Q1.

Introduction:

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission developed a two-part community benefit reporting system that includes an inventory spreadsheet that collects financial and quantitative information and a narrative report to strengthen and supplement the inventory spreadsheet. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. This reporting tool serves as the narrative report. The instructions and process for completing the inventory spreadsheet remain the same as in prior years. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for FY 2018.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Peninsula Regional Medical Center	◉	○	
Your hospital's ID is: 210019	◉	○	
Your hospital is part of the hospital system called None - Independent Hospital.	◉	○	

Q4. The next two questions ask about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. (Optional) Please describe any other community health statistics that your hospital uses in its community benefit efforts.

Q6. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Community Benefit 2019 Market and Demographics w Additional Resources.docx
2.5MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q7. Section I - General Info Part 2 - Community Benefit Service Area

Q8. Please select the county or counties located in your hospital's CBSA.

- ☐ Allegany County
- ☐ Anne Arundel County
- ☐ Baltimore City
- ☐ Baltimore County
- ☐ Calvert County
- ☐ Charles County
- ☐ Dorchester County
- ☐ Frederick County
- ☐ Garrett County
- ☐ Harford County
- ☐ Prince George's County
- ☐ Queen Anne's County
- ☑ Somerset County
- ☐ St. Mary's County
- ☐ Talbot County

- [ ] Caroline County
- [ ] Carroll County
- [ ] Cecil County
- [ ] Howard County
- [ ] Kent County
- [ ] Montgomery County
- [ ] Washington County
- [x] Wicomico County
- [x] Worcester County

Q9. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q10. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Somerset County ZIP codes located in your hospital's CBSA.

- [x] 21817
- [x] 21821
- [x] 21822
- [x] 21824
- [x] 21836
- [x] 21838
- [x] 21851
- [x] 21853
- [x] 21857
- [x] 21866
- [x] 21867
- [x] 21871
- [x] 21890

Q28. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

- [x] 21801
- [x] 21802
- [x] 21803
- [x] 21804
- [x] 21810
- [x] 21814
- [x] 21822
- [x] 21826
- [x] 21830
- [x] 21837
- [x] 21840
- [x] 21849
- [x] 21850
- [x] 21852
- [x] 21856
- [x] 21861
- [x] 21865
- [x] 21874
- [x] 21875

Q32. Please check all Worcester County ZIP codes located in your hospital's CBSA.

- [x] 21792
- [x] 21804
- [x] 21811
- [x] 21813
- [x] 21822
- [x] 21829
- [x] 21841
- [x] 21842
- [x] 21843
- [x] 21851
- [x] 21862
- [x] 21863
- [x] 21864
- [x] 21872

Q33. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.
- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.
- [ ]

Based on patterns of utilization. Please describe.

- [x] Other. Please describe.

Peninsula Regional Medical Center's Primary Service Area historically and currently is Wicomico, Worcester, and Somerset Counties.

Q34. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Q35. Section I - General Info Part 3 - Other Hospital Info

Q36. Provide a link to your hospital's mission statement.

https://www.peninsula.org/about-us

Q37. Is your hospital an academic medical center?

- ○ Yes
- ◉ No

Q38. (Optional) Is there any other information about your hospital that you would like to provide?

Q39. (Optional) Please upload any supplemental information that you would like to provide.

Q40. Section II - CHNA Part 1 - Timing & Format

Q41.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- ◉ Yes
- ○ No

Q42. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q43. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/06/2019

Q44. Please provide a link to your hospital's most recently completed CHNA.

https://online.fliphtml5.com/cxbl/pjhj/#p=1

Q45. Did you make your CHNA available in other formats, languages, or media?

- (●) Yes
- ( ) No

Q46. Please describe the other formats in which you made your CHNA available.

The CHNA is made available in an electronic copy format and a hard copy format that is available to be viewed and distributed to residents of our community. The CHNA is translated into Spanish for our Spanish speaking residents. We are also in the process of reviewing our Creole population to determine if we need to translate the CHNA into Creole.

Q47. Section II - CHNA Part 2 - Participants

Q48. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☑	The Board of Trustees receives a copy of the Community Health Assessment and the Implementation Strategy Plan to review, c and approve. There are also periodic updates to action plans, mi and progress updates.

Board of Directors or Board Committee (system level)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☑	The Board of Trustees receives a copy of the Community Health Assessment and the Implementation Strategy Plan to review, c and approve. There are also periodic updates to action plans, mi and progress updates.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Clinical Leadership (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Physician(s)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Nurse(s)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Social Workers	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit Task Force	☐	☐	☑	☑	☑	☑	☑	☑	☐	☑	Those identified in the preceding positions (nurses, social worke make up the Community Benefit Task Force. Others from Beha Health, Marketing, and Planning were also participants in the Co Benefit Task Force.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Other (specify) Behavioral Health, Marketing, Planning, Diabetes Department, Emergency Department, Cardiac Rehab, Pediatric Endocrinology, and Employee Health and Wellness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Participants in each of these departments used their knowledg unique expertise to contribute to the CHNA.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:

Q49. Section II - CHNA Part 2 - Participants (continued)

Q50. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Wicomico County Health Department and Somerset County Health Department	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Wicomico County LHIC	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Area Agency on Aging -- Please list the agencies here: MAC, Inc. The Area Agency on Aging	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Local Govt. Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Faith-Based Organizations	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - K-12 -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Colleges and/or Universities -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Behavioral Health Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Social Service Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Post-Acute Care Facilities -- please list the facilities here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community/Neighborhood Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations - - Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q51. Section II - CHNA Part 3 - Follow-up

Q52. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q53. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

11/07/2019

Q54. Please provide a link to your hospital's CHNA implementation strategy.

https://www.peninsula.org/community/community-health-needs-assessment-and-implementation-plan

Q55. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q56. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

- ☑ Access to Health Services: Health Insurance
- ☑ Access to Health Services: Practicing PCPs
- ☑ Access to Health Services: Regular PCP Visits
- ☐ Access to Health Services: ED Wait Times
- ☐ Access to Health Services: Outpatient Services
- ☐ Adolescent Health
- ☐ Arthritis, Osteoporosis, and Chronic Back Conditions
- ☑ Behavioral Health, including Mental Health and/or Substance Abuse
- ☑ Cancer
- ☐ Children's Health
- ☑ Chronic Kidney Disease
- ☐ Community Unity
- ☑ Dementias, Including Alzheimer's Disease
- ☑ Diabetes
- ☐ Disability and Health
- ☑ Educational and Community-Based Programs
- ☐ Environmental Health
- ☐ Family Planning
- ☐ Food Safety
- ☐ Global Health
- ☐ Health Communication and Health Information Technology
- ☑ Health Literacy
- ☑ Health-Related Quality of Life & Well-Being
- ☑ Heart Disease and Stroke
- ☐ HIV
- ☐ Immunization and Infectious Diseases
- ☐ Injury Prevention
- ☐ Lesbian, Gay, Bisexual, and Transgender Health
- ☐ Maternal & Infant Health
- ☑ Nutrition and Weight Status
- ☑ Older Adults
- ☑ Oral Health
- ☑ Physical Activity
- ☐ Respiratory Diseases
- ☐ Sexually Transmitted Diseases
- ☐ Sleep Health
- ☐ Telehealth
- ☑ Tobacco Use
- ☐ Violence Prevention
- ☐ Vision
- ☐ Wound Care
- ☐ Housing & Homelessness
- ☑ Transportation
- ☑ Unemployment & Poverty
- ☑ Other Social Determinants of Health
- ☑ Other (specify) Obesity

Q57. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

The needs and priorities identified in Peninsula Regional Medical Center's most recent CHNA are comparable to the needs and priorities identified in the previous CHNA. There is a substantial need when it comes to the population in our CBSA. The same needs and priorities are obesity, diabetes, and behavioral health. The new need added for the 2019 CHNA is Cancer.

Q58. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

On November 7, 2019, the Board of Trustees approved Peninsula Regional's strategic implementation strategy to proceed with the following three themed initiatives: Chronic Disease Management with an emphasis on Diabetes, Cancer and Behavioral Health.

Q59. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q60. Section III - CB Administration Part 1 - Participants

Q61. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	The Board of Trustees receive a copy of the Community Benefit Report (financial & narrative) with a presentation at their monthly education session. Following the education session, the Board fully accepts the Community Benefit Report through the passing of a resolution.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	The Board of Trustees receive a copy of the Community Benefit Report (financial & narrative) with a presentation at their monthly education session. Following the education session, the Board fully accepts the Community Benefit Report through the passing of a resolution.

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☐	☐	☐	☐	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☐	☐	☐	☐	☐	☐	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☐	☐	☑	☑	☑	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☑	Oversees and directs the initiatives.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit Task Force	☐	☐	☑	☑	☑	☐	☐	☐	☑	☑	Those identified in the preceding positions (nurses, social workers, etc. make up the Community Benefit Task Force. Others from Behavioral Health, Marketing and Planning were also participants in the Community Benefit Task Force.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q62. Section III - CB Administration Part 1 - Participants (continued)

Q63. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: McCready Memorial Hospital, Atlantic General Hospital and Children's National Medical Center	☐	☐	☐	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Wicomico Health Department, Somerset Health Department and Worcester County Health Department	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Wicomico County Local Health Improvement Coalition, Healthy Somerset, and the Worcester County Local Health Improvement Coalition	☐	☑	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Area Agency on Aging -- Please list the agencies here: MAC, Inc. (Maintaining Active Citizens)	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Govt. Organizations -- Please list the organizations here: City of Salisbury	☐	☐	☐	☐	☑	☑	☑	☑	☐	The City of Salisbury continues to work on improving the quality of life through events that promote walkability and healthy lifestyles.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☐	☐	☑	Peninsula Regional Medical Center works with Faith Based Organizations in the community to provide healthy lifestyle education, flu shots, facilitate the pairing of people with local health-based resources. The organizations we have partnered with are: Union United Methodist, Ewell United Methodist, New Dimensions, New Macedonia Church, Mount Carmel Baptist, Emanuel Wesleyan, St. Paul AME Zion Church - Berlin, St. Paul's - Salisbury, St. James, AME, St. Peter's Lutheran, Grace United Methodist, Holy Redeemer, and Mt. Zion Baptist.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - K-12 -- Please list the schools here: Wicomico High, Wicomico Middle, Westside Intermediate, Salisbury Middle, Parkside High, James M Bennett High, Bennett Middle, and Fruitland Intermediate	☐	☐	☐	☐	☐	☐	☑	☑	☑	We are working with the Wicomico County Public Schools to identify, provide education, and help maintain active children and adolescents who have diabetes.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Colleges and/or Universities -- Please list the schools here: UMES, Salisbury University, and Wor-Wic Community College	☐	☐	☐	☐	☐	☐	☐	☐	☑	We partner with the local universities in various population health capacities that include participating in university sponsored health fairs. In addition, through sponsorship and education, we support their health and wellness initiatives and pharmacy/nursing education programs.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Nursing School -- Please list the schools here: Salisbury University Nursing School	☐	☐	☐	☐	☐	☐	☐	☐	☑	Nursing students at Salisbury University intern on the Wagner Wellness Van Mobile Outreach Clinic, providing health screenings and health education to medically undeserved areas in the community. The nursing students also learn about the continuum of care from a population health perspective throughout their clinical rotation process among the various departments of Peninsula Regional.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here: University of Maryland Eastern Shore	☐	☐	☐	☐	☐	☐	☐	☐	☑	Pharmacy students at the University of Maryland Eastern Shore intern with Peninsula Regional's pharmacy department and retail pharmacy HomeScripts.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here: C.O.A.T., Resource and Recovery Center	☐	☐	☐	☐	☐	☐	☑	☑	☑	Resource and Recovery Center provides space for Wagner Wellness Van Mobile Outreach Clinic.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here: Worcester County Social Services	☐	☐	☐	☐	☐	☐	☐	☐	☑	Provided space for Wagner Wellness Van Mobile Outreach Clinic.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Post-Acute Care Facilities -- please list the facilities here: Salisbury Genesis, Anchorage, Coastal Hospice, Aurora Nursing Home, Berlin Nursing Home, White Oak SNF, Harrison House, Hartley Hall, and Deers Head Center	☐	☐	☐	☐	☐	☐	☐	☐	☑	Peninsula Regional Medical Center continues to work with post-acute care facilities to provide appropriate transitions of care for patients.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here: Local EMT Services, Lower Shore Clinic, Lower Shore Enterprises, Bayshore Services, Salvation Army, Coastal Hospice, James Leonard Apartments (Low Income Housing), Salisbury Urban Ministries, and the YMCA Delmarva	☐	☐	☐	☐	☐	☐	☐	☐	☑	PRMC continues to partner with local community/neighborhood organizations to increase awareness and engagement in healthy lifestyles and behaviors. Peninsula Regional engages in and partners with each neighborhood organization and their vision, whether it's diabetes screenings and education, nutrition and weight loss, social determinants of health and its corresponding correlation to behavioral health, or any unmet identified health need in the community. These organizations also provided space for the Wagner Wellness Van Mobile Outreach Clinic and subsequently refers patients to physician providers and community based services determined by their condition.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here: Crisfield Clinic, HALO, Inc., Hope, Inc., Chesapeake Health Care, Other Independent and Employed Physicians, (PRCIN - Peninsula Regional Clinically Integrated Network), Dr. Jonathan Patrowicz, Dr. Alon Davis, Dr. Chris Huddleston, and Dr. Vel Natesan.	☐	☐	☐	☐	☐	☐	☐	☐	☑	PRMC continues to partner with these people and organizations to provide awareness and engagement in healthy lifestyles and behaviors. These local organizations partner with PRMC to provide screenings to the local community for diabetes, renal disease, heart disease, etc. The local physicians that are partnered with PRMC see patients from the Wagner Wellness Van if they have been referred for a physician office visit.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q64. Section III - CB Administration Part 2 - Process & Governance

Q65. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- ☑ Yes, by the hospital's staff
- ☑ Yes, by the hospital system's staff
- ☐ Yes, by a third-party auditor
- ☐ No

Q66. Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

Q67. Please describe the community benefit narrative audit process.

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

Q68. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (●) Yes
- ( ) No

Q69. Please explain:

This question was not displayed to the respondent.

Q70. Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

Q71. Please explain:

This question was not displayed to the respondent.

Q72. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (●) Yes
- ( ) No

Q73. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

Peninsula Regional Health System's mission is to improve the health of the communities we serve. Community Benefit Planning and our Strategic Plan Vision 2020 work in unison creating synergy for advancing community health. Peninsula Regional is transforming healthcare within our CBSA as the journey is to partner with our communities and local providers to help them understand how to best manage their pre-existing conditions. The System is focused on wellness, providing the appropriate care in the appropriate setting and connecting them to services and information to promote a healthy lifestyle. Achieving the best outcomes through improving coordination both inside and outside the institution while avoiding preventable hospital admissions/readmissions and emergency room visits. Using the Community Health Needs Assessment as a roadmap to prioritize community health privations, the integration of System Strategy and Community Benefits creates a strong cooperative and focused approach to population health planning and execution. Vision 2020, Peninsula Regional's Strategic Plan, has four overall arching themes, theme 3.0 is "Meet Consumer's Health Needs in All Stages of Life" . This theme has multiple population health and community benefit strategies as evidenced: - Develop a model of care for chronic care management - Promote a sustainable culture of health, well-being, and community engagement - Identify the most important health needs for key population segments during their life journey - Prioritize efforts in areas that drive the best health and efficiency outcomes - Improve health literacy

Q74. (Optional) If available, please provide a link to your hospital's strategic plan.

www.peninsula.org/publications (Please see Vision 2020 and other strategic planning documents)

Q75. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

Q76. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Q77. Based on the implementation strategy developed through the CHNA process, please describe *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q78. Section IV - CB Initiatives Part 1 - Initiative 1

Q79. Name of initiative.

Chronic Disease Management

Q80. Does this initiative address a community health need that was identified in your most recently completed CHNA?

- (●) Yes
- ( ) No

Q81. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Dementias, Including Alzheimer's Disease, Diabetes, Educational and Community-Based Programs, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Tobacco Use, Transportation, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Obesity

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

- [x] Access to Health Services: Health Insurance
- [x] Access to Health Services: Practicing PCPs
- [x] Access to Health Services: Regular PCP Visits
- [x] Access to Health Services: ED Wait Times
- [ ] Access to Health Services: Outpatient Services
- [x] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [x] Children's Health
- [x] Chronic Kidney Disease
- [x] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [x] Health Literacy
- [x] Health-Related Quality of Life & Well-Being
- [x] Heart Disease and Stroke
- [ ] HIV
- [x] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [x] Nutrition and Weight Status
- [x] Older Adults
- [ ] Oral Health
- [x] Physical Activity
- [x] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [x] Sleep Health
- [x] Telehealth
- [x] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Housing & Homelessness
- [x] Transportation
- [x] Unemployment & Poverty
- [x] Other Social Determinants of Health
- [x] Other (specify) Hypertension

Q82. When did this initiative begin?

01/01/2015

Q83. Does this initiative have an anticipated end date?

- ( ) No, the initiative has no anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( )

The initiative will end when a community or population health measure reaches a target value. Please describe.

- [ ] The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

- [ ] The initiative will end when external grant money to support the initiative runs out. Please explain.

- [ ] The initiative will end when a contract or agreement with a partner expires. Please explain.

- [x] Other. Please explain.

1. MAC Chronic Disease Self-Management - This initiative will continue into the next several years.

2. Wagner Wellness Van Mobile Clinic - This initiative will continue into the next several years.

3. Smith Island Telehealth - This initiative will continue into the next several years.

4. SWIFT - This initiative will continue into the next several years.

5. Care Management and Disease Management Program for Chronic Conditions - This initiative will continue into the next several years.

6. Remote Patient Monitoring - This initiative started June 10th, 2019 will continue into FY 2020.

Q84. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

1. MAC Chronic Disease Self-Management - Patients with uncontrolled chronic diseases which are identified via ER visits, the Wagner Wellness Van Mobile Outreach Clinic, Hospital Referrals, PCP Referrals, and other providers. Most of this population is above 50 years old and have been referred for health reasons. 2. Wagner Wellness Van Mobile Outreach Clinic - Residents of PRMC's primary service area who have barriers to care such as no health insurance, no primary care provider, or no transportation. This population is primarily an indigent population with limited income. 3. Smith Island Telehealth - This population is the total population of Smith Island since there are no health care facilities located on the island (approximately 300 residents). 4. Salisbury/Wicomico Integrated First-Care Team (SWIFT) - The targeted population is Salisbury, MD residents who rely heavily on EMS and PRMC for non-emergency care and/or patients who frequently have medically unnecessary ER visits and/or hospital readmissions within 30 days of discharge. 5. Care Management and Disease Management Program for Chronic Conditions – This initiative targets residents who have had an ED or inpatient stay and are determined to be high utilizers of health services. There is a further emphasis on Medicare patients. 6. Remote Patient Monitoring - The targeted population is Medicare patients in Wicomico, Worcester or Somerset County who have had an inpatient stay for CHF, COPD, or Respiratory Failure and have had two or more ED/urgent care/office visits, a change in condition/medications, or hospitalization or skilled nursing facility discharge within the last 90 days.

Q85. Enter the estimated number of people this initiative targets.

6,767

Q86. How many people did this initiative reach during the fiscal year?

1. MAC Chronic Disease Self-Management - 470. (See Attachment A) 2. Wagner Wellness Van - 1,090 patients. (See Attachment B) 3. Smith Island Telehealth - 276 patients. (See Attachment C) 4. SWIFT - 78 residents. (See Attachment D) 5. Care Management and Disease Management Program for Chronic Conditions - 4,845 community members. (See Attachment E) 6. Remote Patient Monitoring - 8 patients (started June 10th, 2019 and will be moving forward into FY 2020) (See Attachment F)

Q87. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention

- [x] Acute condition-based intervention: treatment intervention
- [x] Acute condition-based intervention: prevention intervention
- [x] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [x] Community engagement intervention
- [ ] Other. Please specify.

Q88. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (•) Yes. Please describe who was involved in this initiative.

1. MAC (Maintaining Active Citizens) Chronic Disease Self-Management - MAC, Inc. the Area Agency on Aging.

2. Wagner Wellness Van Mobile Outreach Clinic - Wicomico County Health Department, Worcester County Health Department, Somerset County Health Department, Wicomico County Board of Education, Worcester County Board of Education, Somerset County Board of Education, the City of Salisbury, the Salisbury Fire Department, the Salisbury Police Department, HOPE Inc., HALO Shelter, Salisbury Urban Ministries, St. James AME Church, St. Peter's Lutheran Church, Resource and Recovery Center, Atlantic Club, Marion Pharmacy, MAC Inc. the Area Agency on Aging, National Kidney Foundation, Maryland Food Bank, Wicomico County Community Health Providers, Worcester County Community Health Providers, Somerset County Community Health Providers, the YMCA, and the United Way of the Lower Eastern Shore.

3. Smith Island Telehealth - McCready Health, Marion Pharmacy, Crisfield Clinic, Wicomico County Health Department, Somerset County Health Department, National Kidney Foundation, MAC Inc. the Area Agency on Aging, United Way of the Lower Eastern Shore, and multiple Wicomico and Somerset Community Health providers.

4. SWIFT - Salisbury Fire Department, Salisbury Police Department, City of Salisbury, and the Wicomico County Health Department, and the Maryland Community Health Resources Commission (MCHRC)

5. Care Management and Disease Management Program for Chronic Conditions - Atlantic General, McCready Health, Wicomico County Health Department, Somerset County Health Department, Worcester County Health Department, Wicomico County Community Health Providers, Somerset County Community Health Providers, Worcester County Community Health Providers, United Way of the Eastern Shore, HOPE, Inc., HALO, Inc., Salisbury Urban Ministries, St. James AME Church, St. Peters Lutheran Church, Resource and Recovery Center, Atlantic Club, Marion Pharmacy, MAC, Inc. the Agency on Aging, National Kidney Foundation, Maryland Food Bank, the YMCA, and the Peninsula Regional Clinically Integrated Network (PRCIN)

6. Remote Patient Monitoring – Peninsula Regional, Vivify Health, and Peninsula Regional Clinically Integrated Network (PRCIN)

- ( ) No.

Q89. Please describe the primary objective of the initiative.

1. MAC Chronic Disease Self-Management - Managing chronic diseases to ultimately reduce ER visits, admissions, and readmissions. This is done through programs that are designed to assist with the self-management of chronic diseases, providing the participants awareness and education on controlling their diabetes, hypertension, pain, etc. The programs are available to young adults 18 years of age or older and their families to learn about self-management. These workshops also give the aging population a higher quality of life and sense of independence, ultimately keeping them healthy, strong, and out of the hospital. The goals of this highly interactive community program are to improve individual's self-management skills and self-efficacy; includes key skill-building activities including action planning, problem-solving, decision-making. Weekly topics include: Nutrition, Appropriate exercise for strength, flexibility, and endurance, communicating effectively with family, friends and health care providers, Appropriate use of medications, Techniques to deal with pain, fatigue, frustration, Decision Making and Action Planning and Goal Setting. Outcomes include improved health literacy, patient activation for self-management, increased physical activity, improvement in depression, unhealthy physical days, medication compliance, better health outcomes: (reduced fatigue, pain, shortness of breath. stress. and sleep problems), and fewer sick days, and reduced ED and hospitalization. 2. Wagner Wellness Van Mobile Outreach Clinic - Provides walk-in appointments with a provider for acute needs, health screenings and assessments, education on prevention and management of chronic disease, as well as general health education awareness and literacy. The Wagner Wellness Van Mobile Outreach Clinic connects clients with insurance and primary care resources, community resources to address social determinants of health as well as promotes healthy lifestyle and reducing ED utilization. The van visits low income areas where the social determinants of health indicate the greatest need. It provides care in areas that have a higher prevalence of ER visits, lower median incomes, an indigent population, barriers to care, and overall poor health outcomes. 3. Smith Island Telehealth - To increase access of care to Smith Island (a small rural island on the Chesapeake Bay) residents, provide health education and awareness to residents, and reduce ED utilization. A goal this year was to increase telemedicine opportunities by having DSL Internet installed on Smith Island. 4. SWIFT – The primary objective of SWIFT is to reduce EMS and ED utilization by identifying and providing intervention to the highest ED utilizers. The SWIFT team works collaboratively with high utilizers to reduce overuse of emergency services and improve access to care by connecting these community members to area resources that address behavioral health, chronic disease health, and other social determinants of health. The program also connects utilizers with more appropriate care settings such as primary care offices and FQHCs (Federally Qualified Health Centers). 5. Care Management and Disease Management Program for Chronic Conditions - The primary objective of this initiative is to enroll residents with an emphasis on Medicare patients into evidence-based disease management programs and establish care management relationships with Medicare enrollees before acute episodes occur. Care Management coordination also takes place between the three hospitals to identify high utilizers of services and set up a care management plan to reduce utilization costs and increase health. 6. Remote Patient Monitoring - The primary objective of this initiative is to monitor Medicare patients who have been diagnosed with CHF, COPD, or Respiratory Failure in order to make sure patients adhere to protocols, medications, and are engaged in their medical instructions. The Remote Patient Monitoring also is focused on reducing readmissions, increasing patient/caregiver engagement, and early identification in changes to a patient's health status.

Q90. Please describe how the initiative is delivered.

1. MAC Chronic Disease Self-Management - Workshops/Classes located at MAC, Inc. the Agency on Aging and throughout the community. 2. Wagner Wellness Van Mobile Outreach Clinic - The mobile clinic serves multiple locations in the Tri-County area (Wicomico, Somerset, and Worcester counties). The staff includes an NP, RN, a Medical Assistant, and a Social Worker to help provide care, screenings, and health education to residents of Wicomico, Worcester and Somerset counties. 3. Smith Island Telehealth - Two employed Medical Assistant serves as liaisons for telehealth visits with providers. In-person visits by a provider occur every two weeks with weather permitting. 4. SWIFT - A team consisting of a Paramedic, NP, an RN and a Social Worker, visit patients who are identified as high utilizers of EMS services. A large percentage of these patients have co-occurring behavioral health and chronic disease conditions that are diagnosed by the team. A plan is subsequently created based on a home assessment and then the patient is followed by the team for an average of six months. Referrals to local behavioral health and chronic disease health resources are made for the patient if required. 5. Care Management and Disease Management Program for Chronic Conditions - Care Managers are embedded into Primary Care offices and the ED to identify residents with an emphasis on Medicare patients who are high utilizers of services or are at risk of chronic disease medical attention. The Care Managers then enroll these patients into care management programs and establish a relationship with the patient to get him/her to move towards a healthy lifestyle change. 6. Remote Patient Monitoring – This initiative is delivered by installing remote patient monitoring systems into patients' homes that qualify for the Remote Patient Monitoring Program. The patients are first given a training class in the hospital and then the equipment is installed in the patients' homes by a community health worker.

Q91. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: 1. MAC Chronic Disease Self-Management - 470 participants in 42 workshops. (See Attachment A) 2. Wagner Wellness Van Mobile Outreach Clinic - 1,090 patients. (See Attachment B) 3. Smith Island Telehealth – 276 participants. (See Attachment C) 4. SWIFT - 78 patients. (See Attachment D) 5. Care Management and Disease Management Program for Chronic Conditions - 4,845 participants. (See Attachment E) 6. Remote Patient Monitoring - 8 participants. (See Attachment F)
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [x] Surveys of participants: 1. MAC Chronic Disease Self-Management – (See Attachment A) 6. Remote Patient Monitoring – (See Attachment F)
- [ ] Biophysical health indicators
- [x] Assessment of environmental change: 4. SWIFT - Residents are being connected with local healthcare resources instead of calling 911 and EMS services. 6. Remote Patient Monitoring – Patients are seeing their Primary Care Provider first, instead of immediately visiting the ER.
- [ ] Impact on policy change
- [x]

Effects on healthcare utilization or cost	1. MAC Chronic Disease Self-Management - By residents attending these classes and becoming educated on managing their chronic disease, hypertension, and/or fall risk, ultimately it reduces the chance of a resident needing medical attention and reduces ED utilization and costs. According to the surveys from Attachment A, 100% of people enrolled in the Chronic Disease Self-Management Class have more self-confidence in their ability to manage their health than they did before taking the workshop. 71% of attendees also strongly agreed that they felt more motivated to take care of their health since they took the workshop. If people take care of their health, it reduces the amount of ED utilization from an episode and increases the overall health of the patient. (See Attachment A) 2. Wagner Wellness Van - Patients are getting referred to Primary Care Physicians, which reduces ED costs and utilization. Residents also can receive screenings and be directed to the appropriate medical services if a screening comes back positive. This is important because it is possible for residents to receive medical services before a condition becomes an emergency and affects ED costs and utilization. 3. Smith Island Telehealth - By having the option to speak to a medical professional remotely instead of heading directly to the ED, the medical professional can give an informed assessment of the situation, possibly eliminating a trip to the ED. This type of telehealth consult decreases ED utilization and cost. 4. SWIFT – There was a reduction of ED visits to PRMC of 40% for Total ED utilization and costs are decreased because participants are connected to the correct care in the correct setting instead of utilizing the ED and EMS services. For the first 6 months of FY 2019, SWIFT saw a 40% reduction in ED visits and a $69,000 reduction in charges. (See Attachment D) 5. Care Coordination – By having residents registered for this program, there are a total of 4,845 community members being cared for and Peninsula Regional Medical Center had a Medicare Payment Adjustment Savings of $636,843. (See Attachment E)

- [ ] Assessment of workforce development
- [ ] Other

Q92. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

1. MAC Chronic Disease Self-Management - There were 42 workshops with a total number of 470 participants for FY 2019. There were 16 workshops with 178 participants for “Stepping On” Falls Prevention Classes, 6 workshops with 69 participants for Living Well with Hypertension, and 20 workshops with 223 participants for Chronic Disease Self-Management classes. Between the workshops and managing community members' care by PRMC, there has been a reduction in ED usage and a substantial Medicare Payment Adjustment Savings. (See Attachment A) 2. Wagner Wellness Van Mobile Outreach Clinic - The Wagner Wellness Van expanded its outreach to at-risk communities throughout the Tri-County area. It also went to screening fairs conducted at migrant camps, community centers, schools, shelters and churches, as well as to Smith Island, MD. Over 1,000 community members received medical services from the Wagner Wellness Van. 3. Smith Island Telehealth – A health fair was held which incentivized residents to come, including extended hours and giveaways. A total of 276 residents were seen by the end of FY 2019. A substantial percentage of the total population of Smith Island is watermen. There was a 90% increase in watermen receiving a comprehensive health screening. There was also a 43% increase in total community members attending the health fair. DSL internet was also installed this year, greatly improving the efficiency and accessibility to telehealth services on Smith Island. (See Attachment C) 4. SWIFT - There was a reduction of ED visits to PRMC of 40% for enrollees over a 6-month period. There was also a reduction of $69,000 in total charges for the over 80 community members that are annually being managed by SWIFT. (See Attachment D) 5. Care Management and Disease Management Program for Chronic Conditions - Over 4,800 community members have had their care managed by the three hospitals in this program. There have been signs of improved health outcomes, a reduction in ER utilization and visits based on identifying high utilizers and referring them to intervention classes held at MAC, Inc. In total, there are 4,845 community members that are having their care managed by Peninsula Regional. (See Attachment E) 6. Remote Patient Monitoring - The program started two weeks before the end of the fiscal year, but there were already 8 patients signed up to receive Remote Patient Monitoring (RPM). According to satisfaction surveys by both the patients and physicians, the program is going very well. (See Attachment F)

Q93. Please describe how the outcome(s) of the initiative addresses community health needs.

1. MAC Chronic Disease Self-Management – MAC Chronic Disease Self-Management identifies the community health needs of Diabetes, Health Literacy, Health-Related Quality of Life and Well-Being, Nutrition and Weight Status, Older Adults, Hypertension and Physical Activity. There is a need for chronic disease self-management in our community. There are a substantial number of residents who have diabetes or pre-diabetes, are overweight, are hypertensive, or are nutritionally deficient. As the baby boomer generation ages, there is a need to help educate this demographic about chronic diseases and the potential effects it can have on health. Through the partnership with MAC, Inc., residents are gaining a better understanding of chronic diseases. In turn, the improved education can decrease ER visits and reduce future cost and utilization of the healthcare system. Action plans are created by attendees of the classes because they gain a better understanding of how to manage their symptoms, but also feel motivated to take control of their health. For FY 2019, there were a total of 470 participants in a total of 42 workshops throughout the year. The workshops included: Chronic Disease Self-Management, Living Well with Hypertension and Stepping On Falls Prevention. Based on participant surveys of the Chronic Disease Self-Management workshops, 64% of participants Strongly Agree that they have more self-confidence in their ability to manage their health than they did before taking the workshop. Also, 99% of participants Agree or Strongly Agree that they have a better understanding of how to manage the symptoms of their chronic health conditions. This evidence proves that these participants are learning to make healthy lifestyle choices. In the Stepping On Falls Prevention classes, participants learn ways to make modifications to their home, learn how to be steadier on their feet, understand how physical strength can contribute to reducing falls and other ways to reduce their chance of falling. After completing this workshop, 95% of participants Agree or Strongly Agree that they are more comfortable talking to family and friends about falling. There was an increase in confidence level from 63% to 84% that participants were Sure or Very Sure that they could become steadier on their feet. In the Living Well with Hypertension classes, participants increased taking prescribed blood pressure medication from 79% before the workshop to 100% after the workshop. Participants also had a reduced average systolic blood pressure reading and diastolic blood pressure reading after completing the workshop and learning effective strategies for living with Hypertension. (See Attachment A) 2. Wagner Wellness Van Mobile Outreach Clinic - The Wagner Wellness Van Mobile Outreach Clinic helps break down the barriers of care that some of the residents in PRMC's CBSA experience. This initiative identifies the community health needs of Access to Health Services: Health Insurance, Access to Health Services: Regular PCP Visits, Diabetes, Health Literacy, Health-Related Quality of Life and Well-Being, Heart Disease and Stroke, Immunizations and Infectious Diseases, Nutrition and Weight Status, Older Adults, Chronic Kidney Disease, Respiratory Diseases, Hypertension and Other Social Determinants of Health. For example, the van visits each county weekly so that people without transportation can come to a centralized location to receive health services. The van also provides services to residents who don't have insurance. The screenings performed on the van can help determine if there is a chronic disease that hasn't been identified by the resident such as diabetes, hypertension, or chronic heart failure. If a chronic disease is present, the van helps coordinate referrals to the appropriate community health resources or services. The screenings also provide an educational opportunity by providing nutritional and healthy lifestyle counseling. Drug and alcohol screenings can be performed, and counseling referrals can be coordinated. The indigent and Haitian populations are examples of communities that need help getting medical care due to barriers like transportation, language, no insurance, etc. This fiscal year, the Wagner Wellness Van participated in the 2nd Haitian Health Fair, screening 65 people for diabetes, hypertension, and renal disease. In total, 1,090 community members were impacted by the efforts of the Wagner Wellness Van for FY 2019. (See Attachment B) 3. Smith Island Telehealth – Smith Island Telehealth identifies the community health needs of Telehealth, Diabetes, Health Literacy, Nutrition and Weight Status, Physical Activity and Respiratory Diseases. The improved access to health care with the installation of telehealth provides chronic disease care management services and preventive care opportunities to residents. Physical Activity can be improved through the installation of donated exercise equipment (bikes), donated pedometers, and the provision of walking logs to residents. With the help of a Community Health Worker and telemedicine Primary Care visits, there was improved health literacy and chronic disease management. In FY 2019, 276 patients were served by the Smith Island Telehealth program. There was also a health fair on Smith Island where the community could come out and receive screenings and health information. There was an effort to reach watermen, as they comprise a substantial portion of the total population of Smith Island. Through incentives and extending the hours of the health fair, there was a 90% increase in watermen attending the health fair. (See Attachment C) 4. SWIFT - The SWIFT Program identifies the community health needs of Behavioral Health, Access to Health Services: Regular PCP Visits, Health Literacy, Health-Related Quality of Life and Well-Being and Other Social Determinants of Health. High-utilizing residents who used EMS/ED services are educated about their conditions by the Paramedic, NP, RN, and Social Worker. By identifying single or multiple social determinants of health affecting SWIFT Program participants, referrals can be made to solutions such as behavioral health resources, life coaches, local health resources or chronic disease management classes. 78 SWIFT patients were seen in FY 2019 with the help of EMS and an NP, RN, and Social Worker on the Wagner Wellness Van. (See Attachment D) 5. Care Management and Disease Management Program for Chronic Conditions - This program addresses the community health needs of Diabetes, Health Literacy, Health-Related Quality of Life and Well-Being, Heart Disease and Stroke, Nutrition and Weight Status, Respiratory Diseases and Other Social Determinants of Health by providing wraparound support by multidisciplinary teams in the community. High utilizers of the ED are assigned Social Workers that help direct these patients to healthcare services or community resources to address Social Determinants of Health. For FY 2019, this initiative had a Medicare Payment Adjustment Savings of $636,843. (See Attachment E) 6. Remote Patient Monitoring - This initiative helps to address the community health needs of Respiratory Diseases, Older Adults, and Health Related Quality of Life and Well-Being. By getting Medicare patients who have a respiratory disease into a remote patient monitoring program, it helps the patient understand his/her disease better and keeps a patient accountable with performing protocols assigned by the physician. The monitoring also helps RNs monitor vital signs and symptoms of patients and virtual call patients if needed. The program was started in June and had 8 patients being monitored at the end of FY 2019. Patient and Physician surveys show that both parties are satisfied with the program. (See Attachment F) The goal of this program is to have 50 patients monitored by October.

Q94. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

MAC, Inc. $120,070.78 MAC Rent for space for Cancer Support Group - $33,670 Wagner Wellness Van $451,428.41 ($372,294 grant applied - $126,535 claimed on financial report) Crisfield Clinic – Smith Island $54,894 ($45,191 grant applied - $9,703 claimed on Community Benefits) Interhospital Care Coordinators $1,065,738 ($682,194 grant applied - $440,709 claimed on Community Benefits)

Q95. (Optional) Supplemental information for this initiative.

CB FY 2019 Attachments In Order.docx
8.1MB
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Q96. Section IV - CB Initiatives Part 2 - Initiative 2

Q97. Name of initiative.

Exercise, Nutrition, and Weight

Q98. Does this initiative address a need identified in your most recently completed CHNA?

- (●) Yes
- ( ) No

Q99. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Dementias, Including Alzheimer's Disease, Diabetes, Educational and Community-Based Programs, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Tobacco Use, Transportation, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Obesity

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

- [ ] Access to Health Services: Health Insurance
- [ ] Heart Disease and Stroke

- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Access to Health Services: Outpatient Services
- [x] Adolescent Health
- [x] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [x] Children's Health
- [ ] Chronic Kidney Disease
- [x] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Environmental Health
- [ ] Family Planning
- [x] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health Literacy
- [x] Health-Related Quality of Life & Well-Being
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [x] Nutrition and Weight Status
- [x] Older Adults
- [ ] Oral Health
- [x] Physical Activity
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [x] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Housing & Homelessness
- [ ] Transportation
- [ ] Unemployment & Poverty
- [x] Other Social Determinants of Health
- [x] Other (specify) Hypertension

Q100. When did this initiative begin?

07/01/2017

Q101. Does this initiative have an anticipated end date?

- ( ) No, the initiative does not have an anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ( ) The initiative will end when external grant money to support the initiative runs out. Please explain.
- ( ) The initiative will end when a contract or agreement with a partner expires. Please explain.
- (•)

Other. Please explain.

1. Walk Wicomico - This initiative will continue into the foreseeable future.

2. YMCA Exercise, Nutrition, and Weight - This initiative will continue into the foreseeable future.

3. Maryland Discharge Meal Program - This initiative ended this fiscal year.

4. MAC Chronic Disease Self-Management - This initiative will continue into the foreseeable future.

Q102. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

1. Walk Wicomico - The targeted population is all residents of Wicomico County (100,000+ residents). 2. YMCA Exercise, Nutrition, and Weight - The targeted population includes children, adolescents, and adults who are obese, overweight, have diabetes or prediabetes in Wicomico, Worcester, and Somerset Counties. 3. Maryland Discharge Meal Program - The population this initiative targeted were patients discharged to homes identified as at risk for malnutrition, and/or food insecurities, and/or had been diagnosed with heart failure, chronic obstructive pulmonary disease or diabetes. 4. MAC Chronic Disease Self-Management – Patients with uncontrolled chronic diseases which are identified via ER visits, the Wagner Wellness Van Mobile Outreach Clinic, Hospital Referrals, PCP Referrals, and other providers. Most of this population are above 50 years old and have been referred for health reasons.

Q103. Enter the estimated number of people this initiative targets.

100,000

Q104. How many people did this initiative reach during the fiscal year?

1,147

Q105. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [x] Community engagement intervention
- [x] Other. Please specify.

Healthy Lifestyles and Community Interaction

Q106. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (•) Yes. Please describe who was involved in this initiative.

1. Walk Wicomico - City of Salisbury, Town of Fruitland, Town of Delmar, Maryland Department of Planning, Wicomico County Recreation, Parks, and Tourism, Wicomico County Public Schools, Salisbury/Wicomico Metropolitan Planning Organization, University of Maryland Extension, The YMCA, Shore Transit, and the Wicomico County Health Department.

2. YMCA Exercise, Nutrition, and Weight – The YMCA, Children's National Health System, Wicomico County Schools.

3. Maryland Discharge Meal Program - Maryland Department on Aging.

4. MAC Chronic Disease Self-Management - MAC, Inc. the Area Agency on Aging.

- ( ) No.

Q107. Please describe the primary objective of the initiative.

1. Walk Wicomico - The primary objective of Walk Wicomico is to increase awareness and engagement of healthy lifestyle behaviors by promoting exercise to help with weight loss, increasing energy, reducing the risk of chronic disease, and increasing happiness. "Walk Wicomico" is primarily targeting those that reside in Wicomico County (100,000+). Walk Wicomico is a coalition of partners that meet to create action plans that encourage and provide walking events. Peninsula Regional is an active participant in transforming the community's culture by providing education, guidance and resources towards promoting exercise through walkability. Walk Wicomico has marked walking routes in various locations throughout Wicomico County. It has also participated and launched walking events throughout the year and is engaged with decision makers through input and feedback about making walking safer, easier, and more accessible. 2. YMCA - The primary objective is to reduce the number of children, adolescents and adults in Wicomico, Worcester, and Somerset counties who are considered overweight and to present these people with opportunities to learn about a healthy lifestyle and exercise. There is an MOU signed between the YMCA and Peninsula Regional with the hopes of collaboration on projects directed towards diabetes awareness, education and support for all ages. A partnership has recently been established between Peninsula Regional's pediatric endocrinology outpatient services and the YMCA, in which young patients in need of increased activity can get a referral and a reduced family membership to the YMCA with a personal wellness coach. In the future, the goal is to hold support groups and diabetes events at the YMCAs in Salisbury and Pocomoke. 3. Maryland Discharge Meal Program - The primary objective of this initiative is to provide medically tailored meals to patients discharged to home who have been identified as at risk for malnutrition, and/or food insecurities, and/or been diagnosed with heart failure, chronic obstructive pulmonary disease or diabetes. By providing medically tailored meals, it is the hope that patients will meet nutritional standards given by medical professionals in order to become healthier. 4. MAC Chronic Disease Self-Management – The primary objective of this initiative is to teach self-management of chronic diseases so that residents become healthier individuals. Classes provide awareness, education, and self-management techniques to control diseases like diabetes, hypertension, pain, etc. by improving nutrition and exercise. MAC Chronic Disease Self-Management also is a highly interactive community program to improve individual's self-management skills and self-efficacy; includes key skill-building activities including action planning, problem-solving, decision-making. Weekly topics include: Nutrition, Appropriate exercise for strength, flexibility, and endurance, communicating effectively with family, friends and health care providers, Appropriate use of medications, Techniques to deal with pain, fatigue, frustration, Decision Making and Action Planning and Goal Setting. Outcomes include improved health literacy, patient activation for self-management, increased physical activity, improvement in depression, unhealthy physical days, medication compliance, better health outcomes: (reduced fatigue, pain, shortness of breath. stress. and sleep problems), and fewer sick days, and reduced ED and hospitalization.

Q108. Please describe how the initiative is delivered.

1. Walk Wicomico - The initiative is delivered by providing education, guidance, awareness, and resources towards promoting exercise through walking. The coalition of members created a website and phone application specific to walking opportunities in Wicomico County. The website and application provide locations of walking trails, maps of the walking trails, an events page that lists meetings and walks throughout the month. There is also a resources page that lists resources of topics, a toolkit, walking guides, registration forms for walking clubs and videos on how to start your own walking club. 2. YMCA - Peninsula Regional's pediatric endocrinology outpatient lead nurse practitioner works with the YMCA to refer young patients in need of increased activity. The YMCA provides a free or reduced-cost family membership as well as sessions with a personal wellness coach. Currently, we are also in the planning stages of incorporating nutrition and diabetes Peninsula Regional programs into a new collaborated program with the YMCA. Some options that could be possible would be holding support group sessions at the YMCAs in Salisbury and Pocomoke, providing health and diabetes education and awareness to members in these areas. There would also be monthly meetings held at the YMCA locations to discuss different topics of nutrition, health, exercise and diabetes. 3. Maryland Discharge Meal Program - The initiative was delivered by having meals sent to the homes of the patients who qualified for the program. 4. MAC Chronic Disease Self-Management – The initiative was delivered by workshops/classes located at MAC, Inc. The Agency on Aging and throughout the community.

Q109. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: 1. Wallk Wicomico 745 participants 2. YMCA Exercise Nutrition and Weight - 20 families. 3. Maryland Discharge Meal Program - 15 participants. MAC Chronic Disease Self-Management - 292 participants.
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [x] Surveys of participants: 4. MAC Chronic Disease Self-Management - (See Attachment A)
- [ ] Biophysical health indicators
- [x] Assessment of environmental change: 1. Walk Wicomico - Updated maps of trails. The trails are in Wicomico County and the maps are located on their website www.walkwicomico.com. Also added 1 trail in FY 2019. (See Attachment G)
- [ ] Impact on policy change
- [x] Effects on healthcare utilization or cost: 4. MAC Chronic Disease Self-Management - By residents attending these classes and becoming educated on managing their chronic diseases it reduces the chance a resident would need medical attention and reduces ED utilization and the total cost of care. Diet and exercise play a factor in managing one's chronic diseases and the educational topics discussed at chronic disease self-management classes include those subjects. According to the surveys from Attachment A, 100% of people enrolled in the Chronic Disease Self-Management Class have more self-confidence in their ability to manage their health than they did before taking the workshop. 71% of attendees also agreed that they felt more motivated to take care of their health since they took the workshop. If people take care of their health, it reduces ED utilization from an episode and increases the overall health of the patient. (See Attachment A)
- [ ] Assessment of workforce development
- [ ] Other

Q110. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

1. Walk Wicomico - The social media presence of the Walk Wicomico Facebook page has grown from 193 followers as of 06/30/2018 to 745 followers. There are also more trails with an improved map that includes Trail Heads, Handicap Accessible Trail Heads, Points of Interest, and Restroom/Drinking Fountain markers throughout the map. There are also more pictures being submitted by followers of the Walk Wicomico Facebook page. There were also 15 events throughout the year to promote walking and a healthy lifestyle. (See Attachment G) 2. YMCA Exercise, Nutrition, and Weight – Some observed outcomes that could occur after the joint programs are enacted are positive health outcomes for YMCA members who have prediabetes or diabetes. Some of these measures could be lower blood pressure readings or lower A1Cs. There could also be more community unity and parents of children who have diabetes could become more informed of how to maintain a healthy lifestyle with diabetes and exercise. There could also be walking programs people could sign up for through Walk Wicomico that create a course or trail near the YMCA in Salisbury. 3. Maryland Discharge Meal Program – Observed outcomes of this initiative were 15 participants receiving nutritionally rich meals that otherwise may not have been available to the patient due to multiple factors. 4. MAC Chronic Disease Self-Management - There were 26 workshops with a total number of 292 participants for FY 2019. There were 6 workshops with 69 participants for Living Well with Hypertension and 20 workshops with 223 participants for Chronic Disease Self-Management classes. Between the workshops and managing community members' care by PRMC, there has been a reduction in ED usage and a substantial Medicare Payment Adjustment Savings.

Q111. Please describe how the outcome(s) of the initiative addresses community health needs.

1. Walk Wicomico - The outcomes of this initiative address the needs to improve adolescent health, diabetes, physical activity, and health-related quality of life and well-being. This is done by creating a pathway to get people physically active and healthier by providing information about the walking trails and hosting or being part of walking events around Wicomico County. There is also a sense of community unity at these walking events throughout the county. There were numerous events held throughout the fiscal year in Wicomico County for all ages to improve community unity. Some of these events were a Sneak Peek Walking Tour of the National Folk Festival grounds, a Glow in the Dark Dance Walk at the Salisbury City Park, Walk Maryland Day walks, and the Billion Steps Team Challenge. (See Attachment G) 2. YMCA – There are several community health needs that can be addressed once the YMCA and Peninsula Regional join programs in order to benefit more people in the community. There would be more community unity and support for programs going forward both from Peninsula Regional and the YMCA. Also, child and adolescent health, especially those with prediabetes or diabetes, would benefit from support groups or classes held by the Diabetes Team and Endocrinology Department of PRMC. The initiative would also promote exercise and nutritional rich diets, gradually making residents achieve a healthy weight and have a better quality of life. 3. Maryland Discharge Meal Program - This initiative addresses the community health need of food insecurity for residents in the community. Due to multiple factors, a person discharged from the hospital could not have the proper food he/she is prescribed to eat. (See Attachment H) 4. MAC Chronic Disease Self-Management – This initiative addresses the need for chronic disease self-management in the community. There are all ages of residents who have diabetes or prediabetes, are overweight, nutritionally deficient, or have hypertension. Physical activity, nutrition and weight status, diabetes, hypertension, children's and adolescent health were the needs that were addressed by this initiative. MAC Inc., chronic disease self-management classes teach residents how to manage their chronic diseases independently through diet, exercise and nutrition. Improved education can decrease ER visits and reduce future cost and utilization of the healthcare system. Action plans are created by attendees as they gain a better understanding of how to manage their symptoms, but also feel motivated to take control of their health.

Q112. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Walk Wicomico - $3,076

Q113. (Optional) Supplemental information for this initiative.

CB FY 2019 Attachments In Order.docx
8.1MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q114. Section IV - CB Initiatives Part 3 - Initiative 3

Q115. Name of initiative.

Behavioral Health

Q116. Does this initiative address a need identified in your most recently completed CHNA?

- (●) Yes
- ( ) No

Q117. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Dementias, Including Alzheimer's Disease, Diabetes, Educational and Community-Based Programs, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Tobacco Use, Transportation, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Obesity

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [x] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Access to Health Services: Outpatient Services
- [x] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Nutrition and Weight Status

- [x] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [ ] Children's Health
- [ ] Chronic Kidney Disease
- [x] Community Unity
- [x] Dementias, including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [x] Health Literacy
- [x] Health-Related Quality of Life & Well-Being
- [x] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [x] Housing & Homelessness
- [ ] Transportation
- [ ] Unemployment & Poverty
- [x] Other Social Determinants of Health
- [ ] Other (specify)

Q118. When did this initiative begin?

07/01/2016

Q119. Does this initiative have an anticipated end date?

- ( ) No, the initiative does not have an anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ( ) The initiative will end when external grant money to support the initiative runs out. Please explain.
- ( ) The initiative will end when a contract or agreement with a partner expires. Please explain.
- (•) Other. Please explain.

1. COAT - This program will continue into for the next several years.

2. Opioid Intervention Team - This program will continue for the next several years.

3. PEARLS – This program will continue for the next several years.

4. SWIFT – This program will continue for the next several years

Q120. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

1. Community Outreach Addictions Team (COAT) - This initiative primarily targets the Wicomico County population who have substance abuse issues, behavioral health and socialization issues, high utilization of the ED due to drugs or alcohol, and/or social determinants of health. We have also seen residents from Worcester and Somerset counties present at the hospital with these same health needs. 2. Opioid Intervention Team (OIT) - This initiative targets the population of Wicomico County who are struggling with addiction and their families and friends. Any Wicomico County resident who is, has been, or knows of someone who has issues with addiction. 3. Programs to Encourage Active and Rewarding Lives (PEARLS) - This initiative targets the aging population 60 years old and over who have thoughts of depression or loss. 4. Salisbury/Wicomico Integrated First-Care Team (SWIFT) - This initiative targets the population of Salisbury, MD who rely heavily on EMS and PRMC for non-emergency care and/or patients who frequently have medically unnecessary ER visits and/or have hospital readmissions within 30 days of discharge.

Q121. Enter the estimated number of people this initiative targets.

100,000

Q122. How many people did this initiative reach during the fiscal year?

1. COAT – 341 (See Attachment I) 2. Opioid Intervention Team – 528 (See Attachment J) 3. PEARLS – 68. (See Attachment K) 4. SWIFT – 78 patients. (See Attachment D)

Q123. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [x] Acute condition-based intervention: treatment intervention
- [x] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [x] Community engagement intervention
- [ ] Other. Please specify.

Q124. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (•)

Yes. Please describe who was involved in this initiative.

1. COAT - Salisbury Fire Department and EMS, Wicomico County Health Department, City of Salisbury, Wicomico County Sheriff's Office, and the State's Attorney's Office.

2. Opioid Intervention Team - The United Way of the Lower Eastern Shore, Hudson Health Services, Inc., Community Foundation of the Eastern Shore, Perdue Farms, Pohanka, Avery Hall, Pemberton Pharmacy, Holloway Funeral Home, Hebron Savings Bank, Trinity Sterile, Provident State Bank, Apple Discount Drugs, Chesapeake Health Care, Minuteman, Stephanie Willey, Wicomico County NAACP, Peninsula Alternative Health, LLC, Bank of Delmarva, PKS & Company, P.A., Andrew W. Booth & Associates, Inc., Mr. and Mrs. Brad Gillis, SVN Miller Commercial Real Estate, Farmers Bank of Willards, Vantage Point, Fetch Dog Co., 3rd Friday/City of Salisbury, Recovery Resource Center, Brew River, Salisbury Area Chamber of Commerce, Delmarva Shorebirds, Clarion Call Restoration Ministries, Delmarva Teen and Adult Challenge, Emmanuel Wesleyan Fruitland Campus, First Baptist Church-Salisbury, Oak Ridge Baptist Church, Renovate Church-Delmar, Sonrise Church, St. Alban's Episcopal Church, St. Francis De Sales Catholic Church, St. James AME Zion Church, St. Peter's Episcopal Church, Trinity United Methodist Church, Adams Radio Group, PAC-14, Salisbury Independent, WMDT-47ABC, Comcast Spotlight, and Delmarva Public Radio.

3. PEARLS - MAC Inc., Area Agency on Aging.

4. SWIFT - Salisbury Fire Department, Salisbury Police Department, City of Salisbury, the Wicomico County Health Department, and the MCHRC (Maryland Community Health Resources Commission)

○ No.

Q125. Please describe the primary objective of the initiative.

1. COAT - The primary objective of this initiative is to prevent overdoses, help residents with barriers to addiction and behavioral health treatment, and provide a smooth transition to community and social resources. 2. Opioid Intervention Team - The primary objective of this initiative is to bring awareness and treatment options to residents in Wicomico County with substance abuse issues. 3. PEARLS - The primary objective of this initiative is to help residents age 60+ manage their feelings of loneliness, frustration, anxiousness, restlessness, depression and to improve their quality of life. 4. SWIFT – The primary objective of this initiative is to reduce EMS and ED utilization by identifying and providing intervention to the highest ED utilizers. The SWIFT team works collaboratively with high utilizers to reduce overuse of emergency services and improve access to care by connecting these community members to area resources that address the behavioral health, chronic disease health and other social determinants of health. The program also connects utilizers with more appropriate care settings such as primary care offices and FQHCs.

Q126. Please describe how the initiative is delivered.

1. COAT - This initiative is delivered by having 24/7 phone and in-person peer support specialists linked to the Emergency Department of PRMC. When an overdose comes to the ED, COAT is notified and a support specialist contacts the patient when it is appropriate. The support specialist then helps the patient connect to treatment, local resources, become educated on the dangers of substance abuse, and/or provide support for the patient as he/she navigates through life post overdose. 2. Opioid Intervention Team - This initiative is delivered by creating awareness about substance abuse and the damaging toll it takes not only on the abuser but on the abuser's family, friends, and the community. Awareness campaigns throughout Wicomico County are held and local businesses participate in promoting the color purple, which is the color used to bring awareness to substance abuse. PRMC also participated by adding a secure prescription drug drop box in its Emergency Department and has limited prescription opioids from being used inappropriately. Narcan education and trainings also took place for residents, friends, and family members of addicted residents to appropriately administer Narcan and save someone from dying of an overdose. 3. PEARLS - This initiative is delivered by having free one-on-one counseling sessions to help manage feelings of loneliness, frustration, anxiousness and restlessness and improve the person's quality of life. 4. SWIFT - A team consisting of a Paramedic, NP, an RN and a Social Worker, who visit patients identified as high utilizers of EMS services. A large percentage of these patients have co-occurring behavioral health and chronic disease conditions that are diagnosed by the team. A plan is subsequently created based on a home assessment and then the patient is followed by the team for an average of six months. Referrals to local behavioral health and chronic disease health resources are made for the patient.

Q127. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- ☑ Count of participants/encounters — 1. COAT - 341 unduplicated individuals. (See Attachment I) 2. OIT – 528 participants. (See Attachment J) 3. PEARLS - 68 participants. (See Attachment K) 4. SWIFT – 78 patients. (See Attachment D)
- ☑ Other process/implementation measures (e.g. number of items distributed) — 2. Opioid Intervention Team – Gave Narcan training to 528 people and collected 1,627.5 pounds of prescription medication from the drop-off boxes located around Wicomico County. (See Attachment J)
- ☑

Surveys of participants	3. PEARLS – There were 43% of participants with at least a 50% decrease in PHQ9 score, baseline to final. A PHQ9 assessment is a depression screening assessment. 21% of participants who no longer meet criteria for clinical depression at final. (See Attachment K)
☑ Biophysical health indicators	3. PEARLS – There were 43% of participants in the PEARLS program saw with at least a 50% decrease in PHQ9 score, baseline to final. A PHQ9 assessment is a depression screening assessment. 21% of participants who no longer meet criteria for clinical depression at final. (See Attachment K)
☑ Assessment of environmental change	2. Opioid Intervention Team – There is more community engagement and awareness of opioid abuse and opioid intervention. Wicomico County held a "Go Purple" campaign that local businesses contributed to. PRMC contributed with lighting the entrances to the hospital in purple lights and producing educational videos about the personal and community impact of addiction and where to go for help. There were also purple lollipops and educational pamphlets about opioids and opioid abuse located at the entrances of the hospital and the Ocean Pines Health Pavilion.
☑ Impact on policy change	2. Opioid Intervention Team – At PRMC there is a new policy on prescribing opioids that has since limited the number of opioids prescribed to patients who visit the ED, are discharged from a hospitalization, or from Same-Day-Surgery. There is also a new policy that restricts the use of Hydromorphone to the operating room only at the hospital and the opioid has been removed from all other areas. (See Attachment J)
☑ Effects on healthcare utilization or cost	1. COAT - Continued reduction in heroin overdoses over the years which reduces healthcare utilization and/or cost. (See Attachment I) 2. Opioid Intervention Team - There is a reduction in opioids prescribed by health professionals which limits costs and possibly reduces future healthcare utilization due to dependence on opioids. (See Attachment J) 3. PEARLS – There was a 21% achieved remission rate and a 43% achieved response rate for participants in the PEARLS program. These achievements correlate to decreases in depression which can reduce healthcare utilization and cost. (See Attachment K) 4. SWIFT - There was a reduction of ED visits to PRMC of 40% for Total ED utilization and costs are decreased because participants are connected to the correct care in the correct setting instead of utilizing the ED and EMS services. For the first 6 months of FY 2019, SWIFT saw a 40% reduction in ED visits and a $69,000 reduction in charges. (See Attachment D)
☐ Assessment of workforce development	
☐ Other	

Q128. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

1. COAT - There have been a decrease in heroin overdoses being seen in the Emergency Department from FY 2018 to FY 2019. There was a decrease from 146 overdoses in FY 2018 to 94 overdoses in FY 2019. (See Attachment I) 2. Opioid Intervention Team - There has been better opioid awareness and a better understanding of what opioid abuse can do and what it looks like. As a result, there have been a reduction in overdoses seen in PRMC's Emergency Department. (See Attachment J) 3. PEARLS - Participants in the program are happier and are having better mental health days. 22 participants are also getting involved in exercise, stretching, and/or social activities. (See Attachment K) 4. SWIFT - There was a reduction of ED visits to PRMC of 40% for enrollees over a 6-month period. There was also a reduction of $69,000 in total charges for the over 80 community members that are annually being managed by SWIFT. (See Attachment D)

Q129. Please describe how the outcome(s) of the initiative addresses community health needs.

1. COAT - The outcomes of this initiative address Behavioral Health, including Mental Health and/or Substance Abuse by providing support, preventing overdoses due to substance abuse, and providing a smooth transition to behavioral health or mental health services in the community. The COAT team saw 341 unduplicated people in FY 2019. Of those 341, 238 of these people were from Wicomico County. 45% of those Wicomico County residents helped by COAT were linked to treatment of some kind, in order to curb their addictions and receive help. (See Attachment I) There has also been a significant drop in the number of overdoses seen in PRMC's Emergency Department since the implementation of the COAT program. In FY 2016 there were 245 overdoses and in FY 2019 there were 94 overdoses (See Attachment I). These outcomes support that the COAT program is benefitting the community. 2. Opioid Intervention Team (OIT) - The outcomes of this initiative address Behavioral Health, including Mental Health and/or Substance Abuse by providing a prescription drug drop box for unwanted or expired prescription drugs. The OIT also helps to limit the number of opioid prescriptions written by health professionals in the Emergency Department, Inpatient, and Ambulatory sites. PRMC is below the state of MD and the national average for prescribing opioids to patients. There were also 1,627.5 pounds of prescription medications collected from the 10 drop-off boxes located throughout Wicomico County (See Attachment J). 3. PEARLS – The outcomes of this initiative address Behavioral Health, including Mental Health and/or Substance Abuse by providing support and one-on-one counseling for older adults who are feeling depressed, as well as, feelings of loneliness, frustration, anxiousness and restlessness. By having the one-on-one counseling, the goal is to improve a person's mental health, ultimately leading to improved health, wellness, and independence. The outcomes also address the community health needs of older adults. As a person gets older, he/she may mentally and emotionally hurt from the loss of friends, loved ones, and the sense of independence. PEARLS works to counsel these people and improve their mental health and wellness. In FY 2019 there were 68 total participants. There was a 21% achieved remission rate and a 43% achieved response rate for participants in the PEARLS program. These achievements correlate to decreases in depression which can reduce healthcare utilization and the total cost of care. (See Attachment K) 4. SWIFT - The SWIFT Program identifies the community health needs of Behavioral Health, Access to Health Services: Regular PCP Visits, Health Literacy, Health-Related Quality of Life and Well-Being and Other Social Determinants of Health. High utilizing residents who used EMS/ED services are educated about their conditions by the Paramedic, NP, RN and Social Worker. By identifying social determinants of health affecting SWIFT Program participants, referrals can be made to solutions such as behavioral health resources, life coaches, local health resources or chronic disease management classes. 78 SWIFT patients were seen in FY 2019 with the help of EMS and an NP, RN and Social Worker on the Wagner Wellness Van. (See Attachment D)

Q130. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

HOPE Efforts – Meetings attended by employees - $438.45

Q131. (Optional) Supplemental information for this initiative.

CB FY 2019 Attachments In Order.docx
8.1MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q132. Section IV - CB Initiatives Part 4 - Other Initiative Info

Q133. Additional information about initiatives.

Q134. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

Additional Population Health Initiatives.docx
13.4KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q135. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- ○ Yes
- ◉ No

Q136.

In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Dementias, Including Alzheimer's Disease, Diabetes, Educational and Community-Based Programs, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Tobacco Use, Transportation, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Obesity

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

- ☐ Access to Health Services: Health Insurance
- ☐ Access to Health Services: Practicing PCPs
- ☐ Access to Health Services: Regular PCP Visits
- ☐ Access to Health Services: ED Wait Times
- ☐ Access to Health Services: Outpatient Services
- ☐ Adolescent Health
- ☐ Arthritis, Osteoporosis, and Chronic Back Conditions
- ☐ Heart Disease and Stroke
- ☐ HIV
- ☐ Immunization and Infectious Diseases
- ☐ Injury Prevention
- ☐ Lesbian, Gay, Bisexual, and Transgender Health
- ☐ Maternal and Infant Health
- ☐ Nutrition and Weight Status

- [ ] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [ ] Children's Health
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [ ] Educational and Community-Based Programs
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health Literacy
- [ ] Health-Related Quality of Life & Well-Being
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Housing & Homelessness
- [ ] Transportation
- [ ] Unemployment & Poverty
- [ ] Other Social Determinants of Health
- [ ] Other (specify)

Q137. Why were these needs unaddressed?

Q138. Do any of the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? Specifically, do any activities or initiatives correspond to a SHIP measure within the following categories?

See the SHIP website for more information and a list of the measures:
https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx

	Select Yes or No	
	Yes	No
Healthy Beginnings - includes measures such as babies with low birth weight, early prenatal care, and teen birth rate	○	◉
Healthy Living - includes measures such as adolescents who use tobacco products and life expectancy	◉	○
Healthy Communities - includes measures such as domestic violence and suicide rate	○	◉
Access to Health Care - includes measures such as adolescents who received a wellness checkup in the last year and persons with a usual primary care provider	◉	○
Quality Preventive Care - includes measures such as annual season influenza vaccinations and emergency department visit rate due to asthma	◉	○

Q139. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Please see the initiatives described in Section IV of this Survey.

Q140. Section V - Physician Gaps & Subsidies

Q141. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

- [ ] No gaps
- [x] Primary care
- [x] Mental health
- [x] Substance abuse/detoxification
- [x] Internal medicine
- [ ] Dermatology
- [ ] Dental
- [x] Neurosurgery/neurology

- [ ] General surgery
- [ ] Orthopedic specialties
- [x] Obstetrics
- [x] Otolaryngology
- [x] Other. Please specify. Rheumatology, Urology, and Allergy/Immunology

Q142. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand.

Hospital-Based Physicians	
Non-Resident House Staff and Hospitalists	Included in our submission is a subsidy for our employed hospitalist program. A hospitalist program should be an integral part of any value driven organization which aids in the transformation of a patient from the hospital to home or other designation and avoiding readmissions. Other benefits include shorter length of stay, improved communication between physician and patient/family and the ability of community physician to stay in their offices to treat the community rather than provide inpatient care in what historically has been a medically underserved population.
Coverage of Emergency Department Call	The subsidy in this category is net of trauma reimbursement funds received for general trauma, orthopedic, neurosurgery and anesthesia physician specialties received by the State of Maryland. Peninsula Regional has to provide these specialties plus other specialties to support its Level III trauma designation that are recommended by COMAR regulations.
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	As part of our ongoing strategic planning process, Peninsula Regional regularly evaluates the supply/demand and need for additional physicians and succession planning. In 2018, a consultant was engaged to create a Medical Staff Development Plan; identifying gaps in physicians and physician specialties by geographic location. The plan is based on patient market profiles, access, medical market profiles, physician interviews and staff surveys. Following the plan, Peninsula Regional Medical Group developed a detailed recruitment/retention and succession action plan. The plan has identified the following needs as the Physician Recruiter is actively engaged in recruitment for the following specialties; Primary Care, Urology, Neruology, Gastroenterology, Psychiatry, Cardiology, Pulmonology & OBGYN. Recruitment in a rural area where physician shortages have been identified can be challenging, however, Peninsula Regional Medical Center recently implemented a “Loan Forgiveness Program” which attracts physicians/providers to our opportunities and also requires the Physician to commit to a 10 year employment with the organization.
Other (provide detail of any subsidy not listed above)	Peninsula Regional Medical Center (PRMC) is the regional tertiary referral hospital located on the Delmarva Peninsula, serving a largely rural geographic area that has a combination of both urban and rural challenges. In general, the population Peninsula Regional serves in Wicomico, Worcester and Somerset Counties has lower median incomes, lower graduation rates, fewer college degrees, higher unemployment, lower quality housing and sicker patients, compared to the Maryland average. In comparison to the state of Maryland, all three counties have a higher percentage of families living in poverty. Availability of primary care services continues to be an issue due to a proportionally higher percentage of families not having personal transportation and that fact that several of our counties fall in Maryland’s bottom quartile for primary care access. Residents rely on PRMC, as the tertiary referral center, to provide a full complement of primary care, specialty and sub-specialty services from chronic disease management to neurosurgery and everything in between. Addressing the full spectrum of services is challenging as six counties that PRMC serves have higher Medicare population percentages than the state of Maryland and the United States. As a percentage of the total population, both Worcester County and Sussex County have almost twice as many Medicare residents, at 28% of the population, in comparison to Maryland and the United States, which is approximately 16%. The U.S. Census Bureau projects that by 2030, the number of Medicare residents will exceed 20 percent; this growth in the number of older Americans is expected to increase total health care costs. The shortage of rural physicians is a complex issue, resulting from many of the preceding outlined factors. PRMC strives to provide access to quality health care services to the underserved rural communities on the Peninsula. Every three years, with the help of a consultant, a Medical Staff Development Plan is conducted to strategically and effectively plan for physician recruitment and retention, filling in specialty and primary care service gaps by geography. As evidenced by our Mission Driven Health Services submission, the hospital subsidizes Medical Oncology, Endocrinology, Behavioral Health, Pulmonology, Neurosurgery and other specialties. Without these subsidies, access to these services would be limited or non-existent, and for our most needy populations like Somerset County, traveling across the Bay Bridge for services is not an option. For this reason, Peninsula continues to appropriately provide the right balance of physician services for the region.
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	

Q143. (Optional) Is there any other information about physician gaps that you would like to provide?

Q144. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Q145. Section VI - Financial Assistance Policy (FAP)

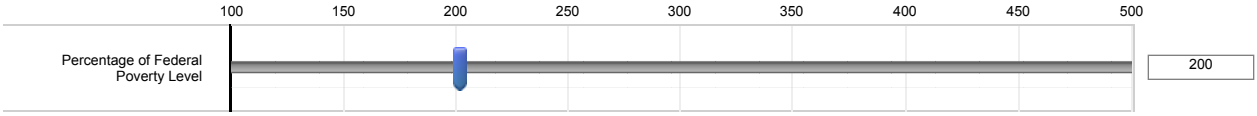
Q146. Upload a copy of your hospital's financial assistance policy.

Appendix I UNCOMPENSATED_CARE_FINANCIAL_ASSISTANCE_06302017.pdf
4.7MB
application/pdf

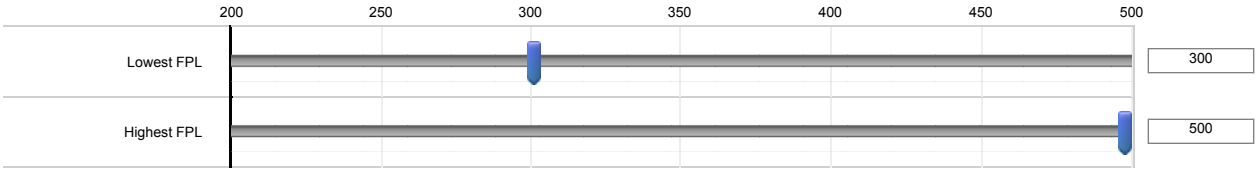
Q147. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

BRO-086 - Financial Assistance With Your Medical Bills Brochure.docx
1.9MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

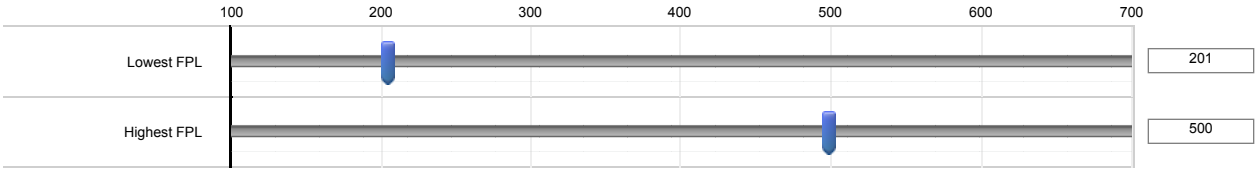
Q148. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL). Please select the percentage of FPL below which your hospital's FAP offers free care.



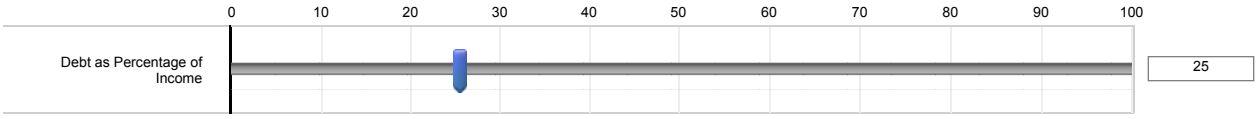
Q149. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.



Q150. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q151. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q152. Has your FAP changed within the last year? If so, please describe the change.

- (●) No, the FAP has not changed.
- ( ) Yes, the FAP has changed. Please describe: [ ]

Q153. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

[ ]

Q154. (Optional) Please attach any files containing further information about your hospital's FAP.

2019 Federal Poverty Guidelines - 04-09-19.pdf
54KB
application/pdf

Q155. Summary & Report Submission

Q156.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (38.352294921875, -75.538597106934)

Source: GeoIP Estimation

From:	Hilltop HCB Help Account
To:	Hilltop HCB Help Account
Subject:	FW: Clarification Required - FY 19 CB Narrative
Date:	Wednesday, July 1, 2020 11:05:38 AM
Attachments:	Peninsula_Regional_FY2019_CBNarrative_Final.pdf

From: Hilltop HCB Help Account

Sent: Tuesday, March 17, 2020 3:57 PM

To: rebecca.righter@peninsula.org

Subject: Clarification Required - FY 19 CB Narrative

Thank you for submitting Peninsula Regional Medical Center's FY 2019 Community Benefit Narrative Report. Upon reviewing your report, we require clarification of certain issues:

- In Question 3 on page 1 of the attached, you confirm that yours is an independent hospital, not part of a larger hospital system. In Question 48 beginning on page 5 and in Question 61 beginning on page 11, you indicated that system-level staff and departments engaged in various activities. Please clarify your intent in these answers.
- In Question 56 on page 10, you selected "Nutrition and Weight Status" as one of the needs identified in your most recent CHNA. You also added "Obesity" under "Other." We feel that "Obesity" would be included under "Nutrition and Weight Status." If you disagree, please explain how the needs differ.
- In Question 81 on page 21 of the attached, where you select the CHNA needs addressed by the Chronic Disease Management initiative, you indicated that the CHNA needs addressed by this initiative include "Access to Health Services: ED Wait Times," "Adolescent Health," "Children's Health," "Community Unity," "Immunization and Infectious Diseases," "Respiratory Diseases," "Sleep Health," and "Telehealth." Your response to Question 56 on page 10 does not include any of these as needs identified in the CHNA. Please indicate whether these needs should have been selected in Question 56, or should not have been selected in Question 81.
- Question 84 on page 18 contains five different population descriptions. Please specify which of the population descriptions applies to the 6,767 people referenced in Question 85.
- In Question 99 on page 22 of the attached, where you select the CHNA needs addressed by the Exercise, Nutrition, and Weight initiative, you indicated that the CHNA needs addressed by this initiative include "Adolescent Health," "Arthritis, Osteoporosis, and Chronic Back Conditions," "Children's Health," "Community Unity," "Food Safety," and "Other:Hypertension." Your response to Question 56 on page 10 does not include any of these as needs identified in the CHNA. Please indicate whether these needs should have been selected in Question 56, or should not have been selected in Question 99.
- Question 102 on page 24 contains four different population descriptions. Please specify which of the population descriptions applies to the 100,000 people referenced in Question 103.
- In Question 117 beginning on page 26 of the attached, where you select the CHNA needs addressed by the Behavioral Health initiative, you indicated that the CHNA needs addressed by this initiative include "Adolescent Health," "Community Unity," and "Housing & Homelessness." Your response to Question 56 on page 10 does not include any of these as needs identified in the CHNA. Please indicate whether these needs should have been selected in Question 56, or should not have been selected in Question 117.
- Question 136 on page 31 had no answer. Please provide a response.
- Question 137 on page 32 had no answer. Please provide a response.

Please provide your clarifying answers as a response to this message. Thank you for your attention to this matter.