UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE REGIONAL HEALTH FY17 COMMUNITY BENEFIT REPORT

HSCRC COMMUNITY BENEFIT REPORTING REQUIREMENTS

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

Please list the following information in Table I below. (For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12-month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

a) Bed Designation – The total number of licensed beds
b) Inpatient Admissions: The number of inpatient admissions for the FY being reported;
c) Primary Service Area (PSA) zip codes;
d) Listing of all other Maryland hospitals sharing your PSA;
e) The percentage of the hospital's uninsured patients by county. (Please provide the source for this data, e.g., "review of hospital discharge data");
f) The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data (e.g., "review of hospital discharge data.")
g) The percentage of the hospital's patients who are Medicare beneficiaries. (Please provide the source for this data (e.g., "review of hospital discharge data.")

Table I

Bed Designation	Inpatient Admissions:	Primary Service Area Zip Codes	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients	Percentage of Patients who are Medicaid Recipients	Percentage of Patients who are Medicare Recipients
UMC at Easton 112	8,222	21601, 21613, 21629, 21632, 21655, 21643, 21663	Anne Arundel Medical Center UMC at Dorchester	**CAROLINE** 0.1% **DORCHESTER** 0.1% **KENT** 0.0% **QUEENANNES** 0.1% **TALBOT** 0.2% **TOTAL 0.5%**	**CAROLINE** 6.6% **DORCHESTER** 4.4% **KENT** 0.8% **QUEENANNES** 2.9% **TALBOT** 9.0% **TOTAL 23.7%**	**CAROLINE** 15.1% **DORCHESTER** 10.1% **KENT** 1.9% **QUEENANNES** 6.6% **TALBOT** 20.7% **TOTAL 54.4%**
UMC at Dorchester 46	1,939	21613, 21643	UMC at Easton Peninsula Regional Medical Center	**CAROLINE** 0.1% **DORCHESTER** 0.5% **KENT** 0.0% **QUEENANNES** 0.0% **TALBOT** 0.1% **TOTAL 0.7%**	**CAROLINE** 2.0% **DORCHESTER** 21.5% **KENT** 0.7% **QUEENANNES** 0.8% **TALBOT** 1.8% **TOTAL 26.8%**	**CAROLINE** 4.5% **DORCHESTER** 48.1% **KENT** 1.5% **QUEENANNES** 1.8% **TALBOT** 4.1% **TOTAL 59.9%**
UMC at Chestertown 26	1,360	21620, 21661, 21678	UMC at Easton Anne Arundel Medical Center Union Hospital	**CAROLINE** 0.0% **DORCHESTER** 0.0% **KENT** 0.2% **QUEENANNES** 0.1% **TALBOT** 0.1% **TOTAL 0.2%**	**CAROLINE** 0.3% **DORCHESTER** 0.0% **KENT** 8.7% **QUEENANNES** 1.8% **TALBOT** 0.1% **TOTAL 11.0%**	**CAROLINE** 2.2% **DORCHESTER** 0.2% **KENT** 61.0% **QUEENANNES** 12.8% **TALBOT** 0.7% **TOTAL 77.0%**

Source: review of hospital discharge data

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

   a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):

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

SRH Admissions by zip code				
Chestertown (CRH)	21620	CHESTERTOWN	752	55.29%
	21661	ROCK HALL	195	14.34%
	21678	WORTON)	146	10.74%
	21651	MILLINGTON	121	8.90%
	21668	SUDLERSVILLE	78	5.74%
	21617	CENTREVILLE	68	5.00%
Chestertown (CRH) Total			1360	
Dorchester (DGH)	21613	CAMBRIDGE	1355	69.88%
	21643	HURLOCK	193	9.95%
	21601	EASTON	100	5.16%
	21631	EAST NEW MARKET	98	5.05%
	21629	DENTON	63	3.25%
	21632	FEDERALSBURG	55	2.84%
	21664	SECRETARY	44	2.27%
	21673	TRAPPE	31	1.60%
Dorchester (DGH) Total			1939	
EASTON	21613	CAMBRIDGE	2248	27.34%
	21601	EASTON	2181	26.53%
	21629	DENTON	853	10.37%
	21643	HURLOCK	496	6.03%
	21632	FEDERALSBURG	464	5.64%
	21617	CENTREVILLE	401	4.88%
	21655	PRESTON	392	4.77%
	21639	GREENSBORO	319	3.88%
	21663	SAINT MICHAELS	319	3.88%
	21660	RIDGELY	238	2.89%
	21673	TRAPPE	229	2.79%
	21671	TILGHMAN	82	1.00%
EASTON Total			8222	

(ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.

(iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., 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).

Statistics may be accessed from:

The Maryland State Health Improvement Process (http://dhmh.maryland.gov/ship/);

The Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/Pages/home.aspx);

The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf) ;

The Maryland Chart Book of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf);

The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)

Demographic Characteristics

Situated on Maryland's Eastern Shore, University of Maryland Shore Regional Health's three hospitals, Shore Medical Center at Easton (SMC at Easton), Shore Medical Center at Dorchester (SMC at Dorchester), Shore Medical Center at Chestertown (SMC at Chestertown) are not for profit hospitals offering a complete range of inpatient and outpatient services to over 170,000 people throughout the Mid-Shore of Maryland.

Shore Regional Health's service area is defined as the Maryland counties of Caroline, Dorchester, Talbot, Queen Anne's and Kent. The five counties of the Mid-Shore comprise 20% of the landmass of the State of Maryland and 2% of the population

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

Shore Regional Health's service area has a higher percentage of population aged 65 and older as compared to Maryland overall. Talbot County has a 27.2% rate for this age group and Kent County has 25.3% of its residents age 65 years or older. These rates are 65% higher than Maryland's percentage, and higher than other rural areas in the state by almost a quarter. Today, more than two-thirds of all health care costs are for treating chronic illnesses. Among health care costs for older Americans, 95% are for chronic diseases. The cost of providing health care for one person aged 65 or older

is three to five times higher than the cost for someone younger than 65.

Source:http://www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf
Hoffman C, Rice D, Sung HY. Persons with chronic conditions: their prevalence and costs. JAMA. 1996;276(18):1473-1479

County Health Rankings for the Mid-Shore counties also reveal the large disparities between counties for health outcomes in the service area. The Mid-Shore Region has 26,203 minority people, representing 25.3% of the total population. In terms of healthcare, large disparities exist between Black or African Americans and Whites as reported by the Office of Minority Health and Health Disparities, DHMH. For emergency department (ED) visit rates for diabetes, asthma and hypertension, the Black or African American rates are typically 3- to 5 fold higher than White rates. Adults at a healthy weight is lower (worse) for Black or African Americans in all three counties where Black or African American data could be reported. Heart disease mortality Black or African American rates are variously higher or lower compared to White rates in individual counties. In Caroline, the Black or African American rate is lower than the White rates not because the Black or African American rate is particularly low, but because the White rate is unusually high. For cancer mortality, Black or African American rates exceed White rates in Dorchester, Kent, Queen Anne's and Talbot. In Caroline, Black or African American rates are lower, again because of a rather high White rate. The Black or African American rates and White rates are below the State Health Improvement Process (SHIP) goals. *Source: http://www.dhmh.maryland.gov/ship.*

http://dhmh.maryland.gov/mhhd/Documents/Maryland-Black-or-African-American-Data-Report-December-2013.pdf

County ranking (out of 24 counties including Baltimore City)								
County	**Health Outcomes**	**Length of Life**	**Quality of Life**	**Health Factors**	**Health Behaviors**	**Clinical Care**	**Social & Economic Factors**	**Physical Environment**
Talbot	7	4	8	5	7	3	11	4
Queen Anne's	5	8	3	6	8	11	6	5
Kent	18	16	21	12	12	13	13	3
Dorchester	23	18	23	22	22	22	22	15
Caroline	21	23	16	21	21	24	18	19

Source: Key characteristics, information and statistics about Mid-Shore source:
http://www.countyhealthrankings.org/app/maryland/2017/county/snapshots/
Maryland State Health Improvement Process, http://dhmh.maryland.gov/ship and its County Health Profiles 2015

Patient Population at Risk for Readmission

High Utilizers were identified across all Shore Regional Health facilities: SMCE, SMCD, SMCC, and SECQ

High utilizers were defined in fiscal year 2017 as anyone with a (modified) Lace score of greater than or equal to 3, readmitted patients, and patients with a length of stay greater than 5 days. High utilizers were also identified geographically by the following service area zip codes:
21601,21613,21620,21629,21663,21655,21661,21643,21632,21660,21617,21678,21651,21673,21623,21625,21631,21639,21666,21668.

Figure 1: Patients (Medicare) High Utilizers by Zip Code:

Row Labels	Count of Postal City	Pct of Col Tot	Cumulative Pct
CAMBRIDGE	859	18.30%	18.30%
EASTON	805	17.15%	35.45%
CHESTERTOWN	360	7.67%	43.12%
DENTON	268	5.71%	48.83%
HURLOCK	174	3.71%	52.54%
FEDERALSBURG	172	3.66%	56.20%
PRESTON	147	3.13%	59.33%
SAINT MICHAELS	138	2.94%	62.27%
CENTREVILLE	124	2.64%	64.91%
ROCK HALL	119	2.54%	67.45%

Source: review of hospital discharge date

Table II

Zip Codes included in the organization's CBSA, indicating geographic areas where the vulnerable populations reside	**Health Enterprise Zone**: Dorchester and Caroline Counties Community: Mid-Shore Region (zip codes 21613, 21631, 21643, 21835, 21659, 21664, 21632) Source: Data from Maryland's State Improvement Plan (SHIP) website and DHMH OMHHD **High utilizers**: 21601,21613,21620,21629,21663,21655,21661, 21643,21632, 21660,21617, 21678,21651,21673,21623,21625,21631,21639,21666,21668

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

	Total Population	White	Black	Native American	Asian	Hispanic or Latino origin
Talbot	37,278	83.3%	13.0%	0.4%	1.4%	6.6%
Dorchester	32,258	67.4%	28.7%	0.5%	1.2%	5.3%
Caroline	32,850	81.3%	14.0%	0.3%	1.1%	7.2%
Queen Anne's	48,929	89.7%	6.6%	0.3%	0.5%	3.6%
Kent	19,730	81.3%	15.3%	0.3%	1.2%	4.5%

	Median Age	Under 5 Years	Under 18 Years	65 Years and Older	Female	Male
Talbot	43.3	4.7%	18.6%	27.9%	52.6%	47.4%
Dorchester	40.7	6.2%	21.4%	20.6%	52.5%	47.5%
Caroline	37.0	6.0%	24%	15.9%	51.2%	48.8%
Queen Anne's	38.8	5.3%	22.3%	18.2%	50.3%	49.7%
Kent	45.6	4.4%	16.7%	25.6%	52.1%	47.9%

Source: https://www.census.gov/quickfacts/fact/table/US/

Median Household Income within the CBSA

	Median Household Income
Talbot	$58,228
Dorchester	$47,093
Caroline	$52,465
Queen Anne's	$85,963
Kent	$58,145

Source: https://www.census.gov/quickfacts/fact/table/US/

Percentage of households with incomes below the federal poverty guidelines within the CBSA	Talbot 10.4% Dorchester 18.1% Caroline 14.4% Queen Anne's 7.2% Kent 14.8% *Source:* : https://www.census.gov/quickfacts/fact/table/US/

Please estimate the percentage of uninsured people by County within the CBSA

Insurance Coverage of the five county region is also reflective of what is typically found in rural communities. A larger percentage of rural residents do not have health insurance compared to urban residents limiting access. The most remote rural residents are the least likely to have health insurance coverage. The uninsured face barriers to care compared to people with health insurance coverage. Rural uninsured are more likely to delay or forgo medical care because of the cost of care compared to those with insurance creating poorer outcomes because care has been delayed.

Percentage of Medicaid recipients by County within the CBSA.

County	% Medicare	% Medicaid	% Uninsured
Caroline	23	18	13
Dorchester	26	19	10
Kent	29	14	9
Queen Anne's	23	9	6
Talbot	33	11	11
Total Service Area	27	14	8
State of Maryland	19	11	11
National	21	13	15

www.towncharts.com/Maryland/Maryland-state-Healthcare-data.html
People can have more than one type of coverage so totals will exceed 100%

Life Expectancy by County within the CBSA

Life Expectancy	All Races	White	Black
Talbot	80.8	81.6	76.5
Dorchester	77.6	78.2	75.7
Caroline	76.1	76.3	75.4
Queen Anne's	79.6	79.7	77.2
Kent	79.5	80.6	74.5

Source: https://health.maryland.gov/vsa/Documents/15annual

Mortality Rates by County within the CBSA

NUMBER OF DEATHS BY RACE

		White		Black				
	All Races*	Total	Non-Hispanic	Total	Non-Hispanic	American Indian	Asian or Pacific Islander	Hispanic **
Talbot	461	400	397	56	56	1	3	3
Dorchester	396	300	298	93	93	0	3	2
Caroline	329	279	276	47	47	2	1	3
Queen Anne's	391	357	353	31	31	0	3	4
Kent	247	205	204	42	42	0	0	1

Source: http://dhmh.maryland.gov/vsa/Documents/Preliminary_Report_2015.pdf

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

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

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

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

DEATH RATES BY RACE, 2014

	All Races	White	Black
Talbot	1228.9	1340.7	1129.3
Dorchester	1222.8	1418.0	1005.8
Caroline	1009.9	1095.4	978.1
Queen Anne's	799.5	824.7	883.9
Kent	1248.3	1303.9	1373.4

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

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

Access to healthy Food

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

Source: http://mdfoodsystemmap.org/glossary (2016)

Quality of housing

County	Home Ownership Rate
Caroline	70.5%
Dorchester	65.6%
Talbot	68.6%
Queen Anne's	83.8%
Kent	71.9%

Source: http://quickfacts.census.gov/qfd/states/ (2011-2015)

	Caroline County. There is a lack of Section 8 Rental Assistance housing in Caroline County. At the present time, only about one- third of the demand has been filled. **Total Housing units 13,482** **Homeownership rate 70.5%** **Median value of owner-occupied housing units, $193,300** **Kent County.** There is a need to provide housing for the homeless, as well as residents who have special needs and require group home or assisted living facilities. **2011-2015** **Total Housing units 10,540** **Homeownership rate 71.9%** **Median value of owner-occupied housing units, $247,200** **Queen Anne's County.** There is a widening gap in the number of homeowners versus renters as incomes exceed the $60,000 threshold. Need for affordable housing for low income households. **Total Housing units 21,032** **Homeownership rate 83.3%** **Median value of owner-occupied housing units, $339,900** **Dorchester County**. Housing in Dorchester County, even though relatively low-priced, is not necessarily more affordable due to the relatively low income of county residents. Compared to the surrounding counties, the housing stock is older, fewer homes are owner- occupied, more households are low to moderate income, and more housing lacks complete plumbing. Problems associated with Dorchester County housing include the following: • High housing costs compared to income • Significant number of homes in poor physical condition • Owner occupancy level for housing units in Cambridge at less than 50 percent • Market demand for rural subdivisions coupled with disincentives for housing developments in towns are resulting in increasing housing development in the unincorporated area of the County **Total Housing units 16,554** **Homeownership rate 65.6%** **Median value of owner-occupied housing units, $187,700** **Talbot County.** The housing issues in Talbot County are complex primarily because of the extreme disparity of income levels in the County. Limited entrepreneurial and job opportunities keep the moderate income wage earners from home ownership. Habitat for Humanity and new Easton Town Council initiatives now require developers to address low to moderate income, affordable home ownership opportunities as part of any new housing development strategy. The net effect will not be known for several years. There is no shortage of high end housing options. Middle income affordable housing remains a countywide issue. **Total Housing units 20,246** **Homeownership rate 68.6%** **Median value of owner-occupied housing units, $319,500** Source :*http://quickfacts.census.gov/qfd/states/* *Maryland State Health Improvement Process, http://dhmh.maryland.gov/ship* *SAHIE-State and County by Demographics and Income Characteristics/* *http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; CDC;and U.S. Census 2010*

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

   √ Yes
   ___No

   Provide date here. 5/25/2016

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

http://umshoreregional.org/about/community-health-needs-assessment-and-action-pla

2. **Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 3?**

   √ Yes 5/25/2016 Enter date approved by governing body here:
   ___No

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

http://umshoreregional.org/about/community-health-needs-assessment-and-action-pla

See **Appendix 8 in the CHNA** in link provided above

Shore Regional Health (SRH) conducted a Community Health Needs Assessment (CHNA) for the five counties of Maryland's Mid-Shore: Talbot, Caroline, Queen Anne's, Dorchester, and Kent. The health needs of our community were identified through a process which included collecting and analyzing primary and secondary data. In particular, the CHNA includes primary data from Talbot, Caroline, Dorchester, Kent, Queen Anne's Health Departments and the community at large. Additionally, Shore Regional Health is a participating member of the Mid-Shore SHIP coalition, where we are partnering with other community stakeholders invested in improving the community's overall health. Members of the Mid-Shore SHIP coalition include community leaders, county government representatives, local non-profit organizations, local health providers, and members of the business community. Feedback includes data collected from surveys, advisory groups and from our community outreach and education sessions. Secondary data resources referenced to identify community health needs include:

Mid-Shore Health Improvement Plan Retrieved from:
http://www.midshorehealth.org/#!priority-areas/c21kz

Maryland Department of Health and Mental Hygiene, Maryland's State Health Improvement Process (SHIP) -39 measures in five focus areas that represent what it means for Maryland to be healthy. Retrieved from: *http://dhmh.maryland.gov/ship/Pages/home.aspx*

Maryland State Health Improvement Measures as Related to Activities in Rural Communities and Workforce Development. Retrieved from: *http://www.mdruralhealth.org/wp-content/uploads/2015/12/Hale.pdf*

Robert Wood Johnson Foundation County Health Rankings and Roadmaps. Retrieved from: *http://www.countyhealthrankings.org/app/maryland/2016/overview*

US Dept of Health and Human Services, Healthy People 2020 (2011). Retrieved from: https://www.healthypeople.gov/2020/topics-objectives

Mid-Shore Behavioral HealthNeeds Assessment 2014 -Key Findings from National, State, and Regional Demographics, Data, Surveys, & Reports. Retrieved from: https://docs.wixstatic.com/ugd/3b412f_bcf54e7a6eff4dd9b28f632e08c39fa5.pdf

Shore Regional Health participates on the University of Maryland Medical System (UMMS) community Health Improvement Committee to study demographics, assess community health disparities, inventory resources and establish community benefit goals for both Shore Regional Health System and UMMS.

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

- Choptank Community Health Systems, Dr. Jonathan Moss, CMO
- Caroline County Minority Outreach Technical Assistance, Janet Fountain, Program Manager
- Talbot County Local Management Board Donna Hacker, Executive Director
- Partnership for Drug Free Dorchester, Donald Hall, Program Director
- Caroline County Community Representative, Margaret Jopp, Family Nurse Practitioner
- Eastern Shore Area Health Education Center, Jake Frego, Executive Director
- Kent County Minority Outreach Technical Assistance, Dora Best, Program Coordinator
- YMCA of the Chesapeake, Deanna Harrell, Executive Director
- University of MD Extension, Aly Valentine, Executive Director
- Kent County Local Management Board, Hope Clark, Executive Director
- Kent County Department of Juvenile Services, William Clark, Director

- Coalition Against Tobacco Use, Carolyn Brooks, Member
- Mt. Olive AME Church, Rev. Mary Walker
- Mid- Shore Mental Health Systems, Holly Ireland LCSW-C, Executive Director
- Associated Black Charities, Ashyria Dotson, Program Director
- Queen Anne County Housing and Family Services, Mike Clark, Executive Director
- Queen Anne County Health Department, Joseph Ciotola MD, Health Officer
- Dorchester County Health Department, Roger L. Harrell, Health Officer
- Talbot County Health Department, Fredia Wadley MD, Health Officer
- Caroline County Health Department, Dr. Leland Spencer, Health Officer
- SRH, Kathleen McGrath, Regional Director of Outreach
- SRH, William Roth, Regional Director - Care Transitions

Shore Regional Health hosted a series of community listening forums in Caroline, Dorchester, Kent, Queen Anne's and Talbot counties to gather community input. In addition, Shore Regional Health meets quarterly with members of the local health departments and community leaders, including:

- Choptank Community Health System: Joseph Sheehan, CEO, Jonathan Moss, CMO
- Health Departments Health Officers:
  - Leland Spencer, M.D. Kent County and Caroline County
  - Roger L. Harrell, MHA, Dorchester County Health Department
  - Joseph Ciotola MD -DHMH Queen Anne's County
  - Fredia Wadley MD, Talbot County Health Department
- Mid Shore Mental Health Systems, Holly Ireland, Executive Director
- Eastern Shore Hospital Center: Randy Bradford, CEO

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

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

Shore Regional Health CHNA 2016 Health Priorities (rank order)

1. **Chronic Disease Management (obesity, hypertension, diabetes, smoking)**
2. **Behavioral Health**
3. **Access to care**
4. **Cancer**
5. **Outreach & Education (preventive care, screenings, health literacy)**

Future Planning:
Maryland Health Care Commission (MHCC) Rural Health Study
During the 2016 Legislative Session, Senate Bill 707 Freestanding Medical Facilities-Certificate of Need, Rates and Definition (SB 707), passed into law and was signed by the Governor on May 10, 2016. The legislation established a workgroup on rural health care delivery to oversee a study of healthcare delivery in the Middle Shore region and to develop a plan for meeting the health care needs of the five counties -- Caroline, Dorchester, Kent, Queen Anne's and Talbot.

The purpose of the study was to assess the health care of the residents of the five-county study area and the capacities of the health system in the region, and propose options for enhancing health and health care delivery on the Mid-Shore. The research team was asked to consider: (1) the limited availability of health care providers and services; (2) the special needs of vulnerable populations, including the frail and elderly, racial and ethnic minorities, immigrants and patients with persistent behavioral illnesses; (3) barriers to access caused by transportation limitations; and (4) the economic impact of closures, partial closures or conversions of health care facilities.

The Summary Report provides highlights of findings from all components of the study and integrates them into key recommendations. Methods and findings are detailed for review at:

http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/rural_health/September%2025th%202017%20Meeting/lgsrpt_%20ExecutiveSummary_rpt_20170928.pdf

The University of Maryland Medical System in partnership with UM Shore Regional Health as members of the Rural Health Care Delivery Workgroup produced a white paper, Commitment to Meeting the Health Care Needs of Our Vulnerable Rural Communities. This paper explores concerns about the unique needs of rural hospitals and communities and can be accessed at:

http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/rural_health/July%2025th%202017%20Meeting/LGSRPT_Shore_White_Paper_rpt20170523.pdf

UM Shore Regional Health takes very seriously the responsibility and commitment, outlined in the recommendations, to collaborate with community health care partners and to engage with, listen to and be responsive to input from these partners and the wider regional 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. Is Community Benefits planning part of your hospital's strategic plan?

_√_ Yes
___ No

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

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

The Strategic Plan supports our **Mission**, **Creating Healthier Communities Together**, and our **Vision**, to be the **region's leader in patient centered health care**. Our goal is to provide quality health care services that are comprehensive, accessible, and convenient, and that address the needs of our patients, their families and our wider communities.

Link to Strategic Plan:
http://umshoreregional.org/~/media/systemhospitals/shore/pdfs/about/handoutupdated-2016.pdf?la=en

Shore Regional Health has established a process of determining which needs in the community are to be addressed through establishment of the Community Health Planning Council. The Community Health Planning Council is responsible for recommending and developing policies, programs and services that carry out the mission of University of Maryland Shore Regional Health to enhance the health of local communities. The council reports through and provides regular updates to senior leadership and the Board Strategic Planning Committee. Ultimately the Community Health Planning Council determines the community benefit activities to be delivered by Shore Regional Health to the community based on best use of resources and areas of expertise.

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

i. Senior Leadership

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

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

ii. Clinical Leadership

1. √ Physician
   Member of the Community Health Planning Council Advises on best practices for the health of populations and prevention strategies

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

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

4. √ Other (please specify)

Pharmacist,

Member of the Community Health Planning Council Advises on best practices for the health of populations and prevention strategies; including medication management activities

Case Management

Member of the Community Health Planning Council Advises on best practices for transitions in care and readmission prevention programs.

iii. Population Health Leadership and Staff

1. √ **CMO-William Huffner, MD, MBA, FACEP, FACHE**
Leader in moving Shore Regional Health to value-based care and population health

2. √ **Director, Outreach and Business Development– Kathleen McGrath**
Responsible for aligning community benefit activities with population health initiatives and Strategic Transformation Plan

Regional Director of Care Transitions – Bill Roth
Works with community coalitions, including SNF medical staff and emergency department leadership to reduce PAUs and readmissions. Developing referral processes for community case management to support population health initiatives.

iv. Community Benefit Operations

1. √ Individual (please specify FTE)

Director, Outreach and Business Development (1FTE)

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

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

Community Health Planning Council

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

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

- Ruth Ann Jones- Ruth Ann Jones , EdD, MSN, RN, NEA-BC – Sr. VP Patient Care Services/CNO
    - Leadership in moving Shore Regional Health to value-based care and population health

- Walter Atha, MD – Regional Director of Emergency Medicine
    - Advises on best practices for the health of populations referral processes for community case management to prevent readmissions. Identifies high risk/utilizer of inpatient and ED.

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

- Brian Leutner, MBA, RT (R) (T) – Executive Director of UM SMC at Dorchester, Regional Cancer Center, Diagnostic and Imaging Center
    - Advises on best practices for the health of populations and prevention strategies for cancer.
    - Ensures optimal participation in local, regional and system health care services, programs and activities.

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

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

- Patricia Plaskon - PhD, LCSW-C, OSW-C, Coordinator of Oncology Social Work

- Advises on best practices for the health of populations, prevention strategies, referral processes for support, wrap-around services for cancer patients.

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

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

- Kevin Chapple, Pharm.D, BCPS – Director of Pharmacy Operations
  - Advises on best practices for the health of populations and prevention strategies; including medication management activities, chronic disease management

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

- Elizabeth Todd MS,BSN,RN I-V, CRRN – Navigator, Shore Comprehensive Rehabilitaion
  - Advises on best practices for the health of populations, prevention strategies, referral processes for support

- Stephen Eisemann, BS, RRT – Regional Manager Cardiovascular & Pulmonary Services
  - Advises on best practices for the health of populations and prevention and management strategies for cardiovascular and pulmonary disease.

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

- John Mistrangelo, ACSW, LCSW-C – Program Administrator, Shore Behavioral Health Services
  - Advises on best practices for management and support services for behavioral health.

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

- Robert Carroll, MBA – Director, Performance Measurement and Improvement
  - Advises on healthcare quality measurement and improvement processes and services that enable the delivery of exceptional health care.

- Mary Jo Keefe – RN,BSN, MSM Director of Nursing
  - Leadership in moving Shore Regional Health to value-based care and population health

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

- Greg Vasas - Decision Support Senior Analyst

- Advises on budget implications of community benefit proposals/plans.

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

Spreadsheet	√ yes	_____no
Narrative	√ yes	_____no

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

Spreadsheet	√ yes	_____no
Narrative	√ yes	_____no

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

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

√ yes _____no

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

The Community Benefit investments are incorporated in the Shore Regional Health (SRH) Strategic Transformation Plan (STP) which supports the efforts currently underway in Maryland, to strengthen primary care and coordinate hospital care with community care; map and track preventable disease and health costs; develop public-private coalitions for improved health outcomes; and establish Regional Partnerships.

Shore Regional Health Strategic Transformation Plan Strategies- submitted to HSCRC December 7, 2015:

1. **Coordinate care/referrals with existing community services** including Shore Regional Health owned and private home health agencies, visiting nurse programs, community outreach programs, municipal and foundation grant-based patient support programs.
2. Work with **skilled nursing facilities** to monitor and **reduce re-hospitalization** and enhance communication when hospital transfer is necessary
3. Develop a robust hospital operated, **chronic disease management and data coordination clinic**
4. Operationalize a hospital based **Bridge Clinic** to better manage patients being discharged from the inpatient **behavioral health** unit at UMSMC at Dorchester. The program supports the goal of reducing readmissions to the inpatient unit and emergency department due to long waits for psychiatric care from community.

University of Maryland Shore Regional Health's STP and community benefit activities provide the framework for improved care coordination to improve care delivery for our community. Development of community benefit initiatives and investments to support STP strategies is ongoing and will continue to be updated to reflect progress and changes.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

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

Organization	Name of Key Collaborator	Title	Collaboration Description
Mid-Shore Mental Health System	Holly Ireland	Executive Director	Consulted with partner and organization to discuss community needs related to behavioral health, access to care, and share data, SRH is a member of the Behavioral Health Integration Workgroup. Time period: 2010- present
Dorchester County Health Dept.	Roger Harrell	Health Officer	Consulted with partners to discuss community needs related to health

			improvement, access to care, share Data Time period: 2010- present partner in HEZ Time Period: 2013-2016
Talbot County Health Dept.	Fredia Wadley, MD	Health Officer	Consulted with partner to discuss community needs related to health improvement, access to care, and share data Time period: 2010- present
Caroline County Health Dept.	Scott T. LeRoy MPH, MS	Health Officer	Consulted with partner to discuss community needs related to health improvement, access to care, and share data, member of Caroline County Taskforce Time period: 2010- present
Queen Anne's County Health Dept.	Joseph Ciotola, MD	Health Officer	Consulted with partner to discuss community needs related to health improvement, access to care, and share data, partner in Mobile Integrated Community Health Program, Geriatric medication management program. Time period: 2010- present
Kent County Health Dept.	Dr. Leland Spencer	Health Officer	Consulted with partner to discuss community needs related to health improvement, access to care, and share data. Time period: 2010- present
Home Ports	Wayne Benjamin MD	Board, Executive	Shore Regional Health consulted with Home Ports to discuss community needs and sponsor of Home Ports health related events Time period: 2010- present
Associated Black Charities	Ashyria Dotson	Program Director	Shore Regional Health consulted with ABC to discuss community needs related to health to disparities, partnered in HEZ Time Period: 2013-2016, present
Recovery for Shore	Sharon Dundon	Founder	Discuss community needs related to health improvement, access to care Time Period: 2012-present

Choptank Community Health Systems	Susan Johnson	VP Quality	Consulted with partners to discuss community needs related to health improvement, access to care, and share data, as well as work on transitions in care and as a member of LHIC Time period: 2010- present
Caroline County Minority Outreach Technical Assistance	Janet Fountain	Program Manager	Consulted with partners to discuss community needs related to health improvement, access to care, share data, and as a member of LHIC Time period: 2013- present
Dorchester County Addictions Program	Donald Hall	Program Director	Consulted with partners to discuss community needs related to health improvement, access to care, share data, and as a member of LHIC Time Period: 2013-2016, present
Eastern Shore Area Health Education Center	Jake Frego	Executive Director	Consulted with partners to discuss community needs related to health improvement, access to care, share data, and as a member of LHIC Time Period: 2013-2016, present
Local Schools	representative varies depending upon topic/agenda and availability	representative varies depending upon topic/agenda and availability	School based Wellness Committee's and participation in education on health topics and careers Time Period: 201-, present
Kent County Minority Outreach Technical Assistance	Dora Best	Program Coordinator	Consulted with partners to discuss community needs related to health improvement, access to care, share data, and as a member of LHIC Time Period: 2013-2016, present
YMCA of the Chesapeake	Deanna Harrell	Executive Director	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC Time Period: 2013-2016, present
University of MD Extension	Aly Valentine	Executive Director	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC Time Period: 2013-2016, present

Kent County Local Management	Hope Clark	Board, Executive	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC Time Period: 2013-2016, present
Kent County Department of Juvenile Services	William Clark	Director	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC Time Period: 2013-2016, present
Coalition Against Tobacco Use	Carolyn Brooks	Member	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC Time Period: 2013-2016, present
Mt. Olive AME Church	Rev. Mary Walker		Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC Time Period: 2013-2016, present
Queen Anne County Housing and Family Services	Mike Clark	Executive Director	Consulted with partners to discuss community needs related to health improvement, and as a member of LHIC Time Period: 2013-2016, present

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

____yes √ no

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

√ yes _____no

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.

Caroline, Dorchester, Kent, Queen Anne's, Talbot counties

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?

A. 1. Identified Need:	**Health Priority #1. Chronic Disease management** Residents of Talbot, Caroline, Dorchester, Kent have a higher rate than the HP 2020 goal rate of related emergency department visits for these chronic diseases —**SHIP OBJECTIVES #27, 28** • Reduce diabetes - related emergency department visits. • Reduce hypertension related - emergency department visits.
B: Name of hospital initiative	**UMSRH Population Health Management: Enhanced transitions in care:** A: Shore Wellness Partner- Community Case Management & B: Follow-up Clinic Both programs address high utilizing patients who are not connected to ongoing primary care • Chronically ill patients with typical, long standing combinations of diabetes, CHF, COPD, and/or kidney disease who are prescribed between 5 and 15 medications • Rural patients with long travel times to care providers and who often do not have access to information technology resources http://dhmh.maryland.gov/ship/SitePages/Home
C: Total number of people within target population	Target Population: Patients with sub-acute mental illness, social isolation, and/or limited family support who need assistance in making healthcare decisions that provide the best care in the best venue. Target population 7,000 people
D: Total number of people reached by the initiative	A. Shore Wellness Partners: 1,384 home visits B. Follow up Clinic: 3,919 patients (775 patients had more than one encounter).

E: Primary objective of initiative:	• Identify follow-up needs from community resources
	• Reduce readmissions during the transitional period related to Chronic Disease Management
	  • Diabetes-related readmission/revisits
	  • Congestive Heart Failure-related readmissions/revisits
	  • Hypertension-related readmissions/revisits
	  • COPD-related readmissions/revisits
	  • Chronic Kidney Disease-related readmissions/revisits
	• Provide assessment of dietary status and educational needs

	• Provide assessment of safe medication use/educational needs/financial assistance needs • Provide transitional case management services
F: Single or multi-year plan:	Multi Year 2016-present
G: Key collaborators in delivery:	• Physician practices (owned by hospital/health system) • Physician practices (not wholly or partially owned by the hospital) • Queen Anne County Mobile Integrated Community Health Program • Upper Shore Aging, Inc Maryland Access Point • Maintaining Active Citizens, Inc • Coastal Hospice & Palliative Care • Compass Regional Hospice • Talbot Hospice • Talbot County Health Department/Adult Evaluation and Review Services • Queen Anne County Health Department/Adult Evaluation and Review Services • Caroline County Health Department/ Adult Evaluation and Review Services • Dorchester County Health Department/ Adult Evaluation and Review Services • Talbot County Senior Center • Caroline County Senior Center • Choptank Community Health- Federalsburg/Denton • Choptank Community Health- Fassett Magee Branch • Shore Home Care, Inc • Shore Wellness Partners • Amedysis Home Health, Inc • Home Call Home Health • Bright Star Home Health • Hill's Drug Store, Inc • Key Collaborator Organization • Integrace Bayleigh Chase • The Pines, Genesis • Briton Woods of Denton • Caroline Nursing Home • Mallard Bay • Chesapeake Woods • Autumn Lake • Shore Nursing & Rehab

H: Impact of hospital initiative:	Community resources engaged as appropriate based on patient-specific needs. Multiple health care referrals generated in order to provide the safest patient care. Reduction in high utilizer or population at high risk for readmission.	
I: Evaluation of outcome	A. Shore Wellness Partners metrics: • 1,032 Nurse home visits • 352 Social workers home visits B. Follow up Clinic Metrics: # of patients: 3,919: (775 patients had more than one encounter) # of referrals (direct referrals) • 54 referrals to Upper Shore Aging (serving Talbot, Kent, Caroline), • 24 referrals to Maintaining Active Citizens, Inc (serving Dorchester), • 9 referrals to Queen Anne County Department of Aging. • 53 people to the Queen Anne County Mobile Integrated Community Health Program (MICH). • (with 53 telehealth visits for the MICH clients)	
J: Continuation of initiative:	Yes, However, SRH is developing a more robust and holistic transitions of care program that will provide systematic referrals and complex case management of high risk patients based on best practices. Shore Wellness Partners social work program will continue to offer financial and social services to support the newly developed Transitions of Care Program.	
K: Expense:	a. $377,942	b.

A. 1. Identified Need: A. 2. How was the need identified:	**Health Priority #2. Behavioral Health** **Health Priority #3. Access to Care** **—SHIP OBJECTIVES #33** Reduce emergency department visits due to mental health conditions. Identified through the CHNA process
B: Name of hospital initiative	**Behavioral Health Bridge Clinic** The Bridge Clinic serves patients discharged from the behavioral health inpatient unit who are unable to access psychiatric care from community due to shortage of psychiatric providers
C: Total number of people within target population	600-700 patients discharged from SRH inpatient psychiatric care require specialized follow-up including case management , therapy, and support/education
D: Total number of people reached by the initiative	Persons Served: 205
E: Primary objective of initiative:	Enhance service continuity between inpatient and community behavioral health care through better access to services and more innovations in the service delivery model. Reduce recidivism of patients with mental health issues in both the ED and Psychiatric Inpatient Unit.
F: Single or multi-year plan:	Multi Year Oct.2015-present
G: Key collaborators in delivery:	• Mid-Shore Behavioral Health System • Eastern Shore Crisis Response • Physician practices • Local Health Depts.
H: Impact of hospital initiative:	The first full year of operation for the Bridge Clinic was successful in reducing readmission rates to the hospital's inpatient psychiatric unit. 24-48 hour access was made available for urgent appointments. Active case management including telephonic follow-up and weekly support groups were provided

I: Evaluation of outcome	Program outcomes: 962 follow-up interventions were provided to 205 patients. Inpatient readmissions trended down for the 12 month period from July 2016 to June 2017. First quarter of operation: average readmission rate 12% compared to final quarter of FY17: average readmission rate 1% for population served.	
J: Continuation of initiative:	Based on the initial success of this initiative, the Hospital will continue this initiative.	
K: Expense:	a. $107,781	b.

A. 1. Identified Need: A. 2. How was the need identified:	**Health Priority #2. Behavioral Health** **Health Priority #5. Outreach and Education** Identified through the CHNA process
B: Name of hospital initiative	UM SRH partnership with **Recovery for Shore (RFS) Program**, promotes recovery through advocacy, education and support
C: Total number of people within target population	Maryland Adult Residents in Need of Treatment, by Region Region 5--Eastern Shore (N=260,715) 25,624 Source: https://bha.health.maryland.gov/State%20Drug%20and%20Alcohol%20Abuse%20Council/Documents/SDAACWeb/FormulaWorkgroup/Reuter_Estimating%20Treatment%20Need.pdf estimated less than one-quarter, are actually in treatment programs
D: Total number of people reached by the initiative	Support 15-20 community events raising awareness and providing support for those affected by substance abuse
E: Primary objective of initiative:	Indicators suggest the quality of life for the target population of those in long-term recovery from alcohol or other drug addiction, improve as a result of the support and advocacy provided by RFS programs. The primary objective of this initiative is to: • Raise the awareness about addiction and recovery • Reduce the stigma about addiction and mental disorders • Advocacy for those in recovery • Engage in community activities that celebrate recovery and wellness
F: Single or multi-year plan:	Multi-year initiative and ongoing 2010-present
G: Key collaborators in delivery:	• Caroline Counseling Center • Caroline County Prevention Services • Chesapeake Treatment Services • Chesapeake Voyagers, Inc. • Circuit Court of Talbot County, Problem Solving Court • Community Newspaper Project (Chestertown Spy and Talbot Spy) • Dorchester County Addictions Program • Dri-Dock Recovery and Wellness Center • Kent County Department of Health Addiction Services • Mid Shore Mental Health Systems, Inc. • Queen Anne's County Department of Health - Addictions Treatment and Prevention Services • University of Maryland Shore Behavioral Health Outpatient Addictions • Talbot Association of Clergy and Laity

	• Talbot County Health Department Addictions Program (TCAP) and Prevention • Parole and Probation • Talbot Partnership for Alcohol and Other Drug Abuse Prevention • University of Maryland Shore Regional Health • Warwick Manor Behavioral Health	
H: Impact of hospital initiative:	Reduction of utilization of emergency room services for ongoing treatment.	
I: Evaluation of outcome	Outcome: RFS events and programs: Participation in 15-20 community events raising awareness and providing support to those affected by substance abuse, serving 5 counties of Mid-Shore. Events include: • Out of the Darkness, Suicide Prevention • Advocacy for naloxone, legislative forums in Centreville and Cambridge • Address alcohol, binge drinking, drug/substance abuse through partnerships listed above • Sponsor peer support programs	
J: Continuation of initiative:	Yes, SRH will continue to support this initiative	
K: Expense:	a. $1,200	b.

A. 1. Identified Need: A. 2. How was the need identified:	**Health Priority #4. Cancer**; **Health Priority #3. Access to Care;** **Health Priority #5. Outreach and Education** Identified through the CHNA process
B: Name of hospital initiative	Shore Regional Wellness for Women Outreach and Wellness for Women Screening
C: Total number of people within target population	Female population of 5 county area • Outreach= age 25+ (approximately 32,000) • Screenings= age 40-65, uninsured/eligible = 2,800
D: Total number of people reached by the initiative	Wellness for Women Outreach: 3,465 lives touched Screenings: 199 patients seen
E: Primary objective of initiative:	SHIP OBJECTIVE #26: Reduce overall cancer death rate Age-adjusted mortality rate from cancer (per 100,000 population) in Maryland is higher than the US cancer mortality rate. Cancer impacts people across all population groups, however wide racial disparities exist. Maryland 2017 Goal 147.4 Maryland rate: 159.3 Caroline County: 173.5 Dorchester County: 195.2 Kent County: 149.7 Queen Anne's County: 160.4 Talbot County: 143.8 **Wellness for Women Outreach** 1. Increase the number of women surviving breast cancer by diagnosing them at an earlier stage through education and promotion of preventative measures and early detection. 2. Diagnose African American and Hispanic women at earlier stages of breast cancer, equivalent to Caucasian women. 3. Educate Latina women in breast self- examination with the assistance of a translator. **Screenings** The program serves as a point of access into care for age and risk specific mammography screening ,clinical breast exam, and genetic testing for breast cancer Offers **no cost mammograms** to eligible women: those under the age of 40 and over 65 who have no insurance and Latina women of all ages who will be screened annually thereafter. Those women needing further diagnostic tests or who need treatment for breast cancer are enrolled in the State of Maryland Diagnosis and Treatment Program through the case manager
F: Single or multi-year plan:	Multi Year 2008-present
G: Key collaborators in delivery:	Participating Hospital Staff; Talbot, QA, Kent, Dorchester, Caroline

<table>
<tr><td></td><td colspan="2">Counties Health Departments for five Counties</td></tr>
<tr><td>H: Impact of hospital initiative:</td><td colspan="2">Reduce cancer mortality</td></tr>
<tr><td>I: Evaluation of outcome</td><td colspan="2">Evaluation of Outcomes:
The stage at diagnosis as reported by the Tumor Registry for the Cancer Center indicates disparity for women in Caroline and Dorchester County. The outreach program increased the community's awareness of breast cancer prevention, detection and treatments.
<u>Outcome</u>: Outreach
3,465 lives touched (some events included both community and professional audiences)
• 73 Community events
• 7 Professional Presentations
Correlation with Outreach:
<table>
<tr><th>County</th><th># of Events</th><th># of Breast Cancer Diagnoses</th><th>Cauc</th><th>AA</th><th>Stage 3 or 4</th></tr>
<tr><td>Tal</td><td>33</td><td>45</td><td>39</td><td>5</td><td>6</td></tr>
<tr><td>Dor</td><td>13</td><td>35</td><td>23</td><td>12</td><td>4</td></tr>
<tr><td>Kent</td><td>2</td><td>22</td><td>18</td><td>4</td><td>4</td></tr>
<tr><td>QA</td><td>8</td><td>14</td><td>10</td><td>4</td><td>2</td></tr>
<tr><td>Car</td><td>18</td><td>23</td><td>18</td><td>4</td><td>4</td></tr>
</table>
<u>Outcome</u>: Screening
Indicators show improved access to care and referral for treatment.
• Screenings: 162 patients seen
• Total African American: 34 (no volume change)
• Total Hispanic: 97 (26% increase in volume)
• Total Caucasian: 30 (45% decrease in volume)
• Total Other: 1
*20% decrease in total volume due to increase in patients with primary insurance
Case Worker: 2,435 patient visits; 382 patient's case managed</td></tr>
<tr><td>J: Continuation of initiative:</td><td colspan="2">Yes, the initiative is continuing</td></tr>
<tr><td>K: Expense:</td><td>a. $53,305 Outreach
$177,441 Screenings, case management</td><td>b.</td></tr>
</table>

A. 1. Identified Need: A. 2. How was the need identified:	**Health Priority #4. Cancer**; **Health Priority #3. Access to Care;** **Health Priority #5. Outreach and Education** Identified through the CHNA process
B: Name of hospital initiative	Prostate Cancer Screening
C: Total number of people within target population	5 county male population This initiative is open to all men, but focused outreach is on areas of county with a high percentage of African American /Black population. Spiritual leaders and churches are contacted and engaged, and requested to encourage their congregations and communities to participate.
D: Total number of people reached by the initiative	2 events Persons Served: 40
E: Primary objective of initiative:	SHIP OBJECTIVE #26: Reduce overall cancer death rate. To Promote early detection of prostate cancer Prostate cancer is the second leading cause of cancer-related deaths for American men. Statistics gathered for 2016 showed prostate cancer cases diagnosed in the following counties: Caroline County: 13 Dorchester County: 25 Kent County: 17 Queen Anne's County: 19 Talbot County: 23
F: Single or multi-year plan:	Multi Year 2006-present
G: Key collaborators in delivery:	Shore Comprehensive Urology Mt. Olive AME Kent County Health Department Talbot County NAACP MOTA Multicultural Center Talbot County
H: Impact of hospital initiative:	Reduce cancer mortality Provided access to screenings to underserved persons of community Increased awareness and detection of prostate cancer

I: Evaluation of outcome	Outcome: Total Number of People Reached by the Initiative Within the Target Population • 40 men attended education seminar. • 23 men were screened, 7 found to have suspicious tumor. • All results reviewed and had followed up with their primary physician.	
J: Continuation of initiative:	Yes, the initiative is continuing	
K: Expense:	a. $6,236	b.

A. 1. Identified Need A. 2. How was the need identified: :	**Health Priority #5: Outreach and Education** **Health Priority #1. Chronic Disease management** **Health Priority #3. Access to Care** Provide outreach for education opportunities to the community for chronic disease awareness and management. **Identified through the CHNA process**
B: Name of hospital initiative	**Education and Support Programs:** • Diabetes, Stroke, Heart Education Programs • Diabetes, Stroke, Heart, Cancer Support Groups • Radio Broadcasts • Heart Wellness Newsletter and Presentations • Maryland Health Matters, public health information • Stroke Education/Presentations • Blood Pressure Screenings
C: Total number of people within target population	5 County population =170,000. (See below for prevalence of disease) Prevalence of **Diabetes** in this community is higher than average within Maryland. Diagnosed Diabetes Among Adults: Caroline County: Prevalence=12.2 2,856 individuals Dorchester County: Prevalence=14.7 3,893 individuals Kent County: Prevalence=8.9 1,549 individuals Queen Anne's County: Prevalence=9.4 3,603 individuals Talbot County: Prevalence=9.5 3,434 individuals Maryland: Prevalence=9.4 Prevalence of **Age-adjusted mortality rate from heart disease** (per 100,000 population). Heart disease is the leading cause of death in Maryland accounting for 25% of all deaths. Prevalence for Maryland= 169.4: 2017 Goal= 166.3 Caroline County: Prevalence=195.6 Dorchester County: Prevalence=190.9 Kent County: Prevalence=154.3 Queen Anne's County: Prevalence=159.8 Talbot County: Prevalence=143.0 In Maryland, 30% of all deaths were attributed to **heart disease and stroke**. Heart disease and stroke can be prevented by control of high blood The rate of emergency department visits due to hypertension (per 100,000 population) in Maryland= 252.2 2017 Goal=234 Caroline County: Rate=257.8 Dorchester County: Rate=465.4 Kent County: Rate=334.7 Queen Anne's County: Rate=187.8 Talbot County: Prevalence=265.1

D: Total number of people reached by the initiative	Total Community Benefit encounters or "touchpoints" in FY2017 was over 2,300 for Diabetes, Stroke, Heart Wellness related Education and Support Groups. Published public health information reaches 77,266 households
E: Primary objective of initiative:	• Reduce incidence of diabetes, stroke, cardiovascular disease • Improve management of diabetes, hypertension, lung and heart health • Support for population managing diabetes, stroke, cancer • Provide educational material to promote a focus on personal health.
F: Single or multi-year plan:	Multi Year 2006-present
G: Key collaborators in delivery:	• Community Senior Centers • UM Center for Diabetes and Endocrinology • UM Center at Easton Primary Stroke Center • Health Departments
H: Impact of hospital initiative:	Raised/improved the level of diabetes awareness, stroke, and heart wellness education and management in the community.
I: Evaluation of outcome	Outcome: Education and support groups well attended and attendees demonstrated increased knowledge post education ***Health Fairs and Education Events including:*** J Queen Anne's County Annual Senior Summit, May 2017; 300 attendees The following educational materials, information and free screenings on the topics were provided, including: o High blood pressure and heart disease o Diabetes o Cancer o Stroke o Hospice services and palliative care o obesity, exercise and nutrition o Free Blood pressure screenings J Homeports Health & Wellness Expo, Sept, 2016 presented strategies to promote health and well-being regardless of age. 200 attendees The following educational materials, information and free screenings on the topics were provided, including: o High blood pressure and heart disease o Diabetes o Cancer o Stoke o Hospice services and palliative care o obesity, exercise and nutrition o Screenings

	o Free Blood pressure screenings o Balance and Fall Risk Testing o Cardiad and Lung Health Risk Assessment o Lung Function Test o Depression and Anxiety Screening **Diabetes Education Series "Ask the Dietitian":** 30 Participants attended 1 hour session to increase their knowledge on managing their diabetes. All participants made progress on developing strategies to improve nutritional health and healthy lifestyles **Diabetes Support Group:** 8-10 patients attend monthly Diabetes support group at multiple locations throughout the five county region. Attendees and their friends and family meet to discuss diabetes: concerns, problems, and challenges. Facilitator provides health education and accurate information. **Stroke Awareness and Warning Signs Education/ Presentations** Inform adults of signs and symptoms, risk factors, and prevention methods for stroke. Two presentations offered with 35 attendees. **Blood Pressure Screenings**- Free screenings offered at multiple locations every week – 275 referrals **Radio Broadcasts** - 200+ listeners for health show **Maryland Health Matters**- published 3x year, mailed to 77,266 households	
J: Continuation of initiative:	These initiatives will continue through FY18.	
K: Expense:	a. $155,591 Direct Costs	b.

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.

Needs Identified not addressed:

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

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

Several additional topic areas were identified by the Community Health Planning Council including: safe housing, transportation, and substance abuse. The unmet needs not addressed by UMC at Easton, UMC at Dorchester, UMC at Chestertown will continue to be addressed by key governmental agencies and existing community-based organizations. While Shore Regional Health hospitals will focus the majority of our efforts on the identified priorities outlined in the current CHNA, we will review the complete set of needs identified in the MHCC Rural Health Study and through work in the upcoming needs assessment due June 30, 2019.

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)

The Community Benefits operations/activities are integrated into the Population Health Strategies through the collaboration between our hospitals and local public health agencies in the development of community health improvement strategies. Through external collaborations, Shore Regional Health (SRH) is working toward collectively solving the complex health and social problems that result in health inequities. Shore Regional Health is increasingly aligning its community health and outreach planning with SHIP and LHIC plans. Leadership from SRH, University of Maryland Medical System, public health and the communities are building on

promising local strategies and applying emerging tools and technologies to improve the delivery of health care.

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.

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.

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	As a result of the prevailing physician shortage, Shore Regional Health has an exclusive contract with anesthesiologists to provide services that would not otherwise be available to meet patient demand.
Non-Resident House Staff and Hospitalists	As a result of the prevailing physician shortage, Shore Regional Health has an insufficient number of hospitalists on staff. Subsidies are necessary to meet patient demand, including the uninsured and underinsured
Coverage of Emergency Department Call	As a result of the prevailing physician shortage, Shore Health has an insufficient number of specialists on staff. Subsidies for emergency department call for the following specialties are necessary to meet patient demand, including the uninsured and underinsured 1. Orthopedics 2. Psychiatric Services 3. Gastroenterology 4. Pediatrics 5. Anesthesia

	6. Neurology
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	Shore Regional Health continues to experience a high percentage of physician shortage for specialists. To address the shortage, ongoing recruitment for the following areas occurred for FY16 1. Psychiatry 2. Neurology 3. Internal Medicine 4. Family Medicine 5. Obstetrics 6. Pulmonary 7. Cardiology
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

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

VI. APPENDICES

To Be Attached as Appendices:

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

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

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
  - in a culturally sensitive manner,
  - at a reading comprehension level appropriate to the CBSA's population, and
  - in non-English languages that are prevalent in the CBSA.
- posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;

- provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
- provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
- includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
- besides English, in what language(s) is the Patient Information sheet available;
- discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

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

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

Appendix I

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

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

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

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

- Shore Regional Health prepares its FAP in a culturally sensitive manner, at a reading comprehension level appropriate to the CBSA's population, and in Spanish.
- Shore Regional Health posts its FAP and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
- Shore Regional Health provides a copy of the FAP and financial assistance contact information to patients or their families as part of the intake process;
- Shore Regional Health provides a copy of the FAP and financial assistance contact information to patients with discharge materials.

- A copy of Shore Regional Health's FAP along with financial assistance contact information, is provided in patient bills; and/or
- Shore Regional Health discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.
- An abbreviated statement referencing Shore Regional Health's financial assistance policy, including a phone number to call for more information, is run annually in the local newspaper (*Star Democrat*)

New Financial Assistance Policy Changes Pursuant to the ACA

ACA Health Care Coverage Expansion Description

Since implementation of the Affordable Care Act's (ACA) Health Care Coverage Expansion Option became effective on January 1, 2014, there has been a decrease in the number of patients presenting to the hospital in either uninsured and/or self-pay status. Additionally, the ACA's Expansion Option included a discontinuation of the primary adult care (PAC) which has also reduced uncompensated care. While there has been a decrease in the uncompensated care for straight self-pay patients since January 1, 2014, the ACA's Expansion Option has not completely eradicated charity care as eligible patients may still qualify for such case after insurance.

The following additional changes were also made to the hospital's financial assistance policy pursuant to the most recent 501(r) regulatory requirements:

1. **LANGUAGE TRANSLATIONS**
    a. Requirement: The new 501(r) regulations lowered the language translation threshold for limited English proficient (LEP) populations to the lower of 5% of LEP individuals in the community served/1000-LEP individuals. [INSERT NAME OF YOUR HOSPITAL] translated its financial assistance policy into the following languages: [INSERT LANGUAGES OF YOUR RESPECTIVE HOSPITAL'S TRANSLATIONS – *see reference chart on the next page*]

2. **PLAIN LANGUAGE SUMMARY**
    a. Requirement: The new 501(r) regulations require a plain language summary of the FAP that is clear, concise, and easy for a patient to understand. [INSERT NAME OF YOUR HOSPITAL] created a new plain language summary of its financial assistance policy in addition to its already-existing patient information sheet.

3. **PROVIDER LISTS**
    a. Requirement: The new 501(r) regulations require each hospital to create and maintain a list of all health care providers (either attached to the FAP or maintained as a separate appendix) and identify which providers on that list are covered under the hospital's FAP and which providers are not. [INSERT NAME OF YOUR HOSPITAL] maintains that list which is available for review.

Appendix III: Financial Policy

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-34
		REVISED:	05/2016
		PAGE #:	1-11
		SUPERSEDES	08/2013

1.0 POLICY

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

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

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

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

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

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

2.0 PROGRAM ELIGIBILITY

2.1 Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, SRH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

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

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

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

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

2.2.4 Patient convenience items.

2.2.5 Patient meals and lodging.

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

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

2.3.1 Refusal to provide requested documentation or providing incomplete information.

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

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

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

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

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

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

2.5 Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section 3 below). If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services and for their overall personal health.

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

3.0 PRESUMPTIVE FINANCIAL ASSISTANCE

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

3.1.1 Active Medical Assistance pharmacy coverage.

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

3.1.3 Primary Adult Care ("PAC") coverage.

3.1.4 Homelessness.

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

3.1.6 Maryland Public Health System Emergency Petition patients.

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

3.1.8 Food Stamp eligibility.

3.1.9 Eligibility for other state or local assistance programs.

3.1.10 Patient is deceased with no known estate.

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

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

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

3.2.2 Lack health insurance coverage.

3.2.3 Not enrolled in Medical Assistance for date of service.

3.2.4 Indicate an inability to pay for their care.

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

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

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

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

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

4.0 MEDICAL HARDSHIP

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

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

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

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

4.2 Patient Balance after Insurance

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

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

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

4.5 Individual patient situation consideration:

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

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

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

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

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

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

5.0 ASSET CONSIDERATION

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

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

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

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

5.2.3 Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

6.0 APPEALS

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

6.2 Appeals can be initiated verbally or written.

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

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

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

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

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

7.0 PATIENT REFUND

7.1 Patients applying for Financial Assistance up to 2 years after the service date who have made account payment(s) greater than $5.00 are eligible for refund consideration.

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

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

8.0 JUDGEMENTS

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

9.0 PROCEDURES

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

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

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

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

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

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

9.2.5 Patients will have thirty (30) days to submit required documentation to be considered for eligibility. If no data is received within 20 days, a reminder letter will be sent notifying that the case will be closed for inactivity and the account referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.

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

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

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

9.3.3 Proof of Social Security income (if applicable).

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

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

9.3.6 Reasonable proof of other declared expenses.

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

9.3.8 Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted.

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

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

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

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

9.6 Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. With the

exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.

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

9.7.1 Post-approval discovery of an ability to pay.

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

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

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

10.0 ***EXTRAORDINARY COLLECTION ACTIONS***

10.1 With the approval of the Patient Financial Services, extraordinary Collection Actions (ECAs) may be taken on accounts that have not been disputed or are not on a payment arrangement. These actions will occur no earlier than 120 days from submission of first bill to the patient and will be preceded by notice 30 days prior to commencement of the action. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

10.1.1 Garnishments may be applied to these patients if Shore Regional Health is awarded judgment.

10.1.2 A lien may be placed on primary home values above $150,000. Shore Regional Health will not pursue foreclosure of a primary residence but may retain our position as a secured creditor if a property if otherwise foreclosed upon.

10.1.3 Closed account balances that appear on a credit report or referred for judgment/garnishment may be reopened should the patient contact Shore Regional Health regarding the balance report. Payment will be expected

from the patient to resolve any credit issues, unless Shore Regional Health deems the balances should remain written off.

Gerard M. Walsh, Chief Operating Officer

Effective	10/05
Approved	Shore Health System Board of Directors: 05/16
Revised	05/16
Revised	02/11
Submitted	JoAnne Hahey, Sr. Vice President/CFO
	Donald Taylor, Director Patient Financial Services
Approved	SHS Board of Directors:

ATTACHMENTS:

- Attachment A - Sliding Scale

Appendix IV

SHORE REGIONAL HEALTH SYSTEM PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy

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

Shore Regional Health System meets or exceeds the legal requirements by providing financial assistance to those individuals in households below 200% of the federal poverty level
and reduced cost-care up to 300% of the federal poverty level.

Patients' Rights

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

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

Patients' Obligations

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

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

Contacts:

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

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

For information about Maryland Medical Assistance

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

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

MHE/DGH/01/12

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

HOJA INFORMATIVA PARA LOS PACIENTES DE SHORE REGIONAL HEALTH SYSTEM

POLIZA DEL HOSPITAL PARA AYUDA FINANCIERA:

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

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

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

DERECHOS PARA LOS PACIENTES:

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

- Asimismo, proporcionará asistencia para afiliación a programas que cuentan con fondos solventados por el Gobierno, tales como Medicaid o afiliación a otras organizaciones que pueden ayudar económicamente.
- Si Ud. no califica para recibir ayuda Médica o financiera, puede optar por un plan de pagos a largo plazo, para pagar su cuenta del hospital.
- Si Ud. considera que erróneamente lo han referido a una agencia de recaudación de dinero, tiene el derecho de contactar al hospital para solicitar ayuda. (ver información para contactarse, en la parte inferior de la hoja)

OBLIGACIONES PARA LOS PACIENTES:

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

1. Colaboren proporcionando información sobre su compañía aseguradora así como información financiera.
2. Provean la información requerida para llenar las solicitudes de Medicaid en el menor tiempo possible.
3. Cumplan con los términos establecidos para el pago.
4. Nos notifiquen inmediatamente al teléfono indicado en la parte inferior de la hoja sobre algún cambio habido en la información que haya sido proporcionada.

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INFORMACION PARA CONTACTARSE:

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

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

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

Appendix V

SHORE REGIONAL HEALTH SYSTEM

Vision Statement

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

MISSION

Creating Healthier Communities Together

Goal

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

VALUES

- Respect
- Integrity
- Teamwork
- Excellence
- Service