
- Educate participants on diabetes self-management and have them set and track personal goals weekly and share goals with their providers
- Partner with MAC, Inc. to collect data on pre and post A1C values

Strategy 2: Wagner Wellness Van Expansion

- **Activities:**
  - Provide outreach to communities utilizing a Nurse Practitioner (NP) to provide primary care services
  - Provide screenings for diabetes (other screenings provided as well)
  - Identify need for and make referrals to community resources for health education programs
  - Ensure those people identified as diabetic or pre-diabetic are referred for primary care follow up
  - Track rate of successful PCP follow up for all referrals
  - Identify barriers to accessing PCP follow up and work towards future solutions

System Resources

- PRMC staff
- Data
- Marketing materials
- Training materials
- Mobile van

Collaborators

- PRMC
- MAC, Inc.
- Atlantic General Hospital (AGH)
- McCready Health
- Peninsula Regional Clinically Integrated Network (PRCIN)
- Local Health Departments in the tri-county area
- Local community centers and churches

2. Priority Area: Exercise, Nutrition, and Weight

Strategies

1. Implement an after-school program for weight loss in collaboration with the YMCA (Healthy Us)
2. Develop and implement Improving Walkability in Wicomico County program

Goal Increase awareness of and engagement in healthy lifestyle behaviors.

Anticipated Impact

- **Objectives:**
  - By November, 2017, PRMC will develop a sustainable program that continues after the current Healthy Us 10-week program in Wicomico County
  - ~~o~~ PRMC will help develop a walkability program in Wicomico County through collaboration with the Wicomico County Health Department and the Eastern Shore Regional GIS Cooperative
- **Evaluation Measures:**
  - # of participants
  - % increased health knowledge
  - % of participants with improved biometrics
  - % of participants that follow-up with sustainable program at 3-, 6-month, and 1 year intervals

Strategy 1: Healthy Us follow up program

- **Activities:**
  - Attend planning sessions with YMCA
  - Develop program content for maintenance of healthy behaviors
  - Determine timeline to expand beyond Wicomico County

Strategy 2: Improving Walkability

- **Activities:**
  - Attend planning sessions of collaborative
  - Determine regions of focus within Wicomico County
  - Explore expansion to other counties
  - Create walkability maps for community members
  - Develop communications plan to message to community

System Resources

- PRMC staff
- Data
- Marketing materials, forms

Collaborators

- Pediatric referring physicians
- Schools
- YMCA
- Wicomico County Health Department
- Eastern Shore Regional GIS Cooperative

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3. Priority Area: Behavioral Health

Strategies

1. Provide coordinated care for identified high utilizers of the hospital and/or emergency room for either medical and/or mental health care (CareWrap).
2. Provide peer support for people who have overdosed or sought help for opioid addiction issues (COAT).

Goal Improve the access to and coordination of care for people with mental health and/or substance abuse issues.

Anticipated Impact

- **Objectives:**
  - PRMC will continue to identify people with mental health issues and medical co-morbidities and enroll into the CareWrap program, to maximize case load capability
  - By December, 2016 PRMC will establish the COAT program and raise awareness of program to referring physicians, nurses, and social workers

- **Evaluation Measures:**
  - Number of participants enrolled
  - # of participants referred
  - Number of participants successfully connected to services
  - % admissions, ED visits and 30 day readmissions pre and post enrollment
  - Monthly data from ED on opioid overdoses collected and reported to county
  - Compare referral cards to services rendered
  - # of participants who have been linked and accepted recovery treatment

Strategy 1: CareWrap

- **Activities:**
  - Educate doctors, nurses, social workers who could refer participants about CareWrap program
  - Identify and refer people with mental health issues and medical co-morbidities to program through doctors, nurses and social workers
  - Connect individuals to resources, drive them to appointments, assist with coordinating medication and therapy resources
  - Hold weekly team meetings to discuss participant progress as well as identify gaps and work towards solutions
  - Review metrics quarterly

Strategy 2: Community Outreach Addictions Team (COAT)

- **Activities:**

- Educate doctors, nurses, social workers, law enforcement who could refer participants to COAT program
- Train peer support specialists
- Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction
- Provide linkages to resources include treatment options
- Provide peer outreach to high risk areas of the community
- Maintain ongoing communications about metrics between PRMC and COAT team
- Monitor ED recidivism for opioid overdose/addictive needs
- Explore ability to expand program outside of Wicomico County

System Resources

- PRMC staff
- Data Collection
- Vehicles/Transportation
- Phone Service
- Staff training and materials as needed

Collaborators

- Lower Shore Clinic of Salisbury, MD
- Wicomico County Health Department
- Wicomico County Sheriff's Department
- Salisbury City Government- Law Enforcement, EMS, Office of the State's Attorney
- Tri-county community PCPs

Future Strategies

PRMC intends to implement a tele-health program for Behavioral Health in the coming years.

PENINSULA REGIONAL MEDICAL CENTER
Part of Peninsula Regional Health System

ADMINISTRATIVE POLICY MANUAL

Subject: Uncompensated Care / Financial Assistance

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

POLICY

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

Definitions:

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

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

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

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

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

PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

The following assets are excluded:

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

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

Collection Coordinator

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

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

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

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

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

P. Naleppa

Peggy Naleppa
President/CEO

Bruce Ritchie
Vice President of Finance/CFO

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

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

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

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

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

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

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

Eligibility Determination Process

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

How to Apply

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

Qualifications

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

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

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

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

Need Assistance?

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

Maryland Medical Assistance Program

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

Patients' Rights and Obligations

Rights:

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

Obligations:

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

Cómo hacer la solicitud

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

Date: 05/09/16
Reviewed:
Revised:

2016 Federal Poverty Guidelines
Updated 04/28/2016

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

MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION

Information About You

Name: _____
First Middle Last

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

Home Address _____

_____

_____ _____
City State Zip Code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip Code

Household Members:

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

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

Do you receive any state or County Assistance? Yes No

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

PA-059 (12/05)

I. Family Income

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

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

II. Liquid Assets

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

III. Other Assets

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

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

IV. Monthly Expense

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

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

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

Applicant Signature _____ Date _____

Relationship to Patient _____

PA-059 (12/05)

Appendix II

Brief description of how the FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014.

Answer:

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

Patients' Rights and Obligations

Rights:

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

Obligations:

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

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.
PENINSULA REGIONAL MEDICAL CENTER

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

BRO-086 (8/16)

Financial Assistance With Your Medical Bills

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.
PENINSULA REGIONAL MEDICAL CENTER

Financial Assistance Policy

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

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

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

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

Eligibility Determination Process

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

How To Apply

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

Qualifications

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

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

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

Need Assistance?

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

Medical Assistance Program

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

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

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Peninsula Regional Medical Group (PRMG) physician charges are not included in the hospital bill and are billed separately, with the exception of self-pay balances. Self-pay balances for hospital services and PRMG services will appear on the same statement. Physician charges outside of the PRMG group are not included in the hospital bill and will be billed separately. Physician charges outside of PRMG are not covered by Peninsula Regional Medical Center's financial assistance policy. A list of providers that deliver emergency and other medically necessary care at PRMC is provided on the website, indicating which providers are covered under PRMC's financial assistance policy and which are not.

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6. All applications received within 240 days of the first post-discharge billing statement will be reviewed. ECA actions will be suspended until the application has been processed.

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

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- Letter from an independent source such as clergy, neighbor, former employer, etc.
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Obligations:

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- Attach supporting documentation and return the form to Peninsula Regional Medical Center in a timely manner.
- Make payment in full or establish a payment plan for services not qualified under Peninsula Regional's Financial Assistance Policy.

Cómo hacer la solicitud

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

Date: 05/09/16 (effective 11/01/16)
Reviewed:
Revised: 07/01/17

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

MISSION

Improve the health of the communities we serve.

VALUES

- **Respect for every individual**
- **Delivery of exceptional service**
- **Continuous improvement**
- **Safety, effectiveness**
- **Trust and compassion**
- **Transparency**
- **Stewardship**

VISION

As the Delmarva Peninsula's referral Medical Center, we will be the leader in providing a system of regional access to comprehensive care that is interconnected, coordinated, safe and the most clinically advanced. We will deliver an exceptional patient and family experience, while fostering a rewarding environment for physicians and employees. Together, Peninsula Regional Medical Center and its physicians will be a trusted partner in improving the health of the region.

8/15

Appendix V

Mission

Improve the health of the communities we serve.

Values

- Respect for every individual
- Delivery of exceptional service
- Continuous improvement
- Safety, effectiveness
- Trust and compassion
- Transparency
- Stewardship

Vision

The trusted high performing innovative leader in the integration of people centered, compassionate healthcare resulting in world class community health and wellness for the Delmarva Peninsula.

PENINSULA
REGIONAL HEALTH SYSTEM