Community Health Needs Assessment and Action Plan

EXECUTIVE SUMMARY FY2013

BOARD APPROVED MAY 22, 2013

Shore Health
University of Maryland Medical System

Chester River Health
University of Maryland Medical System

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Executive Summary

Introduction

Shore Health System (SHS) in collaboration with Chester River Health System (CRHS) conducted a Community Health Needs Assessment (CHNA) for the five counties of Maryland's Mid-Shore. Shore Health System and Chester River Hospital Center serves the five counties of: Talbot, Caroline, Queen Anne's, Dorchester, and Kent. The two Shore Health System hospitals have 188 inpatient beds, including the 20-bed Requard Center for Acute Rehabilitation at Memorial Hospital and a 16-bed inpatient behavioral health unit for adults at Dorchester General Hospital. The Queen Anne's Emergency Center near Grasonville opened in 2010 and operates 24 hours a day, every day, to respond to minor injuries and illnesses as well as to strokes, heart attacks, and traumatic injuries, with seamless coordination when patients need to be transported by ambulance or helicopter to a hospital. The Shore Health System regional network of outpatient services includes primary and specialty physician practices for people of all ages along with diagnostic testing, medical rehabilitation, cancer care, diabetes management, digestive health, home health care and hospice.

Chester River Health System was formed in 1997 to offer state-of-the-art health care to the residents of Kent and Queen Anne's counties and portions of Caroline and Cecil counties. Chester River Health System includes Chester River Hospital Center, Chester River Home Care & Hospice, Chester River Manor Nursing & Rehabilitation Center, and Chester River Health Foundation. Chester River Hospital Center provides inpatient services, 24-hour emergency care, surgical services, outpatient diagnostic services, rehabilitation services, and oncology services.

Our Mission

Shore Health System (SHS) and Chester River Health System (CRHS) exist to serve the Mid-Shore region.

Our Vision

SHS and CRHS will be the provider of “first choice” among patients and physicians of the Mid-Shore. Employees, leadership, and Medical Staff will deliver care through a common culture, adhere to a professional code, and work cohesively as a patient-centered team to ensure the highest favorable outcomes for all the patients we serve.

Our Values

Every interaction with another is an opportunity to care.

Our Community Outreach Mission

To collaborate with partners to build healthy communities

Process

I. Establishing the Assessment and Infrastructure

To complete a comprehensive assessment of the needs of the community, the Association for Community Health Improvement's (ACHI) six-step Community Health Assessment Process was utilized as an organizing methodology. The SHS Community Health Needs Assessment Steering Committee served as the lead team to conduct the Community Health Needs Assessment (CHNA) with input from The University of Maryland Medical Systems (UMMS) Community Benefit Team, community leaders, the public, health experts, and the 5 health departments that serve the Mid-Shore. The SHS CHNA Steering Committee adopted the following ACHI six-step process (See Figure 1) to lead the assessment process and the additional five-component assessment (See Figure 2) and engagement strategy to lead the data collection methodology.

The assessment was designed to:

- Develop a comprehensive profile of health status, quality of care and care management indicators for residents of the Mid-Shore area overall and by county.
- Identify a set of priority health needs (public health and health care) for follow-up.
- Provide recommendations on strategies that can be undertaken by health providers, public health, communities, policy makers and others to follow up on the information provided, so as to improve the health status of Mid-Shore residents.
- Provide access to the data and assistance to stakeholders who are interested in using it.

FIGURE 1 - ACHI 6-Step Community Health Assessment Process

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public. For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following: (1) A description of the process used to conduct the assessment; (2) With whom the hospital has worked; (3) How the hospital took into account input from community members and public health experts; (4) A description of the community served; and (5) A description of the health needs identified through the assessment process.

FIGURE 2 – Five-Step Assessment & Engagement Model

Data was collected from the five major areas illustrated above to complete a comprehensive assessment of the community's needs. Data is presented in Section III of this summary. SHS and CRHS participate in a wide variety of local coalitions including, several sponsored by the Mid-Shore State Health Improvement Process (SHIP) Coalition, Local Health Departments (Talbot, Caroline, Dorchester, Queen Anne's, Kent Counties), Cancer Coalition, Tobacco Coalition, Transportation Coalition, as well as partnerships with many community-based organizations like American Cancer Society (ACS), Susan G. Komen Foundation, American Diabetes Association (ADA), American Heart Association (AHA) to name a few.

II. Defining the Purpose and Scope

Primary Community Benefit Service Area

To effectively reach the mission, SHS in collaboration with CRHS conducted a formal community health needs assessment (CHNA) during FY 2013. As the only three hospitals on the Mid-Shore of Maryland, for purposes of community benefits programming and this report, the Community Benefit Service Area (CBSA) of SHS and CRHS is the five county area (Caroline, Dorchester, Talbot Queen Anne's and Kent). A map showing the service area counties is shown in Figure 3 below:

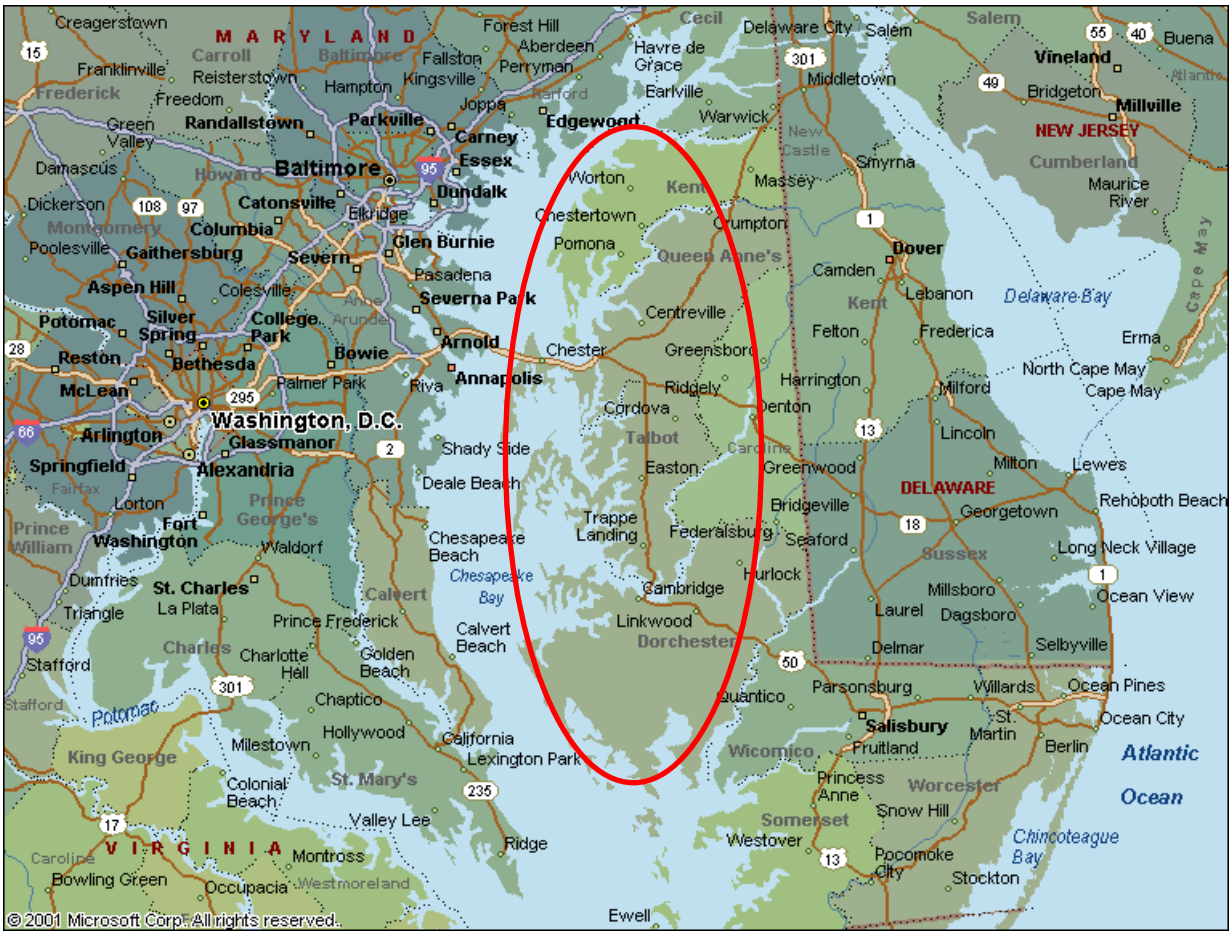


FIGURE 3: Map of Service Area and surrounding area.

Hospital Primary ZIP Codes

Hospital	ZIP Code	Total Cases	% of Cases	Cumu. %
Chester River Hospital	**21620 - Chestertown**	**1160**	**42.8%**	**42.8%**
	21661 - Rock Hall	**273**	**10.1%**	**52.9%**
	21651 - Millington	**236**	**8.7%**	**61.6%**
	21678 - Worton	231	8.5%	70.1%
	21617 - Centreville	136	5.0%	75.1%
	21668 - Sudlersville	103	3.8%	78.9%
	21635 - Galena	76	2.8%	81.7%
Dorchester General	**21613 - Cambridge**	**1431**	**54.9%**	**54.9%**
	21643 - Hurlock	**241**	**9.3%**	**64.2%**
	21631 - East New Market	132	5.1%	69.3%
	21601 - Easton	112	4.3%	73.6%
	21632 - Federalsburg	56	2.1%	75.7%
	21664 - Secretary	44	1.7%	77.4%
	21629 - Denton	44	1.7%	79.1%
	21869 - Vienna	39	1.5%	80.6%
Memorial at Easton	**21601 - Easton**	**2379**	**26.6%**	**26.6%**
	21613 - Cambridge	**828**	**9.3%**	**35.9%**
	21629 - Denton	**804**	**9.0%**	**44.8%**
	21632 - Federalsburg	**567**	**6.3%**	**51.2%**
	21655 - Preston	**469**	**5.2%**	**56.4%**
	21639 - Greensboro	**368**	**4.1%**	**60.5%**
	21643 - Hurlock	363	4.1%	64.6%
	21617 - Centreville	336	3.8%	68.4%
	21660 - Ridgely	315	3.5%	71.9%
	21663 - Saint Michaels	291	3.3%	75.1%
	21673 - Trappe	214	2.4%	77.5%
	21625 - Cordova	206	2.3%	79.8%
	21638 - Grasonville	163	1.8%	81.6%

FIGURE 4: The top percentage of admissions by zip codes within the Mid-Shore

The top zip codes within the Mid-Shore (displayed in Figure 4) represent the top 60% of all admissions in FY12 for SHS and CRHS. The zip codes included in the cumulative total of 80% of all admissions is the primary community benefit service area (CBSA) for SHS and CRHS and comprise the geographic scope of this assessment.

III. Collecting and Analyzing Data

Various sources of data are used in this report to ensure its validity and the use of third party surveyors ensured that the input of residents of the five county area was captured in the assessment. This comprehensive document utilizes data from various federal, state, and local agencies, as well as private consulting and research groups, including:

- U.S. Census Bureau
- Maryland Vital Statistics Administration
- Mid-Shore Regional Health Improvement Coalition
- Maryland Department of Health and Mental Hygiene
- Office of Minority Health and Health Disparities
- HealthStream® Research (phone survey)
- TRG Healthcare
- Hollander, Cohen & McBride Marketing Research (phone survey)

A) Community Perspective

The community's perspective was obtained through two telephone surveys, one online survey, and multiple town listening forums.

HealthStream® Research

Method

To complete the research objectives, 323 consumers were surveyed over the telephone. Surveys (16 Questions) were completed with respondents 18 years of age or older. Only residents living in zip codes defined by Shore Health System were eligible to complete the survey.

Definition of County by ZIP

Area	Zip Code(s)
Caroline County	21609, 21629, 21632, 21636, 21639, 21640, 21641, 21649, 21655, 21660, 21670, 21681, 21682, 21683, 21684, 21685, 21686, 21687, 21688
Dorchester County	21613, 21622, 21626, 21627, 21631, 21634, 21643, 21648, 21659, 21664, 21669, 21672, 21675, 21677, 21835, 21869

Kent County	21610, 21620, 21635, 21645, 21650, 21651, 21661, 21667, 21678
Queen Anne's County	21617, 21657, 21658, 21607, 21623, 21628, 21644, 21656, 21668, 21690, 21619, 21638, 21666
Talbot County	21601, 21606, 21612, 21624, 21625, 21647, 21652, 21653, 21654, 21662, 21663, 21665, 21671, 21673, 21676, 21679

Sampling quotas were established by geographic area. The sample plan called for between 60 and 80 interviews to be conducted within each of five geographic regions comprising the hospital's service area. Calls were made to potential respondents using a random-digit-dialing sampling methodology. HealthStream® employed a "five-call" design in order to complete each interview. This call-back procedure was designed to reduce non-response bias and to ensure that a random sample is surveyed.

The survey was commissioned in April 2012, to provide an assessment of the needs in the communities serviced by Shore Health System and Chester River Health System.

Results

In the Mid-Shore area, the five health issues considered the most serious are:

- cancer (66%)
- obesity (57%)
- obtaining affordable health care (55%)
- substance abuse (54%)
- diabetes (53%)

Analysis revealed the same top health concerns and top health barriers with little deviation from the overall DHMH SHIP county data.

Seriousness Of Various Health Issues
(Percent Consider A Serious Problem)

Health Issue	Total (n=323)	Area: Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Substance Abuse	54%	48%	67%	64%	40%	56%
Tobacco Use	44	44	50	56	40	36
Ambulance Service	7	8	13	9	2	4
Transportation for health purposes	20	23	15	42*	7	20
Asthma or lung disease	34	46	31	29	35	29
Cancer	66	65	69	70	61	65
Domestic violence	27	34	39	32	17	16
Diabetes	53	46	70	48	41	57
Obtaining affordable health care	55	61	59	55	39	61
Dental health	27	34	32	32	15	23
Access to quality health care	24	43	27	30	6	19
Prenatal and infant health	21	25	23	51*	8	9
Infectious disease	18	20	27	9	12	23
Mental illness	32	28	39	37	17	38
Obesity	57	57	80*	52	41	54
Services for the disabled	24	33	31	25	14	17
Sexually transmitted diseases	38	32	59*	32	29	26
Heart disease	49	50	57	53	39	50
High blood pressure or stroke	48	43	57	46	43	51

*Statistically greater than the other counties (p<.05)

Biggest Health Issue/Concern In Your Community

Issue/Concern	Total (n=323)	Area: Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Cancer	24%	23%	20%	26%	23%	28%
Cost/lack of insurance/affordable healthcare	16	15	16	5	20	20
Obesity	8	5	7	7	10	9
Diabetes	7	5	16	5	--	9
Lack of physicians	6	8	4	5	5	9
Drug/alcohol abuse	5	8	2	5	3	7
Other	34	36	35	47	39	18
Don't know/Refused^	22	25	18	21	26	20
None^	7	11	7	6	10	3

^ Excluded from calculations above

Hollander, Cohen & McBride

Transportation issues are common within the rural environment of the Mid-Shore market. Distance can be a hindrance to receiving quality care, especially for the poor. Chester River Health System commissioned a study in February 2012 by the marketing research group Hollander, Cohen & McBride (HCM).

Method

A total of 500 telephone interviews of approximately eight to ten minutes each were conducted for this study. The interviews were stratified to include 100 in each of five counties: Caroline, Dorchester, Kent, Queen Anne's, and Talbot.

Research study designed to identify:

- residents' current hospital usage habits both within and outside of the five-county area
- whether length of residence impacts hospital use
- what is considered a reasonable travel time to access various types of healthcare.

Results

Demographics

- Looking across the five Eastern Shore counties included in this study, residents of Dorchester County (who are furthest from the Bay Bridge) tend to be least educated, have the lowest household income and, on average, have lived in their county for the longest period of time.

- Residents of Kent, Queen Anne's and Talbot Counties are most educated; the highest median household incomes are found in Queen Anne's and Talbot Counties.

Employment

- Kent and Queen Anne's Counties have the greatest proportion of residents employed outside of the home. Employed individuals tend to be younger, more educated, to have a higher household income, are more likely to have minor children in the home, and are more likely to be men.

- Approximately three-quarters of Dorchester, Talbot, and Kent County residents work in the same county where they live compared to less than half of Caroline and Queen Anne's County residents.

Where They Obtain Healthcare

- A majority (76%) of residents who work outside the county where they reside seek healthcare close to where they live.

- Residents of Queen Anne's County (83%) and Talbot County (90%) are particularly likely to look for healthcare options close to where they live.

- Those more likely to seek healthcare close to work live in Caroline County (30%), Kent County (31%) or Dorchester County (33%).

Conclusions

- Most residents live and work in the same county and will travel no longer than half an hour for routine care or to deliver a baby.

- For less routine situations, such as seeing a specialist or having surgery, residents display a greater willingness to travel further; however, it is still a minority who would travel more than an hour unless they are facing a potentially life-threatening situation.

- Younger or newer residents, as well as those who work further from home, display a greater willingness to travel further to see a specialist or for surgery.

- Conveying evidence of surgical experience clearly impacts willingness to travel as a majority would travel further to a hospital where the doctors have greater experience in performing a procedure.

Shore Health Online Survey

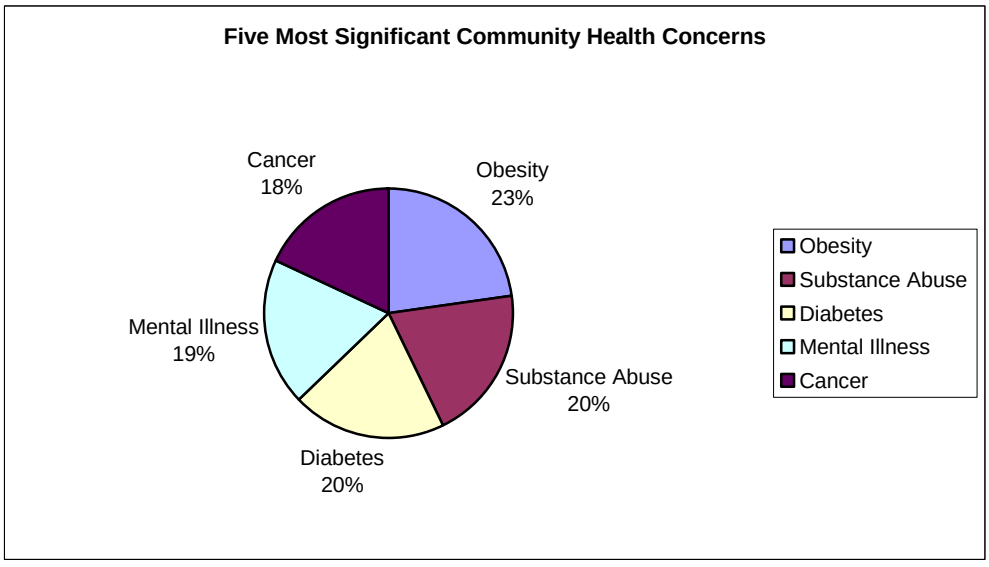
Method

Shore Health System developed a Community Health Needs Assessment online survey in January 2013 for the five county Mid-Shore market using Survey Monkey (surveymonkey.com). The survey was promoted through various channels (internal health system and social service communications, viral marketing, SHIP meetings). Consisting of 14 questions, the research tool was used to identify perceived best met health needs, availability of services and quality of life for Mid-Shore residents, and unmet health needs.

Results

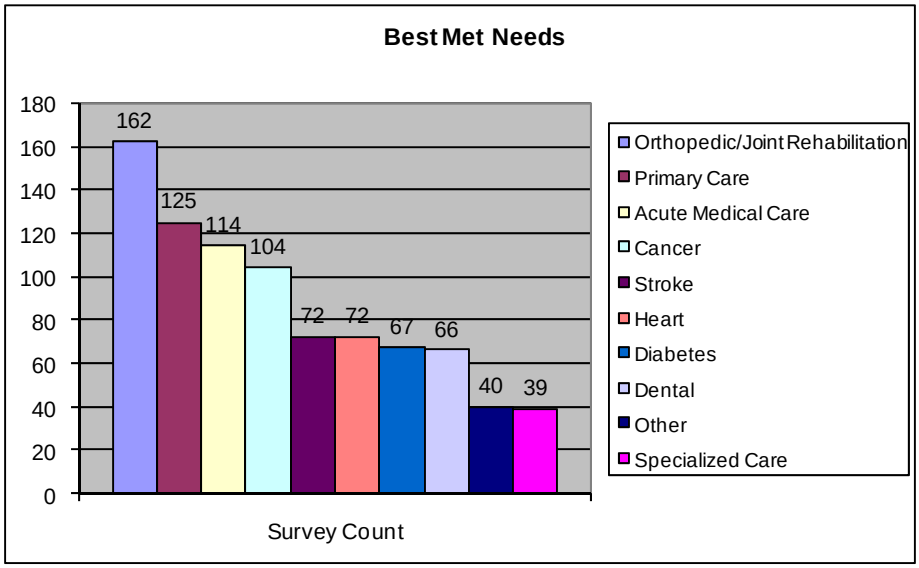
479 responders from Mid Shore communities completed the online survey and the respondents identified the region's top five significant health issues as:

1. Obesity
2. Substance Abuse
3. Diabetes
4. Mental Illness
5. Cancer



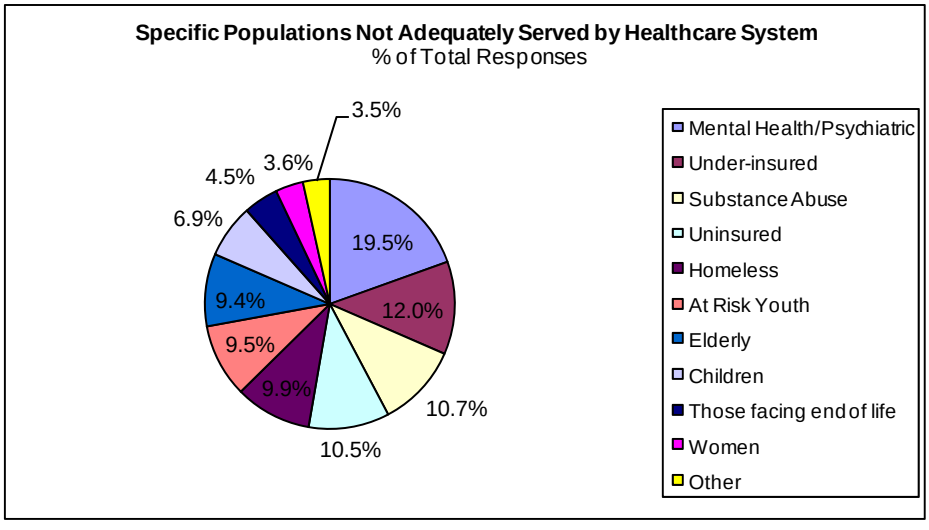
Among the best met needs for the region, the top three are:

1. Orthopedic/Joint Rehabilitation
2. Primary Care
3. Acute Medical Care



Top three specific populations in the Mid-Shore Counties respondents perceive as not being adequately served by the healthcare system:

1. Mental Health/Psychiatric
2. Under-Insured
3. Substance Abuse



Analysis revealed the same top health concerns and top health barriers with little deviation from the overall HealthStream® or DHMH SHIP county data.

B. Health Experts

Maryland SHIP Initiative

The mission of the Mid Shore Health Planning Coalition is to improve the health of residents of the Mid Shore region through a local collaborative effort that identifies, prioritizes, and provides strategic action planning to solve health problems.The Mid Shore Health Planning Coalition identified the top three priorities based on the Maryland SHIP objectives:

1. Adolescent Obesity
2. Adolescent Tobacco Use
3. Diabetes Related Emergency Department Visits

Profile of the 14 Negative Mid Shore SHIP Objectives and How They Compare Across the Five Counties

X = Objective worse than Maryland Baseline and 2014 Objective
# = Objective better or equal to MD baseline but worse than 2014 Maryland Target
@ = Exceeds MD Baseline and 2014 Objective
** = <20 events annually per County

Ranking of the 14 Negative Mid Shore SHIP Objectives Compared to MD Baseline	Caroline	Dorchester	Kent	Queen Anne's	Talbot
1. Food Deserts (Obj. 18) (USDA 2000)	@	X	X	@	X
2. Salmonella (Obj.16) (IDEHA 2009)	**	**	**	**	**
3. Adol Tob Use (Obj. 33) (MYTS 2010)	X	X	X	X	X
4. Teen Births (Obj.5) (VSA 2007-09)	X	X	@	@	@
5. Alzheimer's Admissions (Obj.35) (HSCRC 2010)	**	**	**	**	**
6. Infant Mortality (Obj. 2) (VSA 07-09)	**	**	**	**	**
7. Adol Obesity (Obj. 31) (MYTS 2008)	X	X	X	X	X
8. Suicide (Obj. 8) (VSA 2007-2009)	**	**	**	**	**
9. DM ED Visits (Obj. 27)(HSCRC 2010)	X	X	X	@	X
10. Cancer Deaths (Obj. 26) (VSA 07-09)	X	X	X	X	#
11. Adult Tob Use (Obj. 32) (BRFSS 2008-2010)	X	X	#	X	@
12. Flu Vaccinations (Obj.24)(BRFSS 2008-10)	X	#	X	X	#
13. Beh Health ED Visits (Obj.34) (HSCRC 2010)	X	X	@	@	@
14. Life Expectancy (Obj. 1) (VSA 2009)	X	X	X	#	#

Comparison of Federal, State, and Local Health Priorities

National Prevention Strategy: 2011 Priority Areas	Maryland State Health Improvement Plan (SHIP) 2011	Mid-Shore Health Status Priority Areas
Tobacco Free Living	Healthy Babies	Reduce Adolescent Obesity
Preventing Drug Abuse & Excessive Alcohol Use	Healthy Social Environments	Reduce Adolescent Tobacco Use
Healthy Eating	Safe Physical Environments	Reduce Diabetes Related Emergency Department Visits
Active Living	Infectious Diseases	Reduce Behavioral Health Related Emergency Visits
Injury & Violence Free Living	Chronic Diseases	Reduce overall cancer death rate
Reproductive & Sexual Health	Healthcare Access	Reduce deaths from heart disease
Mental & Emotional Well-Being		Reduce Drug Use & Alcohol Use
		Encourage Early Detection of Cancer
		Create Health Promoting Neighborhoods

C) Community Leaders and Public Forums

Method

Shore Health and Chester River Health held eight community forums in locations throughout the Mid-Shore region during February and March 2012. The purpose of each session was to ask residents of the community to offer their thoughts about the regionalization study underway between Chester River Health and Shore Health.

More than 300 people attended these meetings, which were held in Cambridge, Denton, Easton, Federalsburg, Queenstown, Rock Hall, Sudlersville and Worton. A summary of the themes, issues and concerns expressed by the public during these sessions has been provided to our regionalization study committee to assist them in their work.

Summary of Public Comment:

The following summary highlights major points and themes that were expressed by attendees at our eight community forums held in February and March 2012.

- Participants expressed appreciation for the health systems' inclusion of the general public in the regionalization planning process and applauded such investments as the new Queen Anne's Emergency Center and Shore Health Medical Pavilion in Queenstown. Many participants noted that the quality and breadth of the services currently provided by the health systems' needs to be better understood by Mid-Shore residents.
- Participants from throughout all five counties asked for more and better access to healthcare services. This includes having services closer to where people live, scheduling that better accommodates their needs and preferences, and more efficient coordination of care among the region's health providers. The ability to stay on the Eastern Shore for most healthcare services, rather than traveling across the Bay Bridge or to Delaware, was the most common request.
- Some attendees expressed skepticism that regionalization of healthcare services can work and feared it might cause more people to seek care outside the Mid-Shore region.
- Participants made plain their view that access to care is directly related to access to transportation. Transportation was of special concern for the poor

and elderly, for whom finding transportation is often a barrier to them receiving preventive, routine and urgent care.

- Local availability of specialty care for unique populations is a growing concern. Specific groups cited were the growing geriatric population, children with special needs and those in need of behavioral health services.
- More thought should be given to how technology can contribute to addressing the region's unmet health and medical needs. Examples included telemedicine that could offer patients remote consults with providers. Other participants noted that achieving efficient care coordination is dependent on providers having access to electronic medical records.
- Many expressed the hope that the University of Maryland Medical System will assume an even larger role in addressing the region's healthcare needs. Ideas offered included increasing local access to specialty physicians, developing a rural medicine program, and ensuring that caregivers within UMMS have full access to information about patients who are transferred to, or referred for specialty care within the system.
- Some participants perceive a loss of local control over important health care decisions, and sought reassurance that local boards of directors for Chester River Health and Shore Health will be the decision-makers on matters related to regionalization.
- Citing recent clinical changes at Chester River Hospital, especially in pediatrics and obstetrics, some worried about the commitment of UMMS to maintaining the hospital as an acute care inpatient hospital.

Specialized Studies & Data

Two counties in the Mid-Shore market, Caroline and Dorchester, required additional research based on specific health care related issues.

TRG Healthcare

Method

TRG Healthcare was hired by Shore Health and the Caroline County Commissioner's office with the purpose of conducting a study to gather important information to provide recommendations for enhancing the level of healthcare services in Caroline County.

A Joint Oversight Committee oversaw this process with members from both Shore Health System and the Caroline County Commissioner's office. This Committee met regularly to review data and findings, provide insight into the healthcare needs of the County, provide input, and approve recommendations resulting from this work.

Analysis

- Overall population growth in the County is relatively flat with minimal growth projected over the next five years (1.6%)
- Caroline County has a significantly higher percent of its population who are uninsured. Out of all Maryland counties, only 3 other counties were higher than Caroline County in the percent of uninsured children in 2009
- Compared to similar counties and the United States, Caroline County has higher rates of births to women under 18 and births to unmarried women
- Death rates in Caroline County were significantly higher for:
    - Breast, colon, and lung cancers
    - Coronary heart disease
- Compared to State and county data, Caroline County has a higher rate of adult smoking, mental health issues and chronic diseases, specifically, obesity, diabetes, and asthma
- In addition, utilization of preventive services is lower when compared to State or similar counties for mammography and diabetes screening, flu shots
- 50% of the ambulance admissions to Shore Health emergency rooms are for patients that were treated and released

Dorchester County, Infant Mortality

Method

In December 2011, DHMH developed a comprehensive Plan to Reduce Infant Mortality, with input from stakeholders across Maryland, to provide a framework for Maryland's efforts to address this important and complex public health problem.
In April of 2012, the Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities and Associated Black Charities held a Health Disparities Conference in Cambridge, Maryland with community and healthcare stakeholders. The focus of the conference was Infant Mortality.

Analysis

Infant Mortality in Dorchester County in 2009 was at a rate of 21.9 per 1,000 live births. By comparison, the State of Maryland reported a rate of 7.2 per 1,000 live births.

Maryland PRAMS Data (Prenatal Risk Assessment Monitoring System) from 2001 – 2009 indicates that of women in Dorchester County delivering a live infant:

- 42% smoked during the three months prior to pregnancy
- 19% had at least one episode of binge drinking during the three months prior to pregnancy
- 28% were obese (BMI ≥ 30) just before pregnancy
- 16% were taking a daily multi-vitamin one month prior to pregnancy

Several societal factors contribute to the high infant mortality rate in Dorchester County, including stress from poverty (12.3% of the county household live below the poverty line, compared to a state average 8.6%) and from racism.

The data demonstrated the need for community education and outreach regarding Infant Mortality and the connections between the physical, social, psychological and economic factors, affecting birth outcomes for the families in Dorchester County.

D) Social Determinants of Health (SDoH)

Defined by the World Health Organization as: "...the conditions in which people are born, grow, live, work and age..."

Method

Reviewed data from identified sources:

- U.S. Census Bureau
- Maryland Vital Statistics Administration
- Mid-Shore Regional Health Improvement Coalition
- Maryland Department of Health and Mental Hygiene
- Office of Minority Health and Health Disparities

Results

Local Health Context

The five counties currently share the following similarities:

- Local health departments are required to establish and facilitate local County coalitions overseeing and coordinating tobacco funded interventions as stipulated by the Cigarette Restitution Grant Funds which all county health departments receive.

- All five counties have required School Health Coalitions to comply with State mandates for school health policies.

- All five counties have a prevention coordinator as a component of grant funding through the Alcohol and Drug Abuse Administration which has some flexibility in addressing unhealthy adolescent and adult behavior.

- All five counties have a local management board which is funded to provide community based funding for programs and services related to health and well being of children and families.

The five counties differ significantly in their capacity to:

- Provide accessible public health interventions in the public schools
- Establish relationships and involvement within their respective minority communities
- Foster the interest and concern for public health priorities from local county agencies
- Involve and sustain interest from their local Commissioners that set policy and funding priorities for the county

Additional contextual factors to be considered include those factors that uniquely challenge rural communities:

- The Mid-Shore counties tend to have higher uninsured, unemployed, and low income populations.
- Lack of public transportation system with difficulty accessing health services
- Limited number of non-profits and private organizations as stakeholders to help share in filling gaps
- Health workforce shortage that includes primary care, behavioral health and specialty care

E. Health Statistics/Indicators

Method:

Regularly review the following local data sources:

- Health Disparities Report
- DHMH SHIP data

For national trends and data:

- Healthy People 2020
- Centers for Disease Control reports/updates

Results:

Outcomes Summary for Mid-Shore CBSA,**Cause of Death Data from Maryland Vital Statistics Administration –** www.matchstats.org

	Caroline	Dorchester	Kent	Queen Anne's	Talbot	ALL
2010 Cause Of Death	Counts	Counts	Counts	Counts	Counts	Counts
Heart disease	76	87	58	76	100	397
Major non-cardiac vascular diseases	19	17	17	24	38	115
Malignant Neoplasms	62	83	63	104	100	412
Chronic lower respiratory diseases	23	16	9	25	21	94
Diabetes mellitus	11	9	5	8	8	41
Accidents	22	11	10	15	12	70
Influenza and pneumonia	5	6	9	9	5	34
Septicemia	*	*	9	*	6	*
Alzheimer's Disease	7	8	13	11	22	61
Parkinson's Disease	6	*	0	*	5	*
Human immuno deficiency virus (HIV) disease	*	*	*	*	0	*
Nephritis, nephrotic syndrome, and nephrosis	5	6	*	*	10	*
Homicide	0	*	0	*	*	*
Liver Disease (chronic) and cirrhosis	*	5	*	7	*	*
Suicide	*	*	*	*	5	*
Perinatal conditions	*	*	0	*	*	*
Congenital malformations, deformations and chromosomal abnormalities	0	0	0	*	*	*
Sudden infant death syndrome (SIDS)	0	0	0	*	0	*
Other	44	77	35	66	85	307
Total	280	325	228	345	417	1531

Birth Statistics for the State of Maryland
Live Births of Maryland Residents

	Year of Birth								
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
CAROLINE	407	389	385	419	465	428	477	467	499
DORCHESTER	328	336	308	348	365	325	406	412	451
KENT	203	155	157	167	202	181	189	178	219
QUEEN ANNES	500	470	532	501	509	520	516	557	532
TALBOT	369	355	334	341	388	363	357	368	387

http://www.matchstats.org
Maryland Vital Statistics Administration

Death Statistics for the Mid Shore Counties in the State of Maryland

	Year of Death									
	2004		**2005**		**2006**		**2007**		**2008**	
	Counts	Rate	Counts	Rate	Counts	Rate	Counts	Rate	Counts	Rate
Caroline	302	972.4	296	930.2	320	981.1	304	923.7	315	950.6
Dorchester	348	1125.8	386	1229.3	372	1176.1	372	1168.1	356	1112.6
Kent	264	1348.2	204	1025.2	257	1286.1	251	1255.8	254	1260.5
Queen Annes	367	814.1	366	802.4	354	765.6	386	828.8	356	756
Talbot	407	1162.3	440	1233.1	443	1228.4	447	1235	455	1256.4

http://www.matchstats.org
Maryland Vital Statistics Administration
Statistics: Frequencies and Rate
Year of Death: 2008 ,2007 ,2006 ,2005 ,2004

IV. Selecting Priorities

Analysis of all quantitative and qualitative data described in the above section identified these top six areas of need within the Mid-Shore Counties. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths and mission.

- Obesity
- Diabetes
- Heart Disease/Stroke
- Cancer
- Behavioral Health
- Access to Care/Prevention

V. Documenting and Communicating Results

The completion of this community health needs assessment marks a milestone in community involvement and participation with input from community leaders, the academic community, the general public, SHS/CRHS, and health experts. This report will be posted on the both the Shore Health and Chester River websites under the Community Health Needs section. Highlights of this report will also be documented in the Community Benefits Annual Report for FY'13. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

VI. Planning for Action and Monitoring Progress

A) Priorities & Implementation Planning

Based on the above assessment, findings, and priorities, the CHNA Steering Committee agreed to incorporate our identified priorities with Maryland's State Health Improvement Plan (SHIP). Using SHIP as a framework, the following matrix was created to show the integration of our identified priorities and their alignment with SHIP's Vision Areas (See Table 1). SHS will also track the progress with long-term outcome objectives measured through the Maryland's Department of Health & Mental Hygiene (DHMH). Short-term programmatic objectives, including process and outcome measures will be measured annually by SHS for each priority area through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

In addition to the identified strategic priorities from the CHNA, SHS employs the following prioritization framework. Priorities may need to be adjusted rapidly to address an urgent or emergent need in the community, (i.e. disaster response or infectious disease issue). The CHNA prioritized needs for the Sustained and Strategic Response Categories and the Rapid and Urgent Response Categories' needs will be determined on an as-needed basis.

SHS will provide leadership and support within the communities served at a variety of response levels. Rapid and Urgent response levels will receive priority over sustained and strategic initiatives as warranted.

- Rapid Response - Emergency response to local and national disasters, e.g., weather disasters – hurricanes, earthquake, blizzards, terrorist attack
- Urgent Response - Urgent response to episodic community needs, e.g., H1N1 Flu response
- Sustained Response - Ongoing response to long-term community needs, e.g., obesity and tobacco prevention education, health screenings, workforce development
- Strategic Response - Long-term strategic leadership at legislative and corporate levels to leverage relationships to promote health-related policy or reform and build key networks

Future Community Health Needs Assessments will be conducted every three years and strategic priorities will be re-evaluated then. Programmatic evaluations will occur on an ongoing basis and annually, and adjustments to programs will be as needed. All community benefits reporting will occur annually to meet state and federal reporting requirements.

Table 1 – SHS & CRHS Community Needs Assessment Priorities and Outcomes

Maryland SHIP	SHS Priorities	SHIP Outcome Objectives
Healthy Babies	Maternal/Child Health	1. Reduce low birth weight (LBW) & very low birth weight (VLBW) 2. Reduce sudden unexpected infant deaths (SUIDS) 3. Increase the proportion of pregnant women starting prenatal care in the 1st trimester
Healthy Social Environments	Violence Prevention	1. Reduce child maltreatment 2. Reduce domestic violence
Safe Physical Environments	Fall Prevention Asthma Prevalence	1. Decrease fall-related deaths 2. Reduce hospital emergency department visits from asthma
Infectious Disease	Influenza	Increase percentage of people vaccinated annually against seasonal influenza
Chronic Disease	Obesity/Heart Disease/Diabetes	1. Increase the proportion of adults who are at a healthy weight 2. R educe the proportion of children & who are considered obese 3. Reduce deaths from heart disease 4. Reduce diabetes-related emergency room visits
	Behavioral Health	Reduce number of emergency room visits related to behavioral health conditions
	Cancer	1. Reduce overall cancer death rate 2. Reduce the proportion of adults who are current smokers 3. Reduce the proportion of youths who use any kind of tobacco product
Healthcare Access	Access	Reduce the proportion of individuals who are unable to afford to see a doctor

B) Unmet Community Needs

Several additional topic areas were identified by the CHNA steering Committee during the CHNA including: safe housing, transportation, and substance abuse. While SHS and CRHS will focus the majority of our efforts on the identified priorities outlined in the table above, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still

important to the health of the community, will be met through other health care organizations with our assistance as available. The unmet needs not addressed by SHS and CRHS will continue to be addressed by key governmental agencies and existing community- based organizations. SHS and CRHS prioritized needs identified by the community and the organizations key strengths and available resources. The following table summarizes the programs either currently in use or to be developed to address the identified health priorities.

Maryland SHIP Vision Area	SHS/CRHC Priorities	SHS/CRHC Strategic Community Programs	SHS/CRHC Partners
Healthy Babies	Maternal/Child Health	Prenatal Education & Services	Local Health Depts., Associated Black Charities, MOTA
Healthy Social Environments	Violence Prevention	Child Advocacy Center (CAC)	Local Health Depts., Mid-Shore Mental Health Systems and Talbot County Children's Advocacy Center
Safe Physical Environments	Trauma Prevention Fall Prevention	Shore Rehabilitation Services Balance Center	ENT physicians, Local Health Depts., Shore Wellness Partners
Infectious Disease	Influenza	Flu Clinics, Flu Prevention Ed	Local Health Depts.,
Chronic Disease	Obesity/ Heart Disease/ Diabetes	Shore Wellness Partners, Diabetes Education & Services	AHA, ADA, Mid-Shore SHIP Coalition, Local Health Depts., Competent Care Connections (Health Enterprise Zone)
	Behavioral Health	Mental Health Education & Services	Mid-Shore Mental Health Systems Competent Care Connections (Health Enterprise Zone) Link: www.kenthd.org/pdf/mship/HealthEnterpriseZones.pdf
	Cancer	Free Screenings - Mammograms/PAP Smears, Skin Cancer, Smoking Cessation, Tobacco Prevention Ed	Talbot Tobacco Coalition, ACS, Komen Foundation, Red Devils
Healthcare Access	Access	Shore Wellness Partners, Discharge Follow-up Clinic	Local Health Depts., Competent Care Connections (Health Enterprise Zone) Med-Chi

Appendix 1: Social Determinants of Health Summary

Appendix 1: Social Determinants of Health Summary

Demographic Information on Mid-Shore Counties						
People QuickFacts	Talbot County	Caroline County	Dorchester County	Queen Anne's County	Kent County	Maryland
Population, 2010	37,782	33,066	32,618	47,798	20,197	5,773,552
Population, percent change, 2000 to 2010	11.7%	11.1%	6.3%	17.8%	5.2%	9.0%
Population, 2000	33,812	29,772	30,674	40,563	19,197	5,296,486
Persons under 5 years, percent, 2010	4.9%	7.0%	6.2%	5.7%	4.9%	6.3%
Persons under 18 years, percent, 2010	19.5%	25.2%	21.7%	23.8%	17.6%	23.4%
Persons 65 years and over, percent, 2010	23.7%	13.3%	17.7%	14.9%	21.8%	12.3%
Female persons, percent, 2010	52.3%	51.2%	52.3%	50.3%	52.3%	51.6%
White persons, percent, 2010 (a)	81.4%	79.8%	67.6%	88.7%	80.1%	58.2%
Black persons, percent, 2010 (a)	12.8%	13.9%	27.7%	6.9%	15.1%	29.4%
American Indian and Alaska Native persons, percent, 2010 (a)	0.2%	0.4%	0.3%	0.3%	0.2%	0.4%
Asian persons, percent, 2010 (a)	1.2%	0.6%	0.9%	1.0%	0.8%	5.5%
Persons reporting two or more races, percent, 2010	1.6%	2.1%	1.9%	1.7%	1.8%	2.9%
Persons of Hispanic or Latino origin, percent, 2010 (b)	5.5%	5.5%	3.5%	3.0%	4.5%	8.2%
White persons not Hispanic, percent, 2010	79.0%	78.2%	66.2%	87.3%	78.1%	54.7%
Living in same house 1 year & over, 2006-2010	88.2%	88.8%	88.5%	90.3%	86.2%	85.9%
Foreign born persons, percent, 2006-2010	4.5%	4.7%	3.3%	3.4%	4.2%	13.2%
Language other than English spoken at home, pct age 5+, 2006-2010	6.5%	6.6%	4.0%	5.8%	6.6%	15.9%
High school graduates, percent of persons age 25+, 2006-2010	88.0%	81.6%	81.0%	89.7%	86.0%	87.8%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	32.7%	15.2%	16.5%	29.6%	30.2%	35.7%
Veterans, 2006-2010	4,483	2,995	3,109	4,344	2,073	455,328
Mean travel time to work (minutes), workers age 16+, 2006-2010	24.4	31.6	25	34.4	26.1	31.3
Housing units, 2010	19,577	13,482	16,554	20,140	10,549	2,378,814
Homeownership rate, 2006-2010	76.2%	75.8%	71.1%	84.8%	71.8%	69.0%
Housing units in multi-unit structures, percent, 2006-2010	12.1%	9.4%	13.7%	6.2%	12.6%	25.7%
Households, 2006-2010	15,603	11,828	13,347	17,188	7,735	2,121,047
Persons per household, 2006-2010	2.37	2.73	2.37	2.69	2.41	2.62
Per capita money income in past 12 months (2010 dollars) 2006-2010	$37,958	$24,294	$25,139	$35,964	$29,536	$34,849
Median household income 2006-2010	$63,017	$58,799	$45,151	$81,096	$50,141	$70,647
Persons below poverty level, percent, 2006-2010	6.1%	11.5%	13.4%	5.5%	12.2%	8.6%
Land area in square miles, 2010	268.54	319.42	540.77	371.91	277.03	9,707.24
Persons per square mile, 2010	140.7	103.5	60.3	128.5	72.9	594.8
(a) Includes persons reporting only one race.						
(b) Hispanics may be of any race, so also are included in applicable race categories.						
Source: US Census Bureau State & County QuickFacts						

Appendix 2: Community Health Needs Action Plan

Appendix 2 - Community Health Needs Action Plan

Priority Area: Healthy Babies

Long Term Goal:

1) **Maryland SHIP#3: Reduce the percentage of births that are low birth weight (LBW).**
2) **Maryland SHIP#6: Increase the proportion of pregnant women starting prenatal care in the 1st trimester.**

Annual Objective	Strategy	Target Population	Actions Description	Process Measures	Resources/Partners
Reduce the percentage of births that are low birth weight	Expand and support evidenced-based innovative prenatal programs that reduce LBW	Women in Dorchester and Caroline Counties	Participate in DHMH comprehensive Plan to Reduce Infant Mortality (Appendix 4) Link: **http://dhmh.maryland.gov/babiesbornhealthy/pdf/Plan_Reducing_Infant_Mortality_MD_Dec2011.pdf**	Enroll additional women from Caroline and Dorchester Counties in Prenatal care Program	**Local Health Depts** **Choptank Community Health** **SHS Birthing Center** **Faith Based Partners** **Associated Black Charities**
Increase the proportion of women seeking prenatal care in 1st trimester	Educate women to seek prenatal care within the 1st trimester		Distribute patient education materials to at-risk women on importance and availability of prenatal care through SHS communication channels	Communication/Education plan developed and implemented	

Community Health Needs Action Plan

Priority Area: Healthy Social Environments **Long Term Goal:** **1) Maryland SHIP#7: Reduce child maltreatment.**					
Annual Objective	**Strategy**	**Target Population**	**Actions Description**	**Process Measures**	**Resources/Partners**
Reduce child sexual and physical abuse	Coordinate efforts to ensure that victims of child sexual abuse/assault, and their non-offending family members, have access to support and services in a safe, culturally respectful environment	Children from Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties	Provide forensic interviews, forensic medical examinations, advocacy services and mental health services to children and non-offending family members who may require services and support Attend community events	Provide services to any/all victims of child sexual and physical abuse (at no charge) in a child-focused setting	Talbot County Children's Advocacy Center (CAC), pediatricians, Shore Health System nurses trained in sexual assault forensic examinations, representatives from Talbot County Department of Social Services (TCDSS), law enforcement, and the Talbot County State's Attorney's office

Community Health Needs Action Plan

Priority Area: Safe Physical Environments

Long Term Goal:
1) Maryland SHIP#14: Decrease fall-related deaths
2) Maryland SHIP#17: Reduce hospital emergency department visits from asthma

Annual Objective	Strategy	Target Population	Actions Description	Process Measures	Resources/Partners
Reduce falls	Educate community on treatment options for balance disorders	Adults 65 or older report difficulty with balance or walking	Provide education to community and physicians	Number of events attended	SHS Balance Center
Reduce ED visits from adult asthma	Provide a continuum of care focusing on preventive care to improve the ability of patients and families to work together to manage chronic disease.	At-risk individuals who do not have sufficient resources for follow-up care at discharge.	Expand services to Shore Health System patients through the Shore Wellness Partners Program and Shore Health Discharge Follow-Up Clinic.	Number/Percentage of patients scheduled for the Discharge Follow-Up Clinic per high risk patients Number of referrals to Shore Wellness Partners	SHS Discharge Follow-Up Clinic Shore Wellness Partners Local Health Depts.

Community Health Needs Action Plan

Priority Area: Infectious Disease

Long Term Goal:
1) Maryland SHIP#24: Increase the percentage of people vaccinated annually against seasonal influenza

Annual Objective	Strategy	Target Population	Actions Description	Process Measures	Resources/Partners
Increase percentage of vaccinated people annually against seasonal influenza	Expand access to free flu vaccines in targeted underserved zip codes	Adults & Children in targeted underserved zip codes	Offer various free flu clinics in churches, seniors centers, and various community sites within various targeted zip codes Provide free vaccines to patients' families (during patients' hospitalization) during flu season.	# of vaccinated community members annually	Local Health Departments, CDC, DHMH
	Educate on the importance of receiving annual flu vaccines and immunize against the flu		Provide information on prevention; dispel myths about how getting the vaccine gives you the flu. Partner with Health Depts to provide free vaccines in convenient community locations. Obtain materials from Centers for Disease Control (CDC) on the importance of flu vaccination for distribution in churches, senior centers, website, and community sites.	# of materials distributed # of events attended # of materials distributed	

Community Health Needs Action Plan

Priority Area: Chronic Disease

Long-Term Goals:
1) Maryland SHIP #17 –Reduce emergency department visits from asthma
2) Maryland SHIP #28 – Reduce hypertension related emergency department visits.
3) Maryland SHIP #25 – Reduce deaths from heart disease
4) Maryland SHIP #27 – Reduce diabetes-related emergency department visits

Annual Objective	Strategy	Target Population	Actions Description	Process Measures	Resources/Partners
Reduce emergency department visits due to: asthma, heart disease, hypertension, diabetes.	Provide a continuum of care focusing on preventive care to improve the ability of patients and families to work together to manage chronic disease.	At-risk families and individuals who do not have sufficient resources and are not eligible for other in-home services	Expand Shore Wellness Partners Program. The program is designed to help patients with disease management and life skills so that they can continue to live in their own homes. The service is provided by Shore Health System at no charge for those who qualify. Objectives: • Managing physical health problems • Connection with other community services • Dietary education • Home safety evaluations • Safe medicine use • Education on specific illness and treatments • Emotional support • Monitoring client progress through home visits or phone calls	Reach: • 600 referrals by phone and letters to provide information about the program and the enrollment process • maintain 200 active clients • Reduce hospital admissions for clients in program for greater than 6 months by **.6** visits on average	Shore Wellness Partners Physician practices

Community Health Needs Action Plan

Priority Area: Chronic Disease - Cancer **Long-Term Goals:** **1) Maryland SHIP #26 – Reduce the overall cancer death rate** **2) Maryland SHIP #32 – Reduce the proportion of adults who are current smokers**					
Annual Objective	**Strategy**	**Target Population**	**Actions Description**	**Process Measures**	**Resources/Partners**
Reduce the overall cancer death rate	Increase access to free cancer screenings	Increase breast screening levels among uninsured and underinsured women.	1. Increase the number of women surviving breast cancer by diagnosing them at an earlier stage through education and promotion of preventative measures and early detection. 2. Diagnose African American women at earlier stages of breast cancer, equivalent to Caucasian women. 3. Educate Latino women in breast self examination with the assistance of a translator.	Number of women screened Number of women referred for treatment	Local Health Departments Susan G. Komen for the Cure

Reduce the overall cancer death rate	Educate community on cancer prevention	Adults	Provide info on smoking cessation, secondhand smoke & tobacco prevention information at outreach events	Reach: # of materials distributed per event and totals # of campaigns # of events featuring information # of people attending events # of web page hits	Local Health Departments, Talbot Healthy Community Coalition (Talbot County Cancer Control)
Reduce the overall cancer death rate	Support community partners r/t cancer treatment & prevention	Adults & Children	Provide education, funding & support of joint missions: • Local Health Departments • Komen Foundation	Amount of financial resources provided in $ # of joint events/activities sponsored	Local Health Departments Susan G. Komen for the Cure

Community Health Needs Action Plan

Priority Area: Healthcare Access **Long Term Goal:** **1) Increase the proportion of persons with access to healthcare**					
Annual Objective	**Strategy**	**Target Population**	**Actions Description**	**Process Measures**	**Resources/Partners**
Increase the proportions of persons with access to health care	Assess each patient discharged to determine risk level for readmission and identify possible discharge planning needs. Schedule an appointment for eligible patient with the free Discharge Follow-Up Clinic	• Readmission was within 30 days of prior admission Multiple Emergency Department visits (3 times within 30 days). • No primary care physician. • No insurance • Under insured • Unemployed • Multiple co-morbidities • Polypharmacy (> 10 meds) • Limited/ no support at home • Psychiatric diagnosis (es) • Active cancer • Heart failure • COPD • CVA • Diabetes with complications • Renal failure • Trachesostomy • WoundsOstomy • Readmission Care Coordinator referral	Identify patients to be referred to the Discharge Follow- Up Clinic On every patient an Admission Assessment is to be completed to determine a determine a patient's risk for readmission (low, moderate, high)	• Number/Percentage of readmissions 0-15 days after a DFU Clinic visit. • Number/Percentage of readmissions 16-30 days after a DFU Clinic visit. • Number/Percentage of patients seen in the DFU/scheduled patients • Number/Percentage of all cause readmissions for patients seen in the DFU per scheduled patients • Number/Percentage of Home Care referrals from DFU • Number/Percentage of Shore Wellness Partners referrals from DFU • Number/Percentage of nutrition referrals from DFU • Number/Percentage of PT/OT/ST referrals from DFU • Number/Percentage of social work referrals from DFU • Number/Percentage of REACH referrals from DFU	Shore Wellness Partners SHS Discharge Follow-up Clinic

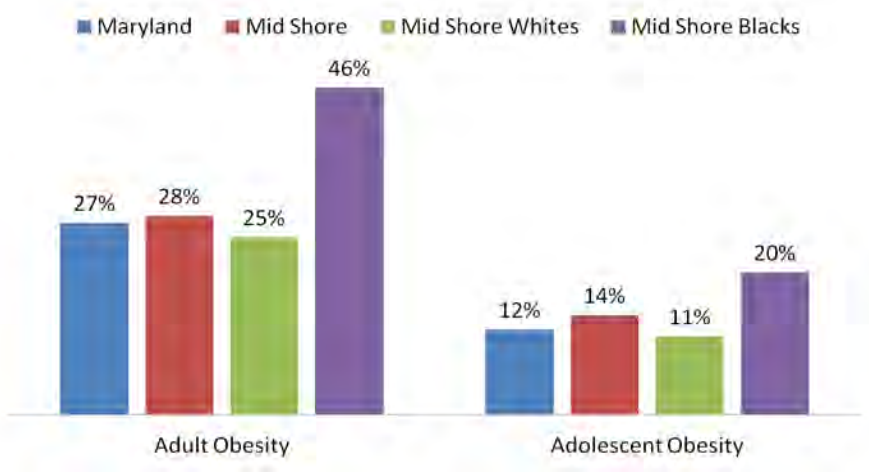
Appendix 2.1: Local Health Improvement Priorities & Strategies

Appendix 2.1

LOCAL HEALTH IMPROVEMENT PRIORITIES & STRATEGIES

Priority #1: Adolescent Obesity

Among the 33 SHIP objectives14 were found to be below the Maryland average. The Mid Shore Health Improvement Coalition (MSHIC) reviewed and discussed these 14 indicators and how they compared across the region. The MSHIC chose adolescent obesity as one of three priorities for strategic action planning due to the impact on premature morbidity and mortality, the magnitude of racial disparity, similar findings across all 5 jurisdictions, and the potential of addressing with evidence based strategies.



According to the Maryland Behavioral Risk Factor Surveillance Survey 2006-2010, and the Maryland Youth Tobacco Survey in 2008, obesity among African American adults (46%) and adolescents, aged 12-19 (20%) residing in the mid shore is almost double when compared to mid shore white adults (25%) and adolescents (11%). The Coalition felt the extreme levels of racial disparity in obesity levels warranted a comprehensive approach focusing on preventive and reduction strategies targeting not only children and adolescents, but examine complimentary strategies targeting African American families.

SHIP Objective #31 – Reduce the proportion of children and adolescents who are considered obese

Indicator: Percentage of youth (ages 12-19) who are obese (MYTS 2008)

Baseline and Mid Shore Goal
Reduce adolescent obesity from its current level of 14% to the Year 2014 Goal of 11%.

Strategy I
Target African American communities throughout the mid-shore region by raising awareness and implementing evidenced based strategies for children, adolescents, and adults.

Actions	Lead Organization/Partners	Timeline/Milestones	Success Measures
Target the African American Community by implementing a region wide faith based initiative, "Body and Soul, Healthy Eating and Healthy Living Program"	Churches, Pastor Associations, Public Agencies, Health Dep., Minority Coalitions, Parks and Recreation	0-3 months – Hire/assign full time health educator to implement project, Identify 3 Af. Am. Churches per county (total of 15 churches), develop recruitment plan to enlist pastors to be involved in Body & Soul Program, hold "Kick-Off" information session at Health Disparities Conference on April 12, 2012, 3-6 months - recruit individual church coordinators, conduct training sessions, establish planning teams and develop program plan 6-9 months –Implement program at each participating church 9-12 months – provide ongoing support through workshops and educational materials 12 months – monitor with evaluation surveys, report to SHIP coalition, public officials	Staff assigned Spreadsheet generated Recruitment Plan, Conference Presentation Coordinator List, Training Schedule, Program Plan Supporting Documentation Workshop materials, Workshop schedule No. Church Activities, No. of Events, Pre/Post Test Surveys
Target food service facilities	Health Dept, Food Service Facilities,	0-3 months – Staff training in model Healthy Stores	Training Dates

that are either owned or cater to Af. Am. Communities, i.e. restaurants, convenience stores, to offer healthier choices	Minority Coalitions, Chamber of Commerce	Initiative 3-6 months – develop recruitment plan for targeting facilities (zip codes in low income areas), focus group with community members in targeted areas 6-12 months – provide training and technical assistance to store owner, media promotion, monitor implementation and evaluation	Recruitment Plan, Meeting Schedule Training Schedule, Media Reports, Survey Data
Target minority communities to engage local family providers and day care centers to participate in healthy practices	Early Childcare Providers, Health Departments, Local Management Boards, Minority Coalitions	3-6 months – develop recruitment plan to enlist 3 AA daycare centers per County, provide education and technical support on healthy practices 6-9 months – implement new policies/protocols on health standards per daycare center 12 months – monitor, report to SHIP coalition, public meetings	Recruitment Plan, # Childcare Providers Recruited # Providers Educated Policy Documents # Health Standards Implemented List of events & meetings

Strategy II

Improve nutrition quality of foods and beverages served or available in schools consistent with the Institute of Medicine's Nutrition Standards for foods in schools.

Improve the quality and amount of physical education and physical activity in schools

Actions	Lead Organization/Partners	Timeline/Milestones	Success Measures
Revise and develop school based wellness policies consistent with current standards for nutrition and physical activity	Board of Ed, School Health Coalition, Health Department, Parents, Teachers	3-6 months – utilize school health counsel to review existing policy, develop revised policy 6-9 months – present to Superintend., Brd of ED., PTA, food service staff, Educate public with print/social media 9-12 months – monitor implementation, report success to SHIP coalition, Brd of Ed, public meetings	Copy of Revised School policy List of Meeting Presentations List of Events or Meeting

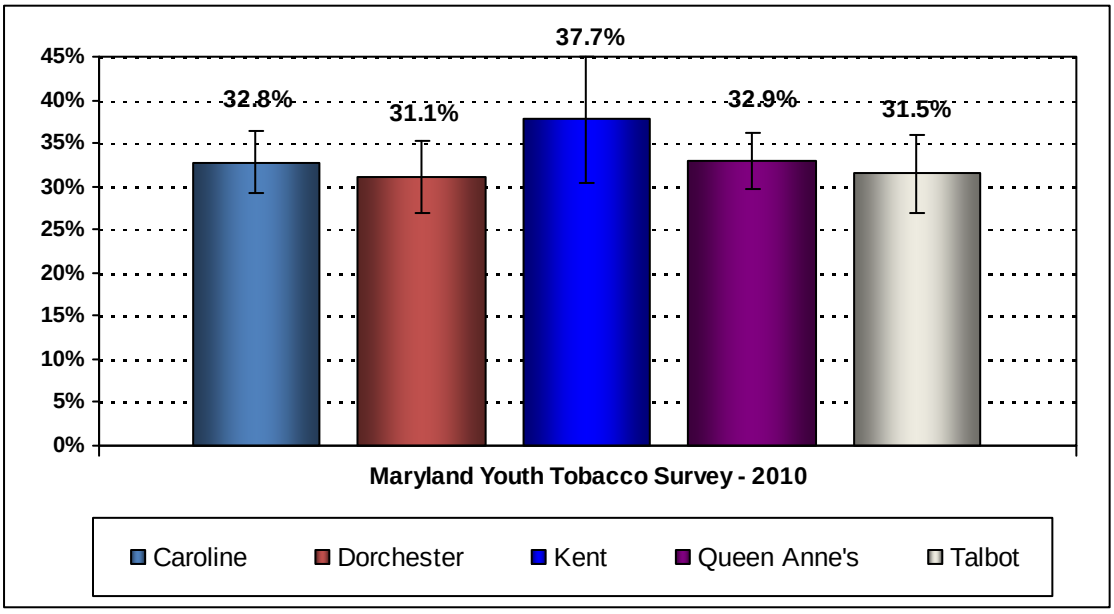
Strategy III

Prevent and Reduce Obesity by Implementing Evidence Based Community Initiatives

Actions	Lead Organization/Partners	Timeline/Milestones	Success Measures
Implement Community Based Initiatives, i.e. Healthy U Delmarva Working Off Weight (WOW)	County Coalitions, Health Departments, Businesses, Public Agencies, Minority Coalitions	3-6 months – establish planning committee, choose best practice, develop plan and recruitment protocols 6-9 months –present plan to local officials, educate public with print/social media 9-12 months – implement protocols, evaluation 12 months – monitor, report to SHIP coalition, public meetings	Planning Document Media Documentation, Presentation Schedule # recruited, pre/post surveys Meeting Schedule

Priority #2: Adolescent Tobacco Use

The MHIC chose adolescent tobacco use as the second of three priorities for strategic action planning due to similar concerns noted with adolescent obesity such as the impact on premature morbidity and mortality, similar findings across all 5 jurisdictions, and the potential of addressing with evidence based strategies.



According to the Maryland Youth Tobacco Survey 2010, tobacco use within the last 30 days for mid shore high school students overall was 33% compared to 25% for the State. As shown above there was no statistically significant difference in smoking prevalence among the 5 counties. In addition, there was no evidence to support a racial or income level disparity when the 8 mid shore high schools were analyzed.

SHIP Objective #33 – Reduce the proportion of youths who use any kind of tobacco product

Indicator: Percentage of high school students (9-12 grade) that have used any tobacco product in the past 30 days (MYTS 2010)

Baseline and Mid Shore Goal

Reduce adolescent smoking from its current level of 33.2% to the State target of 22.3% by 2014

Strategy I **Prevent and reduce tobacco use among youth by implementing school based prevention and cessation activities**			
Actions	**Lead Organization Partners**	**Timeline/Milestones**	**Success Measures**
Implementation of Life Skills, Toward No Tobacco Use Curriculum coupled with School Based Social and Print Media Campaign	Board of Ed, School Health Coalitions, Health Departments	0-3 months – utilize the existing School Health Counsel to plan and develop implementation schedule for a selected curriculum 3-6 months – present to Superintend., Brd of ED., PTA, Educate public with print/social media 6-9 months – implement plan 0-12 - monitor implementation, report success to SHIP coalition, Brd of Ed, public meetings	Implementation Plan Schedule of Presentations # of schools involved Student Pre/Post Self Awareness Surveys
Provide School Based Cessation Programs for High School Students, i.e. Teen Court	Board of Ed, Teachers, School Health Coalition, Health Department	0-3 months – utilize existing School Health Counsel to develop cessation plan 3-6 months – present to Superintend., Brd of ED., PTA, Educate public with print/social media 6-9 months – implement plan 9-12 – monitor/evaluate implementation, report success to SHIP coalition, Brd of Ed, public meetings	Development of Cessation Plan Schedule of Presentations, Media Documentation Evidence of Cessation Plan # participating students # students that complete program, # smoke free after 6 months

Strategy II

Prevent and reduce tobacco use among youth by reducing out of pocket costs for effective cessation therapies

Actions	Lead Organization Partners	Timeline/Milestones	Success Measures
Expand services and provide coverage for patients for expenditures on cessation groups and nicotine replacement or other pharmaceutical therapies	County Based Tobacco Free Coalitions, Primary Care Providers, Health Department	0-3 months – utilize CRF tobacco coalitions to develop revised access plan 3-6 months –recruit new providers, implement access plan 6-9 months – monitor, report findings to SHIP coalition, public meetings 9-12 months – client participation assessment	Access Plan # additional sites or providers recruited Meeting Schedule #completing program, # smoke free after 6 months

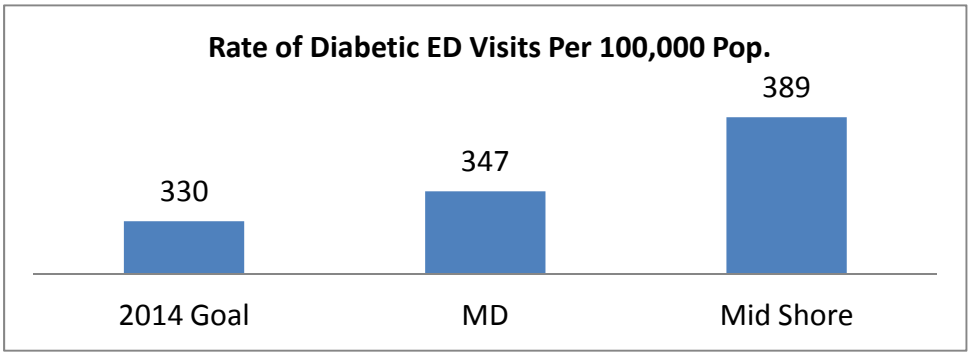
Strategy III

Prevent and reduce tobacco use among youth by active enforcement of retailer sales laws and retailer educations

Actions	Lead Organization Partners	Timeline/Milestones	Success Measures
Retailer education & enforcement of retailer sales law	Law Enforcement, Health Department, Businesses, Parents, Youth, Minority Coalition, Elected Officials	0-3 months – local tobacco coalitions & law enforcement develop action plan 3-6 months - schedule training sessions for retailers, implement action plan 12 months – monitor, report findings to SHIP coalition, public meetings	Action Plan Training Schedule, #annual compliance checks, #educational sessions Meeting Schedule

Priority #3: Diabetes Related Emergency Department Visits

The MHIC chose diabetic emergency department visits as the third of three top priorities for strategic action planning due to the direct relationship to adolescent obesity, the impact on premature morbidity and mortality, significant racial disparity, similar findings across four of the five jurisdictions, and the potential of addressing with evidence based strategies.



According to the Maryland Behavioral Risk Factor Surveillance Survey (BRFSS) 2006-2010 significant health disparities exist in the prevalence of diabetes on the mid shore. The prevalence overall is only slightly higher at 10% compared to the State at 9%, however, among African Americans the prevalence is 18% compared to 9% for whites.

According to the Health Services Cost Review Commission 2010 the mid shore counties have an excessive number of visits to the emergency rooms for care of their diabetes. This is not unexpected and probably results from an array of socioeconomic and infrastructure challenges that include;

- The mid-shore counties tend to have higher rates of uninsured, unemployed, and low income population,
- Lack of public transportation system with difficulty accessing health services,
- Health workforce shortages, i.e., primary care, behavioral health and specialty care

The mid shore also lacks a coordinated system of care to educate and follow at risk diabetic clients once diagnosed in the office or upon emergency room discharge. In fact according to the MD BRFSS 2006-2010, less than 50% of diabetics stated they had ever taken a course or class on how to manage their diabetes.

SHIP Objective #27 : Reduce diabetes-related emergency department visits

Indicator: Rate of ED visits for diabetes per 100,000 population (HSCRC 2010)

Baseline and Mid Shore Goal

Reduce ED visits for diabetes form its current rate of 389.0 to the State target of 330.0 by 2014

Strategy I

Improve diabetes outcomes with diabetes case management and self management training programs

Actions	Lead Organization/Partners	Timeline/Milestones	Success Measures
Identify persons with diabetes who have used emergency department services in past year and target them for diabetes education and case management	Hospital, Primary Care Physicians, Health Department, Patients, EMS	0-3 months – establish planning committee, research guidance documents, establish patient recruitment protocols 3-6 months –approval from hospital admin., present protocol/training to ED staff at Dorchester General, educate public with print and social media, start active recruitment of clients 12-18 months – monitor, report success to SHIP, Hospital Admin/Board 24 months – expand protocols to Chester River & Easton Memorial	Recruitment Protocol/Plan Dates of Training, Media Documentation # Clients recruited Meeting Dates Recruitment Plan and Protocol

Strategy II Promote Early Diagnosis and Screening of Diabetes Targeting At Risk Populations			
Actions	**Lead Organization/Partners**	**Timeline/Milestones**	**Success Measures**
Community outreach and media campaign to promote diabetic screening with HGB A1c testing	Hospital, primary care physicians, health department, media, minority coalitions	0-3 months – establish regional planning committee, research best practices, develop action Plan 3-6 months – implement community outreach and media campaign to include radio broadcasts, billboard promotions, print and social media 9-12 months – evaluate with public surveys of residents attending public agencies, report success to SHIP coalition, public meetings	Action Plan Media Documentation Evaluation Results

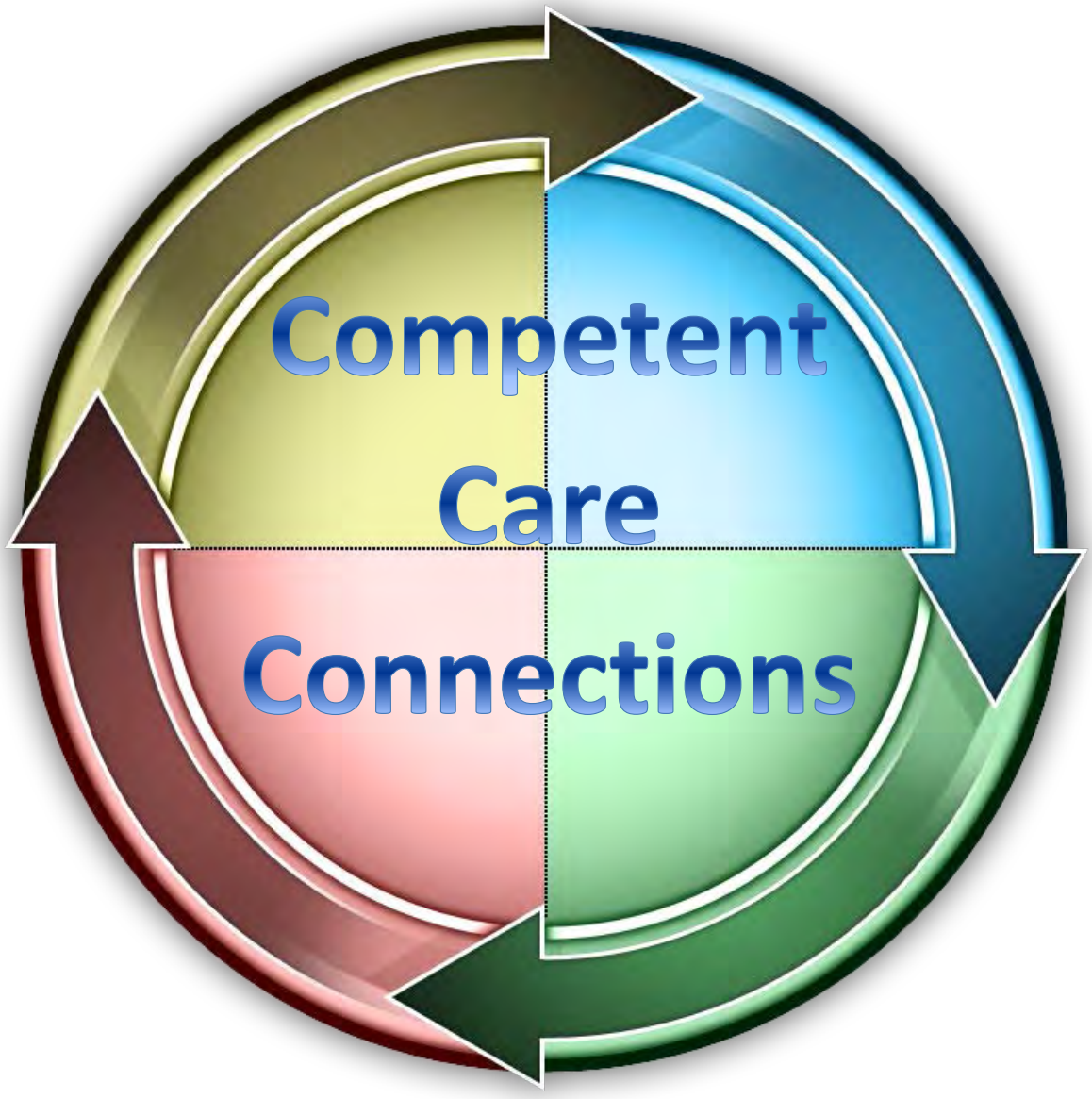
Local Health Planning Resources and Sustainability

The Regional Health Planning Coalition will maintain its planning capability through accessing both direct and in-kind support from the following sources:

- Direct Support:
  - Pro-actively respond to Federal and state grant opportunities
  - Seek support from our local hospitals through their Hospital Community Benefit funds
  - Include support for planning when applying for current State and federal grant funding that share similar goals and objectives such as the Community Transformation Grant, Cigarette Restitution Funds, and other chronic disease funding
- In-Kind Support:
  - Include health improvement planning as part of job description for appropriate local health department staff such as our wellness and prevention coordinators
  - Commitment from the Local Management Boards and Core Service Agencies
  - Commitments from other County agencies such as Juvenile Services, Social Services, and Board of Education
  - Voluntary commitments from various non-profits and community volunteers

Appendix 3: Caroline/Dorchester Health Enterprise Zone Proposal

Caroline/Dorchester Health Enterprise Zone Proposal



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STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor
John A. Hurson, Chairman - Mark Luckner, Executive Director

Health Enterprise Zones
Call for Proposals
Cover Sheet FY2013

Applicant Organization:

Name: Dorchester County Health Department

Federal Identification Number (EIN): 526002033

Street Address: 3 Cedar Street

City: Cambridge State: MD Zip Code: 21613 County: Dorchester - Caroline

Official Authorized to Execute Contracts:

Name: Roger L. Harrell, MHA E-mail: roger.harrell@maryland.gov

Title: Health Officer

Phone: 410-228-3223 Fax: 410-901-8194

Signature: Cheryl J MacLaughlin for Roger L Harrell Date: 11/15/12

Project Director (if different than Authorized Official):

Name: Sandra Wilson (Interim) E-mail: sandra.wilson@maryland.gov

Title: Health Education Program Manager – Dorchester County Health Department

Phone: 410-901-8126 Fax: 410-901-8199

Signature: Sandra L Wilson Date: 11/15/12

Alternate Contact Person:

Name: Beth Spencer E-mail: beth.spencer@maryland.gov

Title: Program Manager School-Based Wellness Centers, Healthy Families Dorchester, School Health Services, & Girls Circle/Teen Pregnancy Prevention - Dorchester County Health Department

Phone: 410-901-8177 Fax: 410-901-8181

HEZ Project Name:

Competent Care Connections – Caroline/Dorchester HEZ

STATEMENT OF OBLIGATIONS, ASSURANCES, AND CONDITIONS

In submitting its grant application to the Maryland Community Health Resources Commission ("Commission") and by executing this Statement of Obligations, Assurances, and Conditions, the applicant agrees to and affirms the following:

1. All application materials, once submitted, become the property of the Maryland Community Health Resources Commission.
2. All information contained within the application submitted to the Commission is true and correct and, if true and correct, not reasonably likely to mislead or deceive.
3. The applicant, if awarded a grant, will execute and abide by the terms and conditions of the Standard Grant Agreement (attached).
4. The applicant affirms that in relation to employment and personnel practices, it does not and shall not discriminate on the basis of race, creed, color, sex or country of national origin.
5. The applicant agrees to comply with the requirements of the Americans with Disabilities Act of 1990, where applicable.
6. The applicant agrees to complete and submit the Certification Regarding Environmental Tobacco Smoke, P.L. 103-227, also known as the Pro-Children Act of 1994.
7. The applicant agrees that grant funds shall be used only in accordance with applicable state and federal law, regulations and policies, the Commission's Call

for Proposals, and the final proposal as accepted by the Commission, including Commission-agreed modifications (if any).

8. If the applicant is an entity organization under the laws of Maryland or any other state, that is in good standing and has compiled with all requirements applicable to entities organized under that law.
9. The applicant has no outstanding claims, judgments or penalties pending or assessed against it – whether administrative, civil or criminal – in any local, state or federal forum or proceeding.

AGREED TO ON BEHALF OF, Dorchester County Health Department , BY:
(Applicant Name)

Roger L. Harrell, MHA, Health Officer
Legally Authorized Representative Name (Please PRINT Name) Title

Cheryl J MacLaughlin for Roger L Harrell
Legally Authorized Representative Name (Signature) Title

COMPETENT CARE CONNECTIONS – Dorchester and Caroline Counties
Health Enterprise Zone Proposal Narrative/ November 15, 2012
Submitted by the Dorchester County Health Department And the Connections Coalition

PROGRAM SUMMARY

Competent Care Connections is an innovative approach developed by 15 organizations in Caroline and Dorchester Counties and designed to significantly improve health care access and health status for individuals living in underserved communities. The primary mission can be summed up in two words: Health Equity. Within a proposed Health Enterprise Zone consisting of a contiguous area ranging from the most southern end of Caroline County to Cambridge, MD in Dorchester County, the "Connections Coalition" proposes to saturate the HEZ with primary care and behavioral health supports in culturally competent ways. For this plan to function successfully, the Coalition has built into the model four key values of cultural competence, citizen leadership, behavioral health care integration, and recruitment and training. These values correspond with strengthening health care access. Health status is addressed through the availability of four health care service teams: Primary Care, Peer Recovery, Community Health, and Behavioral Health. For primary care, strategies include increased nurse practitioner support for school based wellness programs; expanded patient medical care follow-up, and improved incentives for attracting physicians to primary care practices. For Behavioral Health, a new Mobile Health Crisis Team will divert 85% of behavioral health related complaints from hospitalization or incarceration. Also included in this component are school-based and community-based mental health therapists. For Community Health, there are two strategies. The first involves training four community health outreach workers (CHOW) as neighborhood-based support persons. These individuals would be available at no charge to assist community members with achieving positive health outcomes. Second, a health educator would be available to advise individuals who have a goal to lose weight. The fourth component is focused on addictions recovery and utilizes individuals with at least two years clean/sober to serve as Peer Recovery Support Specialists. This strategy will be based out of the DRI-Dock (Dorchester Recovery Initiative) center in Cambridge and it would be closely aligned with each individual's addictions/mental health recovery goals. The collective strategies correspond with the six goals for health improvement. Core diseases selected by the Coalition for emphasis and improvement are Diabetes, Hypertension, and Behavioral Health (emergency department visits) as evidenced by the region's poor statewide ranking for these conditions, especially among African Americans. Reductions in Emergency Department visits related to these diseases or conditions are key objectives targeted during the four years of the grant project.

PROGRAM PURPOSE

The program purposes associated with this proposal are reduction in racial and health disparities among minority populations and within the HEZ, improved healthcare access and health outcomes in underserved communities, and reduced health care costs, hospital admissions and re-admissions.

HEZ GEOGRAPHIC DESCRIPTION

The Connections Coalition carefully considered which contiguous zip codes within the mid-shore region of five counties would benefit most by being named as a Health Enterprise Zone. After the data was reviewed, it was clear there is a defined area of great need encompassing Dorchester and Caroline Counties. Seven zip codes were identified and include Cambridge (21613), Linkwood (21835), Hurlock (21643), East New Market (21631), Secretary (21664), Rhodesdale (21659) – all in Dorchester County, and Federalsburg (21632), in Caroline County.

At 558 square miles, Dorchester County is one of the largest counties in Maryland, with an additional 425 square miles of water (43% of total county area). Geographical characteristics contribute to a maritime and agricultural lifestyle. For the purposes of this proposal, approximately one fourth or 140 square miles represent the contiguous area of the county with the greatest needs for competent health care, especially for minorities, those without health insurance and/or individuals with no transportation. This area begins at the greater Cambridge metropolitan area, continues through northern central region of Linkwood, Secretary, East New Market, and Rhodesdale and throughout the more densely populated area of Hurlock.

Caroline County, located just north of the most eastern part of Dorchester County, is largely an agriculturally-based community with abundant open fields. Farming is a major economic pursuit consisting primarily of poultry, grain, and vegetable crops. Farmers depend on migrant workers to harvest their vegetable crops and as a result, there is a growing population of Hispanic families living year around in the county. Manufacturing accounts for about 14 percent of total employment. Incorporated towns are Denton (the county seat where most services are provided), Federalsburg, Greensboro, Goldsboro, Marydel, Preston, and Ridgely. With a land area of just over 319 square miles, the Federalsburg zip code accounts for 72.2 square miles or 23% of the total county land mass, stretching beyond the city limits and extending well into the central agricultural region of the county nearly to the town of Denton. Federalsburg is located just at the county's south border. (Map attached as Appendix L)

Geographic/Transportation Barriers

There are significant geographic features of this rural area which pose barriers to accessing health care. Many of the roads must circumvent the geographic barriers created by the Chesapeake Bay and its tributaries. These include large tracts of wetland and marsh, around which roads are routed, and isolated islands and peninsulas, some of which are separated from the mainland during high tide. There are limited public transportation options on the Eastern Shore. Delmarva Community Services/Delmarva Community Transit does offer limited access public transportation using a low fare mini bus system with fixed routes and schedules in and around the counties. Medical Assistance transportation is available; however, reservations must be made 48 hours prior to the appointment, limiting the use for acute or urgent care needs. Long waits for other patients using the van service can make the travel an all-day event. Parents who do not have access to child care must pay for each additional child that rides on the van.

HEZ Eligibility – For the seven zip codes proposed for HEZ eligibility, all eligibility requirements were met (where data was available). The Medicaid enrollment rate in the three cities with populations over 5,000 exceeded the Maryland median as did the WIC enrollment rate. Life expectancy in each of the three cities was a range of 4-5 years less than Maryland and the percentage of low birth weight babies also far exceeded the Maryland Median of 6.3. The population of each zip code and the eligibility findings are presented next.

County	City/Town	Zip Code	Population	Medicaid Enrollment Rate (per 1,000)	WIC Enrollment Rate (per 1,000)	Life Expectancy	% Low Birth Weight
Dorchester	Cambridge	21613	16,432	305.01	45.69	75.4	9.4
Dorchester	East New Market	21631	2,233	NA = Not Available	NA = Not Available	NA =Not Available	NA = Not Available
Dorchester	Hurlock	21643	5,203	234.51	37.18	76.7	8.7
Dorchester	Linkwood	21835	473	NA	NA	NA	NA
Dorchester	Rhodesdale	21659	1,530	NA	NA	NA	NA
Dorchester	Secretary	21664	503	NA	NA	NA	NA
Caroline	Federalsburg	21632	6,236	297.86	50.67	74.8	9.1
Total Population/ MD Median			**32,610**	**> 109**	**> 17.9**	**< 79.2**	**>6.3**

COMMUNITY NEEDS ASSESSMENT

Dorchester County has a history of being deeply entrenched in racial prejudice. In the early and late 1960's, the county experienced two major events of civil unrest, receiving national attention. Many positive changes have been made since then, especially in opportunities for employment, decent housing, and higher education. Sojourner Douglass and Chesapeake College are now located in Cambridge. African American and Native American history is a source of pride and an economic boost such as events to celebrate Harriet Tubman and the Nause-Waiwash Indians. In recent years, Dorchester citizens have elected more people of color in positions of power and influence to include the first black female mayor of Cambridge, elected in 2008 and again in 2012. Still, Dorchester County has a long way to go, especially when wide gaps in economics and optimal health are noted between white and minority citizens.

Residents of Dorchester County are challenged by economic conditions that set the population far apart from other Maryland jurisdictions. The county's unemployment rate was 10.7% in 2011, while Maryland's was 8.1%. The percentage of all county people who live in poverty is 13.4 (MD = 8.6%). County children under age 18 who live below the Federal Poverty Line (FPL) currently total 25.2%, the second highest rate in Maryland (MD = 11.8%). For households headed by a single female with children under age 5, the poverty rate is 33.4%. The median household income for Dorchester County is $43,751, compared to Maryland's income level of $69,193 (2010 U.S. Census). There are four Title I Elementary Schools in Dorchester County where the federal government provides academic assistance to support the high percentage of students from low income families. For Dorchester County, the percentage of elementary age children living in poverty at these schools is very high, ranging from 66% to nearly 88%. At least 19% of county residents ages 25 and above DO NOT have a high school diploma, compared to 12.5% for Maryland.

Dorchester County has a population of 32,618 according to the 2010 U.S. Census. This is a 6.3% increase over the 2000 population. At least 6.2% of the population is under age 5, 21.7% is under age 18, and 17.7% are over age 65 (compared to 12.3% for Maryland). The racial and ethnic breakdown in the county is 67.6% Caucasian/Non-Hispanic, 27.7% African American, 3.5% Hispanic/Latino, 1.9% two or more races, 0.9% Asian, and 0.3% American Indian, Pacific Islander, and native Hawaiian.

Caroline County has a very different ethnic distribution. The County's 2010 population was 33,066, an increase of 11.1% over its 2000 population. People under the age of 18 comprise 25.2% of the population, compared to 23.4% for Maryland. People 65 years of age and over account for 13.3% of all residents compared to 12.3% for the state. Of the total population, 78.2% are non-Hispanic Caucasians, 13.9% are African American, 5.5% are Hispanic or Latino, and the remaining residents are from other ethnic backgrounds. An estimated 19% of households with children under 18 years of age are headed by females with no husband present. The figure is 8.2% for single fathers. The number of households where grandparents are living with and responsible for their own grandchildren under 18 years of age is 817. (U.S. Census Bureau) At least 19.8% of county residents ages 25 and above DO NOT have a high school diploma. Of the nine public schools in the county, all five elementary schools are Title I schools. In the Federalsburg area where HEZ services are proposed, there is one Title I elementary school, one middle school, and one high school serving a total of nearly 1400 youth.

In 2011, Caroline County's unemployment rate averaged 8.8%, down from 9.4% in 2010 and 9.2% in 2009. The median household income was $59,689 from 2008-2010, compared to Maryland's at $70,017. Per capita income during the same period averaged $23,979, while it was $34,469 for Maryland. At least 21.4% of county households had an income of under $25,000 (2008-2010 average). In 2010, at least 11.5% of Caroline County residents and 8.6% of Maryland residents lived below the poverty level.

Key Health Indicators - Geographical characteristics, economics, education, and ethnic distribution have a substantial impact on health status and health care access in Caroline and Dorchester Counties. These are evidenced by multiple conditions. An examination of the number of and access to medical professionals earned both counties varying federal and state health professional shortage area designations. For primary care shortage, Caroline and Dorchester have a Medicaid Eligible (population) Designation. For Dental Care, both Caroline and Dorchester have a Low Income Designation, and for Mental Health, both counties have a Geographic Designation. The entire county of Caroline is considered by Maryland as being a Medically Underserved Area and Dorchester County has been declared by Maryland as having the largest population (34.8%) designated as Medically Underserved. Choptank Community Health Systems, a federally qualified health center (FQHC), has a presence in both counties, serving nearly 28,000 patients annually. Without this system, the health care status for citizens would be even more disheartening.

The Maryland Department of Health and Mental Hygiene conducted a comprehensive "Primary Care Needs Assessment" released in October of 2011. They examined 29 primary care health indicators and divided these into two groups to determine health status and health care access for each of Maryland's jurisdictions. From their thorough investigation, both Caroline and Dorchester Counties were listed as two of the six jurisdictions in Maryland having the greatest need for improvement in their health status indicators. Caroline County was again listed as one of the top six Maryland jurisdictions demonstrating the greatest challenge with health care access. Dorchester was listed in the group with the second greatest health care access challenges.

The Connections Coalition, a partnership of health care agencies and citizens representing Dorchester and Caroline Counties, selected several key chronic disease indicators provided on Maryland's State Improvement Plan (SHIP) website to track current available data and rankings. Of the six examined, Emergency Department visits due to Diabetes, Hypertension, and Behavioral Health proved to be the most challenging indicator areas, and thus targets for improvement using HEZ funding support.

Chronic Diseases	Year (s)	Ranking Dorchester 1 = worst	Rate Dorchester	Ranking Caroline 1 = worst	Rate Caoline	MD 2014 Target
Heart disease mortality rate*	2008-2010	13 of 24	198.5	**5 of 24**	230.0	173.4
Cancer mortality rate*	2008-2010	7 of 24	183.4	12 of 24	195.7	169.2
Number of ED Visits Due to Diabetes*	2011	**2of 24**	609.7	**6 of 24**	394.1	300.2
Hypertension ED visits*	2011	**2of 24**	444.2	12 of 24	218.3	202.4
Percentage of obese children/teens	2010	**2of 24**	18.1	9 of 24	13.8	11.3%
ED visits related to behavioral health	2011	**2 of 24**	10,819.2	**6 of 24**	6,992.1	5,028.3

* Per 100,000; Source: Maryland Health Services Cost Review Commission

Regarding health access, the Coalition noted that Caroline County held the 2nd worse position in the State for percentage of individuals under age 65 with health insurance @ 83.9%, compared to the Maryland target of 93.6%. Caroline County also fell below the Maryland target in 2010, with just 86.4% of citizens covered by health insurance, a 10 of 24 jurisdiction ranking (U.S. Census Bureau, SAHIEP)

Recently, the Maryland Department of Health and Mental Hygiene created an interactive data site allowing viewers to track current indicators and jurisdictional status for cities with populations of 5,000 or more. It was this interactive map, the Coalition consulted to track emergency department visits, since these visits are known to be increasing among citizens who reach urgent need status for preventable conditions such as asthma or diabetes. A closer look at specific numbers for the identified HEZ zip codes follows:

Emergency Department Visit Category ➔ Jurisdiction⬇	ED Visits Chief Complaint Asthma	ED Visits Chief Complaint Diabetes	Total ESSENCE ED Visits	Living HIV Case Rate (2009)	Average Heart Disease Death Rate (2006-10)	Average All Cause Death Rate (2006-10)
Cambridge	470	352	33834	259-569**	810.3-886.5**	183.6-211.8***
East New Market	6	16	2531	< 5,000 pop	< 5,000 pop	< 5,000 pop
Hurlock	94	56	8115	259-569**	810.3-886.5**	183.6-211.8***
Linkwood	12	7	940	< 5,000 pop	< 5,000 pop	< 5,000 pop
Rhodesdale	12	12	991	< 5,000 pop	< 5,000 pop	< 5,000 pop
Federalsburg	86	54	7296	259-569**	**886.6-1356.7***	**244.5-382.2***

*=Highest range (of 4) category; **=Second highest range; ***=Third highest range; Note: The town/zip code of Secretary was not included in the Maryland HEZ supplemental data viewer Source: Interactive HEZ Supplemental Map, MD DHMH

After reviewing health status and access indicators, the Connections Coalition members expressed keen interest in investigating these same indicators, where possible, by ethnicity. Racial data was not provided by zip code for the indicators (as of this writing), but were provided by county jurisdiction in a special publication titled "Charts of Selected Black vs. White Chronic Disease SHIP Metrics: Mid Shore Health Improvement Association. Consistent with the focus of the Health Disparities Workgroup of the Maryland Health Quality and Cost Council, several "exceptionally large disparities" in preventable hospitalizations were noted for Caroline and Dorchester Counties within the indicators of Hypertension and Diabetes. For African American citizens, the Emergency Department visit rates were nearly off the charts in both Caroline and Dorchester Counties and much higher than the Maryland averages. **From this report and the prior indicator trends pertaining to ED visits for Diabetes and Asthma, the Coalition honed in on their target for this proposal, with special attention needed for minority populations in both jurisdictions.**

Health Indicator	Dor Black	Dor White	Car Black	Car White	MD Black	MD White	SHIP Target 2014	HP 2020 Goal
Age-adjusted Heart Disease Mortality Rate 2007-2009/ Deaths per 100,000	212	197	209	241	238	184	173	153
Unadjusted Diabetes ED Visit Rates 2010/ Visits per 100,000	**1272**	344	**1091**	269	669	230	330	-
Unadjusted Hypertension ED Visit Rates 2010/ Visits per 100,000	**885**	172	**611**	197	475	136	225	-
Unadjusted Asthma ED Visit Rates 2010/ Visits per 100,000	244	55	166	49	182	41	67	-
Unadjusted % Adults at Healthy Weights 2008-2010/ Percent at Healthy Weight	17	32	28	32	26	37	36	34
Unadjusted % Adults Currently Smoking 2008-2010/ Percent Current Smokers	18	17	24	21	18	15	14	12

Source: Office of Minority Health and Health Disparities

Behavioral Health Emergency Department Visits

Another area of great concern to the Connections Coalition from the data examined is the high rate of Behavioral Health-related Emergency Department visits. Shore Health System (Easton Memorial Hospital and Dorchester General Hospital) conducted an examination of behavioral health cases known to the system specifically for residents from the target zip code areas associated with this proposal: Cambridge, East New Market, Hurlock, Linkwood, Rhodesdale, Secretary, and Federalsburg. The vast majority of cases was emergency department, rather than elected admissions. Data sets were pulled from 10 quarters of service beginning with the first quarter of CY 2010 and ending with the second quarter of CY 2012. During that time there were 1,719 cases or an average of 172 cases per quarter. Of the total cases, the top four presenting conditions were Depressive Disorder, Bipolar Disorder, Anxiety Disorder, and Alcohol Abuse. Age groups with the most cases were 25-34 (298), 18-24 (255), and 45-54 (233). Although

recorded in three separate age groups, it is interesting to note that there was a collective total of 491 cases in the age range of 0-17. Of special interest is the racial distribution of cases. The majority of cases (56%) represented white patients, but minorities occupied the remaining 44% of cases (41% African American), disproportionate to the general population of 35.4% in Dorchester County and 25.2% in Caroline County.

Mid-Shore Mental Health Systems, the core service agency for the five mid-shore counties on the Eastern Shore, tracks public mental health system utilization, Medical Assistance eligibility and penetration rates. Of the 24 Maryland jurisdictions, Dorchester County had the highest penetration rate in the State of Maryland, compared to Baltimore City at 20.3% and Allegany at 20.2%. Distribution of services for the mid-shore area includes the following: 45% of clients are adolescents or younger, 55% are transitional aged youth or older, 81.5% are outpatient, 8% are psychiatric rehabilitation, 87.3% of services were paid by Medicaid, 8.5% were paid by Medicaid – state funded, and 4.2% of clients were uninsured. At least 9.6% of individuals are dually diagnosed. The total cost for services during the first nine months of 2012 was $3,664,292 or a cost of $999.53 per patient. By contrast, the National Alliance of Mental Illness estimates the cost of a single Emergency Department visit at $2400 per patient. The total comparative cost for the 516 patients seen thus far in 2012 is $515,757 for public mental health treatment utilizing multiple sessions per patient vs. $1,238,400 for a one-time ED visit. According to Mid-Shore Mental Health Systems, when comparing the three most recent fiscal years, public mental health service delivery has grown by 13% (from 1659 to 1911 served) in Dorchester County and by nearly 4% (from 1414 to 1467 served) in Caroline County. Since all but one of the publically funded mental health clinics on the Eastern Shore were closed over a decade ago, resources for behavioral health have been strained to non-existent for individuals most at need. Practitioners fill in the gaps by associating with non-profits such as Choptank Community Health Systems, Crossroads Community, Inc. and Channel Markers where funding is available (usually temporarily) and caseloads are high. **Behavioral Health is the third indicator area chosen as a focus for the Competent Care Connections proposal.** Growing behavioral health needs are evidenced by a marked increase in behavioral health ED visits from Caroline and Dorchester Counties, from increases in the utilization of existing behavioral health services, by increases in Emergency Petitions served by the Cambridge Police (from 140 in 2011 to 189 thus far in 2012) and the Federalsburg Police (up to 25 in 2011), and by the astounding increase between 2011 and 2012 in utilization of the Eastern Shore's Mobile Crisis Services from 32 to 132 dispatches in Caroline County and from 25 to 189 dispatches in Dorchester County.

CORE DISEASE TARGETS AND CONDITIONS

After careful review of the data from SHIP, the HEZ interactive maps, the Office of Minority Health and Health Disparities, local sources such as Shore Health Systems, the Mid-Shore Mental Health Systems, Inc., Choptank Community Health Systems, Inc., law enforcement agencies, and Eastern Shore Mobile Crisis Services, the Connections Coalition has unanimously agreed to address the following core disease targets and conditions:

Core Disease	Current and Target Data	Local Conditions
Diabetes	Dorchester = 609.7 overall/ per 100,000 (2011) Dorchester Black citizens = 1272 Caroline = 394.1 overall / per 100,000 (2011) Caroline Black citizens = 1091 MD Target = 300.2 (2014)	Diabetes-related emergency department visits
	Dorchester Black citizens = 17% Dorchester White citizens = 32% Caroline Black citizens = 28% Caroline White citizens = 32% MD Target = 36% (2014)	Healthy weight of adults

	Dorchester overall = 18.1% Dorchester Black females = 20.2% Dorchester Black males = 22.51% Dorchester White males = 19.69% Caroline overall = 13.8% Caroline Black females = 16.51% Caroline Black males = 19.15% Caroline White males = 14.56% MD Target = 11.3% (2014)	Children and adolescents who are obese
Hypertension	Dorchester = 444.2 overall/ per 100,000 (2011) Dorchester Black citizens = 885/ per 100,000 (2010) Caroline = 218.3 overall / per 100,000 (2011) Caroline Black citizens = 611/ per 100,000 (2010) MD Target = 202.4 (2014)	Hypertension-related emergency department visits
	Dorchester Black citizens = 17% (2010) Dorchester White citizens = 32% (2010) Caroline Black citizens = 28% (2010) Caroline White citizens = 32% (2010) MD Target = 36% (2014)	Healthy weights of adults
Behavioral Health Concerns	Dorchester overall = 10,819.2/ per 100,000 (2011) Caroline overall = 6,992.1/ per 100,000 (2011) MD Target = 5,028.3 (2014)	Behavioral-related emergency department visits

Selection of core diseases and local conditions were based on the most recent prevalence rates provided by the Maryland Department of Health and Mental Hygiene. Where possible, rates pertaining to race or ethnicity and gender were also included to better enable local planners to fine tune strategies.

GOALS

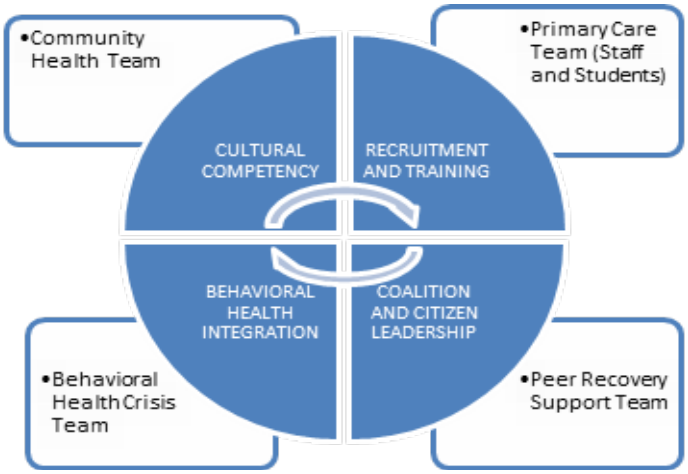
Goals for Competent Care Connections, serving the contiguous area from Cambridge in Dorchester County to Federalsburg in Caroline County are grouped address the two key components of health status and health care access. Required goals and corresponding outcomes are provided next.

Goals	Outcomes
1. Improved positive outcomes and reduced risk factor prevalence corresponding to Diabetes, Hypertension, and untreated Behavioral Health issues	A. Improve healthy weight of adults to MD target level of 36% by 2016. B. Reduce percentage of child and adolescent obesity to MD target level of 11.3% by 2016. C. Reduce incidence of Diabetes by 10% among target population seeking care by 2016. D. Reduce incidence of Hypertension by 10% among target population seeking care by 2016. E. Improve penetration rates of those eligible for behavioral health support and addiction recovery and those who actually receive treatment by 10% by 2016.
2. Expand the primary care workforce.	F. By 2013, increase primary care positions in the HEZ by at least 3.0 FTEs.
3. Increase the community health workforce	G. By 2013, increase community health workers in the HEZ by 5 individuals.
4. Increase community resources for health.	H. Increase opportunities for targeted citizens in the HEZ to access and utilize community resources that promote health and well-being including access to healthy food, opportunities for safe physical activity, resources to support optimal mental health, and resources to support addiction recovery.
5. Reduce preventable emergency department visits and hospitalizations.	I. Reduce or exceed diabetes-related emergency department visits to MD target level of 300.2 per 100,000 by 2016. J. Reduce or exceed hypertension-related emergency department visits to MD target level of 202.4 per 100,000 by 2016. K. Reduce or exceed behavioral health-related emergency department visits to the MD target level of 5,028.3 per 100,000 by 2016.
6. Reduce unnecessary costs in healthcare	L. Decrease unnecessary health care costs related to emergency room visits and preventable diseases by an annual % of 5% in year 1, 10% in year 2, 12% in year 3; 15% in year four.

Stated goals and outcomes are closely tied to the work and evaluation plans. For outcomes where ethnicity, gender, or geographical data are available, measures will be specific to these groups. For outcomes without stated baselines, the baselines will be researched and declared in the first year.

STRATEGIES for Indirect and Direct Care/ Access

The approach for fully addressing the declared goals within the Competent Care Connections (CCC) proposal utilizes an internal quadrant (INDIRECT care and access) of four key values guiding mobilization and implementation of this approach (cultural competency, coalition/citizen leadership, recruitment and training, behavioral health integration) and an external quadrant (DIRECT care and access) with four key components of service delivery strategies (primary care, community health outreach, behavioral health crisis, and peer (addiction/mental health) recovery support).



INDIRECT CARE/ACCESS STRATEGIES

Each of the four values displayed in the internal quadrant (indirect care) and associated strategies for Competent Care Connections are described next.

Value 1: <u>Cultural competency</u> must permeate throughout all communications, especially those between patient and provider, and throughout each consumer experience.

Cultural competence is the leading value for the stakeholders associated with the Competence Care Connections proposal. The Coalition acknowledges it as an area of weakness in primary care and behavioral health settings in the contiguous target area. While some providers do a better job than others utilizing contemporary best practices in cultural competence, it only takes a handful of incidents of demonstrated insensitivity to negatively influence the patient and care practitioner trust in a broader community – because word does get around more easily in rural communities. As evidenced by anecdotal testimony during recent public meetings in Dorchester County, there have been multiple incidents where minority or low-income patients felt demeaned and chose not to return to a health care office, unless it was an emergency, for fear of being disrespected or judged.

To prevent these detrimental experiences in the future and to achieve the desired priority outcome of improved cultural competence in healthcare settings, the Coalition will seek the training coordination expertise of the Eastern Shore Area Health Education Center (AHEC) to develop mandatory and interactive educational workshops for all partners receiving HEZ funding. Every other year beginning with the first year of this HEZ initiative, AHEC will organize a conference devoted to transferring best practices in cultural, linguistic, and health literacy standards for health care personnel and local agency employees such as social workers who frequently are in a position to refer clients to health care providers. Training content will include methods for

raising awareness regarding local demographics, health care needs, cultural/linguistic/ and social determinants of health, cultural differences in seeking and accepting treatment, limitations in literacy pertaining to health care (somatic and behavioral), limited English proficiency, and economic challenges for consumers to include communication, basic needs, and transportation. At least 40 project employees and health professional partners are targeted to attend each of the two cultural competency conferences. To support providers between conference years and when new employees are hired, AHEC will organize cultural competency orientation and booster sessions utilizing the best teaching resources. At least 20 project employees or partner employees will attend orientation or booster sessions annually.

Value 2: Coalition and citizen leadership is realized through authentic engagement. The "Connections Coalition" evolved from a meeting in June of 2012 to explore and verify the most pressing health care needs, to examine disparity in health care, and to develop strategies for response to the anticipated HEZ funding opportunity. Since that time, a total of 10 planning meetings were held in person, by conference call and/or with subgroups to study the needs data, determine service gaps, address cultural competency, select strategies, and negotiate with partners. Initially, 12 partners came together including the local hospital system, two county health departments, the Local Management Board, the mental health core service agency, Associated Black Charities, the Eastern Shore Area Health Education Center, Choptank Community Health System, two private non-profit organizations, a local business, and Delegate Addie Eckardt, from the Maryland House of Delegates. With the outreach generated from this planning process, another 25 partners is anticipated and includes private health care practitioners, faith centers, local law enforcement agencies, the Departments of Recreation and Parks, state agencies such as the Department of Social Services, local fresh food sources, local, colleges, and nationally-recognized health care institutions such as Johns Hopkins and the University of Maryland.

The second component of this value is authentic engagement of citizens. It is a priority of the Coalition to actively involve consumers of the proposed health care services in the Coalition and as future planners and project monitors. These opportunities will be much more than feedback sessions. Authentic participation of consumers involves intentional and compassionate solicitation and utilization of opinions and recommendations. This will be accomplished in several ways to include actual volunteer time, participation in surveys and focus groups, and recognition of citizens for their contributions. Citizen engagement and customer satisfaction will be incorporated in the process measures of the annual evaluation plan with results shared among volunteers, staff, coalition members, and funding sources.

Value 3: Behavioral health care integration with somatic care is essential to reducing emergency department visits and preventable diseases such as diabetes and hypertension.

At the February 2012 CDC's 20th National Conference on Chronic Disease Prevention and Control in Washington DC, the emphasis was on how mental health impacts physical health. Larke Huang, Ph.D., a senior advisor at Substance Abuse and Mental Health Services Administration who is currently detailed at CDC, said that statistics show in any given year, 26.2% of Americans aged 18 and older have a diagnosable mental disorder, and 45% of those have a comorbid, co-existing disorder. A 2006 study found that people with severe mental illnesses die, on average, 25 years earlier than the general population. According to Dr. Huang, "They are not dying of their mental health disorders and they are not dying of their addiction disorders, but they are dying of other kinds of chronic diseases. The early mortality is really linked to a lack of focus or negligence of their physical health disorders."

As a result of a wealth of evidence, the Centers for Disease Control is encouraging national, state, and local health care systems and policy makers to focus on the connection between co-existing behavioral health and chronic somatic diseases. Several leading healthcare models supporting this approach are emerging and include co-locating behavioral and physical health centers, assuring a mental health assessment is included in a physical

health check-up for patients, and increasing behavioral health community supports for patients with physical conditions such as heart disease, hypertension, diabetes, and obesity.

The Centers for Disease Control and the Office of Minority Health are urging state and local healthcare agencies to further consider and address the added burden of chronic disease among minorities due to limited access to both somatic and behavioral health services. Studies also show that exposure to discrimination causes increases in blood pressure and heart rate, but new research from around the world goes further, using advanced methods to examine how repeated experiences with racism are linked to more severe conditions such as coronary blockages and chronically elevated stress hormone levels. Targeted research has demonstrated a significant impact of societal stress for African Americans and the correlation between high stress hormone levels and poor birth outcomes. With high infant mortality and low birth weight rates in Dorchester County, especially among African Americans, linking behavioral health and somatic health care is especially important. A related study, recently published in the journal Health Psychology, examined links between discrimination-based stress in Black women and risk factors for heart disease and stroke.

The Connections Coalition wholeheartedly endorses a response to this HEZ opportunity that strengthens primary care and behavioral health care supports simultaneously. The beginning infrastructure is already in place with health systems such as Choptank Community, Shore Health, Mid-Shore Mental Health, and the Health Departments working in collaboration. The key is strengthening these systems and associated partners with improved capacity and a united mission of health equity. This proposal includes multiple strategies to emphasize the connection between physical and mental health and to address disparity within these two connected realms. Strategies include training primary care and first responder staff in behavioral health impact and resources, adding primary and behavioral health staff at the school based wellness centers, adding community-based behavioral health treatment supports for adults, connecting minority communities with resources through outreach workers, supporting consumers in optimal health decisions and follow up through case management, providing peer addiction recovery support, and supplementing behavioral health crisis response.

Value 4: <u>Recruitment and training</u> of committed health care professionals is central to delivery and retention of competent care.

Recruitment and training are vital to the success of this project and to sustaining the project results for the long term. Within this approach are three distinct opportunities for recruitment and training. First, the Eastern Shore Area Health Education Center (AHEC), as a key partner, is proposing to provide multiple layers of training to address the key principles of this approach and to support practitioners in being stronger health care providers. AHEC will implement trainings designed to cultivate interest and retention in health care careers for young citizens from middle school to college age. Second, Eastern Shore Mobile Crisis Services, with a goal to divert individuals with a mental health crisis from hospitalizations and incarceration, will provide training for law enforcement, detention center staff, and first responders in crisis awareness and response. Third, MedChi, a Maryland physician advocacy organization, will offer training (and incentives) to connect and attract primary care physicians to service in the HEZ communities. Each training opportunity is describe in more detail next:

<u>Eastern Shore Area Health Education Recruitment and Training</u>

The Eastern Shore Area Health Education Center (AHEC) will provide training addressing both primary care and behavioral health components of the Dorchester-Caroline HEZ. Other than the cultural competency and health literacy training described earlier in this narrative, AHEC proposes several recruitment and training opportunities for the purpose of priming high school and college-aged students for health care fields and for training the four teams of health care professionals affiliated with this proposal. To coordinate training, AHEC is requesting HEZ grant funding to support in coordination, supervision, and clerical time toward this project.

A) Community Health Outreach Workers (CHOW) Specialized Training
AHEC agrees to train 30 Community Health Outreach Workers in the HEZ area by providing 2.5 hours of training weekly for 16 weeks in Years 1 and 3, in addition to the onsite orientation CHOWs will receive from their sponsoring agencies. In Years 2 and 4 of this funding opportunity, AHEC will provide additional training to include special topics for continuing education. Based on a community-based participatory research (CBPR) study conducted by Catalani, et al there is consensus on the following core elements of the definition of CHOW: 1. CHOWs are trusted members of the community with a unique access to and understanding of the community. 2. This trust is vital to their work, descriptive of their practice, and inviolate. 3. CHOWs are public health professionals. 4. CHOWs work in a variety of environments on behalf of the community's health.

In this CBPR study, CHOWs uniformly expressed a need for training in two main empowerment areas: core competency and problem specific. Core competencies include the following: Communication, Professionalism, Compassion Fatigue, Community Organizing, Documentation, Cultural Competency, Motivational Interviewing, Conflict Resolution, Time Management, and Trauma Informed Care. Problem specific topics include: Behavioral Health, Substance Abuse, Insurance Enrollment, Smoking Cessation, Diabetes, Nutrition, Physical Exercise, and Hypertension. With this training area are concepts corresponding to targeted population groups such as ethnicity, gender, parent roles, caregiver roles, special needs, children, teens, and transitional aged youth. AHEC will seek local experts to instruct the CHOWs on topics as well, including the expertise of Maryland Healthy Weighs' Executive Director, Linda Breland, RN, MPH to provide a session on nutrition and physical activity. Speakers will also be invited to familiarize CHOWS with local health resources such as ways to access/grow fresh foods at low or no cost, free/low cost recreation and exercise opportunities, affordable housing contacts, and free/low cost behavioral/primary care support.

B. Behavioral Health Interdisciplinary Team Training (BHITT)
Health care students from local area colleges and universities will be recruited to participate in a one to two day didactic and experiential program at a selected behavioral health facility located in Caroline/Dorchester Counties. These include Mobil Crisis Services, Adventist Behavioral Health Residential Treatment Center (provides treatment for adolescents ages 12-18), Shore Health System's Psychiatric Unit (expanding to include pediatrics), Channel Markers, Inc. (provides psychiatric rehab services for adults and youth living in Caroline and Dorchester Counties), the Caroline County Mental Health Clinic, and the Eastern Shore Hospital Center (mental health facility with three psychiatric units and 60 beds under the jurisdiction of DHMH).

Components of BHITT team building, pharmacology, chart reviews, patient interviews, treatment planning, and guest speakers on behavioral health-related topics. Through this educational experience, students have the opportunity to increase their knowledge and skills about interdisciplinary teams and behavioral health patients and to interact with health care professionals and students from other disciplines/universities. An additional benefit of the program is exposing health professional students to rural community-based facilities and agencies to encourage future employment in these underserved areas. BHITT training will be provided free to at least 155 health care students (across 4 years) attending area colleges and universities (Chesapeake College, Wor-Wic Community College, University of Maryland Baltimore, University of MD Eastern Shore, Salisbury University, and Towson University). The training model is based on the success of the Geriatric Assessment Interdisciplinary Team (GAIT) training program. GAIT is funded through a University System of Maryland Redeployment Grant to the Geriatrics and Gerontology Education and Research (GGEAR) interprofessional program at the University of Maryland, Baltimore. Additional funding is provided by the Johns Hopkins Geriatric Education Center for nursing students attending community colleges on the Eastern Shore. Since 1997

the Eastern Shore Area Health Education Center (AHEC) has implemented 72 GAIT programs in all nine counties on the Eastern Shore with more than 800 health professional students from 14 different disciplines.

C. Behavioral Health Continuing Education Program

AHEC has over 15 years of experience providing quality continuing education (CE) programs for health professionals in the region. Since 1997, the Continuing Education program has held 415 programs with over 17,000 participants. The success of these programs is due to the strong collaborative partnerships that have been formed with health care providers, academic institutions and community organizations. Past AHEC behavioral health CE programs have been primarily for the people working in the behavioral health field, i.e. social workers and addictions counselors. There is a significant need to provide primary care providers (such as physicians, physician assistants, nurse practitioners, nurses, pharmacists, and certified nursing assistants) with education on behavioral health. This grant will allow AHEC the opportunity to address that need by offering two Behavioral Health CE programs for 60 primary care providers in each county in the service area per year for eight (8) total trainings in Years1-4.

AHEC has an Interdisciplinary Health Education Committee (IHEC) that can, along with Mid-Shore Mental Health Systems and other regional partners identify appropriate and timely behavioral health topics and potential speakers. Topics selected thus far include Trauma-Informed Care and Compassion Fatigue, which are both critically important to the sustained success of this project. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. Compassion Fatigue training helps professionals in the health care and social work fields to understand the characteristics, causes, risks, and resiliency strategies to prevent or reduce work-related stress. Other topics will include health literacy, social determinants of care, and cultural competency training (for those professionals outside this grant who may not attend the Cultural Competency Conference). Additionally AHEC in partnership with Mid-Shore Mental Health Systems will inform primary care providers about the services available by Eastern Shore Mobile Crisis Services. Expert speakers will be sought through AHEC's long-term relationship with the University of Maryland Baltimore and John Hopkins University. Continuing education credits would be provided for each of the disciplines identified, as well as resource materials for participants to take back to their office/organization. AHEC has many contacts to market the program including physician offices, local hospitals and CCHS, the only FQHC located in the target counties.

D. Health Careers Exploration Summer Camp

AHEC will provide two one-week health career exploration summer day camps targeting 50 Grade 7-10 students annually in Dorchester and Caroline counties who want to explore health careers and improve the health and well-being of their community. Efforts will be made to recruit minority and low income students into the program. AHEC will lead this effort due to 15 years of experience in K-12 Health Careers promotion throughout the Eastern Shore. The AHEC's Health Careers Program has made contact with over 63,000 students from grades K-12 since 1997. AHEC will work in partnership with the public middle and high schools, the new Dorchester Career and Technology Center (DCTC), and local public health agencies and health care organizations. DCTC offers state-of-the-art career and technology education; including medical service training.

The Summer Camp curriculum would be based on the nationally recognized Youth Health Service Corps and would address topics such as public health careers, clinical skills, cultural competency, experiential learning and medically underserved community engagement. The program would also be a springboard to enroll students into summer internships with local public health agencies offering students an opportunity to complete required community service hours. Transportation will be provided for the students to get to the training site and to transfer participants the different agencies they will visit/field trips during the one week session. Students will be recruited in Dorchester county grades 7-10 from the following schools: Cambridge South Dorchester, Maces Lane Middle School, North Dorchester Middle School and North Dorchester High School which accounts for

1,340 students of which 498 African American students. Caroline County students will be recruited from Colonel Richardson Middle and High Schools for a total of 498 students in grades 7-10 (140 African Amer.).

Eastern Shore Mobile Crisis Services Training

Over the years, law enforcement officers have become the front line in psychiatric emergency response. This has become especially true on the Eastern Shore where nearly all of the public mental health clinics have closed. When someone with serious mental illness experiences a psychiatric crisis they often act out as a result of their illness. Their behavior is frequently perceived as aggressive toward officers rather than protective of self because they often become fearful when confronted by law enforcement personnel. In one study, approximately 28% of people with serious mental illness were arrested in a 10-year period, and of these the majority of the arrests were for non-violent charges like crimes against the public order or property offenses. Once incarcerated, they may become more vulnerable to abuse and have increased difficulty reconnecting with services (such as Medicaid, Medicare) upon their release. As a result many individuals simply end up cycling between incarceration, shelters, emergency departments, and inpatient admissions.

Crisis Intervention Teams (CIT) were designed especially with all this in mind. The first CIT was established in Memphis, Tennessee in 1988 after a tragic shooting by a police officer of a man with serious mental illness. Today this model is replicated in 35 states nationwide. The CIT is community collaboration between mental health providers, law enforcement, and consumer advocates and families. Together, these organizations examine the community's needs, develop strategies for meeting those needs, and organize police training.

The training approach proposed as part of this HEZ application, is an Introduction to Behavioral Health for up to 175 law enforcement (every other year), emergency services personnel, school personnel, detention center personnel, emergency room personnel and Probation and Parole personnel. The Introduction to Behavioral Health training is 4 hour training. The curriculum includes: overview of basic mental health and addictions disorders; de-escalation and stabilization techniques specific to individuals with mental health and/or addictions (behavioral health) needs; Hearing Voices sensitivity training; role plays; consumer/family stories; Algorithm for use of resources; and cultural and social determinants considerations for minority citizens. Identified individuals who complete the Introduction to Behavioral Health course will be invited to participate in a 40-hour Crisis Intervention Team Training to further enhance the knowledge and expertise in this area. It is expected that up to 20 individuals annually will participate in the extended training. The final component to this will be the offering of bi-annual refresher courses for behavioral health and Crisis Intervention Team training.

Continuing Medical Education Training

The Maryland State Medical Society, or MedChi, is the largest physician association in Maryland with over 7,500 members. Since 1799 this non-profit organization has successfully performed advocacy, education, and practice support for physicians and their patients. Most recently, MedChi was a co-recipient of the Maryland Regional Extension Center grant. In that role, MedChi led outreach and training efforts that enrolled 1,500 eligible practitioners in the program, exceeding the target by 50%. MedChi is a member of the Connections Coalition and has offered to provide critical primary and behavioral health outreach to help position existing physicians or attract new physicians as providers of health care for individuals living in the HEZ. In addition to enriching primary care capacity (see Primary Care Team section), MedChi has offered to organize training to build the workforce skills and commitment to the mission of health equity by reducing health disparities in a community wide, team based approach to population health. At least six training sessions will be offered annually for up to 20 primary care providers per session.

After conducting an inventory of primary care providers and practices associated with serving the target community, MedChi will conduct outreach to the full continuum of health care providers in order to share public

health and population based data with the HEZ, including the baseline measurements and incremental benchmark measures for health outcomes and goals for the population served in the HEZ. While many providers likely agree with the mission, quantitative evidence is the first step in creating urgency to actively adopt the mission.

MedChi will coordinate opportunities for training in specific skill sets corresponding to the goals of this proposal and will offer Continuing Medical Education (CME) to HEZ located providers. The CME curriculum will be related to specific disease entities found as contributory to health disparities in the region, as well as topics to increase provider awareness of cultural and linguistic competency, health literacy, and social determinants of health. Beyond the competency topics, learning sessions to assist physicians in retaining and growing their practices will include subjects such as effective use of electronic health records to drive practice efficiency, practice management/workflow best practices, key metrics to review for a small practice, and care coordination programs and techniques. MedChi will locate and contract with highly rated and respected instructors to lead the learning sessions. These programs, in combination with other services, will foster an educated, activist health care community committed to serving the public.

DIRECT CARE STRATEGIES

Beyond training and recruitment which is designed to build future health care staffing support and strengthen the competency and capacity of existing health care professionals, are the direct care/access strategies. These consist of four teams: Community Health, Behavioral Health, Primary (Somatic) Care, and Peer Addiction Recovery. Each group is described next.

Strategy Area 1: BEHAVIORAL HEALTH TEAM

The high rate of ED visits for behavioral health, the astounding increase in Mobile Crisis Team dispatches, the increasing public mental health clients, and the disproportionate number of African Americans using emergency department services to attend to behavioral health needs – all combine to emphasize the critically vital need for greater availability and access to behavioral health support in Dorchester and Caroline Counties. Three interventions within this strategy area will directly address behavioral health needs: A) Expansion of Mobile Crisis Teams, B) Behavioral Health nurses posted from the Dorchester and Caroline County School Based Wellness Centers, and C) A full-time Behavioral Health specialist working from Federalsburg.

A. Mobile Crisis Team Expansion

Coming to the Eastern Shore in February of 2010, after the closure of Upper Shore Community Mental Health Center, Affiliated Sante Group (ASG), the largest provider of crisis services in Maryland, was awarded the contract from Mid Shore Mental Health Systems (MSMHS) to start Eastern Shore Mobile Crisis Services (ESMCS). ESMCS currently has two Mobile Crisis Teams serving eight of the nine Eastern Shore Counties, from 9am – midnight, seven days per week, 365 days per year. A Chestertown team serves Cecil, Kent, Queen Anne, and Talbot. The Salisbury team serves Caroline, Dorchester, Somerset and Wicomico counties. Eleven (11) FTEs currently provide this service, including the Director of the Program and Mobile Crisis Coordinator. Master of Social Work interns are also utilized, increasing the staffing capacity by one additional FTE. This intern program has been a substantial source of staff recruitment and retention, with six of the existing staff entering through the internship program.

The primary goal of ESMCS is to divert individuals from hospitalization and incarceration. Since starting in 2010, provision of services has drastically increased. There were 139 dispatches for service in FY10, 292 in FY11 and 832 in FY12. Based on penetration rates of population, Dorchester and Caroline counties are the counties where the most dispatches have been completed. There was a 100% diversion rate for incarceration in each of the fiscal years. There was an 81% Emergency Department diversion in FY10 and FY11, 89% in FY12.

The dollars that will be secured through the Health Enterprise Zone (HEZ) funding, will permit the expansion of ESMCS to add a team that will be specific to Dorchester and Caroline Counties. This team will be staffed 9am – 9pm, 7/365 with a two clinician model. In-kind Mobile Crisis services will be provided from 9pm – midnight by the Salisbury team. This will translate to 4.5 FTE clinicians and Coordinator/Director providing direct service response for this targeted service. An estimated 517 dispatches in the first year to 893 dispatches in the fourth year are expected to be associated with this additional behavioral health support in the HEZ target area. If 85% of the dispatches result in ED visit diversions, the savings across four years could be as much as $4,471,886.

Currently, without the HEZ funding and an additional mobile crisis team, ESMCS response time to Dorchester and Caroline County could be as much as 60 – 90 minutes, depending on where the team is in the four county service area. This is critical time in de-escalating and stabilizing a situation that could very possibly end up in the emergency room or local jail. Having a team based in Cambridge, serving the communities outlined in the HEZ area, could cut that response time down to 20-30 minutes or less in most situations (a vehicle is requested with this proposal). This is particularly crucial if law enforcement or emergency services personnel are called in and feel that their only option is an involuntary behavioral health emergency petition and trip to the emergency room. It should also be noted that immediate consumer follow up to ensure the stabilization of a crisis is provided for 72 hours and continued follow-up occurs for 30 days for consumers not currently linked with existing services.

B. School Based Wellness – Behavioral Health

The Dorchester and Caroline County Health Departments propose to expand primary care through increasing practitioner availability (currently three somatic care practitioners) in existing School Based Wellness Centers (SBWC) that serve high risk populations or Title I schools. According to the National Association of School-Based Health Centers (NASBHC), these programs have demonstrated that they attract harder-to-reach populations, especially minorities and males. One evaluation by Mathmatica Policy Research found a significant increase in health care access by students who used SBHCs: 71% of students reported having a health care visit in the past year compared to 59% of students who did not have access to a SBHC.

A .4 FTE Nurse Practitioner located at the School Based Wellness Center at Maces Lane Middle School in Cambridge and Cambridge South Dorchester High School could provide mental health treatment two days a week as well as medication evaluation and prescriptions for psychotropic medication, if indicated. There is currently only one Child and Adolescent Psychiatrist in Dorchester County and children wait two to three months for an intake appointment. If this position is funded by the HEZ grant, it would directly address the target population of 54% African American students, 6% other minority students, and 71% of all students who are low income according to the Free and Reduced Meal Program enrollment. SBHC staff will work with staff at the DCHD in the MD Children's Health Insurance Program to assist families in enrolling to determine eligibility. Students in need of Substance Abuse treatment will be referred to the Dorchester County Health Department's Addictions Program (DCAP), whose staff can see students on-site at the SBHC through an existing agreement between the two programs. If appropriate, students with mental health concerns can be referred to Channel Marker, Inc. for Psychiatric Rehab Program Services and their beneficial mentoring program. It is projected that the nurse would support 300-700 patient visits annually by students.

Caroline County Health Department proposes to provide one full-time Licensed Certified Social Worker in the three Federalsburg zip codes schools as part of the School Based Wellness Center. The schools are Federalsburg Elementary, Colonel Richardson Middle School, and Colonel Richardson High School. Students eligible for Free and Reduced Meals (FARMS) during 2011 made up 78% of the population at Federalsburg Elementary; 60% at Colonel Middle and 57% at Colonel High. Providing onsite treatment in the school setting allows for better access to care and treatment. One full-time licensed social worker, clinical (LCSW-C), could provide individual, family and group therapy including screening, diagnostic evaluations and crisis intervention; to children,

adolescents and families. By adding this position a focus could be placed on high risk patients who present with a great deal of complexity.

C. Community-Based Behavioral Health Support

A full-time Licensed Certified Social Worker is necessary to serve as a community-based clinician supporting therapy needs for adults from the 21632 zip code (Federalsburg) area. Currently, there is no public or private mental health professional providing services in the zip code. Citizens who are in need of therapy must travel to Denton, then endure a waiting list for one-two months, unless it is an urgent need situation. Social Workers at the Caroline County Mental Health Clinic, the only county run clinic on the shore, are currently managing a caseload of 100 resident clients each. The need for mental health treatment in Caroline County greatly outweighs the existing resources.

This position will represent an extension of the clinic to an office in Federalsburg, for the first time in the history of the clinic. Funding to support a .8 FTE clerical person is also included in this request. It is anticipated that the therapist will serve at least 120 different clients in Year 1 and this will increase to up to 170 clients by Year 4. The number of services provided is expected to range from 865 to 1,230 annually during the same four year time period. As with all facets of the HEZ project, the Social Worker in this position will be connected with primary care resources to be certain clients are improving physical health, along with their behavioral health progress.

Strategy Area 2: PRIMARY CARE TEAM

A. School-Based Wellness – Primary Care

Dorchester County Health Department proposes to hire a .6 FTE Nurse Practitioner located at the School Based Wellness Centers at Maces Lane Middle School in Cambridge and Cambridge South Dorchester and will work with existing staff (who are overwhelmed with student health needs) to provide somatic care three days a week. A risk factor for poor health outcomes was identified in a 2010-11 SBHC Project where Body Mass Index scores were calculated for students receiving services from the program. Thirty-two percent (32%) of MLMS students seen for somatic services had BMIs greater than 25, putting them at higher risk for heart disease, diabetes, and hypertension. This number grew to 45% of students treated at Cambridge-South Dorchester High School (CSDHS). There is clearly a need for intervention as related to childhood obesity, and Nurse Practitioners in School-Based Health Centers have a unique opportunity to provide health education and one-on-one coaching to adolescents. It is projected that the nurse would support 400-650 visits annually by students. SBHC staff will work with staff at the DCHD in the MD Children's Health Insurance Program to assist families in enrolling.

B. Shore Wellness Partners

An effective strategy to address health disparities in the HEZ is through the expansion of the Shore Wellness Partners program. Shore Wellness Partners (SWP), a community care management program, assists patients in managing their chronic diseases, such as diabetes and hypertension. This free program utilizes a team of nurses with advanced training and a medical social worker, who visit individuals in their homes, providing information, resource connections and enthusiastic support. This empowers the community care specialist, who is a nurse, and medical social worker to utilize their problem-solving skills to assist clients in becoming more involved in their own care, which leads to increased client self-management skills. Client participation in self-management is required to remain in the program. The Shore Wellness Partners program is based on a similar community care management program at Poudre Valley Hospital, Colorado, which showed an 81% reduction in financial losses to the organization during 2006 for emergency and inpatient services.

Shore Wellness Partners uses several best practice strategies to assist individuals with chronic diseases, such as coaching and teach-back method. First, staff members coach clients in attaining self-identified health goals by building client knowledge, skills, tools and self-confidence in self-care, which increases the client's self-

management skills. Second, the teach-back method evaluates a client's health literacy. Helping the client to be able to describe the information back substantiates his/her understanding of the communication.

Staffing currently consists of 4 full-time equivalent (FTE) registered nurses and one FTE medical social worker. The community case specialists cover clients in one designated county; however, the medical social worker's service area includes all four counties. For this initiative, an additional FTE for both a nurse and social worker would be added for the services areas of Lower Caroline and Dorchester Counties. The staff will work out of the current SWP location in Cambridge. In addition, the caseload for each clinical staff member will consist of approximately 45-55 clients per year. Staff members schedule the frequency of visits to best meet the client's needs, which could range from one to two times a week to monthly. Some clients could potentially be seen for over a year, depending on the need. For this strategy, the Shore Wellness target group would include clients 18 years of age or older who reside in the lower portion of Caroline and Dorchester Counties. Their primary diagnosis cannot be a psychological disorder other than depression and clients must be ineligible for home health or hospice services. In addition, prospective clients must have at least one chronic disease that makes self-care challenging and often results in the individual being admitted to the hospital. The sponsoring agency for this strategy would be Shore Health System. The proposed expansion for the SWP program would add an additional community case specialist and a medical social worker to focus on the Cambridge and Federalsburg areas and collaborating with other components of Competent Care Connections.

C. Primary Care Capacity Building

As the largest physician association in Maryland, the Maryland State Medical Society proposes to utilize their vast experience to expand access to primary care services in Dorchester and lower Caroline Counties for low income and minority individuals. Other than the training component described earlier in this proposal, MedChi proposes two key ways to improve access. First is to increase the number of primary care practitioners and the second is to assist physicians in building greater efficiency in their offices, leading to increased patient numbers.

With the assistance of a .15 FTE Program Director and a .5 FTE Coordinator, MedChi will engage in a number of actions to realize the objectives. Strategic incentives will be offered to attract and retain physicians to include loan repayment and tax credits. Both will only be available for practitioners who meet specific criteria, including starting or expanding practices that serve residents of the HEZ. Additional incentives will be provided for the meaningful use of certified electronic health records (EHRs). Although this will serve as an incentive to move practitioners to the HEZ, the primary intent is to create inter- and intra-office efficiency so those practitioners offering primary care services in the HEZ can serve additional patients.

Initial steps in this strategy must include conducting an inventory of existing practitioners, then surveying their offices to determine: patient load, payment methods, insurance options, participation in Medical Assistance, practice types, new patient policies, next available appointment times for acute care, average patient times with physicians, referrals and collaborations with behavioral health resources, prevention practices, demographics of patients, ethnicity of staff, ability of staff to speak languages other than English, understanding of health disparities, and cultural competency commitment/awareness. Physicians will also be asked about their desire to increase patient access. From the results of the survey, a profile of physician capacities will be generated. This will lead to the next phase of the program where physicians who meet certain capacity thresholds will be approached about incentive and training opportunities. Physicians who are interested in greater service to the HEZ community will become Competent Care Connections partners and will be guided by MedChi through a process of incentive support (where needed) and capacity building. It is anticipated that three to five physicians per year may be recruited to participate in capacity building. Meanwhile, MedChi will also be reaching out across and beyond the state to communicate incentives and benefits to potential primary care physicians who are interested in opening an new practice in Caroline or Dorchester County. MedChi will market quality of life

benefits, along with service satisfaction and the availability of incentives to attract new physicians. A projection of one physician per year is projected by MedChi to move into the HEZ community and open a practice.

Strategy Area 3: COMMUNITY HEALTH TEAM

The contribution made by community-based health care professionals to the health and well-being of communities is gaining recognition by public health practitioners, researchers, and organizations. Community health employees and volunteers work in many social service and health programs often managing a wide variety of functions. Across these diverse areas, they play a central and essential role in bridging the gap between health institutions and communities of color. Within this proposal, two organizations have offered to hire and guide Community Health Workers in varying functions. These are Associated Black Charities (4 Community Health Outreach Workers) and Healthy Weighs (1 Health Educator). Each program is described next.

A. Community Health Outreach Workers

Associated Black Charities (ABC), located in Cambridge, proposes to hire four (4) .5 FTE Community Health Outreach Workers to serve an average total of 200 citizens annually in Dorchester County and lower Caroline County. These essential workers will be an extension of HEZ program components (Shore Health Partners, School Based Wellness, Behavioral Health, Healthy Weighs, Mobile Crisis Unit, AHEC) as well as existing community resources designed to improve health status and health access by minority and low income citizens.

As a respected and widely popular non-profit organization in Dorchester and Caroline Counties, ABC envisions CHOWs as the primary strategy for PREVENTATIVE CARE. They describe their roles as follows "to educate the community prior to the need for urgent somatic care." ABC further recognizes and supports the need to change behaviors and cultural bias' of certain populations which will ultimately and positively affect the overall health outcomes of the entire specified HEZ. As coordinator for this component, ABC will follow the recommended best practices in the guides such as, "Integrating Evidence-Based Clinical and Community Strategies to Improve Health Methods" (U.S. Preventive Services Task Force) or the "Value of Effective Diabetes Management and Prevention (National Committee for Quality Assurance). They will monitor participants along with referring to primary and or health clinic care if no primary is acknowledged. ABC is committed to maintaining a strong hold within the community by working directly with grassroots programs - both community and faith based providing educational outreach, awareness campaigning and systems navigation assistance to those individuals requiring these resources. Additionally ABC will link with Shore Health Systems Emergency Departments to connect with those individuals initially seen, then follow-up with them regarding health education and behavioral changes to prevent further health status deterioration. CHOW staff will be scheduled for availability between 8 a.m. and 7 p.m. and weekend and nights as needed. Prior to their service to the community, the CHOWs will participate in an extensive training program that will include workshops provided by the Eastern Shore Area Health Education Center (describe earlier in this proposal).

C. Healthy Weighs

The health consequences associated with obesity, particularly diabetes and hypertension, are at the core of what's driving healthcare costs and utilization. Maryland Healthy Weighs offers an effective obesity treatment program for medically complex patients that ultimately improves patient outcomes, reduces healthcare utilization and lowers healthcare costs. Placing an emphasis on long-term weight and health management, the HMR Program utilizes intensive lifestyle education and coaching, accountability, and meal replacements to change the environment in which obesity develops in patients. The goal of the program is not only to promote weight loss but also improve patient health status. The core program, Phase 1, coaches patients through a low-calorie, medically supervised weight-loss phase that typically lasts from 12 to 20 weeks. This is followed by a longer weight maintenance phase (Phase 2). Extensive clinical research clearly demonstrates that meal replacements

favorably change the patients eating environment. Patients are placed in one of three levels of medical supervision (high, intermediate, moderate) based on their current medical status, body mass index (BMI), and risk factors in accordance with the HMR Medical Guidelines. Based on this evaluation, decisions are made regarding lab monitoring, EKG monitoring, frequency of physician and nurse visits, medication adjustments, and physical activity prescription.

Maryland Healthy Weighs has full time weight loss and weight maintenance classes in Cambridge, MD. The program is credentialed with most major insurances for the medical monitoring; some insurances (including Priority Partners) will also cover the cost of the weekly class. The food costs are reasonable at approximately $12-14 per day or $90-100/week; however, low-income patients still have difficulty with the weekly food costs. MHW does accept Care Credit which helps patients stretch the food costs out over time, interest free, if they have acceptable credit. The average food costs for a patient participating in Phase I for 16 weeks is $1500. MHW proposes to serve an additional 60 low-income, diabetic and/or hypertensive patients from the target population (HEZ) in the weight loss program over the next year (approximately 5 new patients/month). A full-time health educator will be hired to partner with Community Health Outreach Workers in recruiting patients to enroll in Healthy Weighs and providing ongoing encouragement and follow-up. MHW will discount the food costs for up to 60 low-income patients per year by approximately 33 percent to improve access to the program.

Strategy Area 4: PEER RECOVERY SUPPORT TEAM

Chesapeake Voyagers and the Dorchester County Health Department (Addictions Services) will work together to hire a full time and a half-time Peer Recovery Support Specialist. Both will be based at the DRI-DOCK (Dorchester Recovery Initiative) addictions recovery center in Cambridge, but will travel to other HEZ zip codes as needed (a vehicle is requested with this proposal). A Peer Recovery Support Specialist (PRSS) is a trained, self-identifying peer of the individual seeking support for alcohol or drug addiction recovery. Tasks performed by peer support specialists may include assisting up to 80 peers annually (120 total) in articulating their goals for recovery, support their peers in learning and practicing new skills, helping them monitor their progress, assisting them in their treatment, modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services. Toward achievement of the HEZ health care goals, the PRSSs will assist participants in job readiness, finding and maintaining employment, accessing health care, engaging in recreational activities, connecting to recovery community, accessing housing, and connecting to 12-Step and other Mutual Aid recovery support groups such as Trauma Support group, Emotions Anonymous, Women's Support group, etc. Both PRSS staff members will attend all pertinent AHEC trainings and will be supervised by a certified addictions counselor within the Dorchester County Health Department's Addictions Program These individuals will collaborate with other key components of the Competent Care Connections project to support peers in accessing and utilizing primary healthcare and other behavioral health components as needed.

USE OF INCENTIVES AND BENEFITS

Utilization of incentives and benefits to support the funding of the strategies featured in Competent Care Connections are listed in the following table by strategy area:

Strategy Area	Incentives and Benefits
Training and Recruitment coordinated by AHEC Cultural Competency Training Community Health Outreach Training Behavioral Health Interdisciplinary Team Training Behavioral Health Continuing Education Program Health Careers Exploration Training	Grant Funding for Innovation Public Health Strategies

Mobile Crisis Service Training	Grant Funding for Innovation Public Health Strategies
Continued Medical Education Training	Grant Funding for Innovation Public Health Strategies
Behavioral Health Team Mobile Crisis Team School-Based Wellness –Behavioral Health Community-Based Behavioral Health Support	Grant Funding for Innovation Public Health Strategies
Primary Care Team School-Based Wellness – Primary Care Shore Health Partners Primary Care Capacity Building	Grant Funding for Innovation Public Health Strategies (Below applicable to Primary Care Capacity Building-only) Tax Credits Against the State Income Tax; Hiring Tax Credits; Loan Repayment Assistance, Priority to Enter the State's Patient-Centered Medical Home Program; Grant Funds for Electronic Health Records
Community Health Team Community Health Outreach Healthy Weighs	Grant Funding for Innovation Public Health Strategies
Peer Recovery Support Team	Grant Funding for Innovation Public Health Strategies
Administrative Support of This Project	Grant Funding for Innovation Public Health Strategies

CULTURAL, LINGUISTIC AND HEALTH LITERACY COMPETENCY

Competency is the foundation of this proposed approach. The Connections Coalition fiercely supports the strategy recommendations for cultural, linguistic, and health literacy recommended by the Maryland Office of Minority Health and Health Disparities. Data pertaining to goals, outcomes and project process will be collected with special attention giving to racial and ethnic data collection, analysis, and reporting. Minority persons have and will continue to be involved in planning, outreach, program delivery, and services. Cultural, linguistic and health literacy competency will be the leading principle, immersed in every component of Competent Care Connections. The hired workforce will be racially and ethnically diverse and every effort will be made to secure bi-lingual employees to serve Spanish speaking customers. It will also be important that social determinants of health are used to guide program planning and service delivery. Clinicians practicing under this initiative will be required to complete "A Physician's Practical Guide to Culturally Competent Care", an on-line course supported by the Office of Minority Health at the United States Department of Health and Human Services. Information from the course will be utilized to assess current practice and make changes as indicated. In addition, guidance from the report titled, "Enhancing the Delivery of Health Care: Eliminating Health Disparities through a Culturally & Linguistically Centered Integrated Care Approach" (Office of Minority Health; Hogg Foundation for Mental Health, June 2012) will be relied upon when planned project details, if funding is awarded. When hiring staff and as consumer coalition members are identified, recruitment will take place within the target population. We will work closely with groups being served to assess program accomplishments, impact and determining need for improvements, through satisfactions surveys, focus groups, key informant interviews, and other means of gathering feedback regarding programming and services. We will rely heavily upon our partner, Associated Black Charities, to assist in providing cultural "reality checks" throughout the detail planning and implementation process. Their role in planning thus far has been instrumental.

APPLICANT ORGANIZATION AND KEY PERSONNEL

As the applicant organization, the Dorchester County Health Department is staffed with 130 people and operates a budget of $7.6 million. The following programs are provided for public consumption: Children's Health Program, Administrative Care/Ombudsman Program, Medical Transportation, Developmental Disabilities Program, Cancer Screening Program, School Based Wellness, Healthy Families Dorchester, Teen Pregnancy Program, Family Planning, Child and Maternal Health, Colonoscopy Screening Program, and the Addictions Program. The Health Officer, Roger Harrell declares his responsibility is to assure that essential public health services are provided to the citizens of Dorchester County. The Dorchester County Health Department is the administration applicant for this grant proposal and is a unit of the Maryland Department of Health and Mental

Hygiene (DHMH). As administrator for this project duties include accepting and monitoring grant funds, filing expenditure and programmatic reports as required, utilizing funds as prescribed and approved within the grant proposal, and assuring cultural relevancy in all aspects of the project. The Health Department is directed by the Health Officer, Roger Harrell, who has a Master's in Health Administration. Dr. James McAnulty serves as the Medical Consultant, under the Health Officer. The Department has six divisions: Administration, Environmental Health, Clinical/Case Management, Family Health, Health Education/Outreach, and the Addictions Program. Health Education

Administrative oversight for this project, if awarded will be provided by Sandy Wilson, who is the Health Education Program Manager for the Dorchester County Health Department. Ms. Wilson, along with Beth Spencer took the lead in coordinating the Coalition planning meetings and preparing this proposal. If project funds are awarded, a .5 FTE Project Director (Coordinator of Special Programs II) will be hired to facilitate the final planning and monitor the implementation of program components. This individual will work along with the Health Department's budget analyst, Cheryl Bailey, to ensure the proper distribution and expenditure of funds by the Coalition partners. A 1.0 FTE Office Clerk is included in the budget to exclusively work with this project. Other key project personnel are listed next, along with their major duties (resumes and job descriptions are attached to this proposal).

Training and Recruitment (Area Health Education Center)

.20 FTE Health Careers Coordinator (Cyndi Slacum): Coordinates marketing, recruitment and logistics of training for middle school and high school youth

.80 FTE Behavioral Health Interdisciplinary Team Training Coordinator (Vacant): Recruits participants and coordinates logistics of training for college students;

.12 FTE Program Monitor (Megan Holthoff): Supervises and facilitates training coordination; Collects project data; Advises regarding training best practices

Mobile Crisis Training and Team (Eastern Shore Mobile Crisis Services)

2.1 FTE Mobile Crisis Team Specialist, LCSW-C (Vacant): Assess and evaluate, perform crisis intervention techniques, and develop a crisis plan for continuation of services related to the client involved.

2.3 FTE Mobile Crisis Team Specialist, LCSW-C (Vacant): Same as above

.5 FTE MCT Program Coordinator (Vacant): Responsible for the daily operation of the mobile crisis program, providing clinical assessment and evaluation services, and supervising the MCT specialists

Continued Medical Education Training/ Primary Care Capacity Building (MedChi)

.15 FTE Program Director (Craig Behm): Supervises coordinator and is lead for recruiting physicians as primary care providers in the HEZ community

.50 FTE Coordinator (Colleen George): Facilitates coordination of physician training opportunities and CEU authorizations; Supports director in recruitment of primary care providers in the HEZ community

School Based Wellness – Behavioral/Primary Care (Dorchester/ Caroline County Health Depts.)

.4 FTE Nurse Practitioner/Behavioral Health (Vacant): Provide mental health assessment & treatment, including individual, family & group sessions; evaluate need for psychotropic medication, prescribe & monitor.

.6 FTE Nurse Practitioner/Primary Care (Vacant): Provide acute care, follow-up, Well Care Visits & Health Education to middle/high school population. Assess for substance abuse. Coordinate care with parent/guardian & primary care provider. Refer for additional services as needed.

1.0 FTE Social Worker, LCSW (Vacant): To provide individual, family and group therapy including screening, diagnostic evaluations and crisis intervention; in all required settings to children, adolescents and adults who have a DSM IV diagnosis in order to enhance their global functioning.

Community-Based Behavioral Health (Caroline County Health Department)

1.0 FTE Social Worker (Vacant): To provide individual, family and group therapy including screening, diagnostic evaluations and crisis intervention; in all required settings to children, adolescents and adults who have a DSM IV diagnosis in order to enhance their global functioning.

.8 FTE Office Clerk (Vacant); Provide administrative office support to the social worker.

Shore Health Partners (Shore Health Systems, Inc.)

1.0 FTE Community Care Specialist, RN (Vacant): Responsible for establishing relationships with clients in the community to facilitate appropriate use of resources, access system and community services and communication with the health care team.

1.0 FTE Medical Social Worker (Vacant): Provides social work services to referred clients to enhance medical treatment, support and maximize the psychosocial functioning and adjustment of clients through phone calls and home visits. Counsels clients, families, and significant others to promote optimal social functioning.

Community Health Outreach(Associated Black Charities)

.65 FTE Community Health Outreach Program Director (Ashyrra Dotson): Serves as a minority consultant to the Connections Coalition; Facilitates detailed planning and training for Community Health Outreach Workers (CHOWS); Recruits and supervises CHOWS

2.0 FTE (four .5 FTEs) Community Health Outreach Workers (Vacant): Attends CHOW and other training opportunities; Becomes completely familiar with community resources; Presents key program information to community groups, faith centers, public agencies, non-profit groups, small businesses, etc.; Works with partners to receive referrals; Recruits referrals in the community; Provides informational and supportive presence to clients

Healthy Weighs (Maryland Healthy Weighs)

1.0 Health Educator (Vacant): Markets program (along with Community Health Outreach Workers) to the target community; Provides health education information regarding nutrition, exercise and weight management to customers; Supports customers in understanding program and achieving goals

Peer Recovery Support (Chesapeake Voyagers, Dorchester County Health Department)

.5 FTE Peer Recovery Support Specialist (Vacant): Provides recovery experience (must have two years clean and sober); Will provide guidance and support to recovering peers in all aspects of recovery model, in acquiring community resources, in accessing primary and behavioral health care, and in meeting personal employment and education goals; Modeling effective coping techniques and self-help strategies

COALITION GOVERNANCE AND PARTICIPATING PARTNERS

At least 17 partners will comprise the fully implemented Connections Coalition, once funding is awarded. Two minority members currently serve representing partner agencies and two minority consumer members will be added to the roster once the program is initiated. Prior to this proposal, 15 partners have been engaged and have contributed their experiences, skills, and knowledge to the development of this proposal. The Dorchester County Health Department will serve as the Coalition home and provide staffing support to the project. Partners and key roles are provided in the following table.

Organization and Name	Key Roles and Responsibilities
Associated Black Charities Ashyrra Dotson	Competency consultant to Coalition; Program lead and supervisor for Community Health Outreach Workers; In-kind office support
Caroline County Health Department Dr. Leland Spencer	Coalition member; Program lead for School Based Wellness Center component; Provides in-kind meeting space
Caroline County Mental Health Clinic Mike Campbell	Coalition member; Supervises community-based behavioral health (in-kind)
Chesapeake Voyagers Diane Lane	Coalition member; Program co-lead for Peer Recovery Support; Provides in-kind supervision/office space for Peer Recovery Program
Choptank Community Health Systems	Coalition member; Assistance with consumer recruitment/referral; Provides in-kind

Sara Rich	meeting space; Markets training
Dorchester County Health Department Roger Harrell, Sandy Wilson	Coalition member; Serves as administrative agency; Provides in-kind meeting space; Supervises School-Based Wellness component; Supervises evaluation procedures; Files quarterly reports
Dorchester Local Management Board Nancy Shockley	Coalition member; Resource builder; Assists (in-kind) with sustainability strategies and performance measures
DRI-DOCK Dorchester Addictions Program	Coalition member; Co-Lead agency for Peer Support Team; Provides in-kind supervision, office space, meeting space
ES Area Health Education Center Jake Frego	Coalition member; Lead agency for AHEC training components; Provides supervision and in-kind meeting space for training
Eastern Shore Mobile Crisis Services – Affiliated Sante Group Carole Masden	Coalition member; Lead agency for Mobile Crisis Team and Training; Provides supervision and monitoring for Mobile Crisis Team members; Coordinates logistics of trainings for law enforcement
Maryland Healthy Weighs Brie Brieland, RN	Coalition member; Lead agency for Healthy Weighs; Provides in-kind office space/ supplies/ supervision for Health Educator
Maryland House of Delegates Hon. Addie Eckardt	Coalition member; Provides in-kind volunteer support as former RN; Assists with sustainability strategies
Maryland State Medical Society Craig Behm	Coalition member: Lead agency for Physician Training and Primary Care Capacity Building; Provides recruitment and engagement with physicians
Mid-Shore Mental Health Systems Holly Ireland	Coalition member; Provides in-kind meeting space as needed; Provides in-kind assistance with sustainability strategies and data collection
Shore Health Systems Kathleen McGrath and Sharon Stagg	Coalition member; Lead agency for Shore Health Partners; Provides in-kind supervision of their component; Assists with project data collection
Consumer Members To Be Determine	Coalition members; Assists with "reality checks" to ensure consumer-driven decisions are made and enforced; Advises re: health equity

WORKPLAN CHART -The workplan chart for Competent Care Connections is attached to this proposal.

EVALUATION PLAN

The Dorchester County Health Department will contract with a local qualified evaluator (university affiliated, if possible) and fully cooperate with state quarterly and annual reporting requirements. Internal evaluation methods will also be employed and will include both process and outcome evaluation. Process evaluation will include a search of recommended participant and partner surveys designed to assess cultural competency and program quality and to determine if the aim of health access has been achieved. Focus groups and/or key informant interviews to include key stakeholders will also be conducted with information compiled from the surveys and the other soft data methods to determine program strengths and challenges. On the quantitative side, hard data collection will include compiling measures in responses to goals and stated objectives (see goals section) to determine if improved health status has been achieved. Both behavioral health and physical health status will be tracked and collectively noted using valid and reliable outcome evaluation procedures, many of which may be borrowed from model integration programs.

The following table includes a list of performance measures (or benchmarks) that lead agencies have suggested tracking for this project. It is not intended to be an exhaustive list as a local evaluator will help to establish a more complete list, based on reliable and valid indicators.

Component	Anticipated Measures Beyond Goals and Objectives
Training and Recruitment	<u>Cultural Competency Training</u> 1) Participation rates and demographic data; 2) Number and length of training sessions; 3) Knowledge and skills of cultural competency principles; 4) Attitudes toward cultural/linguistic competency and health literacy <u>CHOW Training</u> 1) Participation rates and demographic data; 2) Number and length of training sessions (contact hours); 3) Knowledge and core competencies; 4) Knowledge of community resources; 5) Personal confidence levels as a Community Health Outreach Worker; 6) Successful completion of courses; 7) Satisfaction of CHOW performance by employer agencies <u>Behavioral Health Interdisciplinary Team (BHITT)</u>

	1) Participation rates and demographic data (including participation by outside CCC staff such as Certified Nursing Assistances, law enforcement personnel, medical personnel, and First Responders); 2) Student knowledge and skills of interdisciplinary teams; 3) Student knowledge and skills related to behavioral health patient assessment and treatment; 4) Attitudes towards behavioral health patients; 5) Referrals to behavioral health resources including Mobile Crisis Team, DRI-Dock, and community/school resources Behavioral Health Continuing Education Program 1) Participation rates and demographic data (including participation by outside CCC staff such as Certified Nursing Assistances and other medical personnel (A separate first responder training is targeted for 175 people); 2) Student knowledge and skills of interdisciplinary teams; 3) Student knowledge and skills related to behavioral health patient assessment and treatment; 4) Attitudes towards behavioral health patients; 5) Referrals to behavioral health resources including Mobile Crisis Team, DRI-Dock, and community/school resources Health Careers Exploration Camp 1) Participation rates and demographic data; 2) Outcome-oriented pre and post qualitative student and parent surveys; 3) Partner agency assessment; 4) tracking college major, study areas, employment of participants to evaluate long term impact of health careers training; 5) Annual survey to high schools to track health career goals of graduates; 6) Number of health career scholarships awarded to seniors (and demographics) Mobile Crisis Training 1) Number and demographics of participants; 2) Number of law enforcement (and other agency) representatives who have completed training; 3) Pre and post knowledge and practice surveys; 4) Data collected to determine diversions as a result of training Continued Medical Education Training 1) Participation rates and demographic data; 2) Outcome-oriented pre and post qualitative surveys; 3)# of CEUs
Community Health Team	1) Number and demographics of Community Health Outreach Workers and Community Health Educator; 2) Number of training hours; 3) Number of clients supported;4) Number of resources connected to clients 5) Pre and post weights and BMI measures of clients; 6) Other health status trends; 7) Number of connections with primary care/ behavioral health professionals
Primary Care Team	1) Number and demographics of Primary Care participants; 2) Number and demographics of Primary Care Team staff; 3) Trends in health status indicators for clients; 4) Number of physician inquiries about incentives/benefits and adding or starting primary care practices in HEZ; 5) Amount of benefits utilized; 6) Improvements in health status (diabetes, hypertension, weight, etc.)
Mobile Crisis Team	1) Number and demographics of participants served; 2) Number and demographics of Mobile Crisis Team members; 3)Referrals to Mobile Crisis Team/ Number of dispatches annually; 4) Providers that receive Mobil Crisis Team materials; 5) Percent diverted from the Emergency Department (target = 85%) 6) Response time for calls (Target = 30 minutes); 7) # and nature of 72 hour follow up support; 8) # and nature of 30 day follow up support to consumers
Peer Support Recovery T	1) Number and demographics of participants served; 2) Referrals to the DRI Dock Peer Recovery Specialists; 3) Number and nature of connections between peers and community resources; 4) Number of sessions with Peer Recovery Specialists; 5) Number of connections to primary care

A data review group of partner representatives within the Connections Coalition will work along with the local evaluator to determine final measures and data collection methods. Confidentiality and releases of information will be addressed. A final report of evaluation findings will be released annually to funders and the public by the Coalition and partners. The evaluation report will include information on cultural competency changes and an assessment of program implementation, lessons learned patient experience, quality improvements, clinical outcomes, and estimates of cost savings.

SUSTAINABILITY

Partners have considered sustainability at length and developed preliminary plans specific to their agencies. The following suggestions were offered to sustain funding after four years:

Associated Black Charities: ABC will continue to seek and procure funding to support its services throughout the community through the Center for Disease Prevention, DHMH, the Quality Health Foundation and a number of local and state funders supporting the reduction of diabetes incidences and obesity awareness, education and prevention.

Dorchester/Caroline Health Departments: Reimbursements combined with existing grant funds from the MD State Department of Education may help to sustain the School Based Wellness Programs. Establishment of an Electronic Medical Record will allow for more efficient billing processes and increase in collections. As the Recovery Oriented Systems of Care (ROSC) systemic transformation continues to unfold across the nation and across Maryland, the Alcohol & Drug Abuse Administration, Mental Health Administration, and DHMH have committed to increasingly provide financial support and increased funding for Recovery Community Centers and for Behavioral Health Peer Support efforts.

Eastern Shore Area Health Education Center: AHEC will continue to work with its regional academic partners in hopes to incorporate proposed curriculums of the different health professional disciplines, as this has been done for some academic departments for AHEC's GAIT program. Additionally, AHEC will utilize the Sustainability Toolkit: 10 Steps to Maintaining Your Community Improvements developed by the Center for Civic Partnerships. The tool will provide the necessary guidance to establish a long-term sustainability plan to continue the programs initiated by this funding stream.. Furthermore, Dr. Jay A. Perman, the President of the University of Maryland, Baltimore recognizes that all health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches and informatics. AHEC's strong partnership with UMB will continue to grow under the leadership of Dr. Perman and AHEC foresees increased collaboration in interdisciplinary educational and training opportunities to include potential UMB funding. AHEC will work with its academic, health care organization partners, and regional professional societies to sustain funding for the CE programs outlined in this proposal, additionally participant fees for these CE events will help offset some of the costs accrued.

Eastern Shore Mobile Crisis Unit: There is a commitment to investigate and pursue private funding sources such as the Weinberg Foundation, Byrne Foundation, Community Foundation of the Eastern Shore, the Mid-Shore Foundation, and SAMHSA grant opportunities. Affiliated Sante Group including Eastern Shore Mobile Crisis is an active member of a Behavioral Health Administration Committee currently exploring possible financing options for Mobile Crisis and other components of a Crisis Response System continuum including but not limited to: Including the service as part of the Wellness and Prevention portion of the essential benefits package; Adding a soft billing component similar to community ambulances, and; Adding line item allocation in the Behavioral Health Administration budget of DHMH

Maryland Healthy Weighs: Over the 4 year period, it is anticipated that enough data will be generated to show cost effectiveness of covering program food costs that the argument can be made to insurance companies to assist with food costs as well as medical service costs.

Shore Health Systems: Once the grant period is complete, the two positions obtained from the grant would be absorbed into Shore Wellness Partners by Shore Health System.

PROGRAM BUDGET AND JUSTIFICATION The budget and budget justification are attached.

STATE OF MARYLAND

Department of Health and Mental Hygiene

Martin O' Malley, Governor - Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Maryland Department of Health and Mental Hygiene
Office of the Inspector General, External Audits Division
605 S. Chapel Gate Lane (Old School Bldg.) Baltimore, Maryland 21229
Joseph M. Budzynski, Chief, External Audits Division

February 25, 2010

Roger Harrell, MPA, Health Officer
Dorchester Health Department
3 Cedar Street
Cambridge, Maryland 21613

Re: Audit Job Number: 398

Dear Mr. Harrell:

The Office of the Inspector General's External Audit Division has examined the accounts and records of Dorchester County Health Department's (DCHD) relative to its contracts (Schedule SC), for the period of July 1, 2005 through June 30, 2009, with the following Department of Health and Mental Hygiene Administrations (DHMH).

- **Formally AIDS Administration**
- **Alcohol and Drug Abuse Administration**
- **Formally Community Health Administration**
- **Developmental Disabilities Administration**
- **Family Health Administration**
- **Office of Health Services Administration**
- **Office of Emergency Preparedness and Response**

I. Objectives of the Examination

A. To determine the amount of revenue received and allowable expenditures incurred by DCHD for the above-mentioned contracts.

B. To determine that DCHD's financial matters were conducted in accordance with the Department of Health and Mental Hygiene's Local Health Department Funding System Manual, and the approved contracts.

C. To determine any amount due to or from the DHMH for the services provided by DCHD.

D. To determine if the State's expenditures for targeted health services were matched as required under the terms of DCHD's ''Core Services Funding" agreement.

E. To report information that might be of assistance in the operation of programs funded by the above-mentioned contracts.

F. Our examination also included a determination of the current status of three recommendations contained in our audit report, dated June 8, 2006.

II. Presentation of Audit Schedule

This report contains the following schedule:

- Schedule SC: Schedule of Contracts Audited lists all Dorchester County Health Department contracts by Administration included in the audit.

III. Comments and Recommendations

A. Internal Control

DCHD's management is responsible for establishing and maintaining effective internal control. Internal control is a process designed to provide reasonable assurance that objectives pertaining to the reliability of financial records, effectiveness and efficiency of operations including safeguarding of assets, and compliance with applicable laws, rules, and regulations are achieved. Our review of DCHD's internal control system would not necessarily disclose all material weaknesses.

Because of inherent limitations in internal control, errors or fraud may nevertheless occur and not be detected. Also, projections of any evaluation of internal control to future periods are subject to the risk that conditions may change or compliance with policies and procedures may deteriorate.

This report includes findings relating to conditions that we consider being deficient in the design or operation of internal control that could adversely affect DCHD's ability to maintain reliable financial records, operate effectively and efficiently, and/or comply with applicable laws, rules, and regulations. Our report also includes findings regarding instances of noncompliance with applicable laws and regulations. Other less significant findings were communicated to DCHD that did not warrant inclusion in this report.

Our reports are designed to assist DHMH in exercising its oversight functions and to provide constructive recommendations for improving State operations. As a result, our reports generally do not address activities we reviewed that are functioning properly.

Our audit revealed the following weaknesses.

Test of Fee Collections:

During the review of collections the following area of concern was note:

- All collections were not deposited by the first business day following receipt. Comptroller of the Treasury Accounting Procedures Manual section 3.2.1 Cash Receipts Deposit states, "All receipts must be deposited intact no later than the first working day after the day of receipt; however, the preferred method is to deposit on the day received, especially when larger amounts are involved."

  We recommend that all payments received by DCHD be deposited in the bank by the next day of business following receipt.

B. Prior Audit Report

We have determined that Dorchester County Health Department has satisfactorily addressed all of the findings contained in our June 8, 2006 audit report.

IV. Conclusion

As a result of procedures performed in accordance with the examination objectives set forth above, it was determined that no money is due either party.

Please submit a written corrective action plan by March 26, 2010 that addresses a time frame for compliance for each recommendation made in this Audit Report. If you wish to appeal any of the audit findings, you must notify John Nathan, Cost Accounting and Reimbursement, 410-767-7057 or JNathan@dhmh.state.md.us in writing within 30 days of receipt of this report.

We would like to take this opportunity to thank the staff of Dorchester County Health Department for their cooperation and assistance during our examination.

Respectfully submitted,

Signature on file

Joseph M. Budzynski
Chief, Office of the Inspector General's External Audit Division

Signature on file

Efrain Delgado
Supervisor, Office of the Inspector General's External Audit Division

C: Thomas Russell, Inspector General, Office of the Inspector General
Ellwood Hall, Assistant Inspector General, Office of the Inspector General
Thomas Cargiulo, Director, Alcohol and Drug Abuse Administration
Heather Hauck, Director, Infectious Disease and Environmental Health Administration
Sherry Adams, R.N. B.S. CPM, Director, Office of Emergency Preparedness and Response
Russell Moy, M.D., Director, Family Health Administration
Susan Tucker, Director, Office of Health Services Administration
Carlessia Hussein, Ph.D., Director, Cigarette Restitution Fund Program
Donna Gugel, Acting Director, Center for Cancer Surveillance and Control
Michael S. Chapman, Director, Developmental Disabilities Administration
John Nathan, Settlement Officer, Division of Cost Accounting
Greg Jones, Sr., Deputy Chief, Division of General Accounting
Stephen Ayers, Lead Auditor, Audit Division
Kelly Carter, Auditor, Audit Division
File

Eastern Shore Area Health Education Center
BIOGRAPHICAL SKETCHES FOR KEY PERSONNEL

Megan Morse Holthoff, MSHS, Program Monitor: Ms. Holthoff came to AHEC with 14 years of experience in clinical research project management. Prior to coming to AHEC, Ms. Holthoff worked in the academic medical setting serving in a variety of roles: Research Study Coordinator, Project Manager and Regulatory Manager at the University of Vermont and George Washington University. Primary responsibilities included managing projects from inception to completion, following timelines, operating budgets, hiring and managing staff. Ms. Holthoff received a Masters of Science in Health Sciences from George Washington University and a BS in Biology from Hobart and William Smith Colleges. In February 2011, Ms. Holthoff joined AHEC with primary responsibility of program development, process improvement and program evaluation.

Cyndi Slacum, Health Careers Coordinator: Ms. Slacum, with a Bachelors of Arts from the University of Maryland, joined AHEC in 1997 as Health Careers Coordinator. Ms. Slacum's primary responsibility is to begin building the health career pipeline in the 9-County Eastern Shore Region by informing K-12 students in health career opportunities. Activities include visiting different schools and grade levels to share information on opportunities in health careers; participate and/or organize job fairs; aid in the facilitation of student entry into health professions schools and programs; organize health care site visits and student shadowing opportunities.

JOB DESCRIPTION – Behavioral Health
Interdisciplinary Team Training (BHITT) Coordinator
Eastern Shore Area Health Education Center (ESAHEC)

A. PRIMARY FUNCTION

To coordinate, promote and recruit for the Behavioral Health Interdisciplinary Team Training.

B. GENERAL REQUIREMENTS

To work as part of the ESAHEC team to recruit and retain health professionals in the medically underserved areas on the Eastern Shore and offers health care education programs for health professionals in the service area and students from colleges and universities in Maryland and surrounding areas.

C. ESSENTIAL FUNCTIONS/EXAMPLES OF DUTIES

1. Provide ongoing communication with faculty and advisors.
2. Maintain an updated faculty/advisor mailing list.
3. Recruit students and coordinate their registrations for all BHITT programs.
4. Coordinate hotel accommodations and meals for registered students and other participants.
5. Schedule qualified speakers for each program and follow-up with written confirmation.
6. Work with representatives at host sites to schedule and plan individual programs.
7. Update BHITT materials as needed.
8. Ensure that all documentation is completed by students attending each BHITT project.
9. Be present to facilitate all programs on day(s) scheduled.
10. Summarize evaluations, pre/post tests and participant information after each BHITT training session.
11. Submit press releases, photographs and captions to local newspapers after each program.
12. Send Thank You letters after each program to all speakers and host site representatives.
13. Submit all receipts for cash advances and program expenses to the Accountant in a timely manner.
14. Provide a report on each program to the AHEC's Executive Director and Program Evaluator.
15. Oversee budget(s) to ensure that grant funds are not exceeded.
16. Maintain good working relationships with other AHEC staff, faculty and advisors, board members, the health care community and funding sources.
17. Submit articles and photographs for AHEC newsletters and annual report.
18. Attend AHEC staff meetings or provide a written report if unable to attend.

JOB DESCRIPTION – Community Care Specialist
Shore Health System: Community Case Management

A. PRIMARY FUNCTION:

This position is responsible for establishing relationships with clients in the community to facilitate appropriate use of resources, access system and community services and communication with the health care team.

B. GENERAL REQUIREMENTS

1. The CCM-client partnership is designed to improve self care abilities and achieve optimal health for the client.
2. Services include preventative care, health promotion and education accomplished through phone calls and home visits.
3. Utilizes advanced specialty skills to partner with clients throughout the health continuum.
4. Employs a broadened professional perspective to serve as an expert in the education of clients, staff, and community regarding the change process and current health care options.

C. ESSENTIAL FUNCTIONS/EXAMPLES OF DUTIES

1. Assesses client needs, health patterns, and coping skills to identify priorities for case management.
2. Educates and coaches clients, family and significant others to help develop self-care skills and independence.
3. Promotes increased client competence and coping through treatment plans that include education and referral to other necessary resources.
4. Collaborates with client, family, significant others, health care providers and agencies using multidisciplinary, holistic approach to help the client set goals and achieve desired outcomes.
5. Utilizes community resources in the most cost effective manner to best meet clients' developmental, physical, psychosocial, environmental, spiritual, cultural and financial needs.
6. Maintains documentation of client, family, significant others, and medical interactions, consultations and collaboration.
7. Participates in community presentations/education/groups related to case management/disease issues.
8. Assists the client to utilize the health care system appropriately.
9. Participates in program development and improvement through policy and protocol development, budgeting, marketing, research, quality improvement, orientation, staff development, competency and tracking of the community case management program.

JOB DESCRIPTION – Community Health Outreach Worker
Associated Black Charities: Community Health Outreach Project

A. PRIMARY FUNCTION
The primary function of the Community Health Outreach Worker (CHOW) is to serve as a liaison between individuals in need and health and social services providers.

B. GENERAL REQUIREMENTS
Provide direct service, including education and advocacy to enhance the individual's behavioral, psychological and somatic well-being.

C. ESSENTIAL FUNCTIONS/EXAMPLES OF DUTIES
1. Complete Community Health Outreach Worker certificate program.
2. Assist with patient recruitment with a focus on populations experiencing health disparities.
3. Plan, organize and participate in community outreach utilizing culturally and linguistically competent methods.
4. Assist patients in applying for applicable programs for medical, financial or social support and follow-up as needed.
5. Manage paperwork to meet patient care needs including but not limited to: home health services, nursing home referral, and specialty consultation referrals.
6. Provide data for program reports as required by grant guidelines.
7. Other duties as assigned.

JOB DESCRIPTION – Community Outreach Director
Associated Black Charities: Community Health Outreach Project

A. PRIMARY FUNCTION

The primary function of the Community Outreach Director is to develop, implement, act as a liaison between individuals in need and health and social services providers, provide guidance to Community Health Outreach Workers and oversight to the Community Health Outreach Project (CHOP) to serve minority populations in designated zip codes of Dorchester and Caroline Counties with existing health disparities.

B. GENERAL REQUIREMENTS

1. Direct all aspects of the Community Health Outreach Project including recruitment, planning, implementation and evaluation.
2. Collaborate with community partners to facilitate referral of patients for CHOP services.
3. Promote CHOP services through communications with private providers, social services agencies, community programs and faith-based organizations.
4. Maintain awareness of research and publications related to health promotion and disease prevention.

C. ESSENTIAL FUNCTIONS/EXAMPLES OF DUTIES

1. Recruit and hire qualified individuals to serve as Community Health Outreach Workers (CHOW).
2. Serve as preceptor to CHOW staff, both paid and volunteer, in formal, structured programs.
3. Supervise CHOW students, trainees and volunteers in clinic and community settings.
4. Partner with Eastern Shore Area Health Education Center (ESAHEC) to insure staff complete required certificate program.
5. Assist with patient recruitment with a focus on populations experiencing health disparities.
6. Plan, organize and participate in community outreach utilizing culturally and linguistically competent methods.
7. Counsel individuals, families, and/or groups to engage in health promotion and disease prevention activities.
8. Collect and analyze data on clinical service provided to diverse populations and identify barriers to healthcare access.
9. Provide data as required by grant guidelines.

JOB DESCRIPTION – Competent Care Connections Coordinator
Dorchester County Health Department: Health Education Division

A. PRIMARY FUNCTION:

The main purpose of this position is to provide coordination and oversight of the partnerships and services within the Health Enterprise Zone (HEZ) initiative "Competent Care Connections" that will serve residents of Dorchester and Caroline Counties living within identified zip codes.

B. GENERAL REQUIREMENTS

1. Maintains liaison and cooperative relationships with all CCC partners and affiliated agencies and providers.
2. Assists in coordination of training for staff of CCC partners and tracks completion of required components.
3. Makes recommendations for the maximum utilization of existing services as well as for additional or expanded services.
4. Insures that CCC partners are aware of all grant requirements and have systems in place to collect necessary data and information.

C. ESSENTIAL FUNCTIONS/EXAMPLES OF DUTIES

1. Participates in implementation of the various components of the CCC plan.
2. Provides technical assistance to and participates in the activities of other agencies/organizations as related to the CCC plan.
3. Prepares presentations and promotes CCC activities within the community to other agencies and providers.
4. Uses a system for continuous monitoring and evaluation of CCC program activities.
5. Anticipates obstacles to CCC plan activities and works pro-actively with partners to find resolutions.
6. Coordinates the CCC Coalition meetings.
7. Provides periodic reports of CCC program activities to the Health Education Division Administrator.
8. Gathers data and information from CCC partners to prepare required reports.
9. Participates in both internal and external program evaluation activities.

Affiliated Sante Group
Position Description

Job Title: MCT Coordinator
Department: Crisis
Reports To: Chief Executive Officer
Division: Crisis

Summary:

This position is responsible for project oversight, supervision and coordination, as well as outcomes management, grant/contract management, budget management, monitoring and reporting coordination, community relations, EMR (electronic medical record) coordination, and case audits.

Essential Duties and Responsibilities include the following.

In conjunction with the CFO/Controller, responsible for developing/monitoring service budgets and ensuring budgets are met

Responsible for insuring that all contract deliverables are met.

Responsible for the development and achievement of annual goals and objectives and service outcomes

Leads and coordinates service development/expansion activities.

Represents the company in the community and to legislators as needed

Responsible for hiring, orientation, training, termination and supervision of staff in compliance with all company policies and procedures. Develops and manages staff resources and ensures productivity standards are met.

Provides direction, consultation, and training, to staff to improve individual competencies and service outcomes

Ensures the timely and complete documentation of services/billing in the EMR per policy and procedures.

Develops, maintains and supports open staff communication consistent with corporate values in order to achieve positive service and administrative outcomes.

Ensures compliance with company policies and procedures as well as all appropriate federal, state and county regulations

Conducts regularly scheduled staff meetings to exchange clinical and administrative information

Oversees all aspects of the financial aspects of the project.

Prepares all reports for all needed functions.

Participates in ASG Operations team.

Is on-call to the crisis system as needed.

Other duties as assigned

Supervisory Responsibilities

Manages all employees under his/her jurisdiction. Is responsible for the overall direction, coordination, and evaluation of services. Carries out supervisory responsibilities in accordance with the organization's policies and applicable laws. Responsibilities include interviewing, hiring, terminating and training employees; planning, assigning, and directing work; appraising performance; rewarding and disciplining employees; addressing complaints and resolving problems.

Qualifications To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and/or Experience

Master's degree or equivalent; or six to ten years related experience and/or training; or equivalent combination of education and experience.

Computer Skills

To perform this job successfully, an individual should be computer literate and have knowledge and proficiency with the Internet and Spreadsheet /Word Processing software.

Certificates, Licenses, Registrations

Masters Degree or equivalent

Physical Demands The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this Job, the employee is regularly required to sit; use hands to finger, handle, or feel and talk or hear. The employee is frequently required to stand and walk. The employee is occasionally required to reach with hands and arms; climb or balance and stoop, kneel, crouch, or crawl. The employee is frequently required to drive. Specific vision abilities required by this job include close vision.

Language Skills

Ability to read, analyze, and interpret general business periodicals, professional journals, technical procedures, or governmental regulations. Ability to write reports, business correspondence, and procedure manuals. Ability to effectively present information and respond to questions from groups of managers, clients, customers, and the general public.

Mathematical Skills

Ability to work with mathematical concepts such as probability and statistical inference, and fundamentals of plane and solid geometry and trigonometry. Ability to apply concepts such as fractions, percentages, ratios, and proportions to practical situations. Ability to apply mathematical operations to such tasks as frequency distribution, determination of test reliability and validity, analysis of variance, correlation techniques, sampling theory and factor analysis.

Reasoning Ability

Ability to define problems, collect data, establish facts, and draw valid conclusions. Ability to interpret an extensive variety of technical instructions in mathematical or diagram form and deal with several abstract and concrete variables.

Work Environment

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually moderate.

Affiliated Sante Group
Position Description

Job Title: Mobile Crisis Specialist LCSW-C
Department: Mobile Crisis Team
Reports To: Mobile Crisis Team Coordinator
Division: Crisis Response System

Summary:
Assess and evaluate, perform crisis intervention techniques, and develop a crisis plan for continuation of services related to the client involved. While a goal of the service is to divert individuals from emergency room and/or inpatient admission as well as incarceration, there are times when these are needed services for the individual involved. Responsible for all incident documentation, is the on-site resource for any relevant clinical or legal information, and the liaison for collaboration with other involved parties including families, friends, and other community providers.

Essential Duties and Responsibilities:
Includes the following:

Perform a danger assessment, a crisis assessment, and an environmental assessment upon entry to the community situation

Perform a psychiatric evaluation

Effectively perform crisis intervention including de-escalation, crisis planning and implementation

Design appropriate referral recommendations using medical necessity criteria guidelines

Facilitate appropriate linkages for consumer and/or family

Competently make decisions about the need for an Emergency Petition or involuntary commitment procedure and facilitate as needed.

Address populations of children, adolescents, adults, elderly, co-occurring, and intellectual disabilities

Work with families and involved persons to de-escalate the situation, make a crisis plan, and enlist cooperation with recommended treatment

Provide accurate clinical and legal information to family and involved person related to recommendations and possibilities for treatment

Consult in an expert way to police, fire, and other community agencies when asked to do so

Provide consultation and coordination to ED staff, if ED evaluation is necessary

Document interactions using CRS procedures, and communicate all documentation to the Operations Center

Documentation in the Electronic Medial Record (EMR)

Other duties may be assigned.

Supervisory Responsibilities:
This job has no supervisory responsibilities

Qualifications:
To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skills, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and/or Experience:
Master's degree or equivalent. Licensed Mental Health Clinician.

Other Skills and Abilities:
(Preferred) At least three (3) years experience in crisis response

Must demonstrate competence in aggression management, safety procedures, knowledge of resources for community linkages, ability to work in as part of a team.

Physical Demands:
The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is frequently required to talk or hear. The employee is occasionally required to stand, walk, sit, stoop, reach with hands and arms, kneel, crouch, or crawl. Specific vision abilities required by this job include close vision.

Work Environment:
The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually loud.

Affiliated Sante Group
Position Description

Job Title: Mobile Crisis Specialist LGSW
Department: Mobile Crisis Team
Reports To: Mobile Crisis Team Coordinator
Division: Crisis Response System

Summary:
Assess and evaluate, perform crisis intervention techniques, and develop a crisis plan for continuation of services related to the client involved. While a goal of the service is to divert individuals from emergency room and/or inpatient admission as well as incarceration, there are times when these are needed services for the individual involved. Responsible for all incident documentation, is the on-site resource for any relevant clinical or legal information, and the liaison for collaboration with other involved parties including families, friends, and other community providers.

Essential Duties and Responsibilities:
Includes the following:

Perform a danger assessment, a crisis assessment, and an environmental assessment upon entry to the community situation

Perform a behavioral health assessment providing a diagnostic impression with the supervision of an LCSW-C or other equally licensed mental health professional

Effectively perform crisis intervention including de-escalation, crisis planning and implementation

Design appropriate referral recommendations using medical necessity criteria guidelines

Facilitate appropriate linkages for consumer and/or family

Competently make decisions about the need for an Emergency Petition or involuntary commitment procedure and facilitate as needed.

Address populations of children, adolescents, adults, elderly, co-occurring, and intellectual disabilities

Work with families and involved persons to de-escalate the situation, make a crisis plan, and enlist cooperation with recommended treatment

Provide accurate clinical and legal information to family and involved person related to recommendations and possibilities for treatment

Consult in an expert way to police, fire, and other community agencies when asked to do so

Provide consultation and coordination to ED staff, if ED evaluation is necessary

Document interactions using CRS procedures, and communicate all documentation to the Operations Center

Documentation in the Electronic Medial Record (EMR)

Other duties may be assigned.

Supervisory Responsibilities:
This job has no supervisory responsibilities

Qualifications:
To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skills, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and/or Experience:
Master's degree or equivalent.

Other Skills and Abilities:
(Preferred) At least one year experience in crisis response

Must demonstrate competence in aggression management, safety procedures, knowledge of resources for community linkages, ability to work in as part of a team.

Physical Demands:
The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is frequently required to talk or hear. The employee is occasionally required to stand, walk, sit, stoop, reach with hands and arms, kneel, crouch, or crawl. Specific vision abilities required by this job include close vision.

Work Environment:
The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually loud.

MedChi
BIOGRAPHICAL SKETCHES FOR KEY PERSONNEL

Craig R. Behm, Executive Director, MedChi Network Services: Mr. Behm is the Executive Director of MedChi Network Services (MNS), a firm that offers management services to physician practices. MNS is the largest state-designated Management Services Organization in Maryland and co-recipient of the Regional Extension Center grant. MNS manages two Accountable Care Organizations (ACOs), and Mr. Behm is the Executive Director and serves on the Management Board of both. Mr. Behm is leading an expansion of ACOs and related services to enhance the private practice of medicine.

Prior to joining MNS, Mr. Behm worked as a health care business consultant for a small firm in the Baltimore region. He also worked at Erickson Living, a large-scale developer and operator of continuing care retirement communities. He served a number of roles for that company, with the most recent being Corporate Affairs Manager. Mr. Behm holds a Bachelors of Arts from the University of Maryland, College Park and a Masters of Business Administration from the Loyola University Sellinger School of Business.

Colleen George, Office Manager, MedChi Network Services: Ms. George is the Office Manager for MedChi Network Services (MNS), a firm that offers management services to physician practices. MNS is the largest state-designated Management Services Organization in Maryland and co-recipient of the Regional Extension Center grant. MNS manages two Accountable Care Organizations (ACOs), and Ms. George is the Administrative Assistant for both. Ms. George assists in leading the expansion of ACOs and related services to enhance the private practice of medicine. In addition to her role with MNS, Ms. George handles all in-coming Practice Management calls to MedChi.

Her experience with MedChi is a welcome and challenging career change. Prior to joining MedChi, Ms George worked primarily in the retail industry, most recently as a Department Store Manager and Human Resources Manager.

A. PRIMARY FUNCTION:

Provides social work services to referred clients to enhance medical treatment, support and maximize the psychosocial functioning and adjustment of clients through phone calls and home visits.

B. GENERAL REQUIREMENTS

1. Counsels clients, families, and significant others to promote optimal social functioning.
2. Functions as part of the interdisciplinary team responsible for fostering safe treatment environments, and routines that are attuned to cultural, religious, and ethnic differences among clients, families, and caregiver's that show respect for individuality, independence, and choice of each client.
3. Supports System and Nursing Strategic Plans, Relationship-Based Care, and Shared Leadership.

C. ESSENTIAL FUNCTIONS/EXAMPLES OF DUTIES

1. Assesses social, economic, environmental, psychosocial, emotional, family values, and cultural factors that interfere with client, family, and significant other adjustment to illness, treatment and self management.
2. Involves the client, family and significant others in planning for the client's current and ongoing care. Helps them recognize the necessity for possible changes in living patterns and how to adjust.
3. Promotes increased client competence and coping through treatment plans that include education and referral to other necessary resources.
4. Provides support, counseling, and interpretation to family and significant others in understanding the client's problems and goals.
5. Acts as an advocate for services for clients at risk due to mental or physical limitations, providing social crisis interventions as needed.
6. Assists the client to utilize the health care system appropriately.
7. Maintains documentation of client, family, significant others, and medical interactions, consultations and collaboration.
8. Acts as a community resources person to clients, family, significant others, physicians, agencies, and community case management staff. Speaks for the agency as requested by the Director at community awareness functions.
9. Counsels clients; advises on social issues. Directs clients, family and significant others to community agencies for assistance with finances, disabilities, medical recommendations and coping with current problematic situations.
10. Develops and maintains good working relationship with community health, welfare and social agencies and reaches out to the community to develop new resources to meet the client needs.
11. Participates in program development and improvement through policy and protocol development, budgeting, marketing, research, quality improvement, orientation, staff development, competency, interdisciplinary meetings, and tracking of the community case management program.

JOB DESCRIPTION – Nurse Practitioner
Dorchester County: School-Based Wellness Center

A. PRIMARY FUNCTION:

The main purpose of this position is to provide primary health care to students whose parents have enrolled them in the School-Based Wellness Center (SBWC) program administered by the Dorchester County Health Department. This position helps to embody the Health Department's mission to ensure access to health care to Dorchester citizens of all ages.

B. GENERAL REQUIREMENTS

1. Adhere to requirements for confidentiality regarding students' records; discreetly handle sensitive information pertaining to staff, parents and students.
2. Communicate with supervisor and co-workers for schedule changes, closings, personal time off, etc
3. Follow school security procedures
4. Work collaboratively with all staff to provide quality services as a team. Effective communication and positive attitude are essential to the success of the program.

C. ESSENTIAL FUNCTIONS/EXAMPLES OF DUTIES

1. Encourages and assists with enrollment in the School Based Wellness Centers.
2. Assesses and manages physical and psychological problems of students whose parents have enrolled them in the SBWC program.
3. Establishes medical diagnosis and prescribes medications and treatment for common short-term or chronic stable health and/or mental health problems.
4. Prescribes medication, orders and plans therapy according to established School Based Health Center protocols.
5. Orders, performs and interprets laboratory tests.
6. Provides anticipatory guidance and health education in conjunction with community physicians, mental health clinicians, school nurses and the school system for individual students and for groups of students or faculty.
7. Coordinates services provided and to be provided with parents and primary care providers in the community; helps students obtain health insurance and/or a primary care provider.
8. Refers patients to other health care providers in conjunction with their primary provider.
9. May provide training and guidance to lower-level nursing staff.
10. Supervises other staff as designated by the Program Manager.

A. PRIMARY FUNCTION

The Office Clerk assists the Nurse Practitioner and Mental Health Clinician with a variety of clinical, clerical, organizational, and other health-related duties. This position is instrumental in assuring that the School-Based Wellness Center operates efficiently and effectively on a daily basis while interacting with students, parents, school personnel and the community. The Office Clerk is supervised by the Nurse Practitioner or Mental Health Clinician, as designated by the Program Manager. The individual may also perform clinical duties if licensed as a Certified Nursing Assistant.

B. GENERAL REQUIREMENTS

1. Adhere to requirements for confidentiality regarding students' records; discreetly handle sensitive information pertaining to staff, parents and students.
2. Communicate with supervisor and co-workers for schedule changes, closings, personal time off, etc
3. Follow school security procedures
4. Work collaboratively with all staff to provide quality services as a team. Effective communication and positive attitude are essential to the success of the program.
5. Computer proficiency including Microsoft Office and Excel

C. ESSENTIAL FUNCTIONS/EXAMPLES OF DUTIES

Duties may include, but are not limited to the following:

- Prepare chart, supplies and supporting paperwork for the provider
- Distribute health related information
- Complete LabCorp requisition slips and specimen labels
- Contact LabCorp for specimen pick-up, document confirmation number on requisition, document students name on laboratory list, place specimen in lock box and confirm pick-up the next business day
- Clean and straighten exam room after each patient and disinfect table tops and exam table as needed
- Prepare, distribute and collect SBWC enrollment forms each school year
- Update and maintain SBWC student list to document enrollment and other needed information
- Ensure charts are adequate - confirming contact information, insurance, allergies, etc - and take the necessary steps to collect the information - including insurance coverage
- Create, update, maintain and pull charts/health records
- Keep file cabinets neat and well-organized, moving charts as necessary according to policy
- Answer telephone promptly in a professional manner, document and direct as appropriate
- Schedule appointments and follow-up appointments according to policy- tracking as necessary
- Maintain laboratory list to ensure appropriate follow-up

- Maintain flow of the schedule- including calling students to the Wellness Center, ensure appropriate timing of appointments, write passes to return to class
- Enter data into Pat Trac/data collection system
- Utilize the EVS system to verify patient eligibility
- Promote and distribute MCHIP forms when appropriate; follow-up with parents as necessary
- Collect appropriate data, i.e., income verification
- Send correspondence to the student's parent/guardian when appropriate
- Ensure the Health Visit report form is sent/faxed to Primary Care Providers, insurance companies/MCO, billing specialist, etc
- Pick up and transport mail, supplies and materials to and from the health department as necessary
- Daily check temperature history, document results and maintain refrigerators at all assigned schools
- Maintain inventory, rotating stock for cost efficiency and submit inventory list and request in writing to administration quarterly
- Re-stock items as appropriate
- Print/copy appropriate health forms and records
- Complete required statistical reports, assisting with quarterly and annual reports as directed
- Assist mental health clinicians by preparing client address labels, appointment cards, mailing or calling appointment reminders

Additional duties to be performed under CNA licensure:

- Maintain standard precautions
- Obtain vital signs - Height, weight, blood pressure, pulse, temperature, pulse oxygenation, etc. (if licensed)
- Record health information in individual student health records
- Perform Urinalysis, quick strep test, pregnancy test, etc.
- Assist Nurse Practitioner with general duties - i.e - GYN exams
- Administer first aid as necessary
- Complete clinical competencies annually

JOB DESCRIPTION – Peer Recovery Support Specialist
Chesapeake Voyagers & DCHD Addictions Program

A. PRIMARY FUNCTION:

A Peer Recovery Support Specialist (P-RSS) is a trained, self-identifying person in recovery from addiction, mental health, or co-occurring disorder - providing peer support for individuals seeking help. They engage with participants in the community-based DRI-DOCK Recovery & Wellness Center or those needing help in the community, and may link them up with various partners around any number of services and/or activities.

B. GENERAL REQUIREMENTS

1. Provide health and disease prevention information to underserved populations in the community and assist them in adopting healthy behaviors.
2. Identify and refer individuals to public and private resources within the community.
3. Explain and reinforce the health care services and resources available to persons needing special assistance

C. ESSENTIAL FUNCTIONS/EXAMPLES OF DUTIES

1. Assist clients in articulating their goals for recovery, learning and practicing new skills.
2. Assist clients with engagement and monitoring their progress and treatment.
3. Model effective coping techniques and self-help strategies based on the specialist's own recovery experience.
4. Support clients in advocating for themselves to obtain effective services.
5. Follow-up with clients to assure they received services as scheduled.
6. May transport clients for services related to their treatment and recovery.
7. Assist with data collection for report purposes.

JOB DESCRIPTION – Social Worker II, LCSW-C
Caroline County Health Department: Mental Health Clinic

A. PRIMARY FUNCTION:

To provide clinical social work services to mental health clients on an outpatient basis, in a school setting, focusing on high risk clients that present with a great deal of complexity. Able to provide these services to children, adolescents and adults. Must be licensed to provide a psychiatric diagnosis and capable of working with only a minimum of supervision.

B. GENERAL REQUIREMENTS

1. Adhere to requirements for confidentiality regarding clients' records and discreetly handle sensitive information.
2. Work collaboratively with all staff to provide quality services as a team.

C. ESSENTIAL FUNCTIONS/EXAMPLES OF DUTIES

1. To provide individual, family and group therapy including screening, diagnostic evaluations and crisis intervention; in all required settings to children, adolescents and adults who have a DSM IV diagnosis in order to enhance their global functioning.
2. To attend and participate in multidisciplinary treatment team, staff and supervisory meetings to assure best practice and most efficient service delivery.
3. To complete required documentation i.e. contact notes, monthly progress summaries, treatment plans, authorizations, etc. in a timely fashion and in compliance with COMAR regulations.
4. To liaison with other professionals, family members, community agencies to maximize available resources on behalf of the client and his/her family.
5. To provide coverage for other mental health professionals to assure continuity of care, if needed.
6. To represent the agency as necessary in order to provide the awareness of mental health issues.
7. To comply with grant reporting requirements.

Dorchester County
Department of Health

"Working for Healthier People"

3 Cedar Street
Cambridge MD 21613

410-228-3223
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Roger L. Harrell, M.H.A.
Health Officer

November 13, 2012

Mark Luckner, Executive Director
MD Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Dear Mr. Luckner:

On behalf of the Dorchester County Health Department, I am pleased to offer this Letter of Commitment for the Dorchester-Caroline Health Enterprise Zone grant application. The DCHD will be acting as lead agency for this application and funding should it be awarded, as we implement "Competent Care Connections".

As you are well aware, areas within our two counties have struggled with poor health outcomes, particularly in African-American communities. The HEZ initiative offers a unique opportunity to expand our Primary Care workforce and to develop creative strategies to more specifically impact populations who are facing chronic illnesses that not only impact quality of life, but life itself.

In addition to hiring a part-time coordinator to oversee the Dorchester-Caroline HEZ Initiative, the DCHD seeks to expand School-Based Health Center services for middle school students by hiring both primary care and behavioral health staff. The adult community struggling with behavioral health issues will be served by additional Peer Recovery & Support Specialists working through our DRI-Dock program. Staff hired by the DCHD will work in tandem with Health Outreach Workers employed by Associated Black Charities, Mobile Crisis staff with the Affiliated Sante' Group, Caroline County Health Department's Mental Health Clinic, MD Healthy Weighs and Shore Wellness Partners to reduce the impact of chronic illness and to help our residents have healthier, more fulfilling lives. We are also pleased to partner with the Eastern Shore Area Health Education Center (ESAHEC) and MedChi to expand and train the workforce.

We appreciate the opportunity offered to our jurisdictions by the Health Enterprise Zone funding and look forward to working with you and the CHRC if our application is approved. Thank you for your consideration.

Sincerely,
Cheryl S MacLaughlin for
Roger L Harrell
Roger Harrell, MHA
Health Officer

November 7, 2012

Roger l. Harrell, MHA
Health Officer
Dorchester County Health Department
3 Cedar Street
Cambridge, MD 21613

Dear Mr. Harrell,

I am pleased to confirm that Associated Black Charities supports the "Competent Care Connections" grant application through the Maryland Community Health Resources Commission to improve the Health Outcomes within the identified HEZ (Health Enterprise Zones).

As we have partnered with this collaboration during the entire planning process, we are delighted to extend our commitment to this project. We, as the Community Outreach and Health Education Team component, intend through this grant to advance the mission and goals of this collaboration within our sphere of influence and to:

- Manage and Maintain Health Education Outreach efforts through the identified HEZ
- Strategize with partners to identify underserved communities and work within those communities to garner access to quality Health care
- Work within grassroots programs to remove barriers to accessing health care within the HEZ region
- Participate in County/Local Networks to engage and educate communities
- Link communities to resources available within the HEZ
- Become the liaison between the community, behavioral health services and areas of somatic care within the HEZ

Associated Black Charities honors our commitment in assuring the success of this program through our participation.

Sincerely yours,
Ashyrra C. Dotson
Ashyrra C. Dotson, Director of Programs
Associated Black Charities – Dorchester County

Eastern Shore Area Health Education Center

814 Chesapeake Drive
Cambridge, Maryland 21613
Tel: (410) 221-2600; Fax: (410) 221-2605
Email: esahec@esahec .org
Website: http://www.esahec.org

November 5, 2012

Roger L. Harrell, MHA
Health Officer
Dorchester County Health Department
3 Cedar Street
Cambridge, MD 21613

Dear Roger:

The purpose of this letter is to serve as a Letter of Commitment to participate in the Health Enterprise Zone Initiative funded by the Maryland Community Health Resources Commission (CHRC) in collaboration with the Dorchester County Health Department (Coordinating Organization).

After discussing the proposal with the Health Department and other participating agencies, the Eastern Shore Area Health Education Center (AHEC) is excited to take part in this four year program. AHEC is pleased that two of the goals outlined in the HEZ Initiative addresses health care workforce. Our mission, *"Through collaborative partnerships, the AHEC shall become the leader in providing educational services and programs to assist Eastern Shore communities in the recruitment and retention of health care professionals"* is in alignment with the proposal's two workforce goals. By addressing workforce shortage in the region we will improve access to quality health care.

AHEC understands that for the purpose of this project, we will provide following services:

- Development and implementation of a Behavioral Health Interdisciplinary Team Training program to enhance the learning experience of Maryland health professional students
- Two one-week health career exploration summer day camps targeting fifty seventh – tenth grade students in Dorchester and Caroline counties
- Continuing education programs targeting primary care providers to increase their knowledge in behavioral health topics and of available local resources for referral
- Training program for Community Health Workers to include core competency training and specific health topic educational seminars

My understanding is that the approximate dates of the period of performance in which we will participate on the project is expected to be January 2013 through December 2016. I also realize that my participation is contingent upon your proposal actually being funded by the grantor agency, CHRC.

I am very confident in the merits of the proposed program. I look forward to working with you on this promising project and help address health disparities that are prominent in Dorchester and Caroline counties.

Sincerely,

Jacob F. Frego
Executive Director

November 9, 2012

Mr. Roger Harrell, MHA
Health Officer, Dorchester County
3 Cedar Street
Cambridge, MD 21613

Dear Mr. Harrell,

With this letter, Affiliated Sante Group (ASG), is making a commitment to be a part of the coalition submitting the Health Enterprise Zone (HEZ) grant application for Dorchester and Caroline Counties, Competent Care Connections. With a focus of the grant serving to decrease emergency department visits for behavioral health needs, while increasing access to services and decreasing disparities, we believe we are an ideal fit.

ASG is the leading provider of behavioral health crisis services in Maryland and is delighted to expand our Eastern Shore Mobile Crisis Services operations. Through the HEZ, we will create and implement a third mobile crisis team that will be dedicated to serving Dorchester and Caroline County residents experiencing behavioral health crises. We will focus serving individuals in crisis where they are, to assess, stabilize and link them with the most appropriate, least restrictive services with the goal of diverting them from the emergency room and/or incarceration. Our team will be based in Cambridge and have the ability to serve each of the designated areas outlined in the grant. Our Cambridge location will assist us in being more readily available to law enforcement and emergency services personnel, who frequently are the frontlines in provision of interventions.

In addition to the expansion of our Mobile Crisis Services, we will also expand our outreach and training of law enforcement, emergency services and other community partners in the creation of local Crisis Intervention Teams. The training that will be offered will better equip these frontline providers in working with citizens, with the tools needed to divert them from hospitalization and/or incarceration.

My understanding is that the approximate dates of the period of performance in which we will participate on the project is expected to be January 2013 through December 2016. I also realize that our participation is contingent upon your proposal actually being funded by the grantor agency, CHRC.

I am very confident in the merits of the proposed program. I look forward to working with you and this coalition on this promising project of reducing emergency room behavioral health visits and the health disparities currently found in these counties.

If you have any questions or concerns please feel free to contact Frederic Chanteau, ASG CEO, at 301.572.6585 or FChanteau@santegroup.org or me at 410.463.4077 or CMasden@santegroup.org

Sincerely,

Carol Masden, LCSW-C, Director, Eastern Shore Mobile Crisis
For Frederic Chanteau, ASG CEO

Caroline County Health Department

Public Health
Prevent. Promote. Protect.

Leland Spencer, M.D., MPH
Health Officer

Laura Patrick RN, MS
Acting Deputy Health Officer

November 13, 2012

Mark Luckner, Executive Director
MD Community Health Services Resource Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Dear Mr. Luckner,

The Caroline County Health Department (CCHD) is pleased to offer this letter of commitment for the Dorchester-Caroline Health Enterprise Zone grant application. The CCHD has been active throughout the planning process in supporting this initiative and is excited to be a part of this grant opportunity.

The zip code regions highlighted in this proposal struggle with poor health outcomes especially in minority communities. The combination of access to care issues, socioeconomic, and environmental influences consistently rank these areas in the worst quartile for health outcomes compared to other jurisdictions throughout the State. This proposal offers a unique opportunity to impact these determinants of health by expanding the primary care workforce and implementing creative strategies that will have both a short and long term impact.

As part of the Dorchester-Caroline HEZ proposal, the CCHD is committed to expanding access to mental health services to both children and adults within the portion of the HEZ located in the Federalsburg zip code. The CCHD Mental Health Clinic will provide additional staffing and hours of service to both school based wellness centers and outpatient adult clinics. The CCHD will work in tandem with health outreach workers, mobile crisis staff, and the hospital to assure ready access to community based mental health services and appropriate follow up and case management.

Thank you for this opportunity to express our willingness to be an active participant in such an important initiative.

Sincerely,

Leland D. Spencer, M.D., M.P.H.
Health Officer, Caroline County

403 South 7th St. Rm, 218, Denton, MD 21629
410-479-8030 • Fax: 410-479-0554 • TTY Users: 800-735-2258
Website: www.carolinehd.org

Quality Health Care for All
Buenos Servicios de Salud para Todos

Choptank Community Health System, Inc.

November 6, 2012

Roger Harrell, MHA
Health Officer
Dorchester County Health Department
3 Cedar Street
Cambridge, MD 21613

Dear Mr. Harrell:

Choptank Community Health System, Inc. (CCHS) is pleased to have served as a partner with the Dorchester County Health Department on its application for the Health Enterprise Zone (HEZ) designation. The proposed HEZ is inclusive of the larger population areas of Cambridge, Hurlock and Federalsburg while including the smaller population zip codes of East New Market, Secretary, Linkwood and Rhodesdale.

As you know, CCHS is a federally qualified health center that provides medical and dental care to all patients regardless of their insurance status. We offer a sliding fee scale discount based on a patient's income and family size. We have dental and medical offices in both Federalsburg and Cambridge and a medical office in Hurlock.

The HEZ designation is an opportunity to address the health disparities in the targeted locations listed above. Through this partnership, CCHS is committed to serving as a referral source for the Community Health Outreach Workers that are referenced in the HEZ application. Through this collaboration, we will connect those with chronic health conditions such as diabetes to a medical home. Additionally, the introduction of the Mobile Crisis Teams to our service area will benefit our providers and patients. This avenue will give the medical providers a referral source for patients that are in need of behavioral health treatment and assist patients whom may otherwise go to the emergency department for care.

CCHS is committed to working with the Dorchester County Health Department and the other partner agencies in this effort. We will continue to participate in HEZ meetings and provide opportunities to educate our staff on the much needed outreach services that will be available in our communities.

Sincerely,

Joseph M. Sheehan
President and Chief Executive Officer

Administrative Offices
Denton Center · 301 Randolph Street, P.O. Box 660 · Denton, MD 21629 · **410 479-4306** · *Fax* **410 479-1714**

Chesapeake Voyagers, Inc.

Wellness & Recovery Center

342C N. Aurora St. Easton, MD 21601
Phone: 410-822-1601 Fax: 410-822-1621

November 9, 2012

Roger L. Harrell, MHA
Health Officer
Dorchester County Health Department
3 Cedar Street
Cambridge, MD 21613

Dear Mr. Harrell,

Chesapeake Voyagers, Inc. is pleased to participate in the Health Enterprise Zone Initiative funded by the Maryland Community Health Resources Commission in collaboration with the Dorchester County Health Department.

Through the partnerships with such an array of community based organizations, Chesapeake Voyagers, Inc. is looking forward to taking part in this four year program. As a Peer Support organization, we believe that mental health is a significant part of overall health and wellness. Our commitment will be to provide a part-time Peer Support Specialist who will be trained and work collaboratively to provide Peer Support and linkage to mental health resources.

My understanding is that the approximate timeframe of this project is expected to be from January 2013 to December 2016. I also understand that my participation is contingent upon your proposal actually being funded by the Maryland Community Health Resources Commission.

I look forward to working with you on this initiative to assist in addressing disparities that are prominent in Caroline and Dorchester Counties.

Sincerely,

Diane Lane

Diane Lane
Executive Director

Chesapeake Voyagers, Inc. is an Official Affiliate of On Our Own of Maryland, Inc.

Recovery & Wellness Center

Dorchester Recovery Initiative & ***Chesapeake Voyagers***

Letter of Commitment

Please accept this letter of our intent to commit our time, energy, and resources to the success of our Health Enterprise Zone project.

Specifically, the DRI-DOCK Recovery & Wellness Center of the Dorchester County Health Department is committing to the following:

- One full-time Substance Abuse Peer Recovery Support Specialist
- One part-time Mental Health Peer Support Specialist
- One vehicle to provide transportation of behavioral health participants to connect to resources that will support recovery efforts
- The full use of the DRI-DOCK Recovery & Wellness Center, it's staff and any/all activities therein that support ongoing recovery efforts.
- Case Management as provided by the Peer Recovery Support Specialists

As the Recovery Oriented Systems of Care (ROSC) systemic transformation continues to unfold across the state and nation, the Maryland Alcohol & Drug Abuse Administration, Mental Health Administration, and Department of Health & Mental Hygiene have committed to provide financial support and increased funding for Recovery Community Centers and for Behavioral Health Peer Support efforts.

The DRI-DOCK Recovery & Wellness Center has become a role-model for the state in its efforts to grow a network of integrated ROSC services. Maryland has firmly decided to aggressively move forward in this regard and all indications suggest a firm commitment by the State to insure the financial health and sustainability of Recovery Centers such as ours.

Respectfully,

John Winslow, Program Director

Mid-Shore Mental Health Systems inc.

November 9, 2012

Roger L. Harrell, MHA
Health Officer
Dorchester County Health Department
3 Cedar Street
Cambridge, MD 21613

Dear Roger:

The purpose of this letter is to serve as a Letter of Commitment to participate in the Health Enterprise Zone Initiative funded by the Maryland Community Health Resources Commission (CHRC) entitled "Competent Care Connections" in collaboration with the Dorchester County Health Department (Coordinating Organization). I am very confident in the merits of the proposed program.

Mid-Shore Mental Health Systems, Inc. (MSMHS) is excited for the opportunity this has fostered to work with such a multi-disciplinary team under the steadfast leadership of the Health Department, bringing together many essential partners and stakeholders to take part in this four year program. Our mission is "to continually improve the provision of mental health services for residents of Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties through effective coordination of services in collaboration with consumers, family members, providers and community leaders." We believe that the Behavioral Health system should assure quality, cost-effective services that meet the needs of our consumers. Addressing the tremendously high rate of Behavioral Health Emergency Department visits by offering coordinated and competent community based alternatives including a Behavioral Health Mobile Crisis Team specific to this Health Enterprise Zone will improve access to quality health care, improve quality of life and reduce unnecessary health care costs.

MSMHS understands that for the purpose of this project, we will do the following:

- Ensure effective implementation of the Behavioral Health Crisis Team
- Ensure effective implementation of the Peer Recovery Support Specialists
- Ensure community provider engagement in expansion of outpatient behavioral health access and choice to consumers in need.
- Utilize the existing partnerships within our behavioral health community to promote, engage implement and sustain all aspects of this project.

My understanding is that the period of performance in which we will participate on the project is expected to be January 2013 through December 2016. I also realize that my participation is contingent upon your proposal actually being funded by the grantor agency, MCHRC.

I am ecstatic about the coming together of these partners, uniting for a common purpose in addressing the behavioral health needs of our community members as I have never before experienced. I look forward to working with you and your team on this promising project and helping address health disparities that are prominent in our region and surrounding counties.

Sincerely,

Holly Ireland LCSW-C

Holly R. Ireland, LCSW-C
Executive Director

SHORE HEALTH SYSTEM
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

219 South Washington Street
Easton, Maryland 21601
410.822.1000
www.shorehealth.org

Administration

November 12, 2012

Roger L. Harrell, MHA
Health Officer
Dorchester County Health Department
3 Cedar Street
Cambridge,MD 21613

Dear Roger:

The purpose of this letter is to serve as a Letter of Commitment to participate in the Health Enterprise Zone Initiative funded by the Maryland Community Health Resources Commission (CHRC) in collaboration with the Dorchester County Health Department (Coordinating Organization). After discussing the proposal with the Health Department and other participating agencies, Shore Health System's Shore Wellness Partners is excited to take part in this four year program.

The proposed expansion for the Shore Wellness Partners program would add an additional community case specialist and a medical social worker to focus on the Cambridge, Dorchester County and Federalsburg, Caroline County areas. The Shore Wellness Partners program has been recognized as an innovative program by The Maryland Department of Health and Mental Hygiene (DHMH) and the *Journal of the American Medical Association* (JAMA). The Maryland DHMH acknowledged Shore Wellness Partners on their website as a creative program that enhances patient care, improves population health and cuts costs.

Shore Health System understands that for the purpose of this project, we will provide the following services:

- Staff orientation, training, supervisions and administrative support,
- Office space for the two Shore Wellness Partners granted positions for the first year.
- Computers for which to document on the electronic medical record for the first year.

My understanding is that the approximate dates of the period of performance in which we will participate on the project is expected to be January 2013 through December 2016. I also realize that participation is contingent upon the proposal actually being funded by the grantor agency, CHRC.

I am very confident in the merits of the proposed program. Shore Health System looks forward to working with you on this promising project to address health disparities that are prominent in Dorchester and Caroline counties.

Sincerely,

Michael Silgen
Vice President, Strategic Planning / Business Development

MS/KM

APPENDIX ITEM F - Global Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones - Global Budget

Coordinating Organization Name: Dorchester County Health Department

HEZ Project Name: Competent Care Connection - Caroline/Dorchester HEZ

Directions: All applicants must complete the Global Budget Template which provides the annual and total budget request by program benefit and incentive requested. Applicants should choose from the listed benefits and incentives (items 1-8). Applicants are **not** required to request funding in each benefit or incentives area. Applicants requesting CHRC Grant Funding for health programs are required to list each partnering organization and grant request amount under item 8. CHRC Grant Funding and complete the Program Budget Form for each organization. Add or remove lines for CHRC Grant Funding as needed.

Budget Request for Benefits and Incentives Applicants should choose from the listed benefits and incentives (items 1-8) and do not need to request funding from each benefit or incentives.	**Year 1 (January - December 2013)**	**Year 2 (January - December 2014)**	**Year 3 (January - December 2015)**	**Year 4 (January - December 2016)**	**Total HEZ Request**
1. State Tax Credits	$50,000.00	$50,000.00	$50,000.00	$50,000.00	$200,000.00
2. Hiring Tax Credits	$20,000.00	$40,000.00	$60,000.00	$60,000.00	$180,000.00
3. Loan Repayment Assistance	$47,000.00	$82,000.00	$117,000.00	$132,000.00	$378,000.00
4. Participation in the Patient Centered Medical Home Program					$0.00
5. Electronic Health Records	$110,000.00	$90,000.00	$80,000.00	$80,000.00	$360,000.00
6. Capital or Leasehold Improvements					$0.00
7. Medical or Dental Equipment					$0.00
8. CHRC Grant Funding*	$1,456,146.00	$1,377,801.00	$1,316,328.00	$1,312,574.00	$5,462,849.00
8a. Dorchester County Health Department	$220,356.00	$180,127.00	$160,279.00	$155,015.00	$715,777.00
8b. Eastern Shore AHEC	$119,450.00	$116,193.00	$121,650.00	$120,775.00	$478,068.00
8c. Shore Health Systems	$167,302.00	$181,403.00	$177,347.00	$182,644.00	$708,696.00
8d. Caroline County Health Department	$188,367.00	$154,333.00	$152,124.00	$150,115.00	$644,939.00
8e. Associated Black Charities	$91,548.00	$108,028.00	$108,028.00	$108,028.00	$415,632.00
8f. Chesapeake Voyagers	$19,620.00	$18,870.00	$19,226.00	$19,507.00	$77,223.00
8g. Maryland Healthy Weighs	$45,000.00	$46,320.00	$47,680.00	$49,080.00	$188,080.00
8h. Eastern Shore Mobile Crisis System	$384,753.00	$386,519.00	$398,660.00	$411,181.00	$1,581,113.00
8i. MED-CHI	$219,750.00	$186,008.00	$131,334.00	$116,229.00	$653,321.00
Subtotal for Benefits and Incentives	$1,683,146.00	$1,639,801.00	$1,623,328.00	$1,634,574.00	$6,580,849.00
9. Data Collection and Evaluation**	$42,079.00	$81,990.00	$81,166.00	$81,729.00	$286,964.00
10. Indirect Costs***	$139,772.00	$129,576.00	$126,948.00	$127,909.00	$524,205.00
Totals	$1,864,997.00	$1,851,367.00	$1,831,442.00	$1,844,212.00	$7,392,018.00

*Applicants requesting CHRC Grant Funding must also complete Program Budget Form

** Data collection and evaluation should be between 5-10% of the subtotal for benefits and incentives.

*** Indirect Costs may be no more than 10% of the subtotal for benefits and incentives.

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones

Organization Name: Dorchester County Health Department

HEZ Project Name: Competent Care Connection - Caroline/Dorchester HEZ

Grant Program Name: Health Enterprise Zones

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total Organization Request
Personnel Salary					
100% FTE - TBD, Nurse Practioner	$75,000.00	$76,500.00	$78,030.00	$79,591.00	$309,121.00
100% FTE - TBD, Office Clerk	$25,000.00	$25,500.00	$26,010.00	$26,530.00	$103,040.00
50% TBD -Coor.of Special Programs II	$17,057.00	$17,398.00	$17,746.00	$18,101.00	$70,302.00
100% FTE - TBD, Peer Recovery Spec.	$22,448.00	$22,897.00	$23,355.00	$23,822.00	$92,522.00
1. Personnel Subtotal	$139,505.00	$142,295.00	$145,141.00	$148,044.00	$574,985.00
2. Personnel Fringe (up to 65% - Rate)	$55,201.00	$56,305.00	$57,431.00	$58,579.00	$227,516.00
3. Equipment/Furniture	$23,000.00	$1,000.00		$1,000.00	$25,000.00
4. Supplies	$4,500.00	$4,590.00	$4,682.00	$4,776.00	$18,548.00
5. Travel/Mileage/Parking	$950.00	$969.00	$988.00	$1,008.00	$3,915.00
6. Staff Trainings/Development	$3,800.00	$1,500.00	$1,500.00	$1,500.00	$8,300.00
7. Contractual					$0.00
8. Other Expenses	$3,400.00	$3,468.00	$3,537.00	$3,608.00	$14,013.00
Direct Costs Subtotal (lines 1-8)	$230,356.00	$210,127.00	$213,279.00	$218,515.00	$872,277.00
Indirect Costs (no more than 10% of direct costs)	$23,036.00	$21,013.00	$21,328.00	$21,852.00	$87,229.00
Collections	-$10,000.00	-$30,000.00	-$53,000.00	-$63,500.00	-$156,500.00
Totals	$243,392.00	$201,140.00	$181,607.00	$176,867.00	$803,006.00

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones

Organization Name: Eastern Shore AHEC

HEZ Project Name: Competent Care Connection - Caroline/Dorchester HEZ

Grant Program Name: Health Enterprise Zones

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total Organization Request
Personnel Salary					
1a. 20% FTE - [redacted] Health Careers Coordinat	$9,216.00	$9,492.00	$9,777.00	$10,070.00	$38,555.00
1b. 80% FTE - TBD, Behavioral Health Interdisiplinary Team Training Coordinator (BHITT)	$39,936.00	$41,134.00	$42,368.00	$43,639.00	$167,077.00
1c. 12% FTE - [redacted], Program Monitor	$6,451.00	$6,645.00	$6,844.00	$7,049.00	$26,989.00
1. Personnel Subtotal	$55,603.00	$57,271.00	$58,989.00	$60,758.00	$232,621.00
2. Personnel Fringe (23.1% - Rate)	$12,844.00	$13,230.00	$13,626.00	$14,035.00	$53,735.00
3. Equipment/Furniture	$1,500.00				$1,500.00
4. Supplies	$10,350.00	$10,350.00	$10,350.00	$10,350.00	$41,400.00
5. Travel/Mileage/Parking	$4,629.00	$4,768.00	$4,911.00	$5,058.00	$19,366.00
6. Staff Trainings/Development	$3,550.00	$3,550.00	$3,550.00	$3,550.00	$14,200.00
7. Contractual	$6,700.00	$3,500.00	$6,700.00	$3,500.00	$20,400.00
8. Other Expenses	$24,274.00	$23,524.00	$23,524.00	$23,524.00	$94,846.00
Direct Costs Subtotal (lines 1-8)	$119,450.00	$116,193.00	$121,650.00	$120,775.00	$478,068.00
Indirect Costs (10%)	$11,945.00	$11,619.00	$12,165.00	$12,078.00	$47,807.00
Totals	$131,395.00	$127,812.00	$133,815.00	$132,853.00	$525,875.00

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones

Organization Name: Shore Health System

HEZ Project Name: Competent Care Connection - Caroline/Dorchester HEZ

Grant Program Name: Health Enterprise Zones

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total Organization Request
Personnel Salary					
100% FTE - Community Care Specialist (RN)	$79,040.00	$81,411.00	$83,854.00	$86,369.00	$330,674.00
100% FTE - Medical Social Worker	$58,240.00	$59,987.00	$61,787.00	$63,640.00	$243,654.00
1. Personnel Subtotal	$137,280.00	$141,398.00	$145,641.00	$150,009.00	$574,328.00
2. Personnel Fringe (15% - Rate)	$20,592.00	$21,210.00	$21,846.00	$22,501.00	$86,149.00
3. Equipment/Furniture	$650.00	$9,200.00	$0.00	$0.00	$9,850.00
4. Supplies	$1,250.00	$1,288.00	$1,326.00	$1,366.00	$5,230.00
5. Travel/Mileage/Parking	$3,900.00	$4,017.00	$4,138.00	$4,262.00	$16,317.00
6. Staff Trainings/Development	$750.00	$750.00	$750.00	$750.00	$3,000.00
7. Contractual	$2,880.00	$3,540.00	$3,646.00	$3,756.00	$13,822.00
8. Other Expenses	$0.00	$0.00	$0.00	$0.00	$0.00
Direct Costs Subtotal (lines 1-8)	$167,302.00	$181,403.00	$177,347.00	$182,644.00	$708,696.00
Indirect Costs (no more than 10% of direct costs)	$6,600.00	$6,798.00	$7,002.00	$7,212.00	$27,612.00
Totals	$173,902.00	$188,201.00	$184,349.00	$189,856.00	$736,308.00

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones

Organization Name: Caroline County Health Department

HEZ Project Name: Competent Care Connection - Caroline/Dorchester HEZ

Grant Program Name: Health Enterprise Zones

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	**Year 1 (January - December 2013)**	**Year 2 (January - December 2014)**	**Year 3 (January - December 2015)**	**Year 4 (January - December 2016)**	**Total Organization Request**
Personnel Salary					
100% FTE - TBD, Social Worker (LCSW-C)	$41,895.00	$42,733.00	$43,588.00	$44,460.00	$172,676.00
100% FTE - TBD, Social Worker (LCSW-C)	$51,263.00	$52,288.00	$53,334.00	$54,401.00	$211,286.00
80% FTE - TBD, Office Clerk II	$20,000.00	$20,400.00	$20,808.00	$21,224.00	$82,432.00
1. Personnel Subtotal	$113,158.00	$115,421.00	$117,730.00	$120,085.00	$466,394.00
2. Personnel Fringe - (up to 65%)	$62,553.00	$63,804.00	$65,080.00	$66,382.00	$257,819.00
3. Equipment/Furniture	$10,000.00				$10,000.00
4. Supplies	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$8,000.00
5. Travel/Mileage/Parking	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$4,000.00
6. Staff Trainings/Development	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$4,000.00
7. Contractual					$0.00
8. Other Expenses	$20,400.00	$20,808.00	$21,224.00	$21,648.00	$84,080.00
Direct Costs Subtotal (lines 1-8)	$210,111.00	$204,033.00	$208,034.00	$212,115.00	$834,293.00
Indirect Costs (no more than 10% of direct costs)	$21,011.00	$20,403.00	$20,803.00	$21,212.00	$83,429.00
Collections	-$21,744.00	-$49,700.00	-$55,910.00	-$62,000.00	-$189,354.00
Totals	$209,378.00	$174,736.00	$172,927.00	$171,327.00	$728,368.00

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones

Organization Name: Associated Black Charities

HEZ Project Name: Competent Care Connection - Caroline/Dorchester HEZ

Grant Program Name: Health Enterprise Zones

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	**Year 1 (January - December 2013)**	**Year 2 (January - December 2014)**	**Year 3 (January - December 2015)**	**Year 4 (January - December 2016)**	**Total Organization Request**
Personnel Salary					
65% FTE - [redacted],	$25,272.00	$25,272.00	$25,272.00	$25,272.00	$101,088.00
(Community Health Outreach Program Director)					
50% FTE - TBD, Community Health Outreach Worker	$11,700.00	$15,600.00	$15,600.00	$15,600.00	$58,500.00
50% FTE - TBD, Community Health Outreach Worker	$11,700.00	$15,600.00	$15,600.00	$15,600.00	$58,500.00
50% FTE - TBD, Community Health Outreach Worker	$11,700.00	$15,600.00	$15,600.00	$15,600.00	$58,500.00
50% FTE - TBD, Community Health Outreach Worker	$11,700.00	$15,600.00	$15,600.00	$15,600.00	$58,500.00
1. Personnel Subtotal	$72,072.00	$87,672.00	$87,672.00	$87,672.00	$335,088.00
2. Personnel Fringe (15% - Rate)	$10,811.00	$13,151.00	$13,151.00	$13,151.00	$50,264.00
3. Equipment/Furniture	$4,000.00				$4,000.00
4. Supplies	$1,125.00	$1,125.00	$1,125.00	$1,125.00	$4,500.00
5. Travel/Mileage/Parking	$2,040.00	$6,080.00	$6,080.00	$6,080.00	$20,280.00
6. Staff Trainings/Development					$0.00
7. Contractual	$1,500.00				$1,500.00
8. Other Expenses					$0.00
Direct Costs Subtotal (lines 1-8)	$91,548.00	$108,028.00	$108,028.00	$108,028.00	$415,632.00
Indirect Costs (no more than 10% of direct costs)	$9,155.00	$7,562.00	$7,562.00	$7,562.00	$31,841.00
Totals	$100,703.00	$115,590.00	$115,590.00	$115,590.00	$447,473.00

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones

Organization Name: Chesapeake Voyagers, Inc.

HEZ Project Name: Competent Care Connection - Caroline/Dorchester HEZ

Grant Program Name: Health Enterprise Zones

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	**Year 1 (January - December 2013)**	**Year 2 (January - December 2014)**	**Year 3 (January - December 2015)**	**Year 4 (January - December 2016)**	**Total Organization Request**
Personnel Salary					
Vacant - 50% Peer Recovery Specialist	$13,520.00	$13,790.00	$14,066.00	$14,347.00	$55,723.00
1. Personnel Subtotal	$13,520.00	$13,790.00	$14,066.00	$14,347.00	$55,723.00
2. Personnel Fringe (15% - Rate)	$4,000.00	$4,080.00	$4,160.00	$4,160.00	$16,400.00
3. Equipment/Furniture	$1,100.00				$1,100.00
4. Supplies	$500.00	$500.00	$500.00	$500.00	$2,000.00
5. Travel/Mileage/Parking	$500.00	$500.00	$500.00	$500.00	$2,000.00
6. Staff Trainings/Development					$0.00
7. Contractual					$0.00
8. Other Expenses					$0.00
Direct Costs Subtotal (lines 1-8)	$19,620.00	$18,870.00	$19,226.00	$19,507.00	$77,223.00
Indirect Costs (no more than 10% of direct costs)					$0.00
Totals	$19,620.00	$18,870.00	$19,226.00	$19,507.00	$77,223.00

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones

Organization Name: Maryland Healthy Weighs

HEZ Project Name: Competent Care Connection - Caroline/Dorchester HEZ

Grant Program Name: Health Enterprise Zones

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total Organization Request
Personnel Salary					
100% FTE - Health Educator	$40,000.00	$41,200.00	$42,436.00	$43,709.00	$167,345.00
1. Personnel Subtotal	$40,000.00	$41,200.00	$42,436.00	$43,709.00	$167,345.00
2. Personnel Fringe (10% - Rate)	$4,000.00	$4,120.00	$4,244.00	$4,371.00	$16,735.00
3. Equipment/Furniture					
4. Supplies					
5. Travel/Mileage/Parking					
6. Staff Trainings/Development	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$4,000.00
7. Contractual					
8. Other Expenses					
Direct Costs Subtotal (lines 1-8)	$45,000.00	$46,320.00	$47,680.00	$49,080.00	$188,080.00
Indirect Costs (no more than 10% of direct costs)					
Totals	$45,000.00	$46,320.00	$47,680.00	$49,080.00	$188,080.00

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones

Organization Name: Affiliated Sante Group - ESMCS expansion

HEZ Project Name: Competent Care Connection - Caroline/Dorchester HEZ

Grant Program Name: Health Enterprise Zones

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	**Year 1 (January - December 2013)**	**Year 2 (January - December 2014)**	**Year 3 (January - December 2015)**	**Year 4 (January - December 2016)**	**Total Organization Request**
Personnel Salary					
1a) 2.1 FTE MCT Specialist, LCSW-C, TBF		$107,977.00	$111,216.00	$114,552.00	$333,745.00
for 10 months in Year 1 (March-December, 2013)	$87,360.00				$87,360.00
1b) 2.3 FTE MCT Specialist, LGSW, TBF		$98,550.00	$101,507.00	$104,552.00	$304,609.00
for 10 months in Year 1 (March-December, 2013)	$79,733.00				$79,733.00
1c) .5 FTE MCT Program Coordination	$41,370.00	$42,611.00	$43,889.00	$45,206.00	$173,076.00
1. Personnel Subtotal	$208,463.00	$249,138.00	$256,612.00	$264,310.00	$978,523.00
2. Personnel Fringe (15.5%/15.75%/16%/16.25% - Rat	$32,312.00	$39,239.00	$41,058.00	$42,950.00	$155,559.00
3. Equipment/Furniture					
3a) Technology & Communications	$1,450.00	$1,494.00	$1,539.00	$1,585.00	$6,068.00
3b) Technology, Communications, Furniture/Space - Star	$16,700.00				$16,700.00
3c) Vehicle - 1 - Start-Up	$28,000.00				$28,000.00
4. Supplies	$7,030.00	$5,387.00	$5,549.00	$5,715.00	$23,681.00
5. Travel/Mileage/Parking	$13,678.00	$14,088.00	$14,511.00	$14,946.00	$57,224.00
6. Staff Trainings/Development	$22,210.00	$22,876.00	$23,563.00	$24,269.00	$92,918.00
7. Contractual	$14,000.00	$14,360.00	$14,731.00	$15,113.00	$58,204.00
8. Other Expenses	$40,910.00	$39,937.00	$41,097.00	$42,293.00	$164,237.00
Direct Costs Subtotal (lines 1-8)	$384,753.00	$386,519.00	$398,660.00	$411,181.00	$1,581,113.00
Indirect Costs (no more than 10% of direct costs)	$46,050.00	$43,580.00	$44,955.00	$46,370.00	$180,955.00
Totals	$430,803.00	$430,099.00	$443,615.00	$457,551.00	$1,762,068.00

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones

Organization Name: MedChi, The Maryland State Medical Society

HEZ Project Name: Competent Care Connection - Caroline/Dorchester HEZ

Grant Program Name: Health Enterprise Zones

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total Organization Request
Personnel Salary					
1a. 15% FTE - [redacted], Program Director	$15,000.00	$15,450.00	$15,914.00	$16,391.00	$62,755.00
1b. 50% FTE - [redacted], Coordinator	$20,000.00	$20,600.00	$21,218.00	$21,855.00	$83,673.00
1. Personnel Subtotal	$35,000.00	$36,050.00	$37,132.00	$38,246.00	$146,428.00
2. Personnel Fringe (15% - Rate)	$5,250.00	$5,408.00	$5,570.00	$5,737.00	$21,965.00
3. Equipment/Furniture	$10,000.00	$2,000.00	$2,000.00	$1,000.00	$15,000.00
4. Supplies	$12,000.00	$10,000.00	$10,000.00	$8,000.00	$40,000.00
5. Travel/Mileage/Parking	$5,000.00	$4,000.00	$2,000.00	$2,000.00	$13,000.00
6. Staff Trainings/Development	$2,500.00	$2,500.00	$2,500.00	$1,000.00	$8,500.00
7. Contractual	$100,000.00	$80,000.00	$30,000.00	$20,000.00	$230,000.00
8. Other Expenses	$15,000.00	$10,000.00	$5,000.00	$2,000.00	$32,000.00
Direct Costs Subtotal (lines 1-8)	$219,750.00	$186,008.00	$131,334.00	$116,229.00	$653,321.00
Indirect Costs (no more than 10% of direct costs)	$21,975.00	$18,601.00	$13,133.00	$11,623.00	$65,332.00
Totals	$241,725.00	$204,609.00	$144,467.00	$127,852.00	$718,653.00

Dorchester County Health Department
Health Enterprise Zone Budget Justification

Personnel Salary – Salary for new staff positions: One half-time (.5 FTE) Coordinator of Special Programs to oversee implementation of and provide monitoring for the "Competent Care Connections" initiative. One FTE Nurse Practitioner to provide both somatic and mental health care through the School-Based Wellness Center at Maces Lane Middle School. One FTE Office Clerk to provide support for the clinician in the SBWC. One Peer Recovery Specialist to persons with behavioral health issues. Years 2 through 4 include 2% COLA.

Personnel Fringe – Only one position includes full health/retirement benefits for Nurse Practitioner; all other positions are Special Payments Payroll – fringe includes FICA, Unemployment Insurance, Workman's Comp, etc.

Equipment/Furniture – 1st year: $20,000 for vehicle for transporting clients; $3000 for new computers for Coordinator & Peer Recovery Specialist. 2nd year & 4th year: Replacement computers for Nurse Practitioner and Office Clerk.

Supplies – Office supplies for Peer Recovery Specialist and Coordinator; office and clinic/medical supplies for Nurse Practitioner & Office Clerk working in School-Based Wellness Center.

Travel/Mileage/Parking – Work-related travel for client services, meetings, trainings

Staff Trainings/Development – Continuing Education for clinician; coding and billing training for Office Clerk; required mental health training for Peer Recovery Specialist

Contractual – N/A

Other Expenses – telephone, copier use, share of building expenses

Collections - Expected revenue from billing for clinical services.

Indirect Costs 10% indirect cost rate relating to facility and administrative costs.

Eastern Shore Area Health Education
Health Enterprise Zone Budget Justification

1. General Budget Information:

- **Indirect Costs** ($11,945 Year 1) – The Eastern Shore Area Health Education Center has a 10% indirect cost rate relating to facilities and administrative costs.

2. Program Budget Categories

Personnel Salary ($55,603 Year 1): All Year 2, 3 and 4 salaries reflect a 3% increase in base salary.

1a. 20% FTE - [redacted], Health Careers Coordinator ($9,216) will be responsible for developing, planning, marketing and facilitating the Health Careers Summer Exploration Program.

1b. 80% FTE - TBD, Behavioral Health Training Coordinator ($39,936) will be responsible for developing, planning, marketing and facilitating the Behavioral Health Interdisciplinary Team Training (BHITT) Program at 50 % FTE and will be responsible for administering the Continuing Education Program for health professionals at 15% FTE and the Community Health Outreach Worker (CHOW)Training Program Curriculum and Implementation at 15% FTE.

1c. 12% FTE - [redacted], Program Monitor ($6,451) will be responsible for creating monitoring tools for all the proposed AHEC activities (Continuing Education Programming, Health Careers Summer Program, BHITT and CHOW Training); train AHEC staff on managing program data, evaluating data quarterly and will disseminate data and other program specific information to the Lead Agency on a quarterly basis.

Personnel Fringe ($12,844 Year 1) – AHEC fringe benefits are 23.1% of annual salaries and broken down as follows:

Type of Benefit	**% of Payroll**
Health Insurance	5.46%
Alt. Health Insurance	0.70%
Disability	1.07%
Retirement	8.00.%
FICA	7.65%
SUTA	0.22%
TOTAL FRINGE	**23.1%**

Equipment ($1,500) Equipment purchase will occur in Year 1 with one laptop computer ($1,500) required for the new AHEC BHITT position.

Supplies:
Office supplies ($5,275) Consumable office supplies such as copy paper, brochure and certificate paper, pocket folders, printer cartridges, pens, business cards, photocopying, postage and other general office supplies

- **Educational Supplies** ($5,075)– including binders, brochures, books, DVDs, etc. for educational/training participants

Travel:
- **Local Business Travel** ($1,629) Local travel is reimbursed at $0.43/mile for AHEC staff: BHITT Coordinator, Health Careers Coordinator and Program Monitor averaging 3,788 miles in Year One. A 3% increase is included in subsequent years to consider gas inflation.
- **Student Transportation** ($3,000) Health Professional students travelling to the BHITT programs will be reimbursed for costs incurred ($1,500 Y1) and the young students

participating in AHEC's Health Careers Exploration Summer Camp will be bused to the AHEC Center for the training and then will be bused to health care facility sites during the week for a field trip opportunity at $1,500 in Year 1.

Staff Trainings/Development:

$3,550 is requested each year for AHEC Staff development to include one staff member to attend the National Rural Health Conference and one AHEC staff member to attend the National AHEC Organization Annual conference.

National Rural Health Conference:	
Conference registration =	$ 180
Hotel $175 x 3 nights =	$ 525
$40 per diem x 4 days =	$ 160
Airfare and taxi transfers =	$ 525
Total	$1,315

National AHEC Annual Conference:	
Conference registration =	$ 495
Hotel $175 x 5 nights =	$ 875
$40 per diem x 6 days =	$ 240
Airfare and taxi transfers =	$ 625
Total	$2,235

Contractual Costs:

- **Teacher Stipend** ($3,000) AHEC will contract with two High School teachers, one from Colonel Richardson High School in Caroline county and one from South Dorchester High School to assist AHEC's Health Careers Coordinator in the Health Careers Exploration Summer Camp in Years 1-4. Each teacher will receive $1,500 each for the recruitment of students and working with AHEC staff on program planning and assisting during the one week camp.
- **Instructor Fees** ($3,700) AHEC will contract with a local instructor with a minimum of a Masters Degree in Communications to teach the 16 week Core Curriculum of the CHW Training Program in Years 1 and 3 ($3,200 in Years 1 and 3). AHEC will also contract with Maryland Healthy Weighs' Executive Director, Linda Breland, RN, MPH to provide an annual training session on nutrition and physical activity ($500 every year in Years 1-4).

Other Expenses:

- **Conference Logistics** ($15,684)– this would include application/accreditation fees for continuing education credits, facility fees, audio visual equipment rental/support, and speaker honoraria for six programs per year for the AHEC's Continuing Education Department, and speaker honoraria and recognition for AHEC's BHITT Programs, Summer Camp and CHW Training programs.
- **Meals** ($4,520) – this would provide meals for the health professional students that attend the all-day BHITT sessions and lunch for the students that participate in the five-day Health Careers Exploration Camp.
- **Lodging** ($2,000) – lodging is offered to the health professional students that attend the all-day BHITT sessions due to the length of travel to the event.
- **Curriculum** ($2,070) In Year 1 AHEC will purchase a CHW curriculum for the CHW training program and the Youth Health Service Corp curriculum for the Health Careers Exploration Camp which is a $1,320 annual subscription.

In-Kind Contribution:

- ($5,000) AHEC will provide Health Literacy Training as described in the Narrative.

Shore Wellness Partners
Health Enterprise Zone Budget Justification

The budget is based on a 3% inflation rate over the 4 year period.

Direct Costs

Salaries

The Community Care Specialist is responsible for establishing relationships with clients in the community to facilitate appropriate use of resources, access system and community services and communication with the health care team. $38/hour x 2080 = $79,040. The Medical Social Worker provides social work services to referred clients to enhance medical treatment, support and maximize the psychosocial functioning and adjustment of clients through phone calls and home visits.$28/per hour x 2080 = $58,240.

For the first year, personnel subtotal 79,040 + 58,240 = $137,280. The personnel fringe is the personnel subtotal multiplied by 15%. The salaries over the remaining 3 years show a 3% inflation rate.

Equipment/Furniture

For year one, the equipment costs include 2 smart phones at $200 each for a total of $400. Smart phones are needed to be able to look up information, such as pill identification, while in the client's homes. The medical equipment needed the first year includes: 2 home visiting bags at $36 each for a total of $72, one pulse ox at $88, 2 blood pressure cuffs with the standard cuff costing $26.4 and the large adult costing $47.30 for a total cost of $73.70, and a thermometer at $16.50. **All of these items total $650**.

For the second year, the equipment/furniture costs total $**9,200**. This total includes: 2 desks at $1,100 each for a total of $2,200, 2 chairs at $330 each for a total of $660, a filing cabinet at $550, delivery and assembly of equipment at $400, 2 tablet computers at $2,200 each for a total of $4,400, 2 Computer docking stations at $220 each for a total of $440 and a copier/fax/scanner at $550.

Tablets are needed to document in the electronic medical record while in the client's homes. Shore Wellness Partners will provide older computers the first year and the docking stations will be used at the SWP office. When the new clinic opens, new docking stations will be needed along with new computers to ensure the equipment compatibility.

Supplies

It is anticipated that staff members will see approximately 125 clients during the year. The average supply cost per client is $10 multiplied by 125 is **$1,250**. In the remaining years these costs show an inflation rate of 3%.

Travel/Mileage/Education

The total mileage costs are $3,900. It is anticipated the clinical staff will drive on average 150 miles per pay period multiplied by 2 staff members equals 300 times 26 pay periods equals 7,800 miles at .050 cents per mile. The costs over the remaining 3 years show a 3% inflation rate.

Staff Training/Development
Staff development costs for seminar attendance include **$750** per year.

Contractual
This includes: software monthly licensing per month is $140 for 2 for a total yearly cost of $1,680 computers and cell phone service for 2 phones is $100 a month for a total yearly cost of $1,200. This totals $2,880 for the first year. In the second year, with the opening of the clinic internet access per month is $55 for a total yearly cost of $660 is added to the costs. In years 3 and 4 these costs show an inflation rate of 3%.

Indirect Costs
The indirect costs are $550 per month for rent, cleaning, water, sewer, electricity and trash removal. For years 3 and 4 these costs show a 3% inflation rate.

Caroline County Health Department
Health Enterprise Zone Budget Justification

Personnel Salary – Salary for three new positions – 2.0 FTE Licensed Certified Social Workers - Clinical (LCSW-C) and .8 FTE Office Clerk to provide support. One LCSW-C will see students at Federalsburg Elementary and Colonel Richardson Middle & High Schools. One LCSW-C will be located in Federalsburg to serve adult clients. Years 2 through 4 include 2% COLA.

Personnel Fringe – Two positions include full health/retirement benefits for licensed mental health positions; Office Clerk position is Special Payments Payroll – fringe includes FICA, Unemployment Insurance, Workman's Comp, etc.

Equipment/Furniture – 3 new computers for staff; office equipment, office furnishings to set-up Federalsburg satellite

Supplies – Office supplies

Travel/Mileage/Parking – Work-related travel for client services, meetings, trainings

Staff Trainings/Development – Continuing Education for clinicians

Contractual – N/A

Other Expenses – Rent at $1250/month for Federalsburg satellite office plus utilities (heat/air, phone, internet, electric)

Collections - Expected revenue from billing for clinical services.

Associated Black Charities
Health Enterprise Zone Budget Justification

Personnel Salary ($72,012 Year 1): ($87,672 Year 2 – Year 4) with no increase in base salary.

- 60% FTE – [redacted], Director ($25,272): Ms. Dotson is currently the Director of ABC for 40% FTE, her position will be increased by 60% to oversee and coordinate the implementation and staffing for ABC's – Community Health Outreach activities described in the proposal.

- 50% FTE – TBD, CHOW ($11,700 year 1 – allowing for recruiting and hiring) ($15,700 year 2-4) will be responsible for community outreach and identifying gaps in services within the Federalsburg and Hurlock zip codes.

- 50% FTE – TBD, CHOW ($11,700 year 1 – allowing for recruiting and hiring) ($15,700 year 2-4) will be responsible for community outreach within the Cambridge area zip codes.

- 50% FTE – TBD, CHOW ($11,700 year 1 – allowing for recruiting and hiring) ($15,700 year 2-4) will be responsible for community outreach within the Cambridge area zip codes.

- 50% FTE – TBD, CHOW ($11,700 year 1 – allowing for recruiting and hiring) ($15,700 year 2-4) will be responsible for community outreach within the Cambridge area zip codes.

Personnel Fringe ($10,811 Year 1) and ($13,151 each consecutive year) – ABC fringe benefits are 15% of annual salaries

Equipment Desktop, laptop computers and projectors in year one to accommodate the additional staff and volunteers. ($4,000)

Office supplies ($1,125 annually) Consumable office supplies such as copy paper, ink cartridges, pocket folders, printer cartridges, pens, business cards, photocopying, postage and other general office supplies

Travel ($2,040 year one and 6,080 year 2-4) which is reimbursed at $0.51/mile for ABC Community Health Outreach Director, workers and volunteers, approximately 4000 miles year one and 11,000 miles year 2-4; allowing for tolls and parking.

Contractual - $1,500 Year 1 for IT support setting up new computers.

Indirect Costs ($9,155 Year 1 and $7,562 Year 2 - 4) 10% indirect cost rate relating to facilities and administrative costs.

In-Kind Contribution ($31,200 annually) ABC will coordinate efforts with community colleges and universities along with High school graduate students to provide additional volunteer outreach teams to meet the needs of the community. ($31,200 is calculated based on 4-6 volunteers per year working in the same capacity as the Community Health Outreach Workers.

Chesapeake Voyagers, Inc.
Health Enterprise Zone Budget Justification

Personnel Salary – Salary for one .5 FTE Peer Recovery Specialist to persons with behavioral health issues. Years 2 through 4 include 2% COLA.

Personnel Fringe – Special Payments Payroll – fringe includes FICA, Unemployment Insurance, Workman's Comp, etc.

Equipment/Furniture – Laptop for Peer Recovery Specialist

Supplies – Office supplies

Travel/Mileage/Parking – Work-related travel for client services, meetings, trainings

Maryland Healthy Weighs, LLC
Health Enterprise Zone Budget Justification

The budget is based on a 3% inflation rate over the 4 year period.

Direct Costs

Salaries
The Health Educator is responsible for the preparation and delivery of weekly behavioral groups to coach patients on making lifestyle health changes using an empirical, data-driven approach. Position teaches the supporting content of the HMR program, keeps data on active patients, and provides individual coaching and patient follow up. Full time position at 2080 hours/yr x $19.35 = $40,000. The fringe is calculated at 10%. Subsequent year salaries show a 3% inflation rate.

Staff Training/Development
HMR requires all staff to attend annual national training in to stay current with the latest treatment methodologies. Annual training costs include airfare and ground transportation, lodging for three nights and food at $1000 per person.

Affiliated Sante Group
Mobile Crisis Team and Crisis Intervention Team Training Expansion
Health Enterprise Zone Budget Justification

1. ASG Personnel Costs:
All Year 2, Year 3 and Year 4 salaries, as well as all other line items reflect a 3% annual increase in base salary/cost.

The expansion of Affiliated Sante Group's Eastern Shore Mobile Crisis Services with a Caroline/Dorchester County specific team will operate 7 days/week from 9a-9pm. These times are based on the budget constraints of this project. These times were chosen, as historically, 87% of Eastern Shore Mobile Crisis dispatches occur between 9a – 9p. If additional funds should become available we would recommend increasing the hours from 9pm-midnight.

Eastern Shore Mobile Crisis teams are comprised of 2 clinicians on each 12 hour shift. One of the clinicians will be an LCSW-C. The other staff person will be a lesser licensed clinician or MSW intern. Each shift requires the inclusion of an LCSW-C in order to complete a full community based behavioral health assessment, which is needed to divert citizens from the emergency room.

- 1a Mobile Crisis Team Specialist, LCSW-C – 2.1FTE LCSW-C behavioral health clinicians will be added to the ESMCS staff. These clinicians will provide direct services to consumers. Scheduling assignments will be such that there will be an LCSW-C team member on each shift. This staffing will permit full behavioral health assessments and triage services for each consumer. Having this caliber of behavioral health professional will be instrumental in assisting in the diversion of consumers from the ED. Year 1's salary is based on an operational time of 10 months.

- 1b Mobile Crisis Team Specialist, LGSW – 2.3FTE LGSW behavioral health clinicians will be added to the ESMCS staff. These clinicians will provide direct services to consumers. Scheduling assignments will be such that they will be the second team member on each shift. Having 2 behavioral health clinicians on the team permits maximum efficiency, effectiveness and safety. Year 1's salary is based on an operational time of 10 months

- 1c Mobile Crisis Team Coordination – .5 FTE that will be responsible for project oversight, supervision and coordination, as well as outcomes management, grant/contract management, budget management, monitoring and reporting coordination, community relations, EMR (electronic medical record) coordination, and case audits.

2. Equipment/Furniture
- All equipment purchases will be completed in year 1 and are part of the startup costs associated with expansion. As ESMCS services are predominantly provided in the field, where the consumer in crisis is, start up equipment needs reflect this. Toughbooks are a form of highly durable laptop that are utilized in the field by ESMCS staff, 2 are needed at a cost of 2 @ $3,000 each = $6,000. In addition, smart phones are the best form of communication with the team spending the majority of their time in the field, 3 @ $200 each = $600. 3 are needed so that each member of the team in the field needs a phone, as it is critical for each member of the team in field may be split into 2 different cases. Desktop computers (2 @ $600 each = $1200) and all-in-one printers (2 @ $600 = $1,200) will also be needed for the office. Office furniture will also be needed to accommodate the staff.

Furniture includes 4 desks @ $800 each = $3,200; 4 chairs @ $200 each = $800 and 3 file cabinets @ $100 each = $300. Depending on the final office location chosen, build out expenses are included of $4,850. True to the Mobile in Mobile Crisis, a vehicle is needed for the teams to go to the consumers in crisis, and the new vehicle to accommodate this is included in year 1 startup costs of 1 @ $28,000. The chosen vehicle needs to have all wheel drive to maximize utilization despite the weather. Included also in year 1 costs as well as annualized in years 2, 3, and 4 of the project are technology and communications program services costs which assist in maintaining the electronic medical record that this crucial for the continuity of care provided to the consumers served.

3. Supplies

- Books and Publications **($200 base**) - These books and publications are for enhanced staff learning as well as achieving readiness for CARF accreditation.
- Postage **($800 base**)
- Program supplies **($2,400 base + $1,800 start up)**
  - Our Mobile Crisis Specialists each wears a polo shirt with the Sante Group Crisis Services emblem as part of their uniform. In the colder months, jackets also with the Sante Group Crisis Services emblem are worn as part of their uniform. These are provided to staff. Staff supplies their own khaki or black slacks, the other part of their uniform. 2-3 shirts are provided to each staff person. As they are worn on each shift, over the course of a year, they need to be replaced, reflecting the annual budget item. Also in this category are first aid kits, inverters, and other such supplies that are in each of the mobile crisis vehicles. As the team spends most of the day on the road, the inverters permit staff to have outlets available to keep cell phones and Toughbooks charged. By wearing team identified attire, it helps to readily identify team members to law enforcement, emergency services, on scene.
- Supplies **($1,830 base)**
  - Consumable office supplies such as file folders, paper, toner, computer supplies.

4. Travel/Mileage Parking

- Transportation
  - Vehicle Gas – As Mobile Crisis services are provided directly where the consumer is, vehicle gas is needed for each day's dispatches.
  - Vehicle Registration – mandatory expenses to keep the mobile crisis vehicles on the road.
  - Staff mileage – Each member of the mobile crisis team is required to maintain their professional licenses, as well as ongoing expertise, which dictates continuing education courses taken, and travel to the courses. Staff may also incur mileage when attending meetings and trainings. In addition to these miles driven, there is also the mileage incurred during the training of law enforcement, emergency services and other for the expansion of the Crisis Intervention Training services.

5. Staff Trainings/Development

- Mobile Crisis Staff Development Training **($2,880 base)**
  - Each member of the mobile crisis team is required to maintain their professional licenses, as well as ongoing expertise, which dictates continuing education courses taken
- Crisis Intervention Training costs – **($5,330 base)**
  - Cost of printed materials and a meal for each participant in the Crisis Intervention Training (CIT) Introductory/Refresher classes. 9 introductory classes teaching 175 law enforcement, emergency services and other partners ($15/participant x 175 participant

= $2625). In addition there will be one 40 hour (CIT) training each year, for 20 participants. ($26.75/day x 20 participants $535 x 5 days = $2,675)

- Officer Training Stipends **($14,000 base)**
    - In order to offset the cost to the local police and emergency services departments who send staff and have to pay others to ensure coverage, a small stipend for each of these partners participating in the introductory and 40 hour trainings.

6. **Contractual**
    - Crisis Intervention Training Outreach and Education Coordinator – This contractual staff person serves as the Education and Outreach Coordinator for the Crisis Intervention Training expansion services. This staff person is responsible for conducting all of the outreach and follow-up for the 9 introductory and classes and 1 40 hour training. **($20/hour x 600 hours = $12,000 for year 1 with a 3% increase each year thereafter**)
    - MSW Intern – 2 MSW interns will be selected to work with the ESMCS team. Utilizing MSW interns permits the successful use of a workforce development process. This model has been highly successful in recruiting and retaining long lasting employees. **($500/semester x 2 semesters/year x 2 interns = $2,000)**

7. **Other expenses ($40,910 base)**
    - Advertising and Recruitment **($2350 base)**
    - These are the costs incurred with the recruitment of Mobile Crisis Specialists. The annual costs builds in expenses incurred with staff turnover and the need to refill the positions.
    - Communications **($6270 base + $400 start up)**
    - These costs reflect the landline, cell phone, internet, telephonic interpretation services, and conference calling.
    - Insurance **($4665 base)**
    - These costs reflect building, vehicle and liability insurance costs
    - Legal, Accounting and Audit **($2415 base)**
    - These costs reflect payroll services, audit and legal fees.
    - Maintenance **($3860 base)**
    - These costs reflect vehicle maintenance, roadside assistance and software maintenance costs.
    - Printing **($2000 base)**
    - These costs reflect the cost of printed promotional materials for the program.
    - Professional Dues/licenses **($1250 base)**
    - Each of our Mobile Crisis Specialists is required to attain and maintain a professional license. The cost of the license is a service we provide for our staff as a recruitment and retention mechanism. Professional licenses are renewed bi-annually, based on the year the license was secured. Our company experience indicates that on average half of the staff requires license renewal each year.
    - Rent, Utilities and Housekeeping **($16,500 base)**

MedChi
Health Enterprise Zone Budget Justification

1) General Budget Information

Indirect Costs ($21,975 in year 1) – MedChi has a 10% indirect cost rate relating to facility and administrative costs.

2) Program Budget Categories

· Personnel Salary – All salaries reflect a 3% increase year over year.

o 1a. Program Director, 15% FTE – [redacted] will be the project manager responsible for implementing all aspects of the program. He will manage the finances, coordinate across health care practitioners and contractors, and perform evaluations.

o 1b. Coordinator, 50% FTE – [redacted] will be the coordinator. In this role she will work directly with vendors, practitioners, consultants, and other groups in order to plan and execute a variety of program aspects.

· Personnel Fringe – The fringe benefits are calculated at 15% of the base salary.

· Equipment/Furniture – Equipment and furniture estimated to be $10,000 in year 1, which includes outfitting office space with computers, printer, projector, and certain basic office furniture. After year 1 there will be continued, modest expenses related to furniture and equipment and the amount decreases to $2,000 per year in years 2, 3, and 4.

· Supplies – Supplies in year one are estimated to cost $12,000 for office supplies such as copy paper, folders, pens, etc. There will also be costs for educational materials such as brochures, handouts, and binders. Finally, advertising materials such as post cards, web notifications, and postage are included. This amount decreases to $10,000 in years 2, 3, and 4 because there are no start-up costs in the out years.

· Travel/Mileage/Parking – MedChi reimburses mileage at the government rate of $0.55 per mile. Significant driving is expected for both the Coordinator and Program Director in order to attend events, provider support in practices, and participate in meetings. The amount decreases during the program because travel is expected to decrease as physicians are recruited and consulting is performed.

· Staff Training/Development – The field of health IT is rapidly changing and staff will need to attend training, seminars, and potentially conferences in order to stay updated on changes (for example, Meaningful Use Stage 2 and Stage 3 regulations).

· Contractual – A lot of the initial training and consulting will be performed by contractors; it is impractical to maintain those employees full-time because of both the time and expense associated. Contractors will be available as needed, and the Program Manager will be able to identify and use subject matter experts for a variety of topics. Contract expenses will pay for the cost of CME accreditation through an accrediting body. The other portion of contractual spend will go to consultants that can supplement

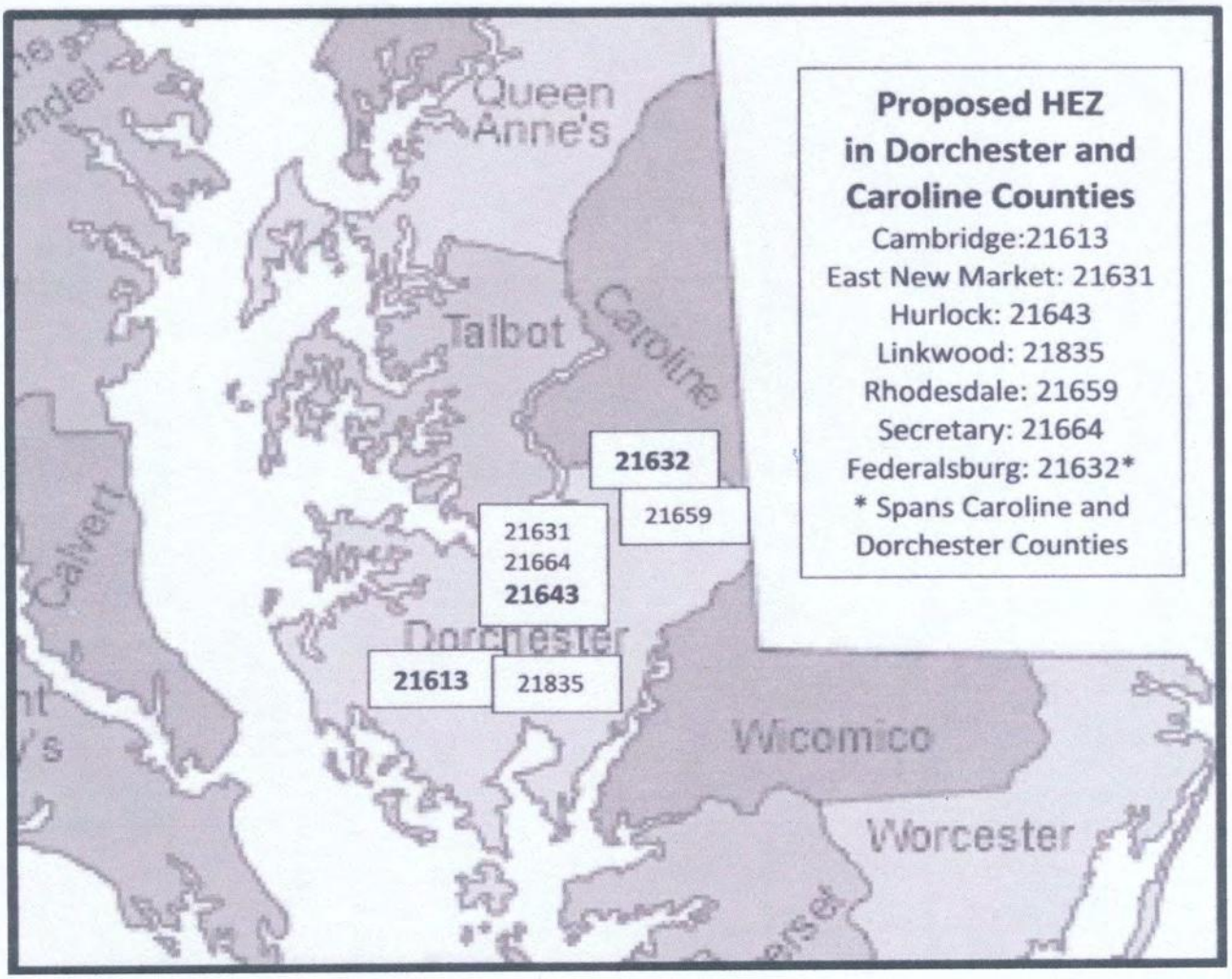
the practice management and EHR support provided by MedChi. The cost of contract services is $100,000 in the first year due to the high volume of outreach and consulting, and decreases over the 4-year program.

· Other Expenses – Other expenses include meals, lodging, space rental, and other similar costs. This amount is budgeted to decrease over the duration of the program.

3) In-Kind Contribution

· Senior leadership from MedChi and the Accountable Care Organization of the Eastern Shore will provide strategic guidance to the program; the time and resources are equivalent to $10,000 per year.

Caroline/Dorchester HEZ Map



APPENDIX ITEM E – WORKPLAN Chart

Maryland Community Health Resources Commission/ Health Enterprise Zones

Organization Name: Dorchester County Health Department – Connections Coalition					
HEZ Project Name: Competent Care Connections **Grant Program Name:** Dorchester-Caroline HEZ -					
Project Purpose: Reduction in racial and health disparities among minority populations within the HEZ; Improved healthcare access and health outcomes in underserved communities, and reduced health care costs, hospital admissions, and readmissions					
Goal 1: Improved positive outcomes and reduced risk factor prevalence corresponding to Diabetes, Hypertension, and untreated behavioral health issues.					
Measure of Success: Reductions in blood sugar, hypertension overall; Plus increased number of patients seeking behavioral health support					
Objective	**Program Activities/Action Steps**	**Expected Outcome**	**Data and Evaluation Measures**	**Organization/Person Responsible**	**Timeframe**
1. Within 12 months, the Health Educator at Healthy Weighs will recruit 60 adults from the target community.	1a. Develop plan for marketing and recruiting community members (that is culturally relevant) and execute 1b. Hire Community Health Outreach Workers; Coordinate with Community Health Workers to recruit Healthy Weigh participants 1c. Meet with clients, provide education, and monitor progress	Improve healthy weight of adults to Maryland target of 36% by 2016	a. # of information impressions re: Healthy Weigh opportunity; # of inquiries from potential customers; # of customers; # of education sessions: Progress weigh ins; Health status checks and results	Healthy Weighs – Brie Brieland, RN	February 2013 – Develop materials March 22013 – Begin seeing clients – then ongoing Quarterly – Provide data and reporting
			b. # of contacts made by CHOWS with community members; # of information impressions transferred; # of enrolled adults: # of sessions; Lbs lost; Health status improvements	Associated Black Charities and Community Health Workers	March 2013 – Hire and train CHOWS; Develop materials for distribution Ongoing – Support clients in attending Healthy Weighs, exercising, and eating well
2.. Within 12 months, the School Based Health Center Nurse will receive 400 student visits.	2a. Hire and orient nurse 2 b. Track youth BMI; Identify youth with BMI at poor health levels 2.c. Meet with youth to develop action plan for fitness	Reduce percentage of child and adolescent obesity to MD target of 11.3% by 2016.	a. Resumes collected; interviews held; person hired b. # of youth BMI recorded; # with poor BMI levels; # of sessions with youth c. Action plans developed; BMI improvements; lbs lost	Dorchester County Health Department – School-Based Health Center	February 2013 – Hire and orient nurse March-April 2013 – Collect data from students and assess April – June 2013 meeting with students, then ongoing
3. Within 12 months, Shore Health Partners will visit 45-55 patients in their homes.	3a. Hire and orient SHP staff and orient 3b. Review patient issues and plans; Meet patients to assess and provide wellness support 3c. Monitor progress; Maintain encouragement	Reduce incidence of Diabetes by 10% among target population seeking care by 2016. Reduce incidence of Hypertension by 10% among target population seeing care by 2016	a. Resumes collected; interviews held; person hired b. # of patients seen. # of patients with appropriate blood sugar, BP, optimal weight c. # of patients improved; # patient retention	Shore Health Systems	February 2013 – Hire two positions and orient March 2013 – Review patient history; determine treatment plan (ongoing) and begin patient visits – Ongoing September and every quarter, collect health measures.

APPENDIX ITEM E – WORKPLAN Chart
Maryland Community Health Resources Commission/ Health Enterprise Zones

Organization Name: Dorchester County Health Department – Connections Coalition					
HEZ Project Name: Competent Care Connections					
Grant Program Name: Dorchester-Caroline HEZ -					
Project Purpose: Reduction in racial and health disparities among minority populations within the HEZ; Improved healthcare access and health outcomes in underserved communities, and reduced health care costs, hospital admissions, and readmissions					
Goal 1: Improved positive outcomes and reduced risk factor prevalence corresponding to Diabetes, Hypertension, and untreated behavioral health issues.					
Measure of Success: Reductions in blood sugar, hypertension overall; Plus increased number of patients seeking behavioral health support					
Objective	**Program Activities/Action Steps**	**Expected Outcome**	**Data and Evaluation Measures**	**Organization/Person Responsible**	**Timeframe**
1. Within 12 months, Psy Nurse Practitioner / Social Worker sees 300 / 400 students at MLM, SDHS/ CRMS, CRHS	1a. Hire and orient Psych/ Social Worker at SMHC 1b. Review patient issues and plans; Meet patients to assess and provide wellness support 1c. Monitor progress; Maintain encouragement	Improve penetration rates of those eligible for behavioral health support and addiction recovery and those who actually receive treatment by 10% by 2016.	a. Resumes collected; interviews held; person hired b. # of patients seen. # of patients with behavioral health challenges c. # of patients improved; # patient retention; Global Functioning scale - improvements	Dorchester County Health Department Caroline County Mental Health Clinic	February 2013 – Hire two positions and orient March 2013 – Review patient history; determine treatment plan (ongoing) and begin patient visits – Ongoing September and every quarter, collect health measures.
Goal 2: Expand the primary care workforce					
Measure of Success: Number of people at baseline in primary care vs number at increments (each year?)					
2. Within 12 months, MedChi will have recruited 3 primary care docs to open offices to underserved population and 1 new doc	2a Conduct inventory of docs and practices related to underserved. 2b. Determine opportunities and incentives for marketing to docs. 2c. Pitch opportunities, incentives and benefits to docs; Assist with transition to underserved	By 2013, increase primary care positions in the HEZ by at least 3.0 FTEs	a. inventory conducted; #of docs targeting underserved; demographics of practices; b.# of opportunities for expansion; # of docs ripe for expansion; # of candidate docs for moving to area c.# who agree; #incentives offered and utilized; # and demographics of new patients	Maryland Physicians Medical Society	February – March – conduct physician inventory March –April – Market and determine options for doc candidate pool April –May - Continue marketing and following up with prospects – ongoing June –December – help to transition and set up docs; Market to public – ongoing Collect quarterly measures - ongoing

APPENDIX ITEM E – WORKPLAN Chart

Maryland Community Health Resources Commission/ Health Enterprise Zones

Organization Name: Dorchester County Health Department – Connections Coalition					
HEZ Project Name: Competent Care Connections					
Grant Program Name: Dorchester-Caroline HEZ -					
Project Purpose: Reduction in racial and health disparities among minority populations within the HEZ; Improved healthcare access and health outcomes in underserved communities, and reduced health care costs, hospital admissions, and readmissions					
Goal 3: Increase the community health workforce					
Measure of Success: # of Community Health Outreach Workers and Health Educators hired					
Objective	**Program Activities/Action Steps**	**Expected Outcome**	**Data and Evaluation Measures**	**Organization/Person Responsible**	**Timeframe**
1. Within 12 months, hire and train five community-based individuals as community health outreach workers	1a. Market opportunity for positions . 1b. Hire and orient 4 (.5 FTE) CHOWS and one Health Educator 1c. Engage community health staff in intensive AHEC training	By 2013, increase community health workers by 5 individuals	a. Resumes collected; interviews held; # of persons hired b. # of training hours; # of topics covered c. # of hours in AHEC training; Improvements in knowledge, awareness, comfort level	Associated Black Charities (CHOW) Maryland Healthy Weighs (Health Educator) Area Health Education Center (training)	February 2013 – Hire five positions and orient March 2013 – Begin four months of training (16 weeks/ 2.5 hours per week) and ongoing May 2013 – Begin matching workers with communities - ongoing Collect data and measures - ongoing
Goal 4: Increase community resources for health					
Measure of Success: Number of underserved people accessing and utilizing new or improved resources for health					
1. Within 18 months, hire the Peer Recovery Support Specialists who will match recovering citizens to local resources (up to 120 citizens seen per year).	1a Hire and orient 1.5 Peer Recovery Support Specialists at DRI-Dock; Attend training 1b. Review client issues and meet to assess and provide safety net and community resources 1c. Monitor progress; Maintain encouragement	By the end of 2014, increase opportunities for targeted citizens in the HEZ to access and utilize community resources that promote health and well-being including access to healthy food, opportunities for safe physical activity, resources to support optimal mental health, and resources to support addiction recovery.	a. Resumes collected; interviews held; # of persons hired b. # of resources inventoried c. # of hours in AHEC training; Improvements in knowledge, awareness, comfort level	Dorchester County Health Department DRI Dock	February 2013 – Hire two positions and orient March 2013 – Begin four months of training (16 weeks/ 2.5 hours per week) and ongoing (with CHOWs) April 2013 – Begin matching individuals with resources - ongoing Collect data and measures - ongoing

APPENDIX ITEM E – WORKPLAN Chart

Maryland Community Health Resources Commission/ Health Enterprise Zones

Organization Name: Dorchester County Health Department – Connections Coalition					
HEZ Project Name: Competent Care Connections					
Grant Program Name: Dorchester-Caroline HEZ -					
Project Purpose: Reduction in racial and health disparities among minority populations within the HEZ; Improved healthcare access and health outcomes in underserved communities, and reduced health care costs, hospital admissions, and readmissions					
Goal 5: Reduce preventable emergency department visits and hospitalizations					
Measure of Success: # of emergency department visits diverted; # of incarcerations diverted					
Objective	**Program Activities/Action Steps**	**Expected Outcome**	**Data and Evaluation Measures**	**Organization/Person Responsible**	**Timeframe**
1. Within 12 months, hire and train five community-based individuals as community health outreach workers	1a. Market opportunity for positions . 1b. Hire and orient 4 (.5 FTE) CHOWS and one Health Educator 1c. Engage community health staff in intensive AHEC training	Reduce or exceed diabetes-related emergency department visits to MD target level of 300.2 per 100,000 by 2016. Reduce or exceed hypertension-related emergency department visits to MD target level of 202.4 per 100,000 by 2016.	a. Resumes collected; interviews held; # of persons hired b. # of training hours; # of topics covered c. # of hours in AHEC training; Improvements in knowledge, awareness, comfort level	Associated Black Charities (CHOW) Maryland Healthy Weighs (Health Educator) Area Health Education Center (training)	February 2013 – Hire five positions and orient March 2013 – Begin four months of training (16 weeks/ 2.5 hours per week) and ongoing May 2013 – Begin matching workers with communities - ongoing Collect data and measures - ongoing
2. Within 12 months hire and train new Mobile Crisis Team (4.4 FTE) to respond to behavioral health crisis episodes	2a. Market opportunity for positions 2b. Hire and train 4.4 individuals 2c. Train 175 first responders in model 2d. Engage new team	Reduce or exceed behavioral health-related emergency department visits to the MD target level of 5,028.3 per 100,000 by 2016.	a. # resumes collected, # of interviews; # of persons hired b. # of training hours and topics c. # of first responders d. # of dispatches	Eastern Shore Mobile Crisis Center	February 2013 – Hire five positions and orient/train March 2013 –Begin rotations into Team - ongoing May 2013 – Fully engage into diversion opportunities
Goal 6: Reduce unnecessary costs in healthcare					
Measure of Success: # of Emergency Department visits from preventable diseases; Cost per visit/ # of patients					
3. Within 12 months Community Health Workers / Recovery Support Specialists/ Social Workers and Shore Wellness Partners will have collectively served nearly 600 citizens	3a. Conduct some guerrilla marketing to get word out about the availability of these services 3b. Follow up with customers to be sure opportunities are being utilized 3c Conduct mid program adjustments as needed	Decrease unnecessary health care costs related to emergency room visits and preventable diseases by an annual % of 5% in year 1, 10% in year 2, 12% in year 3; 15% in year four.	a. # of information impressions; # of face to face visits b. # of referrals between health workers and resources	Associated Black Charities DRI-Dock Caroline County Health Dept. Shore Health System	February – May 2013 – Saturate repetitive information May – December – ongoing; Respond to referrals, follow-up with customers Ongoing - Collect data and measures

Appendix 4: HealthStream 2012 Community Health Needs Assessment

HealthStream®

Shore Health System

2012
Community Health Needs Assessment

Submitted June 2012

7710 Montpelier Road | Laurel, MD 20723
www.healthstream.com

Table of Contents

EXECUTIVE SUMMARY SECTION I

In April 2012, HealthStream® surveyed 323 residents living in the Mid-Shore area of Maryland. The survey was commissioned to provide an assessment of the needs in the communities serviced by Shore Health System.

Consumers were asked about the last time they had a routine doctor's visit for a minor illness or preventative care. In the Mid-Shore area overall, the median number of months since the last visit was 7.32.

Consumers in the Mid-Shore area were asked about where they go most often for routine healthcare needs. In the area overall, doctor's office (86%) is by far the most frequently mentioned.

In the Mid-Shore area overall, the hospital most preferred is The Memorial Hospital in Easton (32%). Other hospitals receiving double-digit preference shares in the area overall are Anne Arundel Medical Center (21%) and Chester River Hospital Center (10%).

Consumers were asked if there was a time in the last 12 months when they or another family member needed to see a doctor or use medical services, but could not. In the Mid-Shore area overall, only 8% of consumers responded "yes" there was. As a follow-up question, consumers were asked why if they responded "yes" there was a time in the last 12 months when they or another family member needed to see a doctor or use medical services, but could not. The largest responses from the twenty-seven respondents who said "yes" were no insurance (50%) and doctor was not available/weekend/scheduling issues (33%).

Consumers were asked if they typically travel outside of their county for medical care. In the Mid-Shore area overall, 46% of consumers responded "yes" they do.

Consumers who responded they typically travel outside of their county for medical care were asked for the main reason. For the Mid-Shore area overall, the most common responses were no physician/services available for the type of care I need (35%), better quality of care outside the county (21%) and know the doctor/used that doctor for years (16%).

Consumers were asked about the factors that most affect the quality of healthcare in the community. In the Mid-Shore area overall, top responses include access to care (33%), economic factors (low income/no insurance) (27%) and the quality/attitude of physicians (18%).

Consumers were asked about their sources of information about general health care issues. In the Mid-Shore area overall, top responses include doctor/nurse/pharmacist (79%), internet (48%) and family member/friend (10%).

Consumers were asked about services not currently available or that are of poor quality that need to be offered or improved. In the Mid-Shore area overall, top responses include pediatrics/children's

care (12%) and maternity services/obstetrical services (10%) and it is notable that 30% of consumers said none.

Consumers were asked about the biggest health issue or concern in their community. In the Mid-Shore area overall, top responses include cancer (24%) and cost/lack of insurance/affordable healthcare (16%).

Consumers were asked if they have seen improvement in health care services offered in the Mid-Shore counties in the past 12 months. In the Mid-Shore area overall, 44% of consumers responded that they have seen improvement in the past 12 months.

On the five-point rating scale where 5 equals "extremely often" and 1 equals "not at all often," the Mid-Shore area's overall rating for how often they feel stressed in a typical week is 2.48.

On the three-point rating scale where 3 equals "always" and 1 equals "never," the Mid-Shore area's overall rating for participating in at least one hour of physical activity a day is 2.25.

Consumers were asked to rate a series of health issues as a serious problem, moderate problem or not a problem. In the Mid-Shore area overall, the five issues considered the most serious problems are cancer (66%), obesity (57%), obtaining affordable health care (55%), substance abuse (54%) and diabetes (53%).

Consumers were asked to rate their current health status using a scale where 5 equals "excellent" and 1 equals "poor." The Mid-Shore overall mean score for health is 3.39.

Consumers were asked the number of days they were too sick to go to work or do normal activities in the last 60 days. The area average was 2.15 days.

This Action Blueprint section presents HealthStream's recommendations to Shore Health System based on feedback from 323 adults in the Mid-Shore area. HealthStream recommends reviewing opportunities and services in two of the five counties that the data suggest have needs.

Caroline County

Caroline County has the longest median time between routine doctor's visit for a minor illness or preventative care (7.58 months). Additionally, 15% of consumers in Caroline County mentioned the need to visit a doctor in the last 12 months but could not. This was the highest county score for this question.

When asked if they travel outside of their county for medical care, 69% of Caroline County respondents said they did, which is statistically higher than any other counties. When asked why they travel outside of the county for medical care, 39% of Caroline County residents mentioned no physician/services available for the type of care I need.

Only 34% of Caroline County residents indicated they have seen any improvements in the health care services offered in the Mid-Shore counties in the past 12 months. When asked to self-assess stress levels, health status, activity levels and days sick in the past 60 days, Caroline County residents are the most stressed, least active, least healthy and had the second most days sick in the past 60 days.

In Caroline County, the five issues considered the most serious problems are cancer (65%), obtaining affordable health care (61%), obesity (57%), heart disease (50%) and substance abuse (48%).

Kent County

Kent County has the shortest median time between routine doctor's visit for a minor illness or preventative care (7.03 months). Additionally, 11% of consumers in Kent County mentioned the need to visit a doctor in the last 12 months, but could not. This was the second highest county score for this question.

When asked if they have seen any improvements in the health care services offered in the Mid-Shore counties, 18% of Kent County residents said "yes." This is roughly half the next highest county's score. When asked about the factor that most affects the quality of health care in their community, 41% of Kent County residents mentioned access to care, which is almost twice as high as their next most common response.

When asked about services not currently available or that are of poor quality in their community, 24% of Kent County residents mentioned pediatrics/children's care, which is double the amount

mentioned in the area overall (12%). Similarly, 33% of Kent County residents mentioned maternity services/obstetrical services, which is slightly over three times the amount mentioned in the area overall (10%).

Kent County has the highest average number of sick days.

In Kent County, the five issues considered the most serious problems are cancer (70%), substance abuse (64%), tobacco use (56%), obtaining affordable health care (55%) and heart disease (53%).

RESEARCH OBJECTIVES/ SAMPLE PARAMETERS

SECTION III

Shore Health System, commissioned HealthStream to conduct a telephone market research survey of consumers living in the hospital's service area. The survey was commissioned to provide an assessment of the needs in the communities serviced by Shore Health System.

Methodology

To complete the research objectives, 323 consumers were surveyed over the telephone in April 2012. Surveys were completed with respondents 18 years of age or older. Only residents living in zip codes defined by Shore Health System (see Chart 1) were eligible to complete the survey.

Sampling quotas were established by geographic area. The sample plan called for between 60 and 80 interviews to be conducted within each of five geographic regions comprising the hospital's service area. Calls were made to potential respondents using a random-digit-dialing sampling methodology. HealthStream employs a "five-call" design in order to complete each interview. This call-back procedure is designed to reduce non-response bias and to ensure that a random sample is surveyed.

Stability Of Results

At the 95% level of confidence, the maximum expected error range for a sample of 323 respondents is ±5.5%. In other words, if 100 different samples of 323 adult consumers in the area were randomly surveyed from the entire population, 95 times out of 100 the total results obtained would vary by no more than ±5.5 percentage points from the results that would be obtained if all consumers in the defined area were surveyed. The table below summarizes the expected error ranges for various results reported in this narrative.

Recommended Allowances for Sampling Error of a Percentage (In percentage points; at the 95% confidence level)

	Sample Size		
Percentages near …	323	80	60
10%	3.3%	6.6%	7.6%
20%	4.4%	8.8%	10.1%
30%	5.0%	10.0%	11.6%
40%	5.3%	10.7%	12.4%
50%	5.5%	11.0%	12.7%
60%	5.3%	10.7%	12.4%
70%	5.0%	10.0%	11.6%
80%	4.4%	8.8%	10.1%
90%	3.3%	6.6%	7.6%

Statistical Testing

Tests for statistical significance have been conducted on mean scores and percentage results to determine significant differences in responses given by various subsegments of the sample. However, statistical testing is not conducted on sample sizes below 30 due to the increased error ranges associated with low sample sizes. Statistical significance has been determined by using independent t-tests for mean scores and z-tests for percentage results at the .05 level of probability.

Chart 1 presents a description of the survey area.

Chart 1
Study Area (2012)

Area	Zip Code(s)	Sample Percent		Household Count *
		Unweighted	Weighted	
Caroline County	21609, 21629, 21632, 21636, 21639, 21640, 21641, 21649, 21655, 21660, 21670, 21681, 21682, 21683, 21684, 21685, 21686, 21687, 21688	19%	19%	12,569
Dorchester County	21613, 21622, 21626, 21627, 21631, 21634, 21643, 21648, 21659, 21664, 21669, 21672, 21675, 21677, 21835, 21869	19	20	13,249
Kent County	21610, 21620, 21635, 21645, 21650, 21651, 21661, 21667, 21678	25	15	9,959
Queen Anne's County	21617, 21657, 21658, 21607, 21623, 21628, 21644, 21656, 21668, 21690, 21619, 21638, 21666	19	24	16,111
Talbot County	21601, 21606, 21612, 21624, 21625, 21647, 21652, 21653, 21654, 21662, 21663, 21665, 21671, 21673, 21676, 21679	19	24	16,130
			Total	68,018

* U. S. Census Bureau (2010 Census)

The survey region has been divided into five areas based on the zip codes shown in Chart 1. U. S. Census Bureau data indicates that there are 68,018 households in the area, with roughly 50% of the households in Queen Anne's and Talbot Counties.

The data were weighted by geographic area to account for the fact that a disproportional sample plan was used. The weighting technique shown next adjusts the data to reflect what would have been obtained if all 68,018 households in the area had been surveyed.

Weighting Technique Used For 2012 Study

Area	Desired Number Of Interviews*	÷	Actual Number of Interviews Conducted	=	Weighting Factor
Caroline County	60		61		.9836
Dorchester County	63		60		1.050
Kent County	47		80		.5875
Queen Anne's County	76		62		1.2258
Talbot County	77		60		1.2833

* Based on the number of households in the area

Presented in Chart 2 are demographic characteristics of the consumers surveyed and includes gender, age, ethnicity, education, employment status, annual household income and health coverage.

Chart 2
Demographic Characteristics

Demographic	Total (n=323)	Area: Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Gender						
Male	30%	26%	27%	30%	33%	30%
Female	70	74	73	70	65	70
Age						
18-34	6%	7%	7%	6%	5%	7%
35-44	16	11	23	19	19	7
45-54	25	28	15	13	34	28
55-64	22	21	32	26	13	20
65-74	22	20	12	23	26	28
75/older	10	14	11	14	4	10
Median (years)	**56.5**	**56.7**	**56.4**	**59.3**	**51.9**	**58.8**
Annual Household Income						
Less than $25,000	20%	29%	30%	23%	12%	12%
$25,000-$49,999	20	22	20	14	14	27
$50,000-$74,999	18	18	22	23	10	22
$75,000-$99,999	21	20	16	22	24	24
$100,000 or more	21	12	12	18	41	16
Don't know/Refused	17	16	17	19	18	15
Median (thousands)	**$63,530**	**$48,770**	**$49,900**	**$64,110**	**$90,560**	**$62,450**
Health Insurance Coverage						
Yes	91%	85%	92%	95%	97%	88%
No	9	15	8	5	3	12
Ethnicity						
White	86%	90%	75%	94%	87%	85%
African-American	11	7	25	5	5	14
Native Hawaiian or other Pacific Islander	0	--	--	--	2%	--
Asian	0	--	--	1%	--	--
Some other ethnicity	3%	3%	--	--	7%	2%

(continued)

Chart 2 (Cont'd)
Demographic Characteristics

Demographic	Total (n=323)	Area: Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Health Insurance						
Medicare	29%	33%	35%	37%	17%	28%
A PPO	27	33	25	20	33	22
A traditional insurance plan that places no restrictions on the healthcare providers that may be used	15	10	13	13	20	16
An HMO	15	12	15	18	15	14
Medicaid, Welfare or Public Assistance	4	7	--	4	5	5
Has insurance but does not know what type	3	3	7	--	--	5
Some other type of managed care health plan that restricts or specifies the healthcare providers your household may use	3	--	5	4	2	5
TriCare/Federal Government	2	--	--	3	7	2
No health insurance coverage	2	2	--	1	2	3
Education						
High school incomplete, or less	8%	15%	7%	5%	6%	8%
High school graduate or GED	29	34	38	28	21	25
Technical, trade or business school	2	--	3	6	--	2
College/University incomplete	17	16	17	21	13	20
College/University complete	35	25	28	33	50	33
Postgraduate work/degree	9	10	7	8	10	12
Employment Status						
Employed, working 1-39 hours per week	17%	11%	25%	14%	15%	18%
Employed, working 40 or more hours per week	34	33	23	33	47	30
Not employed, looking for work	4	5	7	1	2	7
Not employed, NOT looking for work	7	10	8	3	8	5
Retired	31	33	25	35	27	37
Disabled, not able to work	7	8	12	14	2	3

SURVEY RESULTS SECTION IV

This section of the report presents results by question for the Mid-Shore area overall, by county and demographic segments, where applicable.

Chart 3
Last Time Visited A Doctor For Minor Illness Or Preventative Care

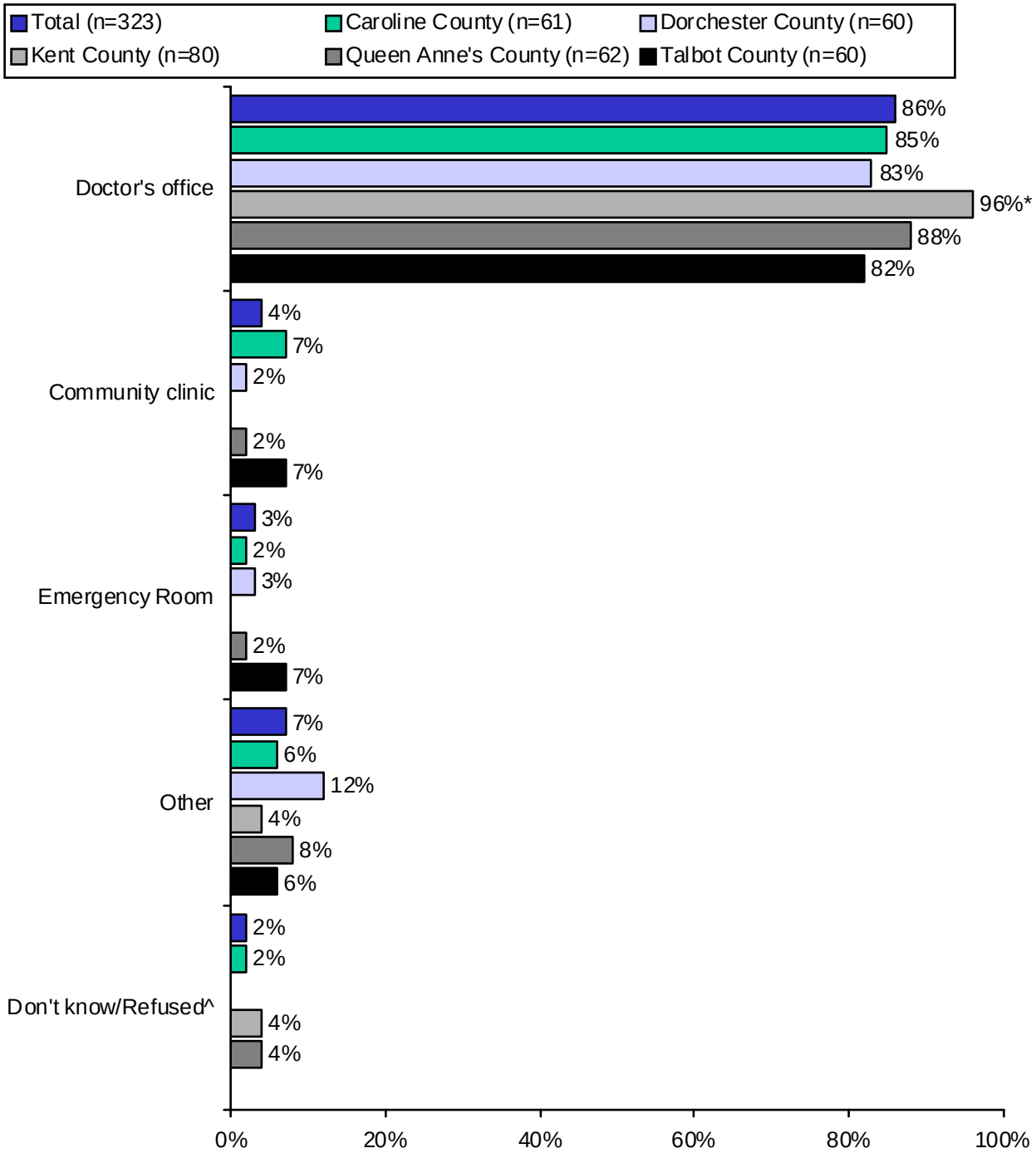
Last Doctor Visit	Total (n=323)	Area: Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Within 12 months	87%	84%	90%	91%	85%	86%
Within 13-18 months	5	5	5	1	7	5
Within 19-23 months	2	7	3	4	--	--
Within 2-5 years	5	5	2	1	8	8
More than 5 years since last visit	0	--	--	3	--	--
Never/Don't know/Refused^	1	--	--	--	2	2
Median Number of Months Since Last Doctor Visit	**7.32**	**7.58**	**7.11**	**7.03**	**7.45**	**7.36**

^ Excluded from calculations above

Consumers were asked about the last time they had a routine doctor's visit for a minor illness or preventative care. In the Mid-Shore area overall, the median number of months since the last visit was 7.32. Counties above this number are Caroline (7.58), Queen Anne's (7.45) and Talbot (7.36) counties. Counties below this number are Kent (7.03) and Dorchester (7.11) counties.

Demographic groups with the longest periods between doctor visits are those between 18 and 34 years of age (11.08 months) and those households with an annual income between $25,000 and $49,999 (8.59 months). Demographic groups with the shortest periods between doctor visits are those between 65 and 74 years of age (6.58 months), retired or disabled consumers (6.73 months) and those with more than 3 sick days in the last 60 days (6.77 months).

Chart 4
Used Most Often For Routine Healthcare Needs

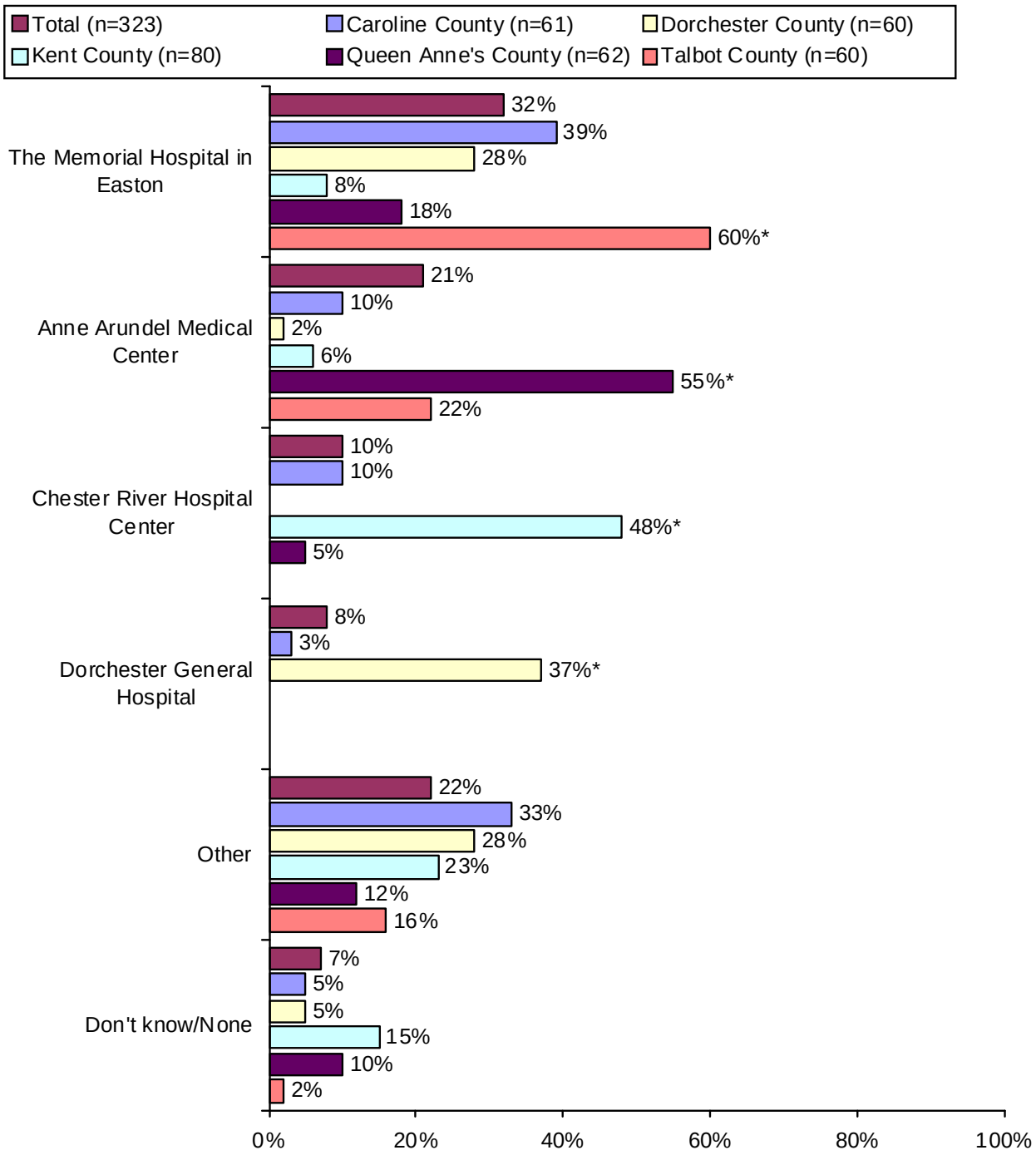


*Statistically greater than the other counties (p<.05)
^ Excluded from calculations above

Consumers in the Mid-Shore area were asked about where they go most often for routine healthcare needs. In the area overall, doctor's office (86%) is by far the most frequently mentioned. County scores range from 82% of consumers in Talbot County using a doctor's office to 96% of consumers in Kent County mentioning the doctor's office as where they go most often for routine healthcare needs.

Demographic groups with the highest mention of using a doctor's office as where they go most often for routine healthcare needs are those 75 or more years of age (96%), those households with an annual income between $75,000 and $99,999 (93%) and those households using an HMO or PPO for health insurance (93%). Demographic groups with the lowest mention of using doctor's office as where they go most often for routine healthcare needs are those with a high school education incomplete, or less (70%), those households with an annual income between $25,000 and $49,999 (72%), with some other kind of health care insurance (73%), race other than white (76%) and those consumers between 35 and 44 years of age (76%).

Chart 5
Hospital Preferred Overall



*Statistically greater than the other counties (p<.05)

In the Mid-Shore area overall, the hospital most preferred is The Memorial Hospital in Easton (32%). Other hospitals receiving double-digit preference shares in the area overall are Anne Arundel Medical Center (21%) and Chester River Hospital Center (10%). When analyzed by county, proximity appears to be the main determinant in preference. In Caroline County, consumers preferred The Memorial Hospital in Easton (39%). In Dorchester County, consumers preferred Dorchester General Hospital (37%) and The Memorial Hospital in Easton (28%). In Kent County, consumers preferred Chester River Hospital Center (48%). In Queen Anne's County, consumers preferred Anne Arundel Medical Center (55%). Finally, in Talbot County, 60% of consumers preferred The Memorial Hospital in Easton.

Consumers were asked if there was a time in the last 12 months when they or another family member needed to see a doctor or use medical services, but could not.

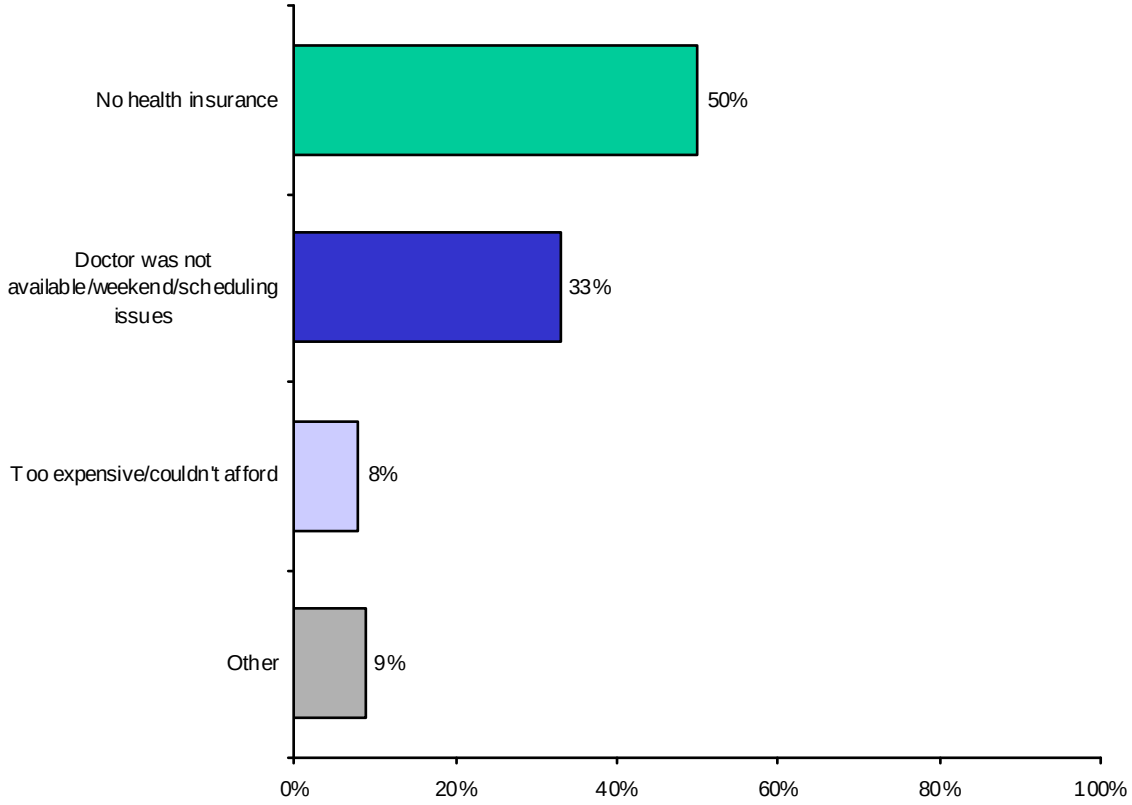
Chart 6
Need To Use A Doctor In Last 12 Months But Could Not

Response	Total (n=323)	Area: Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Yes	8%	15%	7%	11%	6%	2%
No	92	85	93	89	94	98
Don't know/Refused^	1	--	--	1	--	2

^ Excluded from calculations above

In the Mid-Shore area overall, only 8% of consumers responded yes there was. County scores ranged from 2% of consumers in Talbot County to 15% in Caroline County.

Chart 6A
Reasons Could Not See Doctor When Needed (n=27)



Demographic groups with the highest affirmative response to not being able to see a doctor or use medical services when needed in the last 12 months are consumers with less than a high school education (18%), those consumers with some other kind of health care insurance (18%), consumers not employed (19%) and consumers between 35 and 44 years of age (14%). Demographic groups with the lowest affirmative response to not being able to see a doctor or use medical services when needed in the last 12 months are those households with an annual income between $50,000 and $74,999 (1%), consumers between 65 and 74 years of age (2%) and males (4%).

As a follow up question, consumers were asked why if they responded "yes" there was a time in the last 12 months when they or another family member needed to see a doctor or use medical services, but could not. The largest responses from the twenty-seven respondents who said "yes" were no insurance (50%) and doctor was not available/weekend/scheduling issues (33%). Sample sizes by county were all in the single digits and therefore too small for inclusion in this analysis.

Consumers were asked if they typically travel outside of their county for medical care.

Chart 7
Typically Travel Outside Of County For Medical Care

		Area				
Response	Total (n=323)	Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Yes	46%	69%*	43%	50%	55%	18%
No	54	31	57	50	45	82*
Don't know/Refused^	1	3	--	--	--	--

*Statistically greater than the other counties (p<.05)
^ Excluded from calculations above

Chart 7A

Main Reason To Travel Outside Of County For Medical Care

Reason	Total (n=152)	Area				
		Caroline County (n=41)	Dorchester County (n=26)	Kent County (n=40)	Queen Anne's County (n=34)	Talbot County (n=11)
No physician/services available for the type of care I need	35%	39%	27%	55%	24%	36%
Better quality of care outside the county	21	20	19	20	24	27
Know the doctor/used that doctor for years	16	17	19	13	21	--
Local doctors not on my insurance plan	8	2	15	10	9	--
Convenience/location	5	7	4	--	6	9
Closer to my place of work	5	7	4	--	9	--
Other	10	7	12	3	9	27

In the Mid-Shore area overall, 46% of consumers responded "yes" they do typically travel outside of their county for medical care. County scores ranged from 18% of consumers in Talbot County to 69% in Caroline County.

Demographic groups with the highest affirmative response to they typically travel outside of their county for medical care are households with an annual income of less than $25,000 (57%), households with an annual income between $50,000 and $74,999 (52%) and those with three or more sick days in the last 60 days (52%). Demographic groups with the lowest affirmative response to they typically travel outside of their county for medical care are those consumers with less than a high school education (36%), households with an annual income between $25,000 and $49,999 (37%) and those consumers with some other kind of health care insurance (38%).

Consumers who responded they typically travel outside of their county for medical care were asked for the main reason. For the Mid-Shore area overall, the most common responses were: no physician/services available for the type of care I need (35%), better quality of care outside the county (21%) and know the doctor/used that doctor for years (16%). Analysis by county shows that the same three responses are, generally, the most common responses by county as well. It is noteworthy that slightly more than half of the respondents in Kent County (55%) mention no physician/services available for the type of care I need, which is by far the highest response across the counties.

Consumers were asked what medical services they received outside of the county.

Chart 7B
Medical Services Received Outside Of County
(Two Responses)

Medical Service	Total (n=152)	Area: Caroline County (n=41)	Dorchester County (n=26)	Kent County (n=40)	Queen Anne's County (n=34)	Talbot County (n=11)
Doctor appointments	63%	64%	65%	59%	56%	88%
Primary Care	13	6	13	11	22	12
Hospitalization	13	17	4	5	22	--
Surgery	11	6	22	19	9	--
Dental appointments	9	8	22	8	3	--
Emergency care	8	11	4	5	6	12
Outpatient treatment	7	3	4	8	9	12
Laboratory and other tests	6	14	4	5	3	--
X-rays	5	3	9	5	6	--
Other	13	17	9	17	13	12
Don't know/Refused^	7	7	12	3	3	18
None^	4	5	--	5	3	9

^ Excluded from calculations above

In the Mid-Shore area overall, 63% of consumers responded doctor appointments, 13% said they received primary care outside of the county, 13% responded hospitalization and 11% said surgery.

Interesting discrepancies by county from the area overall may prove useful. In Caroline County, 14% of consumers mention leaving the county for laboratory and other tests and 11% of consumers mention leaving the county for emergency care. In Dorchester County, 22% of consumers mention leaving the county for surgery and dental appointments. Similarly, in Kent County 19% of consumers leave the county for surgery. Queen Anne's County reflects the area overall and Talbot County's sample is very small.

Consumers were asked about the factors that most affect the quality of healthcare in the community.

Chart 8
Factors That Most Affect The Quality Of Healthcare In Community

		Area				
Factor	Total (n=323)	Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Access to care	33%	44%	18%	41%	41%	19%
Economic factors (low income/no insurance)	27	30	45	22	14	25
Quality/Attitude of physicians	18	9	21	7	16	31
Other	22	17	16	30	29	25
Don't know/Refused^	32	26	39	24	31	37
None^	6	3	7	9	10	3

^ Excluded from calculations above

In the Mid-Shore area overall, top responses include access to care (33%), economic factors (low income/no insurance) (27%) and the quality/attitude of physicians (18%). County scores for access to care ranged from 18% of consumers in Dorchester County to 44% in Caroline County. County scores for economic factors ranged from 14% of consumers in Queen Anne's County to 45% in Dorchester County. County scores for quality/attitude of physicians ranged from 7% of consumers in Kent County to 31% in Talbot County.

Consumers were asked about their sources of information about general health care issues.

Chart 9
Source Of Information About General Health Care Issues
(Two Responses)

Source	Total (n=323)	Area				
		Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Doctor/nurse/pharmacist	79%	85%	81%	79%	75%	78%
Internet	48	32	42	48	58	57
Family member/Friend	10	8	12	8	8	12
Other	28	22	32	29	24	34
Don't know/Refused^	1	--	3	--	2	2
None^	2	2	2	--	3	2

^ Excluded from calculations above

In the Mid-Shore area overall, top responses include doctor/nurse/pharmacist (79%), internet (48%) and family member/friend (10%). County scores for doctor/nurse/pharmacist ranged from 78% of consumers in Talbot County to 85% in Caroline County. County scores for internet ranged from 32% of consumers in Caroline County to 58% in Queen Anne's County. County scores for family member/friend ranged from 8% of consumers in Caroline, Kent and Queen Anne's Counties to 12% in Dorchester and Talbot Counties. It is interesting to note that the internet is mentioned more often in Queen Anne's County (58%) and Talbot County (57%) than the other three counties.

Demographic groups with the highest responses for doctor/nurse/pharmacist for a source of information about general health care issues are consumers with less than a high school education (89%), households with an annual income between $25,000 and $49,999 (89%), consumers with a high school education or less (89%) and consumers with Medicare (89%). Demographic groups with the lowest responses for doctor/nurse/pharmacist for a source of information about general health care issues are those consumers between 18 and 34 years of age (68%), those consumers with some other kind of health care insurance (70%) and consumers with a college degree or postgraduate degree or work (71%).

Demographic groups with the highest responses for internet as a source of information about general health care issues are consumers between the ages of 18 and 34 (73%), consumers who are unemployed (67%), consumers who are between the ages of 35 and 44 (66%), households with an annual household income of $100,000 or more, consumers with a college degree or postgraduate degree or work (63%), consumers with an HMO/PPO (63%) and consumers who work 40 or more hours per week (62%). Demographic groups with the lowest responses for internet for a source of information about general health care issues are those consumers 75 years of age or older (9%), consumers with Medicare (20%), households with an annual income of $25,000 or less (25%),

consumers who are retired or disabled (26%), consumers with less than a high school education (27%) and consumers who are high school graduates (28%).

Consumers were asked about services not currently available or that are of poor quality that need to be offered or improved.

Chart 10
Health/Medical Services Not Currently Available/Poor Quality That Need To Be Offered Or Improved (Two Responses)

		Area				
Health/Medical Service	Total (n=323)	Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Pediatrics/children's care	12%	3%	16%	24%	13%	3%
Maternity services/obstetrical services	10	3	3	33	--	3
Hospital care	7	12	3	8	13	3
Cardiology/heart services	7	9	13	5	6	3
Cancer/oncology services	6	--	6	2	19	10
Mental health/psychiatric services	6	6	6	3	6	7
General healthcare services	6	9	3	3	6	7
Dental services	5	3	6	--	--	14
Gynecology services	5	6	10	8	--	--
Emergency room/emergency medical services	5	15	--	3	--	3
Other	31	34	34	11	37	47
Don't know/Refused^	21	22	22	12	19	28
None^	30	25	27	9	55	23

^ Excluded from calculations above

In the Mid-Shore area overall, top responses include pediatrics/children's care (12%) and maternity services/obstetrical services (10%) and it is notable that 30% of consumers said none. County scores for pediatrics/children's care ranged from 3% of consumers in Talbot and Caroline counties to 24% in Kent County. County scores for maternity services/obstetrical services ranged from 3% of consumers in Caroline, Dorchester and Talbot counties to 33% in Kent County. It is noteworthy that in the area overall, while 30% of consumers responded there were no services, but in Kent County, only 9% of consumers said there were no services. This implies that Kent County consumers feel there are fewer services currently not available or that are of poor quality than in the area overall.

Not surprisingly, demographic groups with the highest responses for pediatrics/children's care are consumers between 18 and 34 years of age (34%) and consumers between 35 and 44 years of age (29%). Conversely, demographic groups with the lowest responses for pediatrics/children's care are those consumers 75 years of age or more (4%).

Demographic groups with the highest responses for maternity services/obstetrical services are consumers with traditional health insurance (25%), consumers between 18 and 34 years of age (18%) and consumers employed between 1 and 39 hours per week (16%). Demographic groups with the lowest responses for maternity services/obstetrical services are those consumers with some other kind of health insurance, with Medicare and who are not employed (all with 3%).

Consumers were asked about the biggest health issue or concern in their community.

Chart 11
Biggest Health Issue/Concern In Your Community

		Area				
Issue/Concern	Total (n=323)	Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Cancer	24%	23%	20%	26%	23%	28%
Cost/lack of insurance/affordable healthcare	16	15	16	5	20	20
Obesity	8	5	7	7	10	9
Diabetes	7	5	16	5	--	9
Lack of physicians	6	8	4	5	5	9
Drug/alcohol abuse	5	8	2	5	3	7
Other	34	36	35	47	39	18
Don't know/Refused^	22	25	18	21	26	20
None^	7	11	7	6	10	3

^ Excluded from calculations above

In the Mid-Shore area overall, top responses include cancer (24%) and cost/lack of insurance/affordable healthcare (16%). County scores for cancer ranged from 20% of consumers in Dorchester County to 28% in Talbot County. County scores for cost/lack of insurance/affordable healthcare ranged from 5% of consumers in Kent County to 20% in Queen Anne's and Talbot counties.

Demographic groups with the highest responses for cancer are consumers between 65 and 74 years of age (37%), consumers with traditional insurance (37%) and consumers with a high school degree (35%). Conversely, demographic groups with the lowest responses for cancer are those consumers who are not employed (9%).

Demographic groups with the highest responses for cost/lack of insurance/affordable healthcare are consumers 75 years of age or older (30%), males (23%) and households with between $50,000 and $74,999 in annual income (22%). Demographic groups with the lowest responses for cost/lack of insurance/affordable healthcare are those consumers with less than a high school education (7%) and households with less than $25,000 in annual income (10%).

Consumers were asked if they have seen improvement in health care services offered in the Mid-Shore counties in the past 12 months.

Chart 12
Seen Improvement In The Health Care Services Offered In The Mid-Shore Counties In The Past 12 Months

		Area				
Response	Total (n=323)	Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Yes	44%	34%	46%	18%	71%*	39%
No	56	66	54	82*	29	61
Don't know/Refused^	10	8	13	9	5	15

*Statistically greater than the other counties (p<.05)
^ Excluded from calculations above

In the Mid-Shore area overall, 44% of consumers responded that they have seen improvement in the past 12 months. County scores ranged from 18% of consumers in Kent County to 71% in Queen Anne's County.

Demographic groups with the highest affirmative responses to having seen improvement in the health care services offered in the Mid-Shore counties in the past 12 months are consumers with a race other than Caucasian (63%), consumers between 55 and 64 years of age (62%), households with $100,000 or more in annual income (55%) and consumers with traditional insurance (55%). Demographic groups with the lowest affirmative responses to having seen improvement in the health care services offered in the Mid-Shore counties in the past 12 months are those consumers who are with 1 to 2 sick days in the past 60 days (23%), consumers with less than a high school education (26%) and consumers between 18 and 34 years of age (27%).

Chart 13
How Often Feel Stressed In A Typical Week

Response	Total (n=323)	Area: Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Extremely often	8%	8%	7%	9%	10%	8%
Very often	12	12	18	9	10	10
Moderately often	23	32	23	23	23	17
Slightly often	32	31	27	29	30	40
Not at all often	25	17	25	30	27	25
Don't know/Refused^	2	3	--	1	3	--
Mean	**2.48**	**2.64**	**2.55**	**2.37**	**2.47**	**2.37**

Scale: 5=extremely often; 1=not at all often
^ Excluded from calculations above

On the five-point rating scale where 5 equals "extremely often" and 1 equals "not at all often," the Mid-Shore area's overall rating for how often they feel stressed in a typical week is 2.48. County scores ranged from 2.37 in Caroline and Talbot counties to 2.64 in Caroline County.

Demographic groups with the highest mean score for how often they feel stressed in a typical week are consumers who had 3 or more sick days in the last 60 days (3.10), consumers with some other kind of health insurance (2.85), consumers who are not employed (2.79) and consumers between 18 and 34 years of age (2.77). Demographic groups with the lowest mean score for how often they feel stressed in a typical week are those consumers who are 75 or more years of age (1.78), consumers who are between 65 and 74 years of age (2.08) and consumers who are retired or disabled (2.25).

Chart 14
Participation In At Least One Hour Of Physical Activity A Day

Response	Total (n=323)	Area				
		Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Always	36%	33%	38%	36%	35%	37%
Sometimes	53	50	48	51	52	60
Never	11	17	13	13	13	3
Don't know/Refused^	1	2	--	3	--	--
Mean	**2.25**	**2.17**	**2.25**	**2.23**	**2.23**	**2.33**

Scale: 3=always; 1=never
^ Excluded from calculations above

On the three-point rating scale where 3 equals "always" and 1 equals "never," the Mid-Shore area's overall rating for participating in at least one hour of physical activity a day is 2.25. County scores ranged from 2.17 in Caroline County to 2.33 in Talbot County.

Demographic groups with the highest mean activity levels are consumers with 1 to 2 sick days in the past 60 days (2.38), males (2.35), consumers with traditional insurance (2.34), consumers who are 18 and 34 years of age (2.32) and households with $100,000 or more in annual income (2.32). Demographic groups with the lowest mean activity levels are consumers with 3 or more sick days in the last 60 days (1.88), consumers who are not employed (2.08) and consumers with less than a high school education (2.13).

Consumers were asked to rate a series of health issues as a serious problem, moderate problem or not a problem. The following table presents the percentage of consumers who consider each health issue to be a serious problem, both in the Mid-Shore area overall and by county.

Chart 15
Seriousness Of Various Health Issues
(Percent Consider A Serious Problem)

		Area				
Health Issue	Total (n=323)	Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Substance Abuse	54%	48%	67%	64%	40%	56%
Tobacco Use	44	44	50	56	40	36
Ambulance Service	7	8	13	9	2	4
Transportation for health purposes	20	23	15	42*	7	20
Asthma or lung disease	34	46	31	29	35	29
Cancer	66	65	69	70	61	65
Domestic violence	27	34	39	32	17	16
Diabetes	53	46	70	48	41	57
Obtaining affordable health care	55	61	59	55	39	61
Dental health	27	34	32	32	15	23
Access to quality health care	24	43	27	30	6	19
Prenatal and infant health	21	25	23	51*	8	9
Infectious disease	18	20	27	9	12	23
Mental illness	32	28	39	37	17	38
Obesity	57	57	80*	52	41	54
Services for the disabled	24	33	31	25	14	17
Sexually transmitted diseases	38	32	59*	32	29	26
Heart disease	49	50	57	53	39	50
High blood pressure or stroke	48	43	57	46	43	51

*Statistically greater than the other counties (p<.05)

In the Mid-Shore area overall, the five issues considered the most serious problems are cancer (66%), obesity (57%), obtaining affordable health care (55%), substance abuse (54%) and diabetes (53%). In Caroline County, the five issues considered the most serious problems are cancer (65%), obtaining affordable health care (61%), obesity (57%), heart disease (50%) and substance abuse (48%). In Dorchester County, the five issues considered the most serious problems are obesity

(80%), diabetes (70%), cancer (69%), substance abuse (67%) and a tie between obtaining affordable health care and sexually transmitted diseases (59%). In Kent County, the five issues considered the most serious problems are cancer (70%), substance abuse (64%), tobacco use (56%), obtaining affordable health care (55%) and heart disease (53%). In Queen Anne's County, the five issues considered the most serious problems are cancer (61%), high blood pressure or stroke (43%), obesity (41%), diabetes (41%) and a tie between substance abuse and tobacco abuse (40%). Finally, the five issues considered the most serious problems in Talbot County are cancer (65%), obtaining affordable health care (61%), diabetes (57%), substance abuse (56%) and obesity (54%).

Consumers were asked to rate their current health status.

Chart 16
Self-Described Current Health Status

		Area				
Response	Total (n=323)	Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
Excellent	13%	10%	8%	14%	18%	15%
Very good	40	30	40	41	45	42
Good	26	36	30	24	19	23
Fair	15	21	17	13	10	15
Poor	6	3	5	9	8	5
Mean	**3.39**	**3.21**	**3.30**	**3.39**	**3.55**	**3.47**

Scale: 5=excellent; 1=poor

The results presented in Chart 16 use a scale where 5 equals "excellent" and 1 equals "poor." In the Mid-Shore area overall, the average score is 3.39. Queen Anne's County (3.55), Talbot County (3.47) and Kent County (3.39) have the highest self-described current health status. Caroline County (3.21) and Dorchester County (3.30) have the lowest self-described current health status.

Consumers were asked the number of days they were too sick to go to work or do normal activities in the last 60 days.

Chart 17
Number Of Days Too Sick To Go To Work/Do Normal Activities In Last 60 Days

		Area				
Days	Total (n=323)	Caroline County (n=61)	Dorchester County (n=60)	Kent County (n=80)	Queen Anne's County (n=62)	Talbot County (n=60)
0	74%	73%	71%	68%	79%	75%
1-2	11	8	16	12	10	11
3-5	4	7	2	4	3	5
6-10	3	2	4	4	3	2
10 or more	8	10	7	13	5	7
Don't know/Refused^	4	2	7	4	--	7
Mean	**2.15**	**2.52**	**2.03**	**3.24**	**1.50**	**1.95**

^ Excluded from calculations above

The area average was 2.15 days with Queen Anne's (1.50 days), Talbot (1.95 days) and Dorchester (2.03) counties below that average and Kent (3.24) and Caroline (2.52) Counties above that average. Kent County, in particular, is interesting, given the previous chart where Kent County's consumers' self-described health status was on par with the area average (3.39) and in the middle of the group, while the number of days consumers in Kent County missed work or were too sick to do normal activities was 1.5 times the area average.

Appendix 4.1: Hollander Cohen & McBride

Eastern Shore Healthcare Study

HOLLANDER COHEN & McBRIDE
MARKETING RESEARCH

Eastern Shore Healthcare Study

February, 2012

Table of Contents

H&M MARKETING RESEARCH

Introduction

- In order to determine the healthcare usage habits of residents of five Eastern Shore counties, a quantitative research study was designed. Specifically, the objectives of this research are to identify:
  - residents' current hospital usage habits both within and outside of the five-county area,
  - whether length of residence impacts hospital use, and
  - what is considered a reasonable travel time to access various types of healthcare.
- A total of 500 telephone interviews of approximately 8 to 10 minutes each were conducted for this study. The interviews were stratified to include 100 in each of five counties: Caroline, Dorchester, Kent, Queen Anne's, and Talbot.
- The issue of non-coverage bias introduced by the shift toward cell phone-only households was handled with age quotas to ensure a sufficient sample of younger individuals (proportionate to the number that exist in the overall population in the five Eastern Shore counties included in this study) were interviewed. Such quotas were established based on the findings of a recent Pew Research Center study that indicated cell-phone only households and those that have landlines are relatively similar except that members of cell-phone only household tend to be younger.
- When reviewing results in total, the margin of error for this study is +/- 4%, worst case scenario. Typically, the +/- is under 3% for those measures over 90%. When comparing results between the five counties, the margin of error increases to a maximum of 10% and is more typically under 6% for measures over 90%.

Executive Summary

Demographics

- Looking across the five Eastern Shore counties included in this study, residents of Dorchester county (who are furthest from the Bay Bridge) tend to be least educated, have the lowest household income and, on average, have lived in their county for the longest period of time.
- Residents of Kent, Queen Anne's and Talbot Counties are most educated; the highest median household incomes are found in Queen Anne's and Talbot Counties.

Employment

- Kent and Queen Anne's Counties have the greatest proportion of residents employed outside of the home. Employed individuals tend to be younger, more educated, to have a higher household income, are more likely to have minor children in the home, and are more likely to be men.
- Approximately three-quarters of Dorchester, Talbot, and Kent County residents work in the same county where they live compared to less than half of Caroline and Queen Anne's County residents.

Where They Obtain Healthcare

- A majority (76%) of residents who work outside the county where they reside seek healthcare close to where they live.
  - Residents of Queen Anne's County (83%) and Talbot County (90%) are particularly likely to look for healthcare options close to where they live.
  - Those more likely to seek healthcare close to work live in Caroline County (30%), Kent County (31%) or Dorchester County (33%).

Willingness to Travel

- A majority of residents will travel no more than 30 minutes for:
  - A routine check-up with a family practice physician, internist, gynecologist, or pediatrician (85%), or
  - To deliver a baby (83%).

Executive Summary

- When it comes to seeing a specialist such as an orthopedic doctor, dermatologist, or a diabetes specialist, more than half (53%) said they would not be willing to travel more than half an hour, although more than a third (35%) said they would travel up to an hour, and 1 in 8 (12%) said they would travel more than a hour.
- Residents would be willing to travel a little longer in order to see a specialist for a potentially life-threatening diagnosis or condition such as cancer diagnosis, care, or treatment: 31% still said they would travel no more than half an hour, but 28% said they would travel up to an hour, and 41% would be willing to travel more than an hour.
- Those most willing to travel further tended to be younger, more educated, and to have a higher household income or to live in Kent County.
- Experience can overcome reluctance to travel. When presented with the case of needing hernia or gallbladder surgery, a majority of residents said they would be more likely to travel to a hospital an hour away where doctors perform the procedure every day (71%) than to use the closest hospital where doctors perform the procedure only a few times per month (29%).
  - Residents most willing to travel to a hospital an hour away are younger, more educated, and have higher incomes. They are also more likely to have children at home and to work outside of their county of residence.
  - Willingness to travel positively correlates with length of time living in the county – the shorter the time of residence, the greater the willingness to travel further.

Hospitals

- The hospitals residents prefer, have used, and would recommend varies by county of residence.
  - In Kent County, Chester River Hospital Center dominates – 63% prefer it, 69% have used it in the past three years and 48% would recommend it for delivering babies.
  - Talbot County residents prefer (84%), have used (80%), and would recommend for obstetrics (83%) Memorial Hospital of Easton.

Executive Summary

- A majority in Caroline County prefer (62%), have used (69%) and would recommend as a place to have babies (66%) Memorial Hospital of Easton
- In Queen Anne's County, more residents prefer (48%), have used (42%), and would recommend for delivering babies (50%) Anne Arundel Medical Center. Significant prooortions also have used and would recommend for obstetrics Memorial Hospital of Easton and Chester River Hospital Center.
- In Dorchester County, more residents prefer (47%) and have used (61%) Dorchester General Hospital, but few (8%) would recommend it for delivering babies. Nearly as many prefer (37%), have used (46%), and most would recommend for delivery of babies (73%) Memorial Hospital of Easton.

- Working outside of the county and years living in the county also influences opinion and use of hospitals to some degree. Newer residents and those who work outside of their home county are more likely to prefer and use Anne Arundel Medical Center, as well as to recommend it for delivery of babies. Those who have lived in their county longer are more likely to prefer and use Dorchester General or Peninsula Regional.

Conclusions

- Most residents live and work in the same county and will travel no longer than half an hour for routine care or to deliver a baby.
- For less routine situations, such as seeing a specialist or having surgery, residents display a greater willingness to travel further; however, it is still a minority who would travel more than an hour unless they are facing a potentially life-threatening situation.
- Younger or newer residents, as well as those who work further from home, display a greater willingness to travel further to see a specialist or for surgery.
- Conveying evidence of surgical experience clearly impacts willingness to travel as a majority would travel further to a hospital where the doctors have greater experience in performing a procedure.

H&M
MARKETING RESEARCH

Demographics

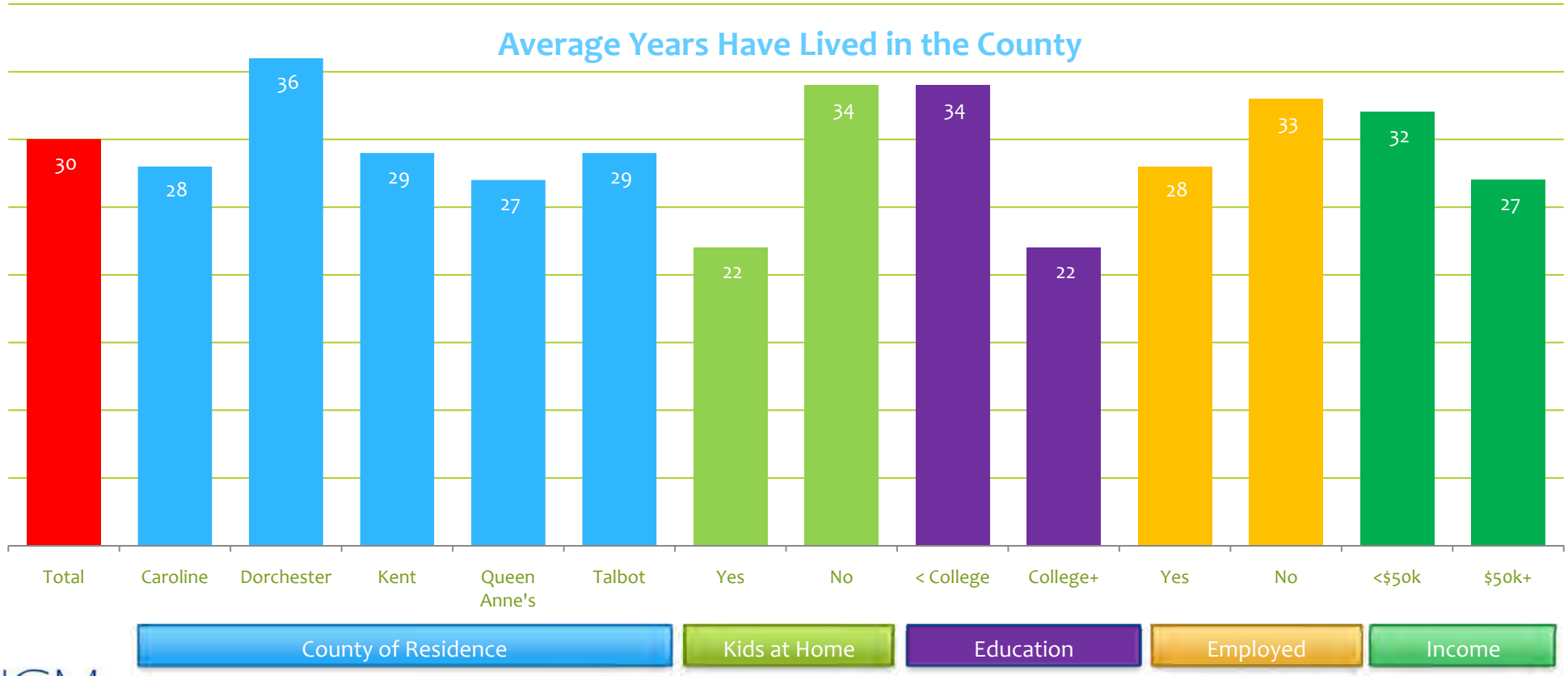
- Residents of Caroline and Dorchester Counties are least educated. Dorchester County residents are also least liked to be employed, most likely to be single, and most likely to be African-American or black.
- Residents of Kent, Queen Anne's, and Talbot Counties are most educated. Incomes are highest in Queen Anne's and Talbot Counties.

		County of Residence				
	Total	Caroline	Dorchester	Kent	Queen Anne's	Talbot
Average # in household	2.8	2.8	2.6	2.9	2.9	2.7
Have minor children in household	36%	40%	35%	38%	36%	30%
Marital status: married/partnered	72%	75%	61%	74%	71%	79%
Single/divorced/separated/widowed	28%	25%	39%	26%	29%	21%
Median age of respondent	54	53	54	53	53	59
Education: high school or less	42%	60%	55%	32%	31%	33%
some college	21%	13%	21%	19%	24%	26%
college graduate	37%	27%	24%	49%	45%	41%
Employment status: employed FT	49%	52%	40%	51%	59%	42%
employed PT	9%	3%	8%	13%	7%	12%
Not employed/retired/disabled/student	42%	46%	52%	36%	34%	46%
Ethnicity: white/Caucasian	87%	87%	68%	90%	97%	91%
African-American/black	11%	9%	29%	9%	1%	7%
Other	2%	4%	3%	1%	2%	2%
Median annual household income	$58.5k	$55.0k	$41.5k	$55.9k	$70.7k	$64.9k
Gender: female	59%	50%	69%	60%	52%	62%
Male	41%	50%	31%	40%	48%	38%

Length of Residence

Those who have, on average, lived in their county of residence for the longest period of time tend to be:

- Dorchester County residents,
- those who do not have children at home,
- less educated,
- less likely to be employed, and
- of lower income levels.

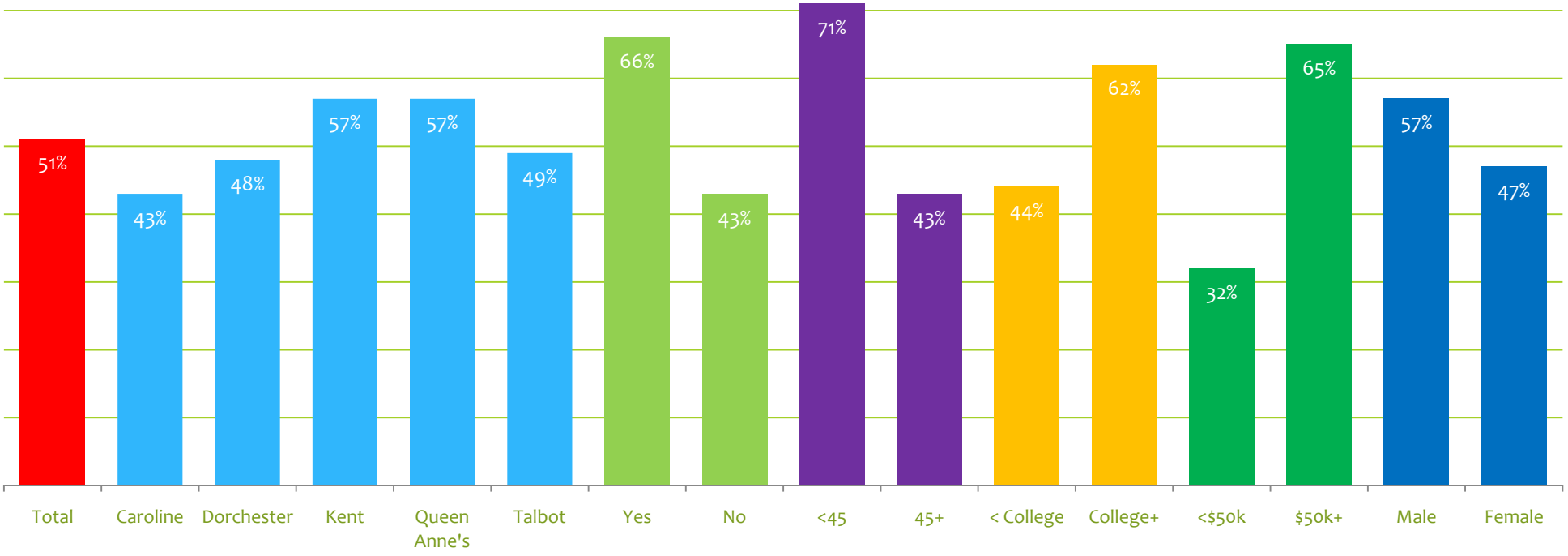


Employment

Those most likely to be employed outside of the home are:

- Kent or Queen Anne's County residents,
- those who have children at home,
- younger residents,
- those with a college degree,
- residents with higher household incomes, and
- men.

Employed Outside of the Home



Q1a

Work Location

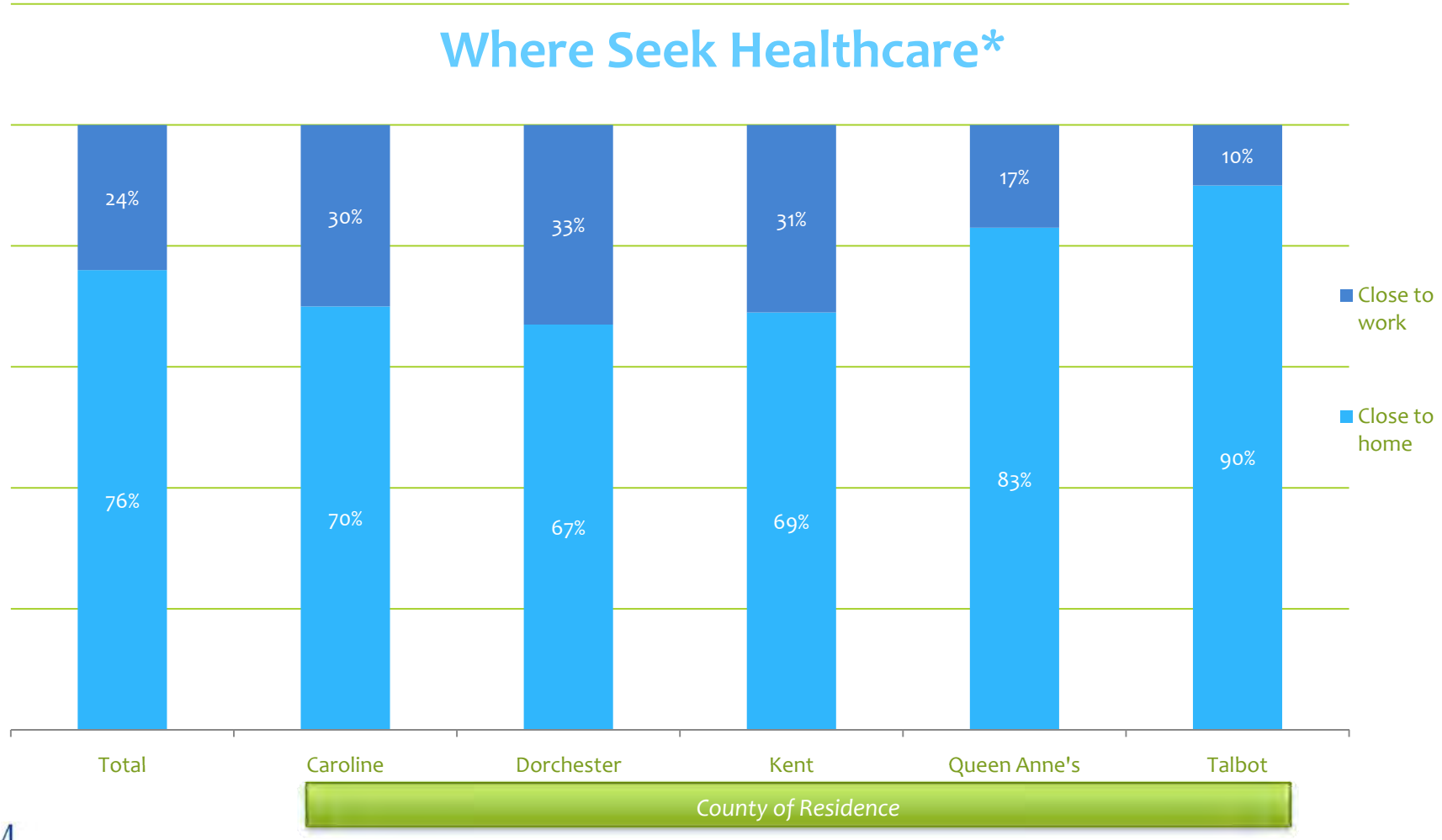
- Among those who work, residents of Dorchester, Kent, and Talbot Counties tend to work in the same county where they live.
- In contrast, less than half of Caroline and Queen Anne's County residents work in the country where they live.
  - More than 1 in 5 Queen Anne's County residents work in Anne Arundel County.
  - One in five Caroline County residents work in Talbot County and nearly as many work in Anne Arundel County.

County where employed*:	Total	County of Residence				
		Caroline	Dorchester	Kent	Queen Anne's	Talbot
Talbot County	21%	20%	13%	0%	2%	78%
Kent County	18%	0%	0%	73%	7%	0%
Dorchester County	15%	2%	74%	2%	0%	2%
Queen Anne's County	15%	10%	2%	7%	44%	6%
Caroline County	9%	39%	7%	0%	0%	8%
Anne Arundel County	8%	15%	0%	2%	23%	2%
Out of state (Delaware, Virginia)	4%	5%	0%	7%	5%	2%
Prince George's County	2%	2%	0%	2%	5%	0%
Cecil County	2%	0%	0%	4%	4%	0%
Other counties	6%	7%	4%	4%	11%	2%
(n)	(249)	(41)	(46)	(56)	(57)	(49)

*Among those who work outside the home

Healthcare

- A majority of those who work outside of their county of residence seek healthcare close to where they live. This is especially true of Queen Anne's and Talbot County residents.
- Those most likely to seek healthcare services close to where they work are residents of Caroline, Dorchester, and Kent Counties who work outside of their home county.



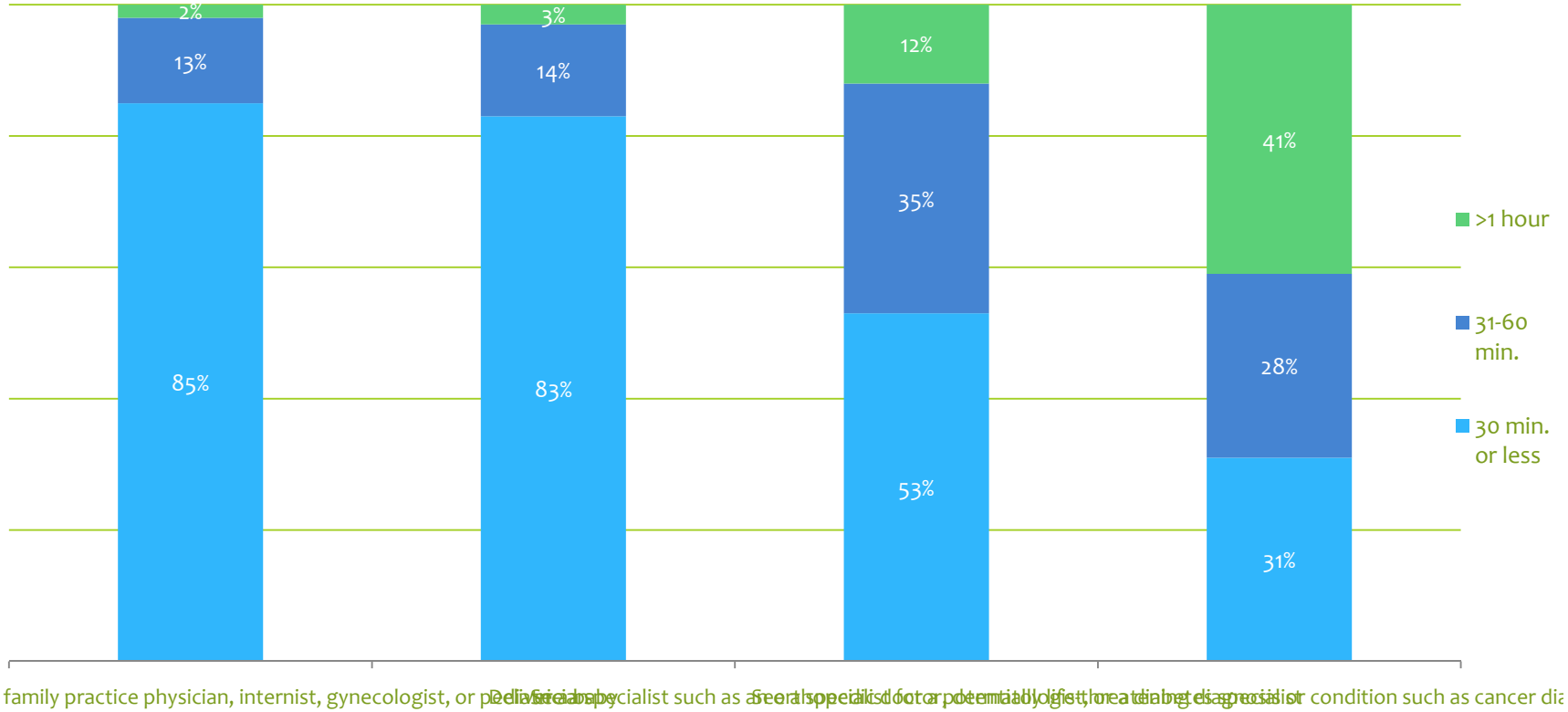
Q3

*Among those who work outside the county where they reside

Travel Time

- Few residents would travel more than half an hour for a routine check-up or to deliver a baby.
- About half would travel longer than half an hour to see a specialist, although only just over 1 in 10 would travel more than an hour.
- For a potentially life-threatening diagnosis, care, or treatment of such a condition, a majority would travel a longer distance than for other types of healthcare. More than a third would travel more than an hour.

Reasonable Length of Time to Travel for Healthcare Services



Q4a-d

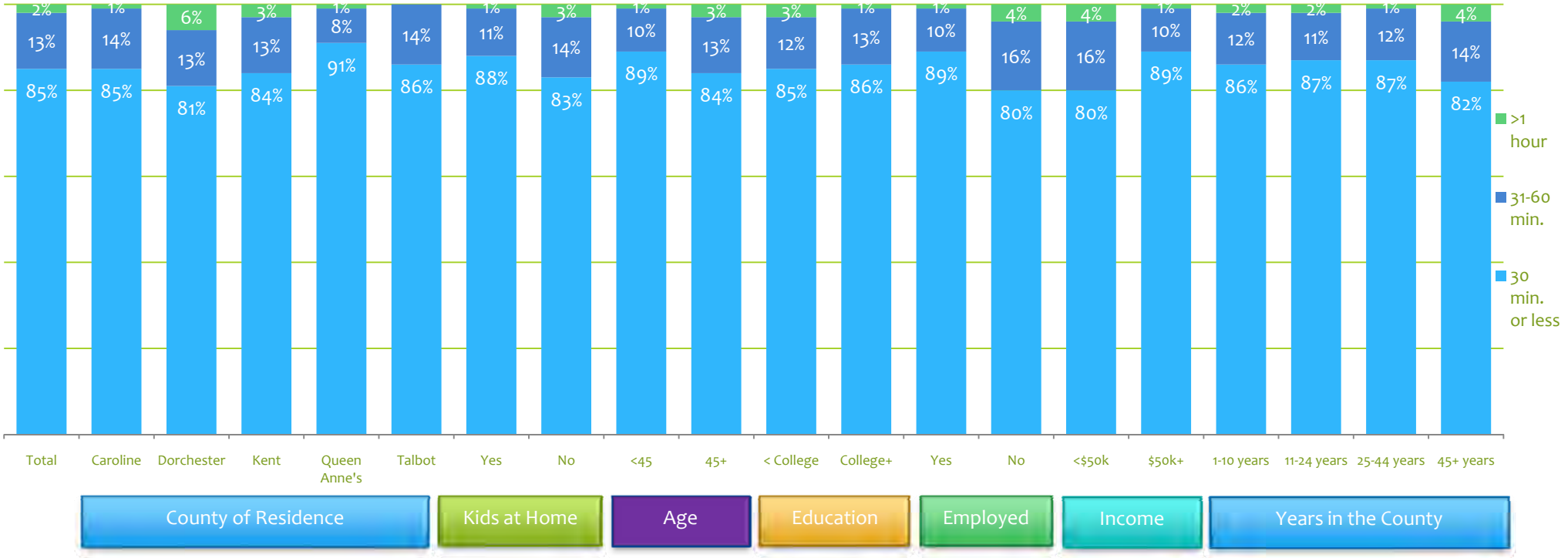
Travel Time for routine care

Although few would travel more than half an hour for routine care such as a check-up with a family practice physician, internist, gynecologist, or pediatrician, a few groups show a slightly greater disposition to travel a little longer, including:

- Dorchester County residents,
- those who are not currently working, and
- residents with a household income below $50,000.

Factors such as the presence of children in the household, age, education, and length of residence do not appear to significantly impact opinions in this area.

Reasonable Length of Time to Travel for a Routine Check-up



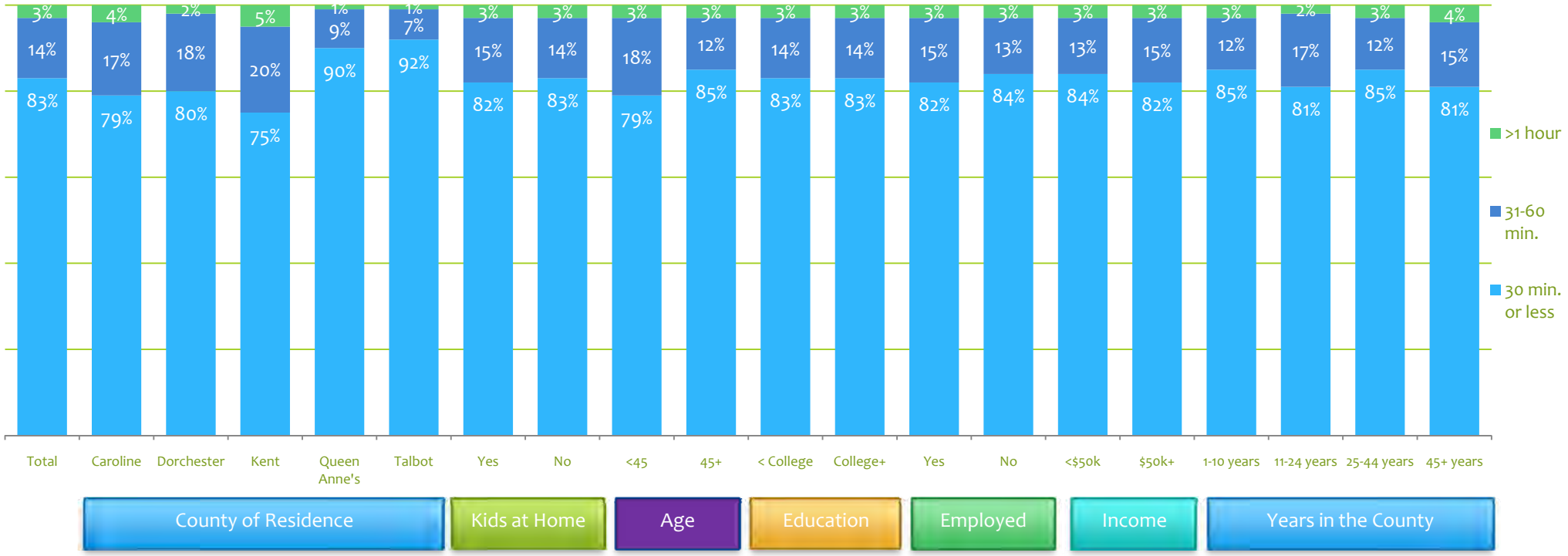
Q4a

Travel Time

to deliver a baby

- A majority would not travel more than 30 minutes to deliver a baby; residents of Queen Anne's or Talbot Counties are particularly unlikely to travel a longer distance.
- Factors such as the presence of children in the household, education, employment status, household income, and length of residence in the county have no significant impact on the length of time residents are willing to travel.

Reasonable Length of Time to Travel to Deliver a Baby



Q4d

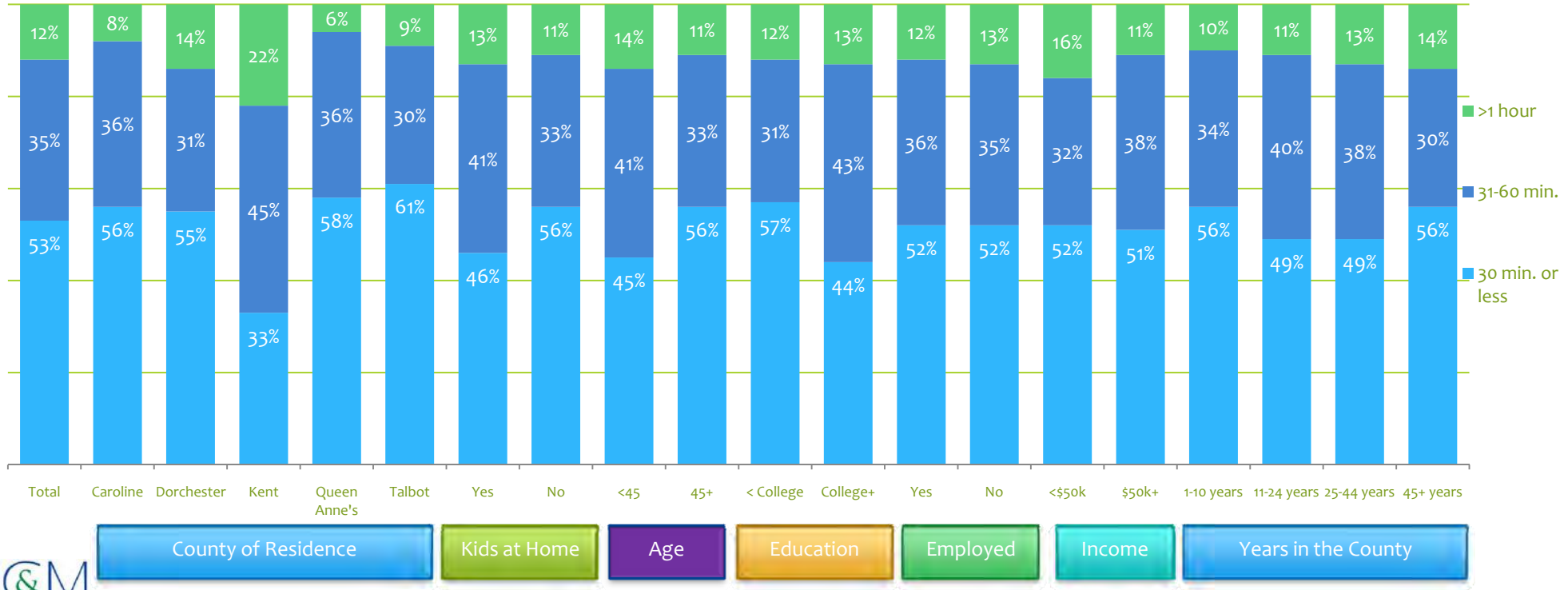
Travel Time

to see a specialist

Nearly half would travel more than half an hour to see a specialist such as an orthopedic doctor, dermatologist, or a diabetes specialist, especially:

- Kent County residents,
- those with children living at home,
- residents under age 45, and
- those with a college degree.

Reasonable Length of Time to Travel to see a Specialist



Q4b

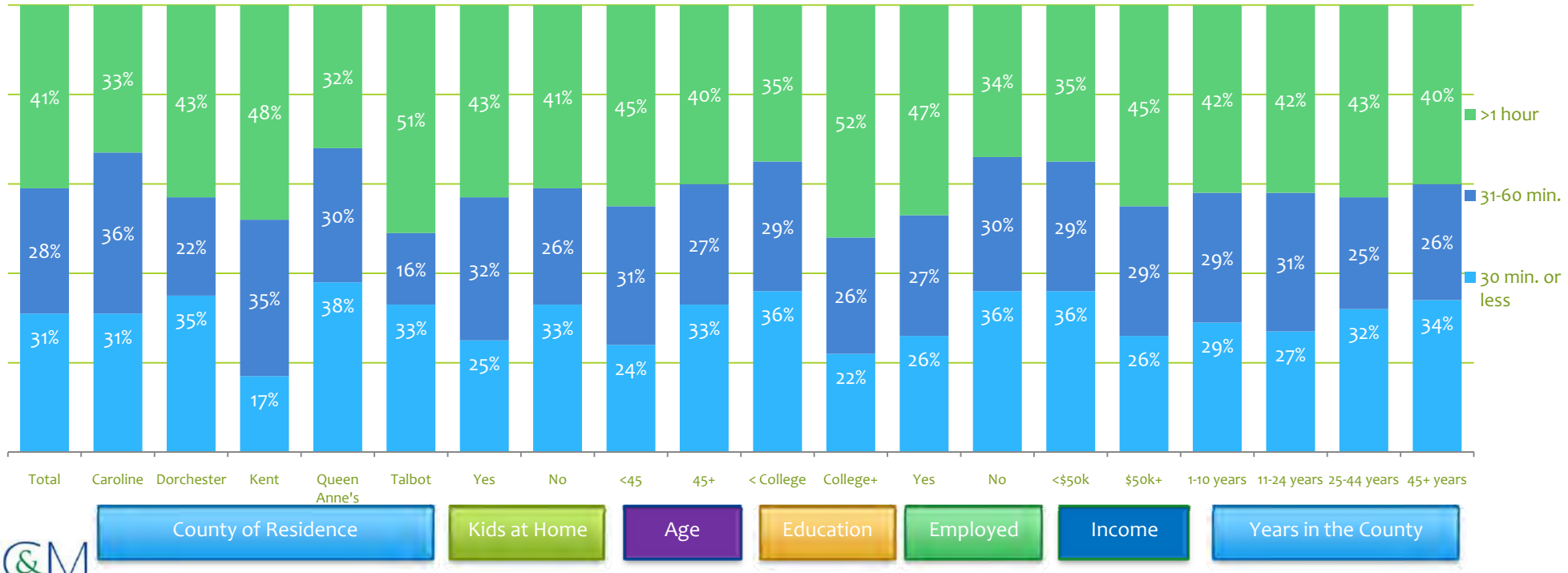
Travel Time

for a life-threatening condition

More than a third would travel more than an hour to see a specialist for a potentially life-threatening diagnosis or condition such as cancer diagnosis, care or treatment. Those particularly likely to travel such a distance include:

- Kent and Talbot County residents,
- college educated residents,
- those who are working, and
- and residents with a household income above $50,000.

Reasonable Length of Time to Travel to See a Specialist for a Potentially Life-threatening Condition



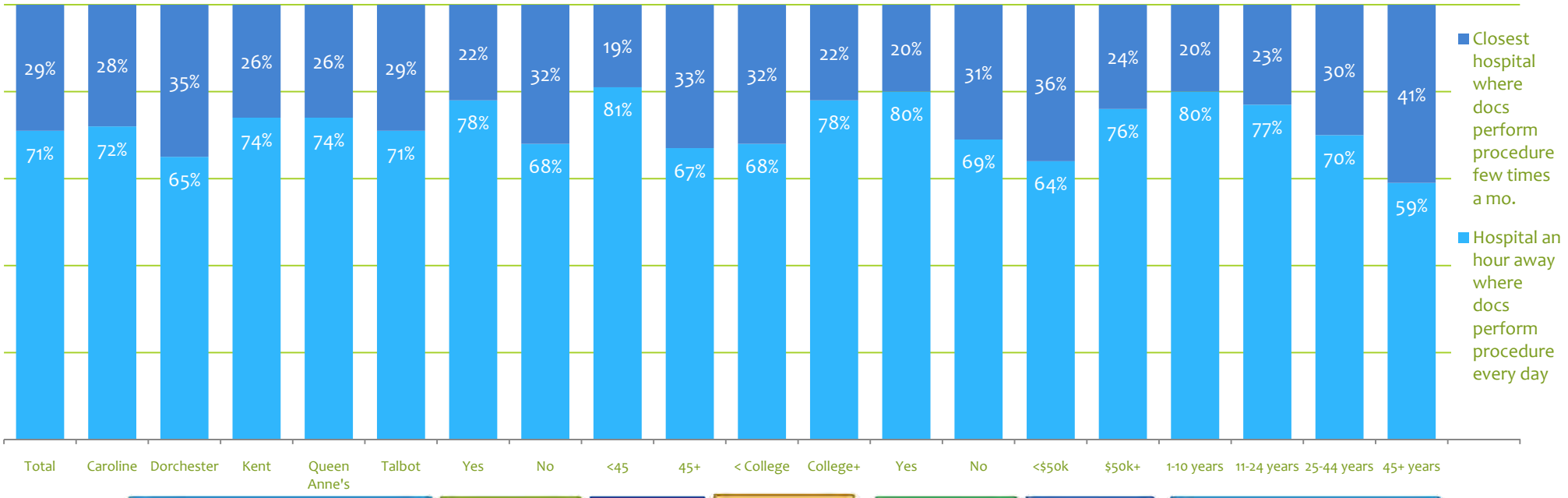
Q4c

Willingness to Travel for a surgical procedure

When it comes to surgery, most residents will travel to take advantage of experience. A majority said they would prefer having a hernia or gallbladder surgery performed at a hospital located an hour away where doctors perform the procedure every day rather than at the closest hospital where the procedure is performed by doctors only a few times each month. Residents particularly willing to travel include:

- those with children at home,
- residents under age 45,
- those with a college degree,
- those who work outside the county in which they live,
- residents with a household income above $50,000, and
- those who have lived in their county of residents for less than ten years.

Preferred Option for a Surgical Procedure for a Hernia or Gallbladder



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Q8

Preferred Hospital

- As might be expected, the preferred hospital varies based on county of residence, but overall, Memorial Hospital of Easton was one of the most preferred in all but Kent County.
- Chester River Hospital Center was among the top choices in Kent and Queen Anne's Counties.
- Newer residents and those who work outside of the county where they live were more likely to say Anne Arundel Medical Center is their preferred hospital, but were less likely to mention Dorchester General as their favorite.

		County of Residence					Work Outside County		Years in the County		
	Total	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Yes	No	1-10 years	11-44 years	45+ years
Memorial Hospital of Easton	41%	62%	37%	4%	21%	84%	43%	41%	43%	39%	44%
Chester River Hospital Center	17%	2%	0%	63%	19%	0%	15%	17%	10%	22%	15%
Anne Arundel Medical Center	15%	8%	0%	9%	48%	7%	22%	13%	17%	20%	4%
Dorchester General Hospital	10%	4%	47%	0%	0%	1%	2%	12%	7%	6%	20%
Johns Hopkins (including Bayview)	4%	2%	3%	5%	3%	5%	3%	4%	8%	2%	3%
Peninsula Regional	2%	2%	9%	0%	0%	0%	2%	2%	1%	1%	5%
Christiana Hospital, Delaware	2%	0%	0%	10%	1%	0%	3%	2%	4%	2%	1%
University of Maryland Hospital	2%	2%	2%	2%	2%	1%	2%	2%	2%	2%	2%
Nanticoke Memorial Hospital, DE	2%	7%	1%	0%	0%	0%	2%	2%	4%	1%	0%
Kent General Hospital, DE	1%	4%	0%	0%	1%	0%	0%	1%	0%	1%	1%
Union Hospital of Cecil County	1%	0%	0%	4%	0%	0%	2%	1%	1%	.4%	1%
Kent & Queen Anne's Hospital	1%	1%	0%	2%	0%	0%	0%	1%	0%	1%	1%
Shore Health	1%	2%	0%	0%	0%	1%	1%	1%	1%	.4%	1%
Other	2%	3%	1%	1%	5%	1%	2%	2%	3%	3%	1%
(n)	(491)	(96)	(99)	(99)	(99)	(98)	(95)	(396)	(114)	(238)	(138)

Hospital Used in the past three years

Hospitals used for any type of hospital care such as inpatient care, emergency care, or same-day surgery are similar to those that are preferred with a few exceptions:

- In Dorchester County, 37% said Memorial Hospital of Easton is their preferred hospital but 46% have used it in the past three years.
- Also in Dorchester County, 47% said they prefer Dorchester General Hospital, but 61% have used it.

		County of Residence					Work Outside County		Years in the County		
	Total	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Yes	No	1-10 years	11-44 years	45 years
Memorial Hospital of Easton	44%	69%	46%	7%	19%	80%	43%	44%	53%	40%	45%
Chester River Hospital Center	19%	4%	0%	69%	21%	0%	19%	19%	14%	22%	17%
Dorchester General Hospital	14%	4%	61%	0%	1%	2%	7%	15%	12%	9%	23%
Anne Arundel Medical Center	12%	6%	0%	4%	42%	5%	18%	10%	11%	15%	5%
Johns Hopkins (including Bayview)	5%	5%	2%	4%	6%	6%	6%	4%	6%	4%	5%
University of Maryland Hospital	4%	2%	3%	5%	7%	5%	2%	5%	3%	4%	6%
Peninsula Regional	3%	3%	11%	0%	0%	1%	5%	2%	2%	2%	6%
Christiana Hospital, Delaware	2%	1%	0%	10%	0%	0%	3%	2%	5%	1%	1%
Nanticoke Memorial Hospital, DE	1%	5%	2%	0%	0%	0%	2%	1%	4%	1%	0%
Union Hospital of Cecil County	1%	0%	0%	5%	1%	0%	4%	.4%	1%	1%	1%
Kent & Queen Anne's Hospital	1%	2%	0%	1%	1%	0%	1%	1%	1%	.4%	1%
Kent General Hospital, Delaware	1%	0%	0%	1%	2%	0%	0%	1%	0%	.4%	1%
Other	5%	5%	1%	6%	10%	4%	6%	5%	7%	6%	3%
(n)	(496)	(98)	(100)	(100)	(99)	(99)	(95)	(401)	(118)	(239)	(138)

Hospital Would Recommend

to family and friends for delivering babies

- In 4 out of 5 counties, Memorial Hospital of Easton is among the top choices of a hospital residents would recommend to a family member oe friend for delivery of babies.
- Anne Arundel Medical Center is a top choice in three out of five counties (and is the #1 choice among Queen Anne's residents).
- Chester River Hospital Center is a top choice in Kent and Queen Anne's Counties and Christiana Hospital in Delaware is the second most popular choice in Kent County.

		County of Residence					Work Outside County		Years in the County		
	Total	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Yes	No	1-10 years	11-44 years	45+ years
Memorial Hospital of Easton	51%	66%	73%	8%	23%	83%	43%	53%	50%	46%	60%
Anne Arundel Medical Center	18%	14%	3%	14%	50%	8%	28%	30%	25%	23%	3%
Chester River Hospital Center	12%	3%	0%	48%	13%	1%	12%	12%	8%	13%	14%
Christiana Hospital, Delaware	4%	0%	0%	18%	1%	0%	6%	3%	3%	4%	2%
Peninsula Regional Hospital	3%	1%	11%	0%	0%	2%	1%	7%	1%	1%	7%
Dorchester General Hospital	2%	1%	8%	0%	2%	0%	1%	5%	1%	2%	3%
Johns Hopkins (including Bayview)	2%	0%	1%	3%	1%	3%	1%	3%	2%	1%	2%
Kent General Hospital, Delaware	1%	3%	0%	1%	2%	0%	1%	1%	0%	1%	2%
Union Hospital of Cecil County	1%	0%	0%	5%	0%	0%	1%	1%	2%	1%	0%
Nanticoke Memorial Hospital, DE	1%	5%	0%	0%	0%	0%	1%	1%	2%	1%	0%
Kent & Queen Anne's Hospital	1%	0%	0%	3%	0%	0%	0%	1%	0%	.4%	1%
Other	5%	8%	4%	1%	8%	2%	5%	5%	0%	4%	5%
(n)	(431)	(79)	(93)	(79)	(92)	(88)	(86)	(345)	(99)	(209)	(123)

Appendix: Questionnaire

Telephone Questionnaire
Eastern Shore Health Care Survey

Hello, this is……. of Hollander Cohen & McBride, an independent research firm. We are conducting a study with residents to get their opinions regarding local health care services.

A. We must accurately represent the population, so could you tell me if you are over or under age 21?

-2 OVER → **A1.** Is that... -2 21-44

-3 45 to 59 or

-4 60 or over?

-3 UNDER → **Thank & Terminate**

[ ] DK/RF → **Thank & Terminate**

B. It is important that we speak to the person in the household who is most responsible for making decisions regarding health care. Are you that person? (IF ASKED: The person who would be most likely to choose which hospital or health care provider to use in various situations.)

-2 Health care decision maker

-3 Other person is health care decision maker → **ASK TO SPEAK TO THIS PERSON. IF HE/SHE IS NOT AVAILABLE, MAKE ARRANGEMENTS TO CALL BACK.**

[ ] DK/RF

C. Do you or any member of your household work for any medical organization, such as a hospital, minor emergency clinic, nursing home, medical practice or home health care firm, or a marketing research or advertising company?

-2 YES → **Thank & Terminate**

-3 NO

[ ] DK/RF → **Thank & Terminate**

D. We must accurately represent the population, so could you tell me which Eastern Shore County you live in?

-2 CAROLINE

-3 DORCHESTER

-4 KENT

-5 QUEEN ANN'S

-6 TALBOT

-7 OTHER → **Thank & Terminate**

[ ] DK/RF → **Thank & Terminate**

Telephone Questionnaire

1. How long have you been a resident of (insert answer from QD) county? _0 – 99_ Years **(< 6 months = "0")**

1a. Are you employed outside of your home?
-2 YES → **Continue**
-3 NO → Skip to Q4
[ ] DK/RF → **Skip to Q4**

2. In what county do you work?
-2 ANNE ARUNDEL
-3 CAROLINE
-4 CECIL
-5 DORCHESTER
-6 KENT
-7 QUEEN ANN'S
-8 SOMERSET
-9 TALBOT
-10 WICOMICO
-11 WORCESTER
-12 OTHER (SPECIFY)_____ **Q2_OS**
[ ] DK/RF

ASK Q3 IF Q"D" NOT EQUAL Q "2":
ASK IF (QD=2 AND Q2<>3) or (QD=3 AND Q2<>5) or (QD=4 AND Q2<>6) or (QD=5 AND Q2<>7) or (QD=6 AND Q2<>9)
3. In general, do you seek health care services close to...
-2 where you live or
-3 where you work
[ ] DK/RF

Telephone Questionnaire

4. In your view, what is a reasonable length of time that would be acceptable to travel for the following health care services?

	30 minutes or less	31-60 minutes	More than 1 hour	RF/DK
a. for a routine check-up with a family practice physician, internist, gynecologist or pediatrician	2	3	4	0
b. to see a specialist, such as an orthopedic doctors, dermatologist, or a diabetes specialist	2	3	4	0
c. to see a specialist for a potentially life-threatening diagnoses or conditions, such as cancer diagnosis, care, or treatment.	2	3	4	0
d. to deliver a baby	2	3	4	0

5. Which one hospital are you most likely to consider your family's preferred hospital? **(accept only one response)**

-2 ANNE ARUNDEL MEDICAL CENTER **[BLHOSP 1 REPLY]**
-3 ATLANTIC GENERAL
-4 CHESTER RIVER HOSPITAL CENTER
-5 DORCHESTER GENERAL HOSPITAL
-6 McCREADY FOUNDATION
-7 MEMORIAL HOSPITAL OF EASTON
-8 PENINSULA REGIONAL HOSPITAL
-9 UNION HOSPITAL OF CECIL COUNTY
-10 OTHER **(SPECIFY)**_____ **Q5_0S**
[ ] DK/RF

6. During the past 3 years, which hospitals have you and your family used for **any type** of hospital care such as inpatient care, emergency care, same-day surgery etc. **[BLHOSP 1 - 9 REPLIES]**

-2 ANNE ARUNDEL MEDICAL CENTER
-3 ATLANTIC GENERAL
-4 CHESTER RIVER HOSPITAL CENTER
-5 DORCHESTER GENERAL HOSPITAL
-6 McCREADY FOUNDATION
-7 MEMORIAL HOSPITAL OF EASTON
-8 PENINSULA REGIONAL HOSPITAL
-9 UNION HOSPITAL OF CECIL COUNTY
-10 OTHER **(SPECIFY)**_____ **Q6_0S**
-11 NONE **(THIS ANSWER ONLY SHOWS UP IN THIS QUESTION)**
[ ] DK/RF

7. If you were asked by a family member or friend to recommend a hospital for delivering babies, which **one** hospital would you recommend? **(accept only one response)** **[BLHOSP 1 REPLY]**

-2 ANNE ARUNDEL MEDICAL CENTER
-3 ATLANTIC GENERAL
-4 CHESTER RIVER HOSPITAL CENTER
-5 DORCHESTER GENERAL HOSPITAL
-6 McCREADY FOUNDATION
-7 MEMORIAL HOSPITAL OF EASTON
-8 PENINSULA REGIONAL HOSPITAL
-9 UNION HOSPITAL OF CECIL COUNTY
-10 OTHER **(SPECIFY)**_____ **Q7_0S**
[ ] DK/RF

8. Please consider the following scenario: Your doctor tells you that you need a surgical procedure for your hernia or gallbladder. He gives you the following choices; which would you prefer?

-2 You can have the surgery done at your closest hospital, where the procedure is performed by doctors a few times each month, or
-3 You could have the surgery performed at a hospital located an hour away where doctors perform the procedure every day.

[ ] DK/RF

Telephone Questionnaire

Now I'd like to ask you some questions for classification purposes. Your answers will only be used to categorize the survey.

9. a. Including yourself, how many people live in your household? 1 – 20 RF **[IF 1, SKIP TO Q 10]**

   b. How many are under the age of 18? 0 – 10 RF

10. Are you married, [PAUSE] or living with someone as a couple, or are you single, divorced, separated, or widowed?

    -2 MARRIED -3 COUPLE -4 SINGLE/DIVORCED/SEPARATED/WIDOWED RF

11. Please stop me when I reach the category that includes your age. Are you:
    -2 21-24,
    -3 25 to 34,
    -4 35 to 44,
    -5 45 to 54, or
    -6 55-64, or
    -7 65 or over?
    RF

12. What is the highest grade of school you have had the opportunity to complete?

    -2 LESS THAN HIGH SCHOOL
    -3 HIGH SCHOOL GRADUATE
    -4 SOME COLLEGE
    -5 COLLEGE GRADUATE
    -6 POSTGRADUATE WORK
    RF

13. Are you currently employed full-time, a full-time student, employed part-time, or not employed?

    -2 EMPLOYED FULL TIME
    -3 EMPLOYED PART TIME
    -4 FULL TIME STUDENT
    -5 NOT EMPLOYED/ RETIRED/DISABILITY
    RF

Telephone Questionnaire

14. Do you consider yourself to be….. [READ CATEGORIES]

-2 White Caucasian
-3 African-American or other Black
-4 Hispanic
-5 Asian
-6 Or some other ethnic group? **(SPECIFY)** _____**Q14_0S**
RF

15a. And lastly, is the total annual income of all members of your household over $50,000 or under $50,000?

-2 Over $50,000 -3 Under $50,000 RF/DK

b. If over $50K, is it:

1 $50,000 - $75,000
2 $75,000 - $100,000,
3 $100,000 - $150,000
4 OVER $150,000?

c: If under $50K, is it: **RECODE RESPONSES**

(1) 4 $35,000 - $50,000,
(2) 3 between $25,000 - $35,000,
(3) 2 $15,000 to $25,000, or
(4) 1 under $15,000?

16. -1 MALE -2 FEMALE

[VERIFY]And I dialed _____. Is that correct?
[PHONE NUMBER]

My name is _____, and this survey is being conducted by the research firm of Hollander Cohen & McBride. That's all the questions I have. Thank you for taking the time to speak with me.

Appendix 4.2: A Summary of Public Comment Regarding the Possible Regionalization of Health Care Delivery to the Mid-Shore

CHESTER RIVER HEALTH
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

SHORE HEALTH
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

A summary of public comment regarding the possible regionalization of health care delivery to the Mid-Shore

BACKGROUND

Shore Health and Chester River Health held eight community forums in locations throughout the Mid-Shore region during February and March 2012. The purpose of each session was to ask residents of the community to offer their thoughts about the regionalization study underway between Chester River Health and Shore Health.

More than 300 people attended these meetings, which were held in Cambridge, Denton, Easton, Federalsburg, Queenstown, Rock Hall, Sudlersville and Worton. A summary of the themes, issues and concerns expressed by the public during these sessions has been provided to our regionalization study committee to assist them in their work.

GOALS OF THE MID-SHORE HEALTHCARE RGIONALIZATION STUDY

The goals of our regionalization study are to ensure that:

1) our health systems continue to provide the people of Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties access to the health care services they need,
2) the health care services provided by our health systems meet the highest possible standards of clinical quality, and
3) our health systems stay fiscally sound in a period of unprecedented health care change.

STUDY PROCESS AND TIMELINE

In addition to seeking comments from the residents of the communities that we serve, our healthcare regionalization study is considering information from a variety of other sources. For example, we have held dozens of formal and informal discussions with our physicians and employees; local, state and federal elected officials; emergency providers; regulators and healthcare partners.

The regionalization study group is expected to continue its work through summer 2012 and is charged with finding answers to the following questions:

- Are our health systems well prepared to survive and thrive in a future health care environment that will present new and difficult challenges?

- Does a regionalized approach to delivering health care promise potential benefits that are not possible with our current delivery model?

- Patients in our rural region increasingly expect local health care providers to offer the same depth and breadth of services as large medical centers located in big cities. How should we respond to their expectations?

- Generally, the more frequently a physician performs a particular medical procedure, the better are the results for the patient. Our rural setting makes achieving high volumes of procedures difficult, however, especially when we offer the same specialized medical services in multiple locations in the Mid-Shore region. Would patients benefit if we didn't try to do everything everywhere, and instead concentrated specialized medical services?

- Now that most health care services are provided outside of a hospital setting, how should our network of facilities change and grow?

- Would a regionalized approach to health care delivery aid us in recruiting to our region the next generation of physicians and health professionals?

- If we change how we deliver health care services in the region, what patient and community needs must we be aware of and plan for?

- What is the proper role and responsibility of the health systems in addressing patient and community needs, and what is the proper role and responsibility of other agencies and state and local governments in meeting those needs?

- What partnerships and coalitions, both existing and new, will be essential to achieving a successful implementation of a regionalization plan?

SUMMARY OF PUBLIC COMMENT

The following summary highlights major points and themes that were expressed by attendees at our eight community forums held in February and March 2012. Although this presentation is intended to reflect the many issues and questions that came up, it is a summary, and does not claim to account for every opinion expressed by every individual who participated.

Further, this summary should not be regarded as an action plan for the health systems to implement, but rather as information for the regionalization study committee to consider. In fact, some of the topics raised in the sessions are beyond the scope or responsibility of the health systems. We have included them nonetheless to achieve an accurate accounting of the sessions.

- **Participants expressed appreciation for the health systems' inclusion of the general public in the regionalization planning process and applauded such**

investments as the new Queen Anne's Emergency Center and Shore Health Medical Pavilion in Queenstown.

- **Many participants noted that the quality and breadth of the services currently provided by the health systems' needs to be better understood by Mid-Shore residents.**

- **Participants from throughout all five counties asked for more and better access to healthcare services. This includes** having services closer to where people live, scheduling that better accommodates their needs and preferences, and more efficient coordination of care among the region's health providers. The ability to stay on the Eastern Shore for most healthcare services, rather than traveling across the Bay Bridge or to Delaware, was the most common request.

- **Some attendees expressed skepticism that regionalization of healthcare services can work and feared it might cause more people to seek care outside the Mid-Shore region.**

- **Participants made plain their view that access to care is directly related to access to transportation.** Transportation was of special concern for the poor and elderly, for whom finding transportation is often a barrier to them receiving preventive, routine and urgent care.

- **Local availability of specialty care for unique populations is a growing concern.** Specific groups cited were the growing geriatric population, children with special needs and those in need of behavioral health services.

- **More thought should be given to how technology can contribute to addressing the region's unmet health and medical needs.** Examples included telemedicine that could offer patients remote consults with providers. Other participants noted that achieving efficient care coordination is dependent on providers having access to electronic medical records.

- **Many expressed the hope that the University of Maryland Medical System will assume an even larger role in addressing the region's healthcare needs**. Ideas offered included increasing local access to specialty physicians, developing a rural medicine program, and ensuring that caregivers within UMMS have full access to information about patients who are transferred to, or referred for specialty care within the system.

- **Some participants perceive a loss of local control over important health care decisions, and sought reassurance that local boards of directors for Chester River Health and Shore Health will be the decision-makers on matters related to regionalization.**

- **Citing recent clinical changes at Chester River Hospital, especially in pediatrics and obstetrics, some worried about the commitment of UMMS to maintaining the hospital as an acute care inpatient hospital.**

FREQUENTLY ASKED QUESTIONS AND THE ANSWERS PROVIDED:

Of the many questions asked during our eight community forums, the following questions were asked most often. The answers provided to these questions are included.

Q. What is the status of the plan to replace Memorial Hospital in Easton?

A. Shore Health plans to file a Certificate of Need (CON) for the replacement to Memorial Hospital this September. Review of the CON by the Maryland Health Care Commission will likely take six months. If the CON is approved, we are projecting a 2016 opening of the new medical center, which would be located off of US Route 50 north of the Easton Airport and adjacent to the Talbot County Community Center.

Q. Were decisions about the outcome of the regionalization study made before the public process began?

A. No decisions about the outcome of the study were made in advance. Some people have confused the preliminary report of an external consultant as representing the conclusions of the regionalization study group, which is inaccurate. The regionalization study group is not expected to make its final recommendations until summer 2012 at the earliest.

Q. **Will local boards of directors from Chester River Health and Shore Health decide the outcome of the regionalization study?**

A. While the study group does have limited representation of individuals from the corporate offices of University of Maryland Medical System, the majority of the study committee is comprised of administrators and Board members of Chester River Health and Shore Health. The study group's report will be reviewed and decided upon by the local boards of the two health systems.

Q. What consideration are you giving to transportation issues and to the challenges the poor and elderly confront in accessing health services?

A. We recognize that transportation access on the Mid-Shore is a challenge, especially for some populations. Our study will give transportation significant attention. However,

solutions to transportation will need to be considered in partnership with other local agencies.

Q. What are you doing to bring the services of more physician specialists to the region?

A. As part of our regionalization study, we hope to identify opportunities to offer the services of more physician specialists in more locations throughout the region. Part of the recruitment effort will involve working with the University of Maryland School of Medicine. Other efforts include working with specialists practicing at Memorial Hospital at Easton and Union Hospital in Elkton to develop strategies that will assist them in offering office hours in communities where their specialty medical services are needed.

Q. What are the challenges of recruiting physicians and other health professionals to practice here?

A. Recruiting physicians and other health professionals to rural areas is challenging, since most have trained in urban areas and are often oriented to practicing in urban and suburban settings. Reimbursement rates for physicians in Maryland are less competitive than in many other states. Newly credentialed physicians increasingly are looking for practice settings that allow them maximum flexibility and control over their time. Specialists look for a population base large enough to fill their practice with patients. Additional challenges vary from county to county, and can include such factors as quality of school systems and employment opportunities for spouses. In addition to increasing our physician recruitment efforts, we are focused on recruiting highly trained professionals who can supplement and complement physician services, such as physician assistants and nurse practitioners.

Q. What is the University of Maryland Medical System doing to help improve health care in our region?

A. The University of Maryland Medical System (UMMS) is committed to addressing the region's healthcare needs and has invested tens of millions of dollars in the Mid-Shore region. Regrettably, there are physician shortages in all 12 hospitals that are a part of UMMS, just as there is a shortage of physicians across most of Maryland. Our medical system, as well as every other medical system in Maryland, has limited ability to solve every physician shortage. Nonetheless, UMMS is partnering with the University of Maryland School of Medicine and our mid-shore hospitals to create opportunities to bring residents, fellows and medical students, as well as primary and specialty physicians, to our region.

Q. What are your plans for increasing healthcare services in Caroline County, which is one of only two counties in Maryland without a hospital and the only county without an emergency center?

A. Although it is technically separate from the regionalization study, Shore Health and the the Caroline County Commissioners have created a task force, consisting of key county representatives, that is charged with identifying the county's current and projected health needs. This study is being conducted parallel to the regionalization study. Results of the Caroline County study should be available late in 2012.

Q. Why do ambulances sometimes bypass the nearest ER in my community and take patients to a more distant hospital?

A. Emergency medical service (EMS) providers must follow emergency care protocols established by the Maryland Institute for Emergency Medical Services Systems. So for example, if EMS personnel suspect that a patient may be having a stroke, they follow a protocol that mandates taking the patient to the closest designated stroke center, rather than to the closest emergency department.

Q. Why was the Obstetrics Unit closed at Chester River Hospital Center?

A. This difficult decision was made in response to the decision by the only obstetrics practice in Kent County to cease deliveries at Chester River Hospital Center and to deliver babies exclusively at Anne Arundel Medical Center. The CRHS Board evaluated the obstetrics department's viability, and determined that without a local obstetrics practice that is committed to delivering babies at CRHC, the hospital cannot maintain an obstetrics unit. Additionally, since Drs. Moorman and Webb continue to provide prenatal and postnatal care to the Kent County community from their Chestertown office, establishing a second, competing obstetrics group would not be practical, since the county's population cannot support four OB physicians. CRHC already had the lowest number of births of any hospital in Maryland—186 babies were delivered in 2011. The next lowest hospital, in Garrett Country, had 50 percent more births than Chester River. In comparison, Memorial Hospital in Easton had more than 1,000 births during the same period, while Anne Arundel Medical Center had nearly 5,000 births.

Q. Why were pediatric services eliminated at Chester River Hospital Center?

A. Contrary to widespread rumors, Chester River Hospital Center continues to treat and stabilize all ill and injured children who come to the hospital for emergency care, which overwhelmingly is the primary medical need of children. Last year, while the emergency department at Chester River handled more than 3,300 pediatric patients, only 73 children were admitted to the hospital. When children present to the Chester River emergency department, the vast majority are evaluated, treated and released. In the relatively few cases when inpatient care is warranted, the children are stabilized and transferred to another hospital. The majority of pediatric patients who require hospital admission are transferred to a hospital with a dedicated pediatric specialty unit. However, children 14 years and older continue to be admitted to Chester River Hospital for medical care. On a case-by-case basis, children 12 years and older who require surgery, such as for an

appendix removal, are evaluated in the emergency department, stabilized and may be admitted to Chester River Hospital by a surgeon.

When necessary, children are transferred to one of the following hospitals: Memorial Hospital in Easton, Union Hospital in Elkton, Baltimore Washington Medical Center in Glen Burnie, Anne Arundel Medical Center in Annapolis and Christiana Hospital in Newark, Delaware, as well as pediatric "centers of excellence" including AI Dupont Hospital for Children, Johns Hopkins Children's Center and University of Maryland Children's Hospital. Chester River Hospital has agreements with these institutions to ensure seamless, doctor-to-doctor transfers of pediatric patients.

Appendix 4.3: Caroline County, MD

Community Needs Assessment – Final October 2012

CAROLINE COUNTY, MD

COMMUNITY NEEDS ASSESSMENT – *FINAL*

OCTOBER 2012

SHORE HEALTH
UNIVERSITY OF MARYLAND
MEDICAL SYSTEM

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Project Overview

- TRG Healthcare was hired by Shore Health and the Caroline County Commissioner's office to conduct a study to assess the healthcare needs of Caroline County.
- The purpose of conducting this study was to gather important information to provide recommendations for enhancing the level of healthcare services in Caroline County.
- A Joint Oversight Committee oversaw this process with members from both Shore Health System and the Caroline County Commissioner's office.
- This Committee met regularly over the past 6 months to review data and findings, provide insight into the healthcare needs of the County, provide input, and approve recommendations resulting from this work.

Members of the Joint Oversight Committee

- John Barto – MIEMS, Region IV Office
- William Beall – Mayor, Federalsburg
- Dale Brown – Community Member
- Wayne Howard – Community Member
- Ken Kozel – President and CEO Shore Health System
- Keith McMahan – Shore Health System Board Member
- Larry Porter – County Commissioner
- Joe Sheehan – CEO, Choptank Community Health
- Mike Silgen, VP, Strategic Planning & Business Development
- Leland Spencer, MD – Health Officer, Caroline County
- Sal Verteramo, MD – Emergency Department Regional Director – Shore Health
- Sara Visintainer – Caroline County Commissioners Office
- Patti Willis – Senior Vice President of External Relations & Development, Shore Health System

Process and Timing

- The Kick off meeting was held Thursday March 15, 2012 in the Caroline County Circuit Courthouse
- Follow up calls were made after the initial meeting with: Leland Spencer, MD, John Barto, Joe Sheehan, Brian Ebling, Patty Willis, Mayor Beall, Ken Kozel, Mike Silgen, Wayne Howard, Larry Porter, and Sara Visintainer, and Sal Verteramo, MD, and Keith McMahan
- There were 2 additional meetings held:
  - April 19, 2012
  - June 7, 2012
- The final meeting was held on October 1, 2012 to present the final document, findings and recommendations based on Pro Formas

Caroline County: Summary Findings from Data Analyses

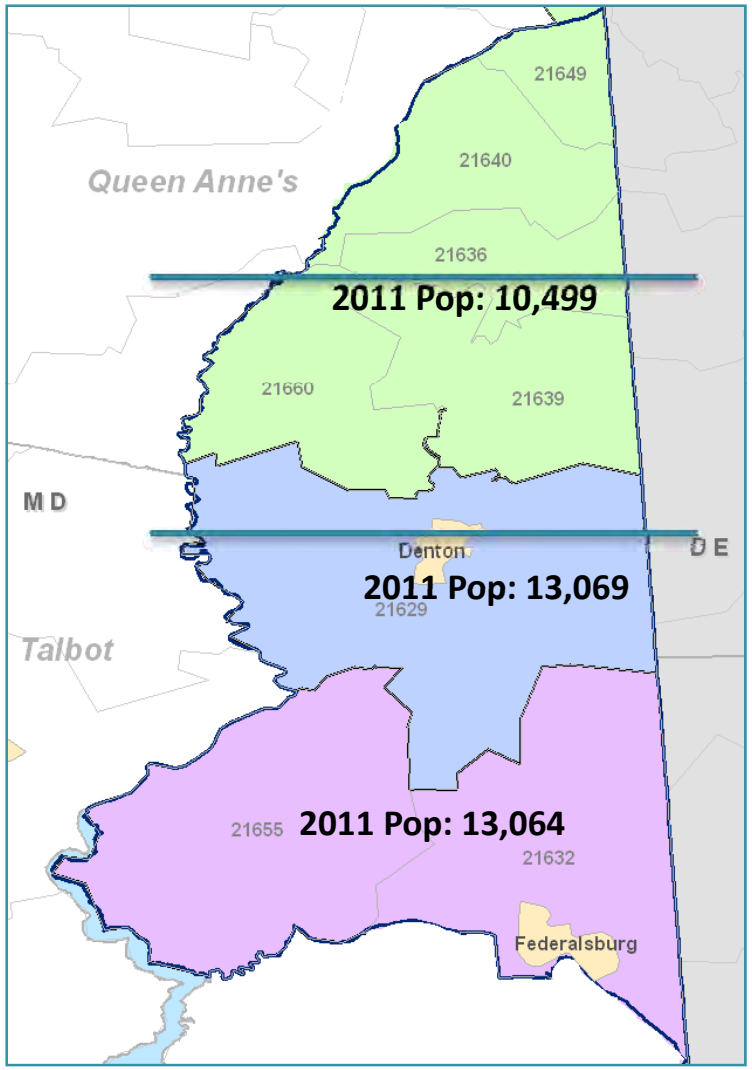
- Overall population growth in the County is relatively flat with minimal growth projected over the next five years (1.6%)
- Caroline County has a significantly higher percent of its population who are uninsured. Out of all Maryland counties, only 3 other counties were higher than Caroline County in the percent of uninsured children in 2009
- Compared to similar counties and the United States, Caroline County has higher rates of births to women under 18 and births to unmarried women
- Death rates in Caroline County were significantly higher for:
  - Breast, colon, and lung cancers
  - Coronary heart disease
  - Stroke
  - Suicide
- Compared to State and county data, Caroline County has a higher rate of mental health issues and chronic diseases, specifically, obesity, diabetes, and asthma
- In addition, utilization of preventive services (or availability) is lower when compared to State or similar counties for mammography and diabetes screening, flu shots
- Based on national benchmarks, the County could support an additional 2.5 primary care physicians or advanced practice professionals

Caroline County: Summary of Issues and Healthcare Needs

- Access to transportation is limited in Caroline County.
- The population within the County is spread through out, not concentrated in one or two areas, making access to public transportation and healthcare facilities even more challenging.
- Many Counties within the State of Maryland are experiencing significant budgetary issues due to the State shifting costs to the individual county budgets. This has the potential to reduce certain services that are now available to residents, in particular mental health services.
- Access to primary care providers is limited, especially access to pediatricians. There are several practitioners that are at or close to capacity in their practices or are not accepting new patients.
- There are no specialists in the County with the exception of a 1 gynecologist at Choptank 2 days per month.
- There are no OB/GYN physicians or family practitioners in the County who deliver babies. The County Health Department provides a maternity care clinic in Denton for prenatal care but coordinates with physicians outside the County for deliveries.
- There is limited access to mental health services. The County Department of Health is the only provider in the County for addiction services.
- Limited access to information technology resources for health professionals in the County including telemedicine and electronic medical records.

North, Central, South Market Segments

- Due to the variation in population density within Caroline County, the data was broken up into three segments: North, Central, and South as shown on the map *(population divided by lines shown on map)*
- The tables that follow summarize the healthcare services that could be supported based on population and the current services available
- Healthcare services have been broken up into the following categories:
  - Preventive Services
  - Routine Services (e.g. primary care and diagnostics)
  - Urgent Care Services
- The data for emergent (acute care) is shown starting on page 49. There is no hospital in this County.



Southern Market

Services	Services/Providers	Need Based on 2010 Population	Gap	Recommendations
Preventive Services	Choptank facility and Health Department providing screenings for breast, cervical and colorectal cancers	*Populations for Screenings/ Education:* • 18 + - Smoking: **9,642** • Female 45 + Breast and Cervical Screenings – **2,857** • Male 55 + Prostate Screenings – **3,185** • Total 65 + Stroke / Heart Disease – **1,724**	Prostate screenings Lung cancer	Continue working with Mid Shore Local Health Action Plan led by Dr. Leland Spencer
Routine Services				
Primary Care	**7.06** FTE Providers	**7.27** (IM, FP, Pediatrics)	Based on data - no need for additional PC physicians *-however* - 1 PC is not accepting new patients, Choptank is at capacity and 1.6 of FTE's are school based NPs	Add after hours primary care services to increase access, reduce transports to hospitals that could be managed in County
After Hours Services	None currently	Total Transports to Shore Health Facilities Per 1,000 = **64.3**		Provide services 2days per week from 5 -8pm – Pro Forma developed
Diagnostic	None currently	There were approximately 2,400 patient encounters from southern zip codes travelling to Denton Diagnostics in 2011		Evaluate developing diagnostic services (x-ray and lab services) Pro –Forma developed

Southern Market

Southern Market Physicians

Affiliation	Specialty	FTE	Name	Address	City	State	Zip
Choptank	Family Practice	0.8	Kathryn Cook, MD	215 Bloomingdale Avenue	Federalsburg	MD	21632
Choptank	Family Practice	1	Lyndsey Young, NP	216 Bloomingdale Avenue	Federalsburg	MD	21632
Choptank/School Based	Family Practice	0.83	Susan Clark, NP	25390 Richardson Rd	Federalsburg	MD	21632
Choptank/School Based	Family Practice	0.83	Susan Hagie, NP	302 University Avenue	Federalsburg	MD	21632
Mainly nursing home and geriatric patients	Internal Medicine	1	Paul M. Reinbold, MD	321 Bloomingdale Ave.	Federalsburg	MD	21632
Nanticoke Family Practice - Does not take MD Insurance	Family Practice		John A. Appiott, DO	3304 Hayman Drive	Federalsburg	MD	21632
Preston Family Physicians	Family Practice	0.8	Melinda Butler, MD	3683 Choptank Road	Preston	MD	21655
Preston Family Physicians	Family Practice	1	Timothy J. Sniezek, MD	3683 Choptank Road	Preston	MD	21655
Preston Family Physicians	Family Practice	0.8	Arlene Stevens, NP	3683 Choptank Road	Preston	MD	21655
	Total FTE PC Physicians	**3.6**					
	Total FTE Advance Practice	**3.46**					
	Total Providers	**7.06**					

Physician Need

Specialty	GMENAC	Hicks & Glenn	Average of 10 Sources	Physicians/ NP In the County	Gap (Based on Average)
Primary Care					
Family Practice	3.29	4.40	3.16	3.6	0.44
NP & PA				3.46	3.46
Internal Medicine	3.77	2.33	2.68		-2.68
Pediatrics	1.65	1.69	1.42		-1.42
Total	**8.72**	**8.42**	**7.27**	**7.06**	**-0.21**

Central Market

Services	Services/Providers	Need Based on 2012 Population	Gap	Recommendations
Preventive Services	Choptank facility and Health Department providing screenings fro breast, cervical and colorectal cancers – Shore Health providers also doing screenings and are present at health fairs and community events	*Populations for Screenings/Education:* • 18 + - Smoking: **9,866** • Female 45 + Breast and Cervical Screenings – **2,922** • Male 55 + Prostate Screenings – **3,333** • Total 65 + Stroke / Heart Disease – **1,807**	Prostate screenings Lung cancer	Continue working with Mid Shore Local Health Action Plan led by Dr. Leland Spencer
Routine Services				
Primary Care	**9.03** FTE Providers	**7.27** (IM, FP, Pediatrics)	Based on data there is no need for additional PC physicians – however – 2 of the 3 Shore physicians at capacity – 3rd at 75%	Choptank just recently recruited an additional primary care physician – no need for additional
After Hours Services	None currently	Total Transports to Shore Health Facilities Per 1,000 = **71.5**		Add after hours services 2 days a week – Pro Forma developed
Diagnostics	Denton Diagnostic Center	Have existing facility	Denton Diagnostics not at capacity – x-ray, lab walk in – mammography available same day	Review expanding Denton Diagnostic Center hours to support after hours – Pro-Forma developed

Central Market

Central Market Physicians

Affiliation	Specialty	FTE	Name	Address	City	State	Zip
Choptank	Family Practice	1	James E. Lacey, MD	609 Daffin Lane	Denton	MD	21636
Choptank	Pediatrics	1	Krysta Mints, NP	609 Daffin Lane	Denton	MD	21629
Choptank	Pediatrics	0.9	Sheri N. Moore, DO	609 Daffin Lane	Denton	MD	21629
Choptank	Internal Medicine	1	Dr. M Salmonsen DO	609 Daffin Lane	Denton	MD	21629
Choptank	Family Practice	1	Kevin Tate MD	609 Daffin Lane	Denton	MD	21629
Choptank	Gynecology	0.1	John J. LaFerla, MD	609 Daffin Lane	Denton	MD	21629
Choptank/School Based	Family Practice	0.83	Daisy Werkheiser, NP	10990 River Road	Ridgley	MD	21660
Shore Family Medicine	Family Practice	1	Wafik I. Zaki, MD	836 South 5th Street	Denton	MD	21629
Shore Family Medicine	Family Practice	0.8	Herman, Kim, MD	836 South 5th Street	Denton	MD	21629
Shore Family Medicine	Family Practice/Geriatrics	0.8	James Sides, MD	836 South 5th Street	Denton	MD	21629
Limited due to hospital schedule	Internal Medicine	0.5	Korah M. Pullimood, MD	912 D. Market Street	Denton	MD	21629
Hours by appointment only - no set days or hours	Family Practice/Occ Med	0.2	Christian Jensen, MD	9307 Corkell Rd	Denton	MD	21629
	Total FTE PC Physicians	**7.2**					
	Total Specialty Physicians	**0.1**					
	Total FTE Advance Practice	**1.83**					
	Total Providers	**9.13**					

Physician Need

Specialty	GMENAC	Hicks & Glenn	Average of 10 Sources	Physicians/ NP In the County	Gap (Based on Average)
Primary Care					
Family Practice	3.29	4.40	3.17	4.8	1.63
NP & PA				1.83	1.83
Internal Medicine	3.78	2.33	2.68	1.5	-1.18
Pediatrics	1.65	1.69	1.42	0.9	-0.52
Total	**8.72**	**8.42**	**7.27**	**9.03**	**1.76**

Northern Market

Services	Services/Providers	Need Based on 2012 Population	Gap	Recommendations
Preventive Services	Choptank facility and Health Department providing screenings for breast, cervical and colorectal cancers	*Populations for Screenings/ Education:* • 18 + - Smoking: **7,451** • Female 45 + Breast and Cervical Screenings – **1,095** • Male 55 + Prostate Screenings – **2,110** • Total 65 + Stroke / Heart Disease – **1,095**	Prostate screenings Lung cancer	Continue working with Mid Shore Local Health Action Plan led by Dr. Leland Spencer
Routine Services				
Primary Care	**3.90** FTE PC Providers (2 Physicians, 1.9 PAs)	**5.84** (IM, FP, Pediatrics)	**1.94 Total Need**	Develop long term plan to recruit additional primary care physicians in conjunction with Choptank if volumes and current capacity support
After Hour Services	None currently	Total Transports to Shore Health Facilities Per 1,000 = **42.8**		If required after recruitment of PC physician(s), develop after hours services
Diagnostics	None currently			Develop to support primary care physicians if volumes support

Northern Market

Northern Market Physicians

Affiliation	Specialty	FTE	Name	Address	City	State	Zip
Choptank	Family Practice	1	Doug Hamsher, PA-C	316 Railroad Ave	Goldsboro	MD	21636
Choptank	Family Practice	1	Patricia J. Karnes-Amzibel, DO	316 Railroad Ave	Goldsboro	MD	21636
Choptank	Internal Medicine	1	Eric Hermansen, MD	316 Railroad Ave.	Goldsboro	MD	21636
Choptank	Gynecology (2 Days/Month)	0.1	John J. LaFerla, MD	316 Railroad Ave.	Goldsboro	MD	21636
Choptank/School Based	Family Practice	0.9	Christina Bartz, PA	625 North Street	Greensboro	MD	21639
	Total FTE PC Physicians	**2**					
	Total FTE Advance Practice	**1.9**					
	Total Specialty Physicians	**0.1**					
	Total Providers	**4.00**					

Physician Need

Specialty	GMENAC	Hicks & Glenn	Average of 10 Sources	Physicians/ NP In the County	Gap (Based on Average)
Primary Care					
Family Practice	2.65	3.54	2.54	1	-1.54
NP & PA				1.9	1.90
Internal Medicine	3.03	1.87	2.16	1	-1.16
Pediatrics	1.33	1.35	1.14		-1.14
Total	**7.01**	**6.77**	**5.84**	**3.90**	**-1.94**

General Recommendations for Increasing Access to Healthcare Services in Caroline County

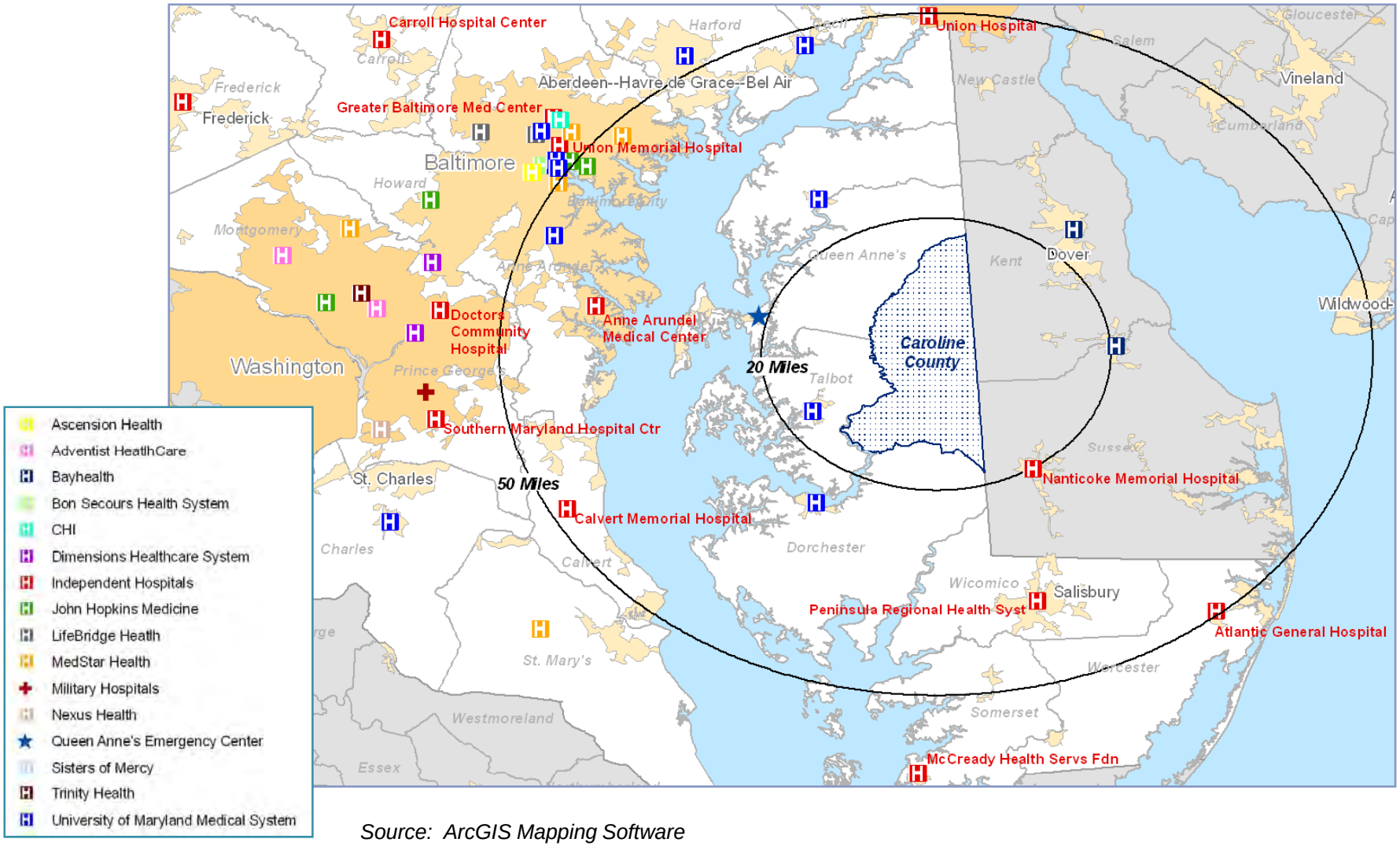
1. ***Short Term:*** Create outcomes measures to monitor success of new programs, initiatives, services (*see next page*)
2. ***Short Term:*** *Aggressively market in cooperation with Choptank, the after hours services available*
3. ***Short Term:*** Establish a relationship with Salisbury University's Nurse Practitioner program to create potential training sites and for future recruitment needs.
4. ***Mid Term:*** If legislation passed, apply for grant funding through the pilot program creating Health Enterprise Zones in underserved communities
5. ***Mid to Long Term:*** Develop an after hours call center potentially based at Shore Health, to screen calls and direct patients to the most appropriate services
6. ***Mid to Long Term:*** Expand the role of Care Coordinators in clinics to reduce inpatient and emergency room admissions and manage individuals with chronic conditions (Shore Wellness Partners). Could be shared between Shore Health and Choptank.
7. ***Mid to Long Term:*** Integrate and coordinate all community prevention and health education activities, as feasible, with an integrated calendar and promotion function.
8. ***Mid to Long Term:*** Explore development of outreach clinics for needed specialists, specifically addressing the need for OB/GYN
9. ***Mid to Long Term***: Connect to telemedicine services based at UMMS as they become available to increase access to specialty physician services.

Outcomes Measures for After Hours Services

- Urgent care priority 3 transports in the County
- Volume of visits in after hours clinics – including tracking of:
  - New patients versus existing patients
  - Reason for visit
  - Follow up care including if diagnostics were needed
  - Other?
- Wait times to schedule office appointments for follow up

General County Overview

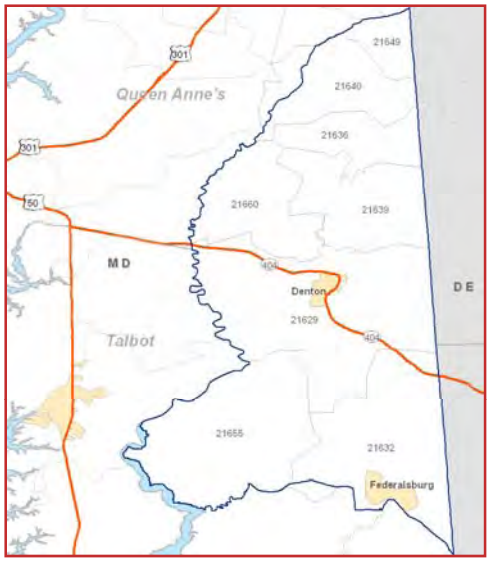
Map of County and Surrounding Areas



Source: ArcGIS Mapping Software

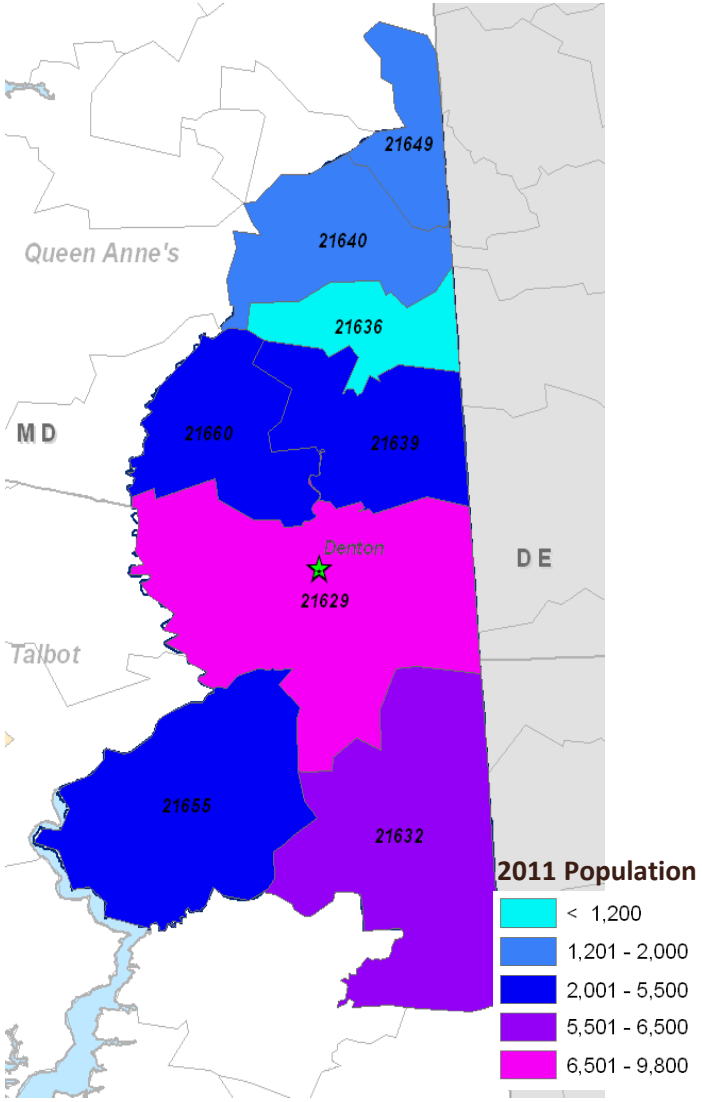
Caroline County

- Caroline County, MD is a rural county with the county seat in Denton.
- It is the only county in the State not represented by a resident legislator in the Maryland General Assembly.
- Caroline is the only Eastern Shore county not to touch either the Chesapeake Bay or Atlantic Ocean.
- It is one of three Maryland counties that does not have an interstate or U.S. Highway running through it.



- Caroline County is the only county east of the Mississippi River to never feature any heavy industry besides agriculture.
- Caroline County is one seven jurisdictions participating in One Maryland Program, which offers significant tax credits for capital investments that create jobs.
- There are no hospitals in the county.
- There are ten incorporated municipalities in the County: Denton, Federalsburg, Goldsboro, Greensboro, Henderson, Hillsboro, Marydel, Preston, Ridgely, Templeville.

2011 Population of Caroline County

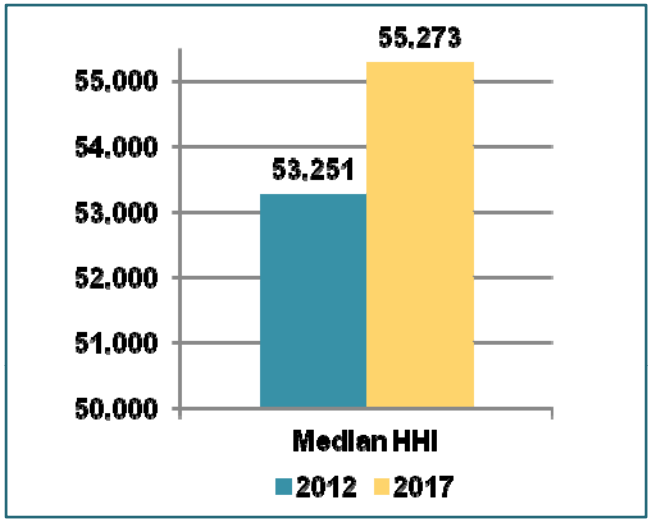


Zip Code	City	2011 Population	2017 Population Estimate	% Change 2011 - 2017
21629	Denton, MD	9,768	10,327	5.7%
21632	Federalsburg, MD	6,488	6,563	1.2%
21636	Goldsboro, MD	1,189	1,087	-8.6%
21639	Greensboro, MD	4,973	4,762	-4.2%
21640	Henderson, MD	1,831	1,854	1.3%
21649	Marydel, MD	1,828	1,962	7.3%
21655	Preston, MD	5,361	5,220	-2.6%
21657	Queen Anne, MD	1,135	1,241	9.3%
21660	Ridgely, MD	4,062	4,207	3.6%
Caroline County		**36,635**	**37,223**	**1.6%**

Source: Claritas Nielsen Site Report

Additional Population Statistics

Caroline County Population by Race					
Race	2,012	2,017	2012 % of Total	Pop Change	% Change
White	28,669	29,462	79.9%	793	2.8%
Black	4,843	4,851	13.5%	8	0.2%
Indian	131	146	0.4%	15	11.5%
Asian	207	225	0.6%	18	8.7%
Pacific Islander	60	74	0.2%	14	23.3%
Dual Race	813	984	2.3%	171	21.0%
Other	1,174	1,481	3.3%	307	26.1%
Total	35,897	37,223	100.0%	1,019	2.8%



	2012	2017	% Change	Maryland
Total Population:	35,897	37,223	3.69%	
Population Under 18:	8,937	9,185	2.77%	
% Under 18:	24.90%	24.68%	-0.22%	23.40%
Population Over 65:	4,627	5,496	19%	
% Over 65:	12.89%	14.77%	1.88%	12.30%
% of Children in Poverty	19%	NA	NA	13.00%
% With High School Diploma:	77%	NA	NA	82.00%
% With Some College	45%	NA	NA	66.00%

Source: Claritas Nielsen Site Report

Health Insurance Coverage

	Caroline County	Maryland
2009 percent of popultation without health coverage under 65 years	**17.3%**	14.5%
2009 uninsured kids under the age of 19	**7.4%**	5.3%
2009 percent of population enrolled in Medicaid	**14.1%**	8.9%
2009 percent of population enrolled in Medicare	**15.3%**	13.0%
2009 percent of population with Dual Eligibles	**2.8%**	1.7%

- Caroline County has a significantly higher percent of its population who are uninsured
- Out of all Maryland counties, only 3 other counties were higher than Caroline County in the percent of uninsured children in 2009

Source: City-Data.com, US Censes Bureau

Health Status

Birth Measures and Infant Mortality

County Percent	Similar County Range	Birth Measures	US Percent 2005
8.0	5.4 - 8.0	Low Birth Wt. (<2500g)	8.2
1.5	0.8 - 1.5	Very Low Birth Wt (<1500g)	1.5
12.5	8.7 - 12.7	Premature Births (<37 weeks)	12.7
4.7	2.3 - 4.2	Births to Women under 18	3.4
2.3	1.2 - 2.6	Births to Women age 40-54	2.7
47.0	27.3 - 37.8	Births to Unmarried Women	36.9
15.6	9.3 - 36.5	No Care in First Trimester[1]	16.1

[1] Include 37 states, New York City and DC

County Rate	Similar County Range	Infant Mortality[2]	US Rate 2005
3.8	3.8-9.8	Infant Mortality	6.9
3.8	3.8-9.7	White non Hispanic Infant Mortality	5.8
NRF	0.0-6.1	Black non Hispanic Infant Mortality	13.6
NRF	0.0-11.6	Hispanic Infant Mortality	5.6
3.3	1.9-6.9	Neonatal Infant Mortality	4.5
0.5	1.5-3.8	Post-neonatal Infant Mortality	2.3

[2] Infant mortality: deaths per 1000 live births (Neonatal: <28 days; post-neonatal: day 28 to under one year)

Source: Community Health Status Indicatores.hhs.gov – Measures of Birth and Death data tables

Death Measures

County Rate	Similar County Range	Death Measures[1]	US Rate 2005
29.5	16.9 -32.8	Breast Cancer (Female)	24.1
22.1	13.6 - 24.2	Colon Cancer	17.5
173.5	121.4 - 199.9	Coronary Heart Disease	154.0
NRF	0.4 -5.0	Homicide	6.1
72.4	44.0 -70.9	Lung Cancer	52.6
29.6	16.5 - 37.1	Motor Vehicle Injuries	14.6
52.2	43.6 - 73.5	Stroke	47.0
12.5	7.9 - 18.5	Suicide	10.9
14.4	17.8 - 28.3	Unintentional Injury	39.1

[1] Rates are age-adjusted to the year 2000 standard; per 100,000 population
NRF – No report, fewer than 10 events occurred during the specified time period.

Source: Community Health Status Indicatores.hhs.gov – Measures of Birth and Death data tables

Behavioral Risk factor Survey

The Behavioral Risk Factor Surveillance System is an ongoing telephone surveillance program designed to collect data on the behaviors and conditions that place Marylanders at risk for chronic diseases, injuries, and preventable infectious diseases. The typical sample size is approximately 8,900 households, and collects information mainly on residents 18 years of age and older.

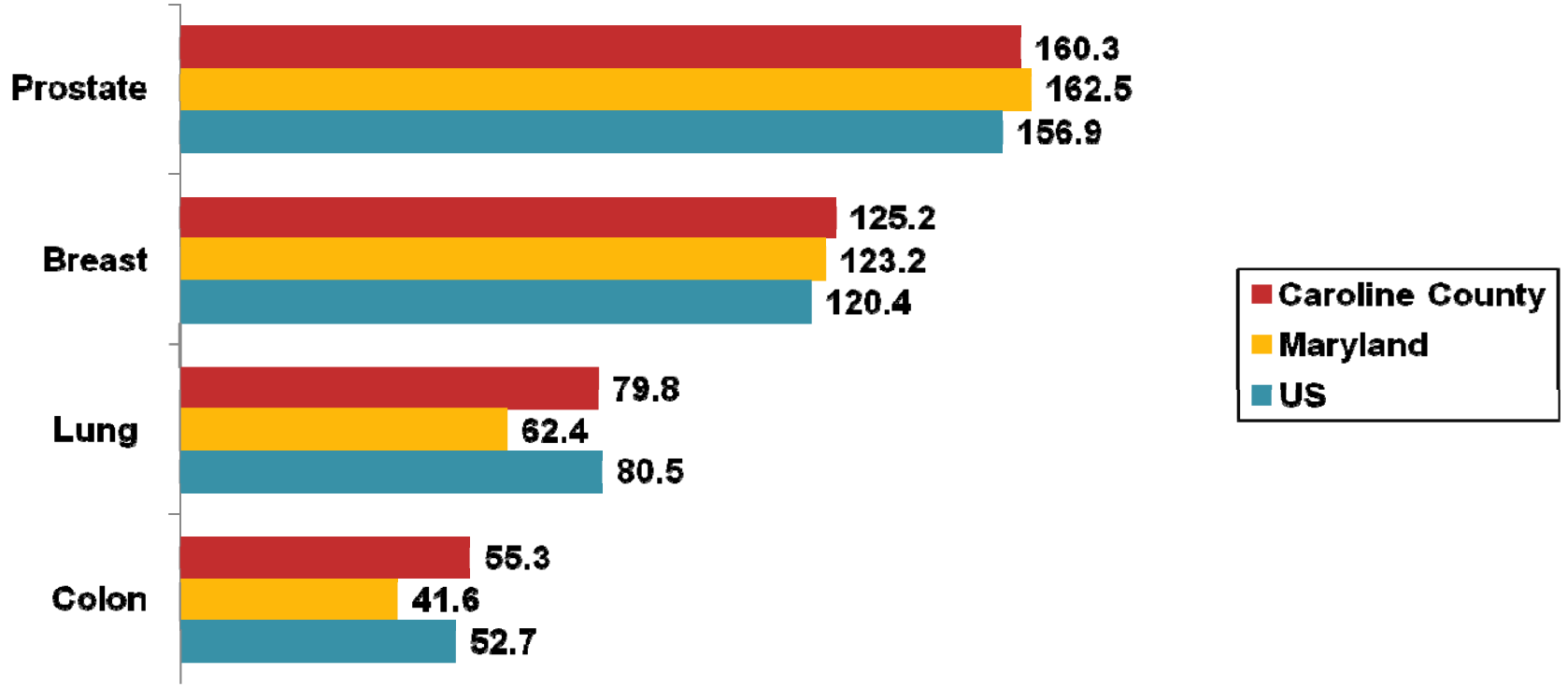
2009	Caroline County	Maryland
Life Expectancy at Birth	**75.7**	78.6
Percent of adults who reported their health status as fair/poor	**16.3%**	12.7%
Percent of adults who reported being obese (BMI +30)	**30.5%**	25.9%
Percent of adults who reported being told they have High Blood Pressure	26.4%	28.8%
Percent of adults who reported being told they have High Cholesterol	**32.0%**	25.8%
Percent of adults who reported being current smokers	**21.5%**	16.8%
Percent of adults who reported being told they have Diabetes	**12.0%**	8.4%
Percent of adults who reported being told they have Asthma	**14.3%**	13.5%
Percent of adults who reported being diagnosed with Anxiety Disorder	**13.3%**	11.8%
Percent of adults who reported being diagnosed with Depressive Disorder	**19.9%**	16.2%
Percent of women (40+) who reported having a Mammogram	87.9%	88.0%
Percent of women (18+) who reported having a Pap Smear within past 3 years	88.2%	85.8%
Percent of residence (50+) who reported having a Sigmoidoscopy or Colonoscopy	**63.2%**	68.8%
Percent of adults who reported having a flu shot within the past year	**30.9%**	35.9%
Percent of women reported receiving prenatal care in the first trimester	80.5%	80.1%
Percent of adults who reported visiting a dentist in the past year	**66.8%**	73.2%
Percent of adults reported having All permanent teeth removed	**7.0%**	3.6%

- This survey data shows many highlighted categories that have a significantly higher rate as compared to Maryland including:
  - Mental health issues
  - Chronic diseases – Obesity, Diabetes, Asthma
  - Smoking
- In addition, preventive services are utilized less (dentist, flu shots)

Source: Maryland Behavioral Risk Facto Surveillance System, 2006-2009

Cancer Incidence Rates

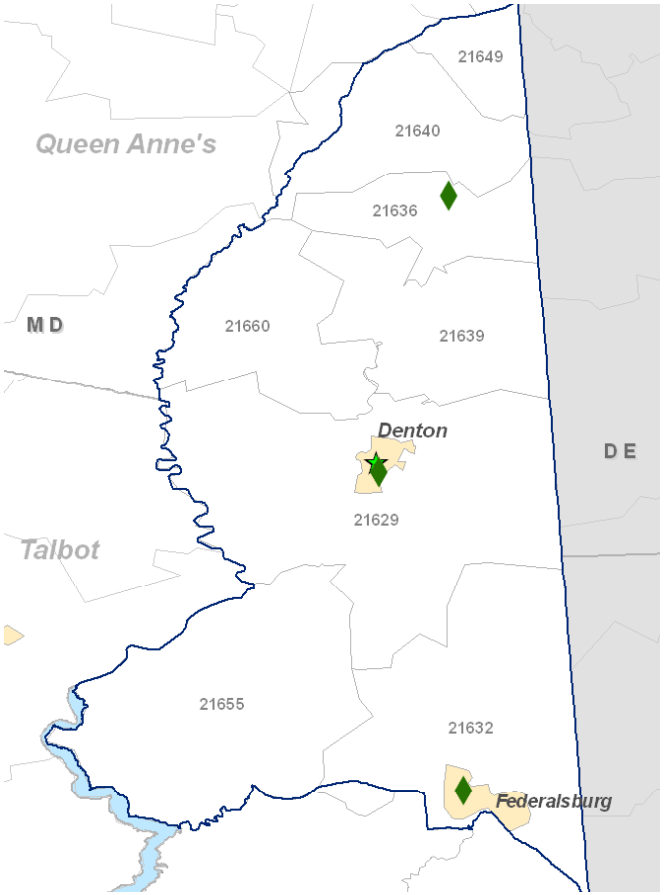
Age-Adjusted Incidence Rates* by Top Cancer Sites:
Caroline County, Maryland State, U.S. 2007 ***(per 100,000 Population)***



**Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population*
Oral, Melanoma and Cervical Cancer rates were too low to report for Caroline County
Source: Maryland Cancer Registry

Access to Care

Choptank Community Health Centers: Primary Care Services



Choptank Community Health System, Inc. (CCHS) It is a private, non-profit community health center providing primary health care services in three locations in Caroline County along with locations in Dorchester and Talbot Counties. Each of it's health centers are Federally Qualified Health Centers (FQHCs)

CCHS health centers provide a full range of primary medical and dental services.

As an FQHC, CCHS is able to use federal funding to expand current services and develop new programs to meet the health care needs in the area.

Affiliation	Type	Name	Address	City	State	Zip
Choptank Health System	Health Center	Federalsburg Medical & Dental	215 Bloomingdale Avenue	Federalsburg	MD	21632
Choptank Health System	Health Center	Goldsboro Medical & Dental Center	316 Railroad Avenue	Goldsboro	MD	21636
Choptank Health System	Health Center	Denton Medical Center	609 Daffin Lane	Denton	MD	21629

Choptank Community Health Centers: Services

- Choptank provides comprehensive primary care services in all three of its locations.
- Pediatric services are offered only at its Denton Medical Center location.
- Providers at each of the centers have medical staff privileges or coverage at the Memorial Hospital in Easton and Dorchester General Hospital in Cambridge.
- The **Goldsboro and Federalsburg Medical Centers** also provides General Dentistry services.
- **School Based Wellness and Dental Services –** Choptank provides services in every public school in the County – a Nurse Practitioner rotates through every school providing sports physicals, sick calls, vaccinations, and other primary care services
- **Migrant Worker Health Care Services –** During summer months, Nurse Practitioners provide primary care services to the migrant worker population for a $15 registration fee (care subsidized by Federal 330 Grant)
- Urgent care services are not available at any of the three sites and the Denton facility is the only site offering one day with hours until 7pm. Saturday hours were available at one facility but volumes were not reached so the hours were discontinued.

Choptank Community Health Centers: Hours

Denton Medical Center

Family Practice office hours:
Monday 7:30 am to 7 pm
Tuesday 7:30 am to 5 pm
Wednesday 7:30 am to 5 pm
Thursday 7:30 am to 5 pm
Friday 7:30 am to 4:30 pm

Pediatrics office hours:
Monday, Tuesday, Wednesday & Friday
walk in hours for sick children: 7:30 am to 9 am,
scheduled office hours: 8 am to 5 pm.

Thursday walk in hours for sick children:
8 am to 9 am,
scheduled office hours:
9 am to 4:40 pm.

Goldsboro Medical Center

Office hours are:
Monday thru Friday
8:00 a.m. – 4:30 p.m.

Dental Office Hours:
8 am to 4:30 pm Monday thru Friday

Federalsburg Medical and Dental Centers

Medical office hours are:
Monday, Tuesday, Thursday , Friday 8am-5pm
Wednesday 8am-430pm

Dental office hours are:
Monday, Tuesday, Thursday , Friday 8am-5pm
Wednesday 8am-430pm

Specialty Physicians: Need Based on Population

Specialty	GMENAC	Hicks & Glenn	Average of 10 Sources	Physicians/ NP In the County	Gap (Based on Average)
Allergy & Immunology	0.31	0.37	0.37		
Anesthesiology	3.20	N/A	2.39		
Cardiology	1.17	1.39	1.13		
Cardiovascular Surger	N/A	N/A	0.42		
Child Psychiatry	1.36	N/A	1.36		
Dermatology	1.05	0.77	0.78		
Emergency Medicine	2.04	1.10	1.43		
Endocrinology	0.31	0.29	0.30		
Gastroenterology	0.99	0.62	0.76		
Hematology-Oncology	1.36	0.88	1.07		
Infectious Diseases	0.34	0.23	0.28		
Neonatology	0.20	N/A	0.20		
Nephrology	0.41	0.33	0.37		
Neurology	0.83	0.81	0.81		
Neurosurgery	0.40	0.46	0.43		
Obstetrics/Gynecolog	3.61	4.07	3.76		
Ophthalmology	1.81	1.76	1.74		
Orthopaedic Surgery	2.27	1.98	1.73		
Otolaryngology	1.25	0.88	0.93		
Pathology	1.83	N/A	1.83		
Physical Med & Reha	0.48	N/A	0.48		
Plastic Surgery	0.41	N/A	0.38		
Psychiatry	5.81	N/A	3.66		
Pulmonary Diseases	0.54	0.55	0.46		
Radiology	2.65	N/A	2.06		
Rheumatology	0.26	0.26	0.26		
Surgery, General	3.62	4.85	3.03		
Thoracic Surgery	0.31	0.26	0.28		
Urology	1.16	1.06	0.99		
Total	**39.96**	**22.92**	**33.68**		

Source: The Medicus Firm

- There are no specialists in the County with the exception of 1 gynecologist at Choptank 2 days per week
- The biggest need for specialists based on the data is:
  - OB/GYN
  - General Surgery
  - Psychiatry

Caroline County Department of Health

- The Caroline County Health Department provides services to prevent communicable disease and promote wellness.
- The Department operates **ten programs** for:
  - Addictions
  - Developmental disabilities
  - Health education and vital statistics
  - Adult health and geriatrics
  - Child health
  - Communicable disease control
  - The environment
  - Maternity and family planning
  - Mental health and wellness promotion
- In addition to prevention and wellness services, the Department offers direct health care services:
  - **Maternity care clinic in Denton** – run with Nurse Practitioners offering prenatal care – they coordinate with OB physicians out of the County for deliveries as there are no OB's or FP physicians who deliver babies
  - **Mental Health Clinic** – services include psychiatric evaluations, individual, group and family therapy for adults, adolescents and children, medication management, nursing services, Information/referral services, school based therapy services available in all Caroline County Public Schools – **These are the only mental health services available in the County**
    - All services are provided by a staff of psychiatrists, nurses, social workers

Health Education and Preventive Services: Dept. of Health

Department of Health: Caroline County

- The Department of Health has 3 nurses who provide preventive services throughout Caroline County. Services targeted at under or uninsured but individuals with insurance also provided services. Provide services throughout the County at health fairs, and churches – have 15 core churches where regular services provided. Specifically, services provided include:
  - **Breast and Cervical Cancer Screenings** – for women ages 40 – 64 who have no insurance and meet the income guidelines. A clinical breast exam, pap test, and mammograms are offered at no cost
  - **Colorectal Cancer Screening Program** – for men and women ages 50 and above who have limited or no insurance. A colonoscopy is provided.
  - **Community Transformation Grant Worksite Wellness** – This is a new program where nurses go out to community businesses and hold health fairs and smoking cessation classes.
  - **Tobacco Program** – Hold smoking cessation classes on Wednesdays during the day and at the YMCA on Thursday mornings. Provide free patches, lozenges and nicotine gum

Choptank Community Health Centers

- The Department of Health contracts with Choptank to provide the actual screening/follow up services after clients are enrolled from community events. Choptank providers are present at most of the Department of Health's fairs and community events to provide education and information on services. See follow page for a complete listing of preventive services offered at all Choptank facilities.

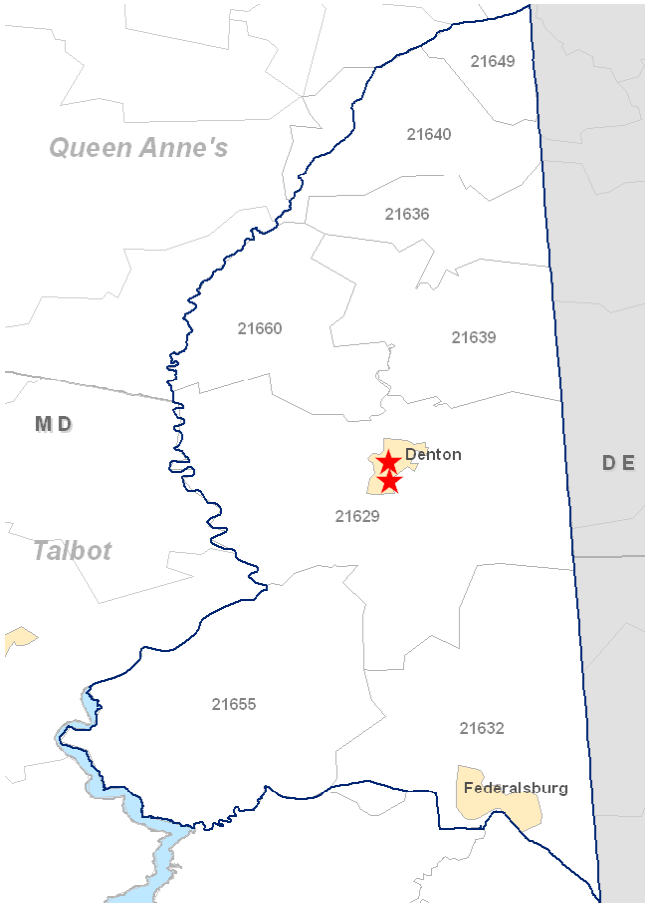
Health Education and Preventive Services: Choptank

- Annual Physicals
- Routine Gynecological exams
- Vaccines/immunizations, flu shots
- Prostate Cancer Screening - PSA
- Cervical Cancer Screening – Pap Smear
- Colon Cancer Screening – fecal occult blood, colonoscopies
- Osteoporosis Screening – Bone Density Screening
- Osteopenia Follow Up – Bone Density Follow Up
- Hypertension, Diabetes, Asthma and Cholesterol Screening
- Counseling, screening and vaccines for healthy pregnancies
- Regular Well-Baby and Well-Child Visits, from birth to age 21
- Counseling for smoking cessation
- Counseling for healthy eating and weight loss
- Alcohol & Substance Abuse Screening
- Depression Screening
- Alzheimer's & Dementia Screening

School Based –

- Asthma & Obesity Initiatives

Denton Diagnostic Services



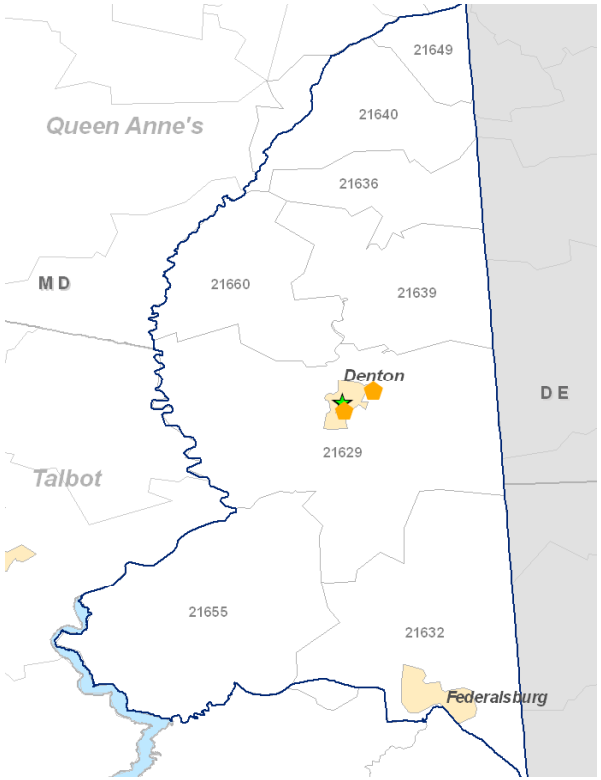
Denton Diagnostics Center

Services:

- X-ray
- MRI
- Lab
- EKG
- Holter Monitors
- Mammograms

Affiliation	Type	Name	Address	City	State	Zip
Shore Health	Diagnostics	Denton Diagnostic Center	838 S 5th Avenue	Denton	MD	21629
Shore Health	Diagnostics -**Rehab Only**	Denton Diagnostic Center	920 Market Street	Denton	MD	21629

Nursing Homes/Skilled Nursing



- **The Wesleyan Center at Denton** includes:

  Heritage Community – Independent living
  Homestead Manor – Assisted Living

- **Envoy of Denton** shares the Wesleyan Retirement Center Campus of Independent and Assisted Living and includes:

  Haven Court – a specialized secured unit for Dementia Residents.

- **Caroline Nursing Home and Rehabilitation Center** is a 98 bed, non-profit, skilled facility.

  Caroline Nursing Home and Rehabilitation Services Inc. provides comprehensive physical, occupational, speech therapy, and medical services. Caroline Nursing Home and Rehabilitation Center is a Medicare certified outpatient rehabilitation agency.

# on Map	Affiliation	Type	Name	Address	City	State	Zip
		Nursing Home	Wesleyan Retirement Community	425 Colonial Drive	Denton	MD	21629
		Nursing Home	Homestead Manor	410 Colonial Drive	Denton	MD	21629
		Nursing Home	Envoy of Denton	420 Colonial Drive	Denton	MD	21629
		Nursing Home	Caroline Nursing & Rehab	520 Kerr Avenue	Denton	MD	21629

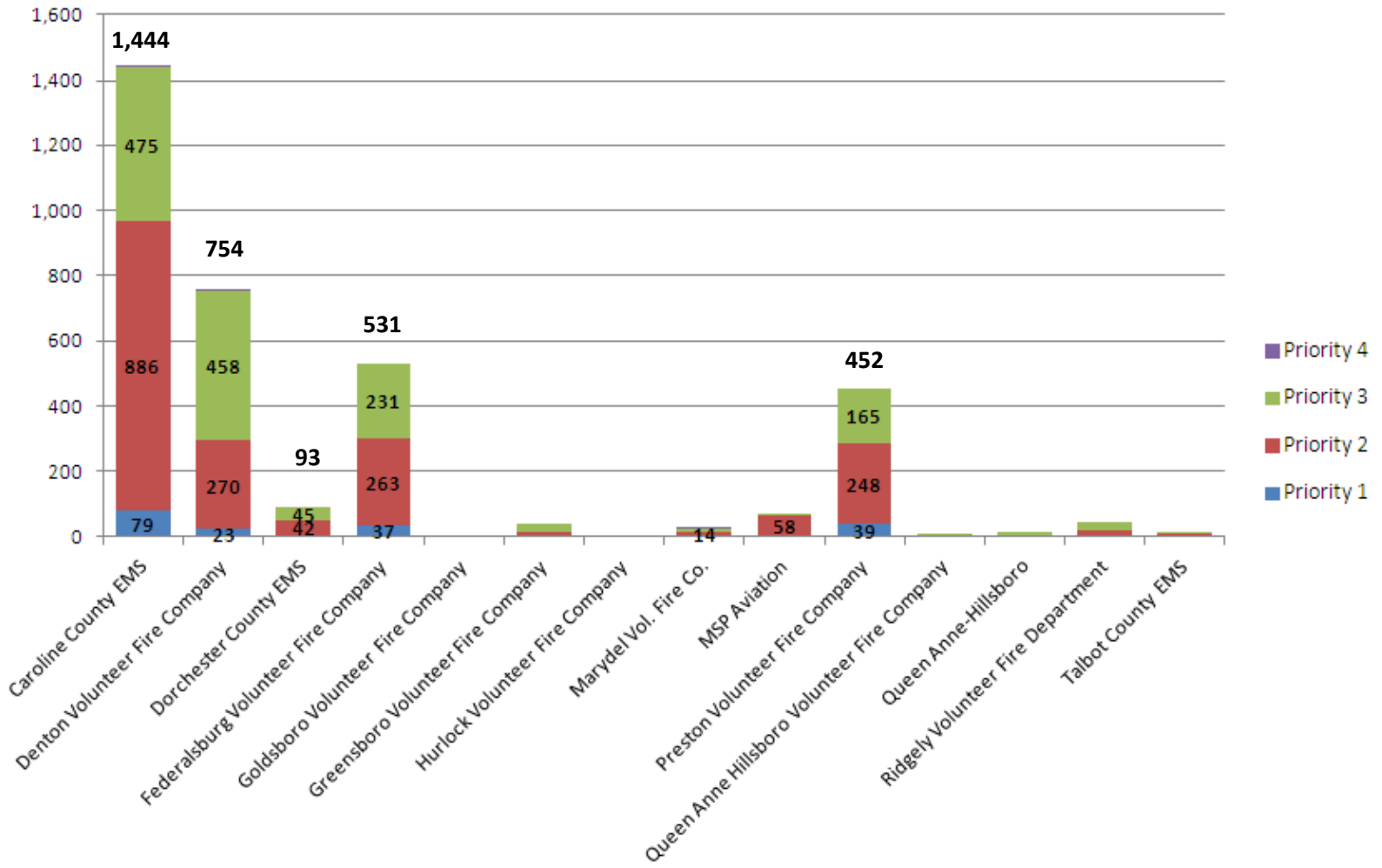
Transportation Services

In addition to “fixed route” public transportation, there are additional options for individuals in Caroline County who do not have their own means of transportation.

- **Delmarva Community Transit – One Stop**: This is a free service that provides information and assistance to access community agencies for assistance with transportation solutions
- **Services for Veterans:**
  - **Maryland Services:** Veterans in Caroline County needing rides to mental or behavioral health appointments may ride at no cost to destinations in the county and to locations in Baltimore and Perry Point. They will provide door to door transportation if public transportation is not available
  - **Delmarva United Way Veterans Transportation Program**: Provides free rides to medical services for veterans in the County who are 60 years or older.
  - **The One Call-One Click Veterans Transportation Service**: Provides one toll free number connecting veterans and their families with transit services in the County
- **Medical Assistance (MA)**: Transportation is available to and from medical appointments for individuals who have MA
- **Sunshine Senior & Family Services, LLC**: Located in Denton and provides wheelchair accessible van transportation for a cost

Emergency Services Data

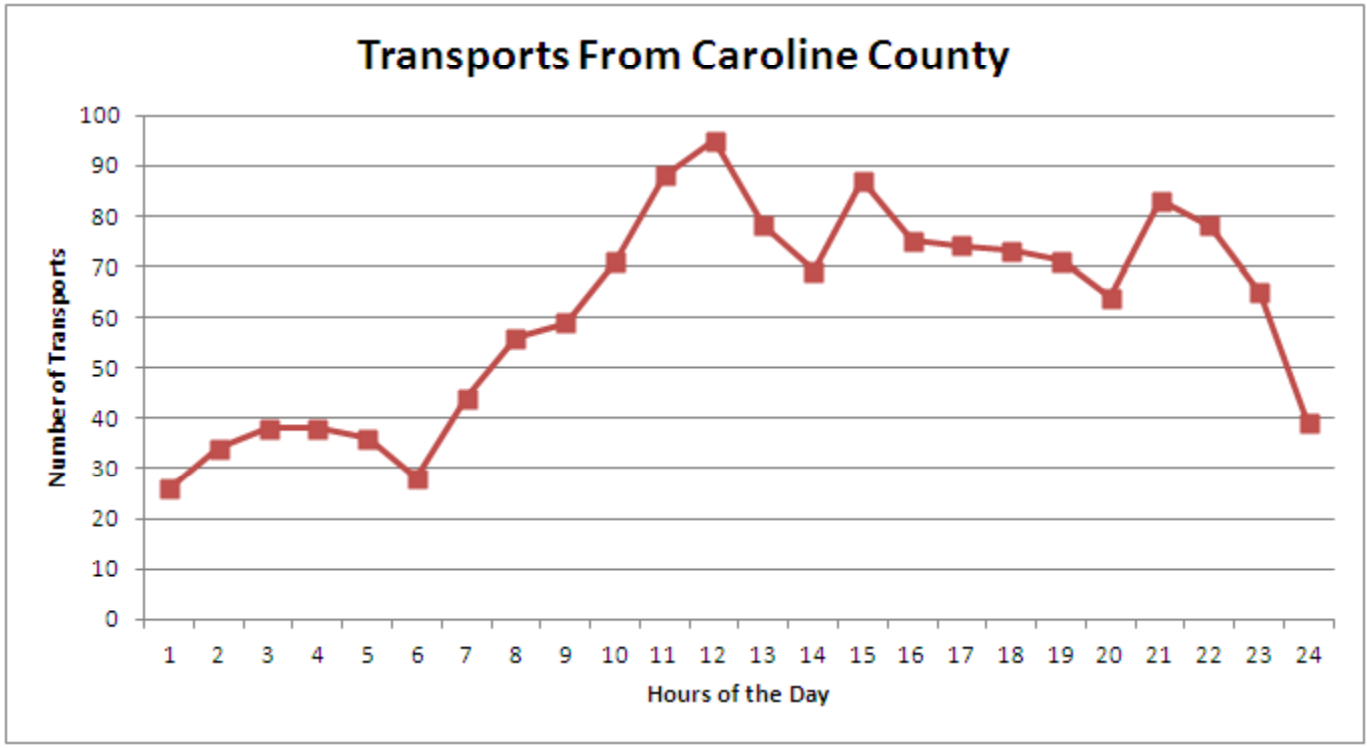
2011 Ambulance Transports By Town and Priority



Source: MIEMSS Database

Total transports at top of each bar – Total for Caroline County = 3,482

2011 Ambulance Transports By Hour of the Day: **Priority 3**



Total Number of Priority 3 Transports: 1,469 (42% of total transports)

Source: MIEMSS Database

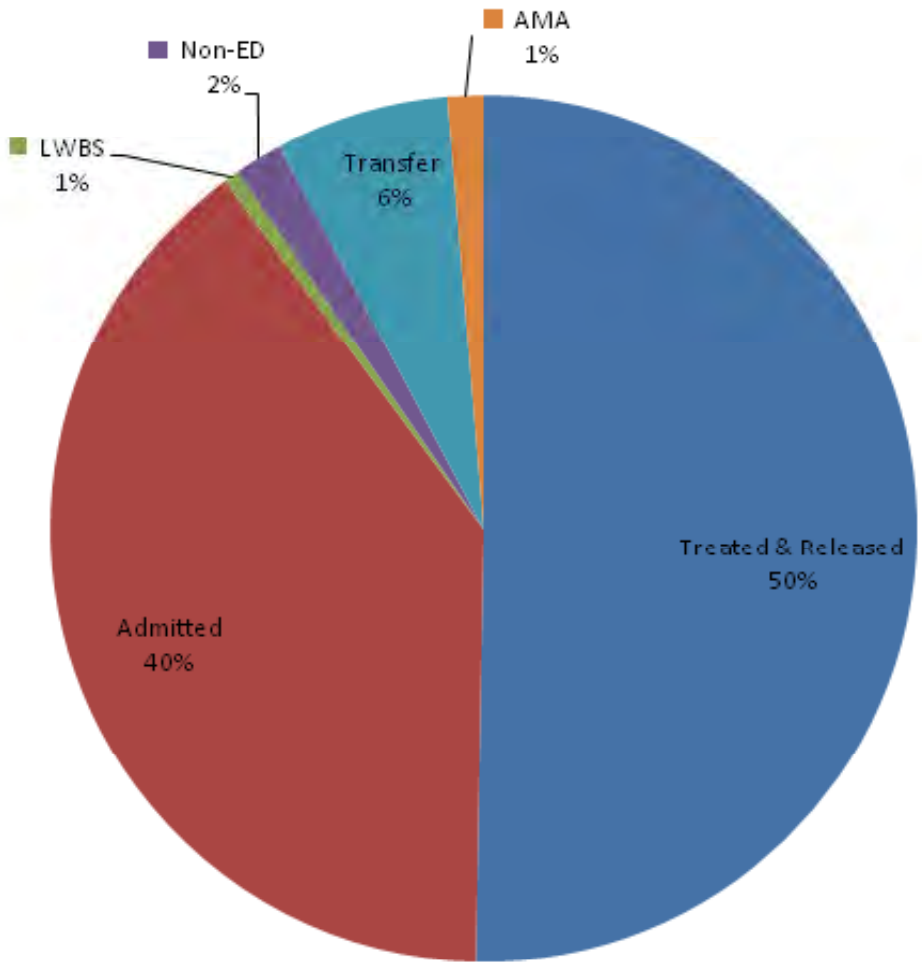
2011 Ambulance Transports: Receiving Facility

Receiving Facility	Caroline County EMS	Denton Volunteer Fire Company	Dorchester County EMS	Federalsburg Volunteer Fire Company	MSP Aviation	Preston Volunteer Fire Company	Ridgely Volunteer Fire Departme	All Others	Grand Total
Shore Health Systems, Easton Memorial	1,132	708	57	349		360	42	68	2,716
Nanticoke Memorial Hospital	16	22	28	158		74		0	298
Bayhealth Medical Center - Kent Hospital	196	6						24	226
Chester River Hospital Center	54	1					1	4	60
R Adams Cowley Shock Trauma Center Adult Trauma Unit	5	3	1		30			1	40
Shore Health Systems, Dorchester General	3	2	4	14		7		0	30
Peninsula Regional Medical Center Trauma Unit	5	2		2	17	3		0	29
Bayhealth Medical Center - Milford Hospital	11	3						0	14
Johns Hopkins Hospital Pediatric Trauma Unit	2			1	10			0	13
Peninsula Regional Medical Center	1		2	6	1	3		0	13
Shore Health System - Easton Memorial Primary Stroke Center	7	1				1		1	10
Queen Anne's Emergency Center	6	2						0	8
Other Facility	2	3						0	5
Johns Hopkins Hospital					2	1		0	3
Peninsula Regional Medical Cardiac Interventional Center	2					1		0	3
Union Memorial Hospital Curtis Hand Center		1			2			0	3
Christiana Care Health Systems - Wilmington Hospital						2		0	2
Johns Hopkins Hospital Eye Trauma Center					2			0	2
Anne Arundel General Cardiac Interventional Center								1	1
Anne Arundel Medical Center	1							0	1
Bayhealth Medical Center, Kent Hospital Cardiac Interventional Cent	1							0	1
DuPont Memorial Hospital								1	1
Johns Hopkins Children's Center Pediatric Burn Center			1					0	1
Union Hospital of Cecil County				1				0	1
University of Maryland Medical System Primary Stroke Center					1			0	1
Grand Total	**1,444**	**754**	**93**	**531**	**65**	**452**	**43**	**100**	**3,482**

Source: MIEMSS Database

Emergency Services Data: Shore Health Transport Data

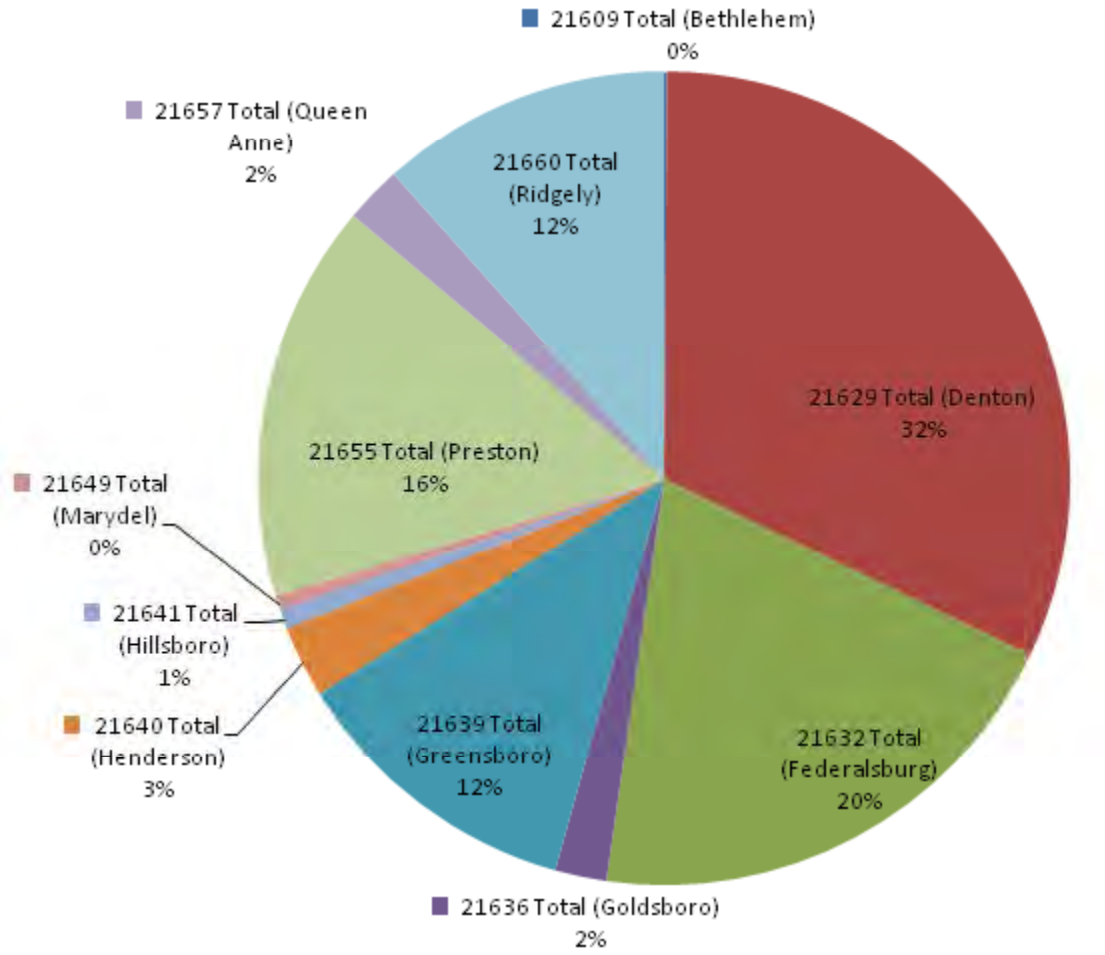
2011 Caroline County Arrivals by Ambulance



2011 CC Ambulance Arrivals	
Treated & Released	1,120
Admitted	880
LWBS (Left without being seen)	13
Non-ED	40
Transfer	144
AMA (Left against medical advice)	30
Total Patients	2,227

Source: Caroline County Task Force Emergency Department Data

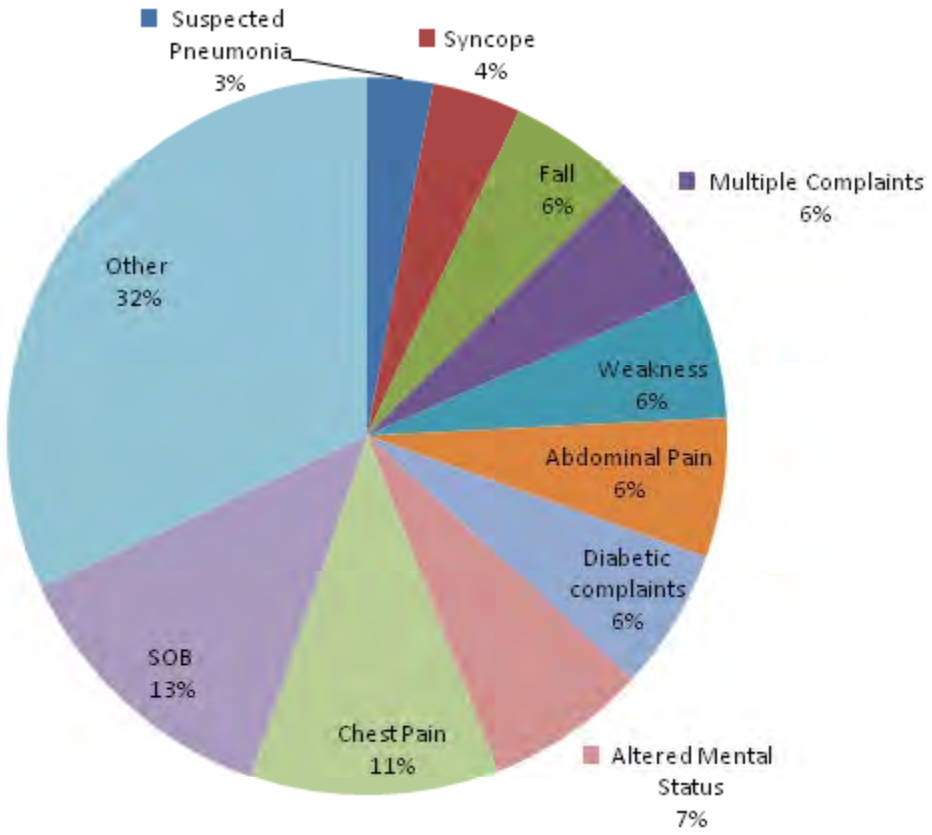
2011 Ambulance Admissions to Hospital from Caroline County by Zip Codes



2011 Caroline County Patients Admitted by Zip Code	
21609 Total (Bethlehem)	1
21629 Total (Denton)	282
21632 Total (Federalsburg)	177
21636 Total (Goldsboro)	18
21639 Total (Greensboro)	104
21640 Total (Henderson)	25
21641 Total (Hillsboro)	7
21649 Total (Marydel)	5
21655 Total (Preston)	139
21657 Total (Queen Anne)	20
21660 Total (Ridgely)	102
Total Patients	880

Source: Caroline County Task Force Emergency Department Data

2011 Ambulance Admissions to Hospital: Chief Complaint



2011 CC Admissions by Ambulance by chief complaint	
Suspected Pneumonia	26
Syncope	35
Fall / Injury	50
Multiple Complaints	51
Weakness	51
Abdominal Pain	55
Diabetic complaints	56
Altered Mental Status	64
Chest Pain	98
SOB (Shortness of breath)	113
Other*	281
Total Admissions	880

Over 50 additional complaints fall into the "other" category, none of which make up greater than 2% of the total

Source: Caroline County Task Force Emergency Department Data

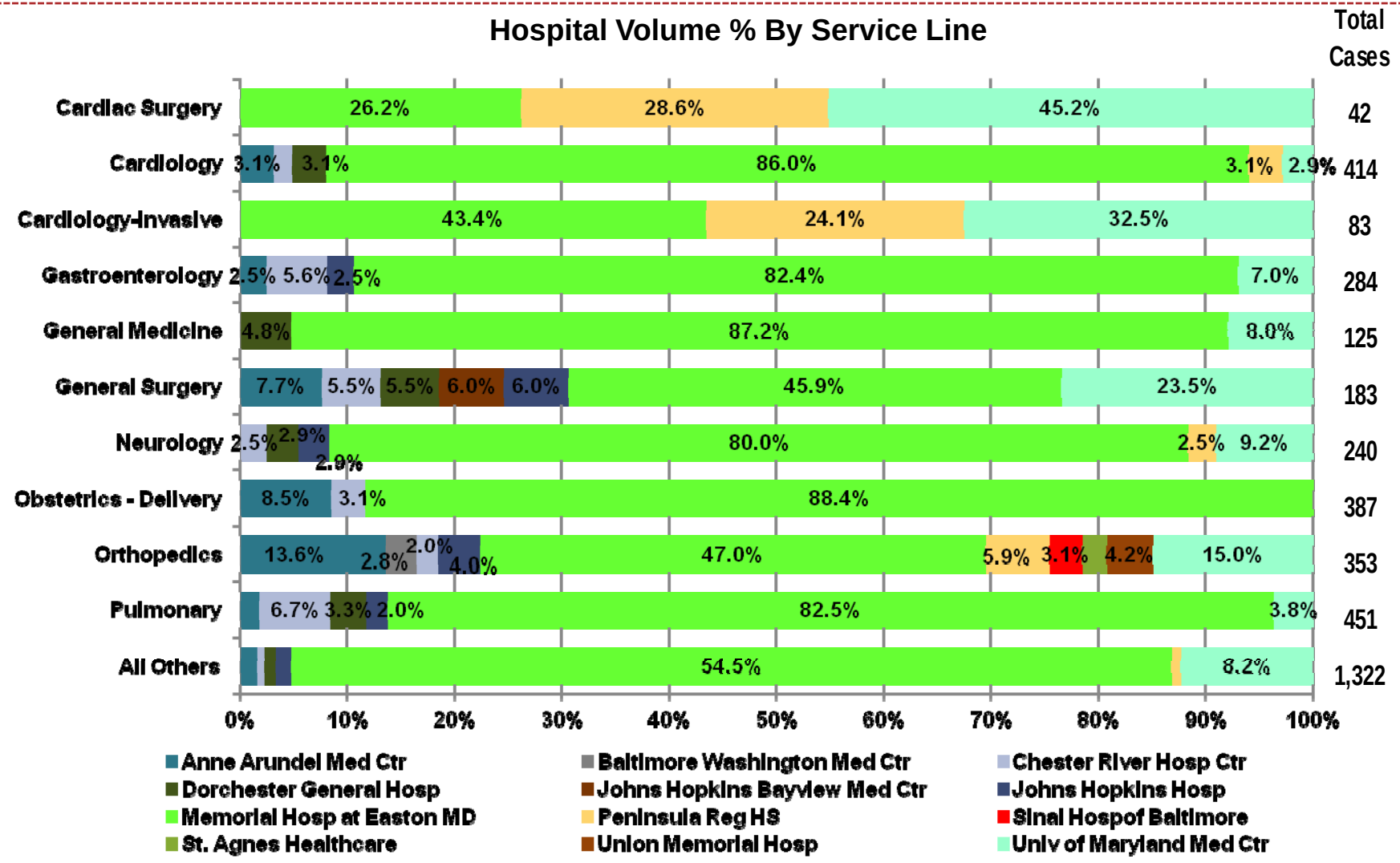
2011 Ambulance Transports To Specific Hospitals By Zip Code

	2011 Ambulance Transports by Zip Code		
	Memorial Hospital At Easton	Dorchester General Hospital	Queen Anne's Emergency Center
21609 Total (Bethlehem)	3		
21629 Total (Denton)	708	10	11
21632 Total (Federalsburg)	438	39	2
21636 Total (Goldsboro)	41	1	
21639 total (Greensboro)	286	7	2
21640 Total (Henderson)	60	1	
21641 Total (Hillsboro)	12		1
21649 Total (Marydel)	18	4	
21655 Total (Preston)	256	11	3
21657 Total (Queen Anne)	37		1
21660 Total (Ridgely)	266	1	8
Total Transports	**2,125**	**74**	**28**

Source: Caroline County Task Force Emergency Department Data

Caroline County Inpatient Volume

Inpatient Volume by Service Line: 2011



Source: Intellimed Report on Caroline County Maryland

Inpatient Volume by Service Line: 2011: All Others

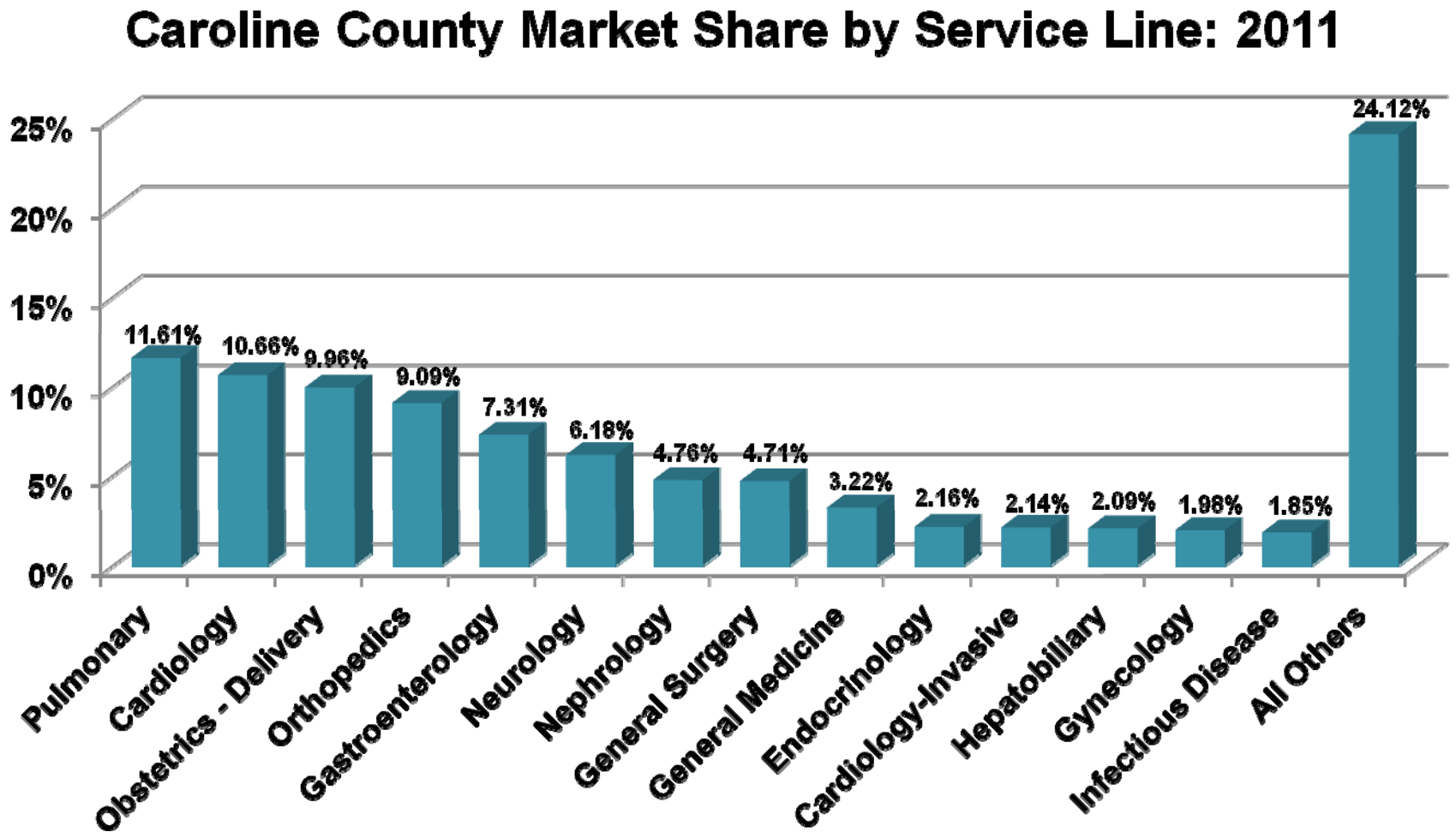
Cardiac Surgery	42
Memorial Hospital at Easton MD	11
Peninsula Regional Health System	12
University of Maryland Med Ctr	19
Cardiology	**414**
Anne Arundel Medical Center	13
Chester River Hospital Ctr	7
Dorchester General Hosptial	13
Memorial Hospital at Easton MD	356
Peninsula Regional Health System	13
University of Maryland Med Ctr	12
Cardiology-Invasive	**83**
Memorial Hospital at Easton MD	36
Peninsula Regional Health System	20
University of Maryland Med Ctr	27
Dermatology	**6**
Memorial Hospital at Easton MD	6
Endocrinology	**84**
Chester River Hospital Ctr	6
Memorial Hospital at Easton MD	78
Gastroenterology	**284**
Anne Arundel Medical Center	7
Chester River Hospital Ctr	16
Johns Hopkins Hospital	7
Memorial Hospital at Easton MD	234
University of Maryland Med Ctr	20
General Medicine	**125**
Dorchester General Hosptial	6
Memorial Hospital at Easton MD	109
University of Maryland Med Ctr	10
General Surgery	**183**
Anne Arundel Medical Center	14
Chester River Hospital Ctr	10
Dorchester General Hosptial	10
Johns Hopkins Bayview Medical Ctr	11
Johns Hopkins Hospital	11
Memorial Hospital at Easton MD	84
University of Maryland Med Ctr	43

Gynecology	77
Anne Arundel Medical Center	8
Memorial Hospital at Easton MD	69
Hematology	**36**
Memorial Hospital at Easton MD	36
Hepatobiliary	**81**
Memorial Hospital at Easton MD	60
University of Maryland Med Ctr	21
Infectious Disease	**72**
Memorial Hospital at Easton MD	58
Peninsula Regional Health System	7
University of Maryland Med Ctr	7
Nephrology	**185**
Dorchester General Hosptial	9
Memorial Hospital at Easton MD	176
Neurology	**240**
Chester River Hospital Ctr	6
Dorchester General Hosptial	7
Johns Hopkins Hospital	7
Memorial Hospital at Easton MD	192
Peninsula Regional Health System	6
University of Maryland Med Ctr	22
Neurosurgery	**25**
Johns Hopkins Hospital	6
Memorial Hospital at Easton MD	9
University of Maryland Med Ctr	10
Obstetrics - Delivery	**387**
Anne Arundel Medical Center	33
Chester River Hospital Ctr	12
Memorial Hospital at Easton MD	342
Obstetrics - Other	**23**
Memorial Hospital at Easton MD	23
Oncology	**64**
Memorial Hospital at Easton MD	54
University of Maryland Med Ctr	10

Orthopedics	353
Anne Arundel Medical Center	48
Baltimore Washington Med Ctr	10
Chester River Hospital Ctr	7
Johns Hopkins Hospital	14
Memorial Hospital at Easton MD	166
Peninsula Regional Health System	21
Sinai Hospital of Baltimore	11
St. Agnes Healthcare	8
Union Memorial Hospital	15
University of Maryland Med Ctr	53
Other	**6**
University of Maryland Med Ctr	6
Otolaryngology	**39**
Johns Hopkins Hospital	7
Memorial Hospital at Easton MD	24
University of Maryland Med Ctr	8
Plastic Surgery	**8**
Memorial Hospital at Easton MD	8
Pulmonary	**451**
Anne Arundel Medical Center	8
Chester River Hospital Ctr	30
Dorchester General Hosptial	15
Johns Hopkins Hospital	9
Memorial Hospital at Easton MD	372
University of Maryland Med Ctr	17
Rheumatology	**18**
Memorial Hospital at Easton MD	18
Thoracic Srugery	8
University of Maryland Med Ctr	8
Trauma	**50**
Memorial Hospital at Easton MD	17
University of Maryland Med Ctr	33
Urology	**47**
Memorial Hospital at Easton MD	47
Vascular	**50**
Anne Arundel Medical Center	6
Memorial Hospital at Easton MD	38
University of Maryland Med Ctr	6
All Other	**443**
Grand Total	**3884**

Source: Intellimed Report on Caroline County Maryland

Inpatient Volume by Service Line



Source: Intellimed Report on Caroline County Maryland

Caroline County Medicare Patients Admitted To Delaware Hospitals: 2009 Data

- Access to Delaware inpatient data is limited. The only data publicly available is Medicare data
- There were a total of **192** Medicare admissions to Delaware Hospitals in 2009 from Caroline County
- **Kent General** and **Nanticoke Memorial** had the majority of those admissions with 94 and 67 respectively

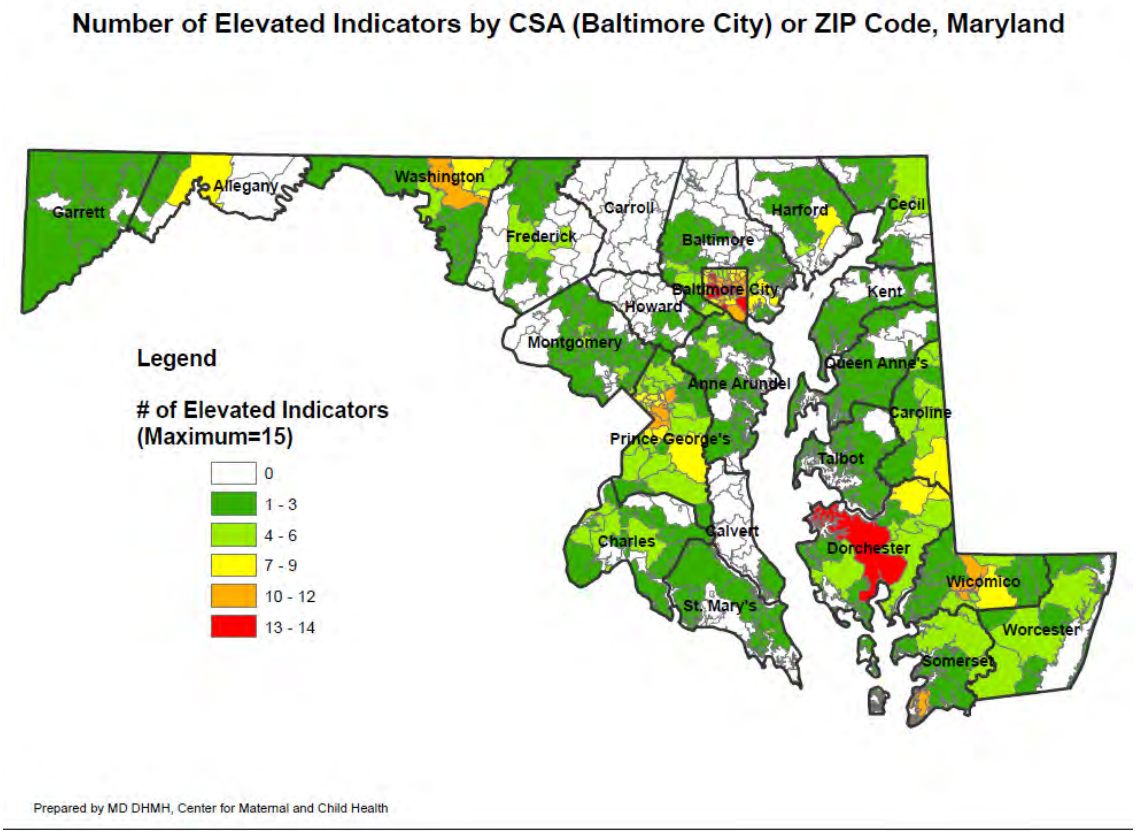
Medicare Admissions By Service Line

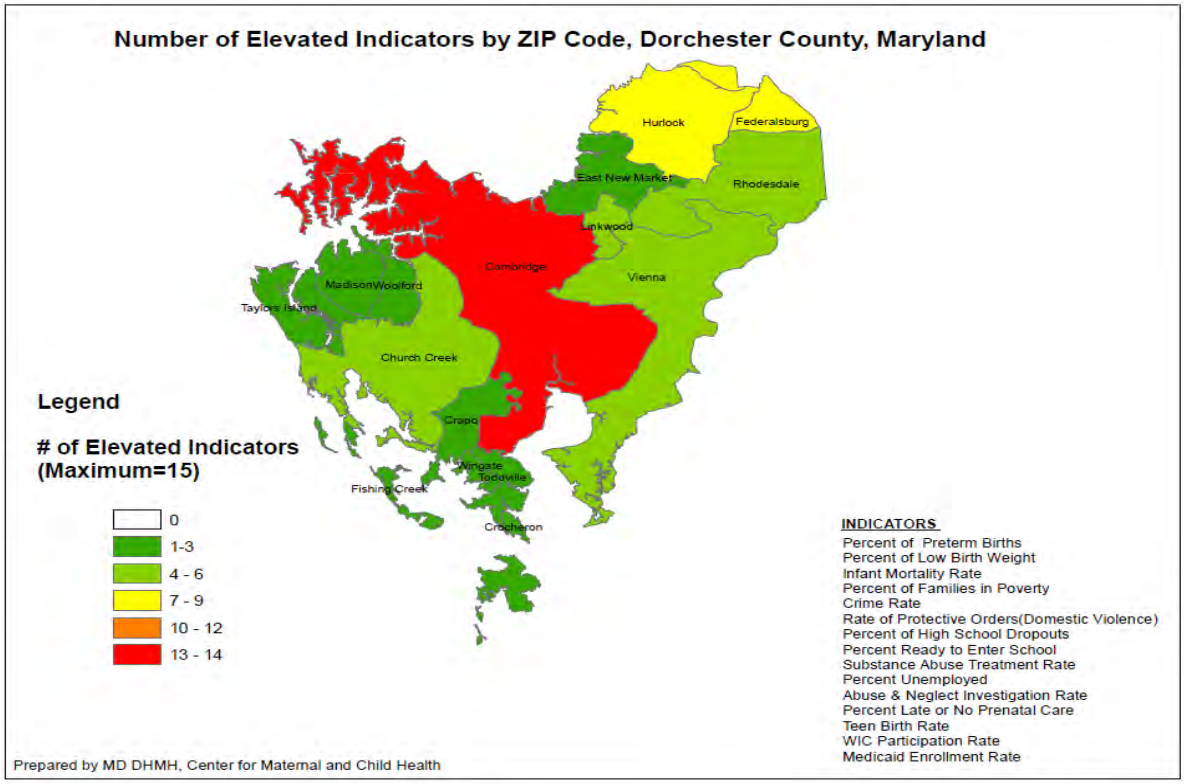
Service Line	Admissions
Pulmonary	34
Cardiology	30
Orthopedics	17
Neurology	16
Psychiatry	13
Infectious Disease	12
Invasive Cardiology	11
GI	10
General Surgery	9
General Medicine	6
Nephrology	6
Cardiac Surgery	5
All Others	23
Total	**192**

Source: Intellimed Data

Appendix 4.4: Dorchester County Infant Mortality Crisis

Dorchester County Infant Mortality Crisis

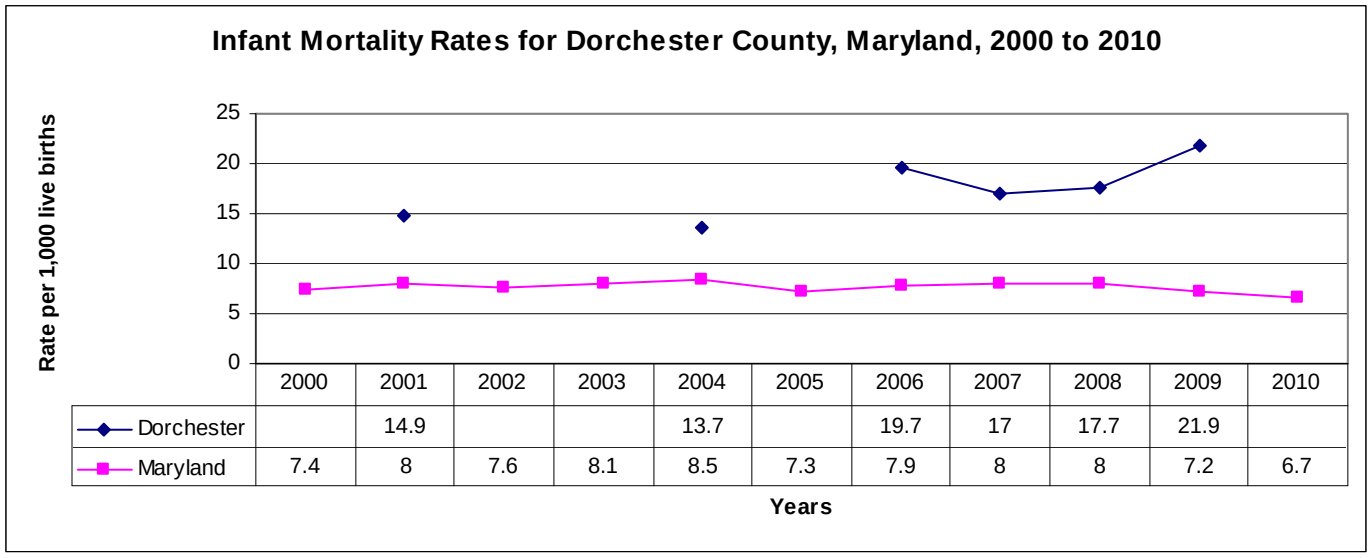




Dorchester in the Spotlight

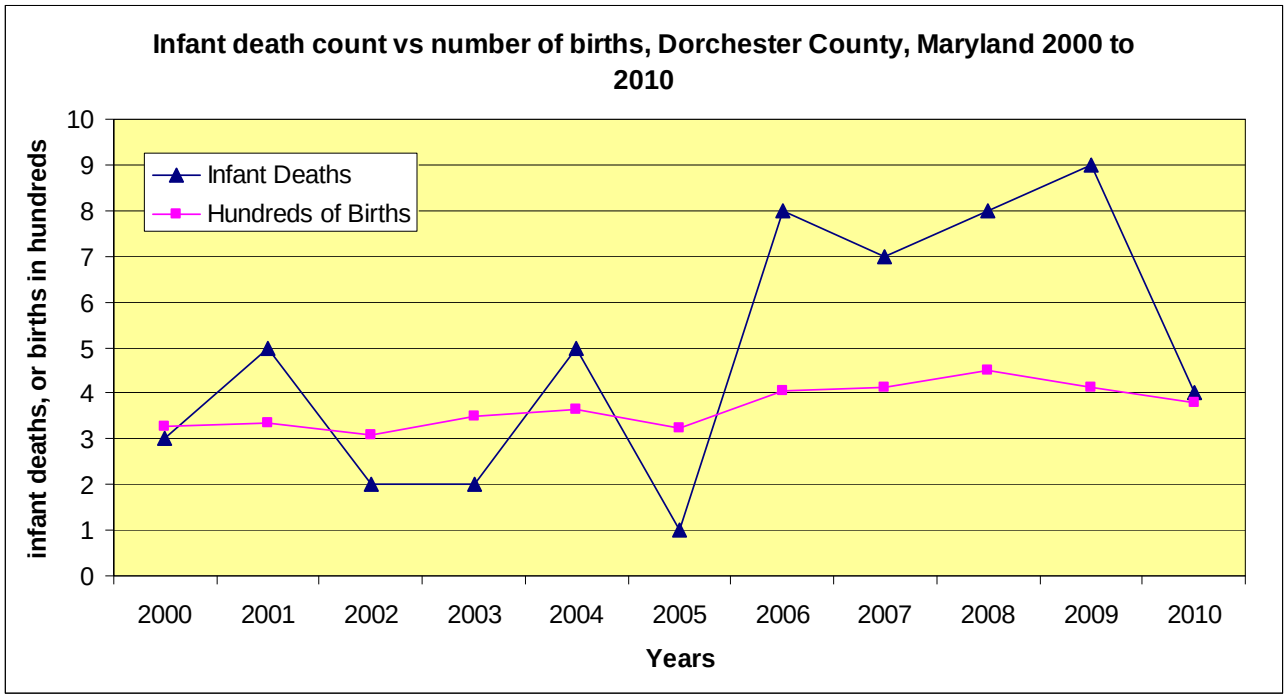
	Dorchester County	Margin of Error	National Benchmark*	Maryland Trend	Rank (of 24)
Social Determinants of Health					**22**
High school graduation	78%			82%	
Some college	43%	38-49%	68%	66%	
Unemployment	10.70%		5.40%	7.50%	
Children in poverty	26%	18-33%	13%	13%	
Inadequate social support	22%	19-26%	14%	20%	
Children in single-parent households	47%	40-53%	20%	33%	
Violent crime rate	554		73	620	
Access to recreational facilities	12		16	12	

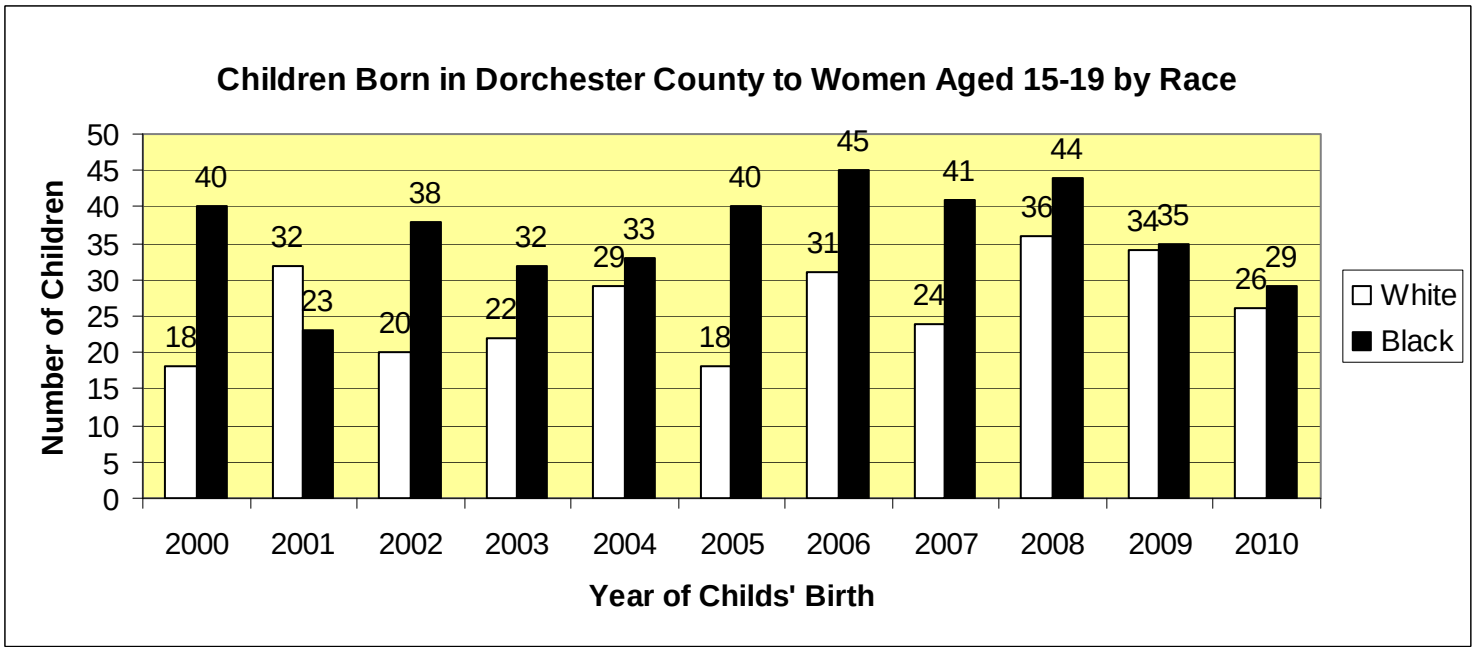
Social Determinants of Health Indicators
Changes in Infant Mortality in Dorchester County

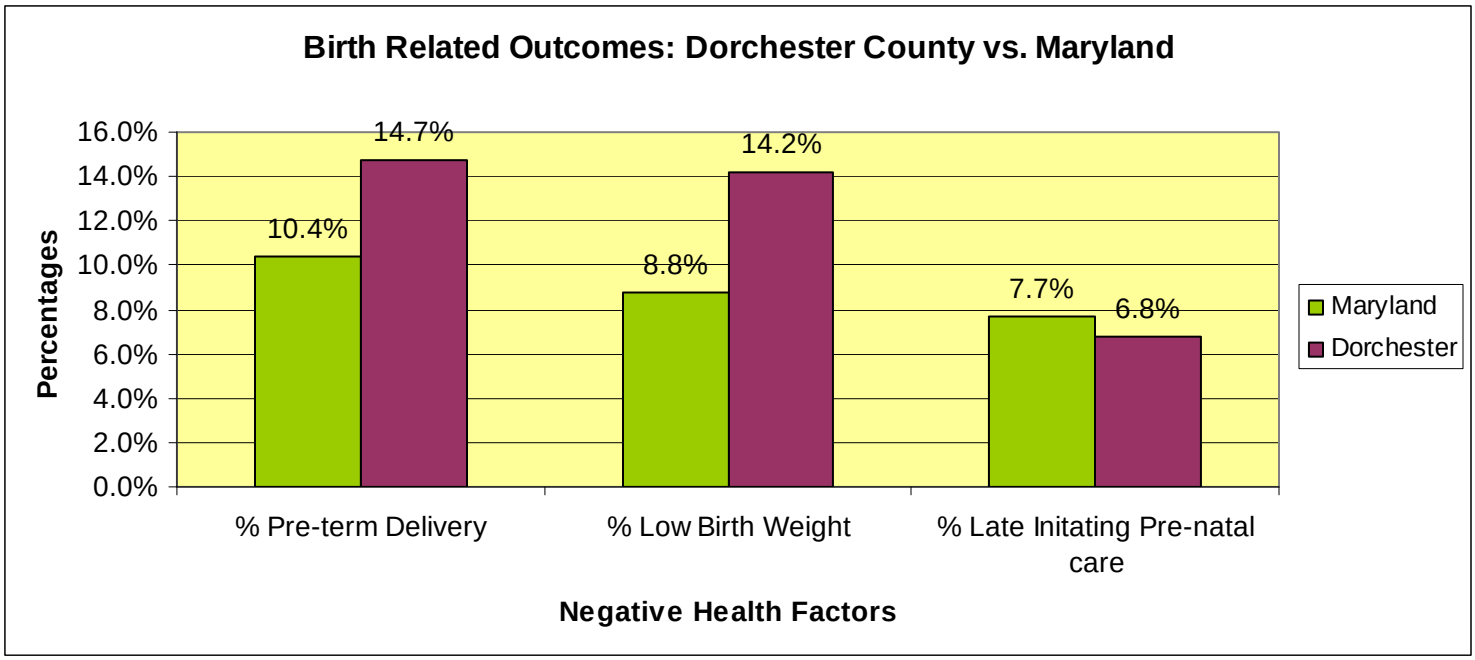


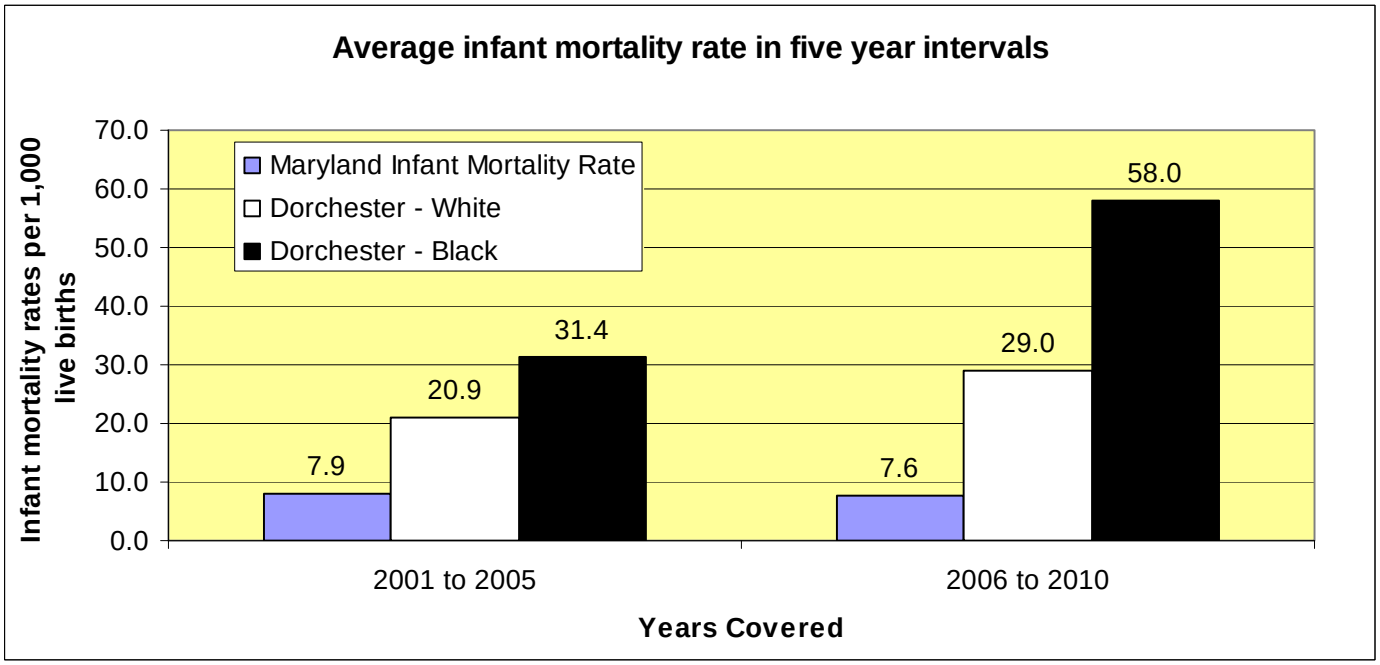
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Dorchester		14.9			13.7		19.7	17	17.7	21.9	
Maryland	7.4	8	7.6	8.1	8.5	7.3	7.9	8	8	7.2	6.7

Infant Mortality vs. Infants Birth Rate






Birth Related Outcomes: Dorchester County vs. Maryland
Percentages
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
10.4%
14.7%
8.8%
14.2%
7.7%
6.8%
% Pre-term Delivery
% Low Birth Weight
% Late Initating Pre-natal care
Negative Health Factors
Maryland
Dorchester


Average infant mortality rate in five year intervals
Infant mortality rates per 1,000 live births
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Maryland Infant Mortality Rate
Dorchester - White
Dorchester - Black
7.9
20.9
31.4
7.6
29.0
58.0
2001 to 2005
2006 to 2010
Years Covered

The Role of these Factors in Infant Mortality

In an analysis of seven infant and two fetal deaths occurring in Dorchester (2009):
8 of 9 had insurance, 7 of 9 had Medicaid
7 of 9 started prenatal care in 1st/2nd trimester
2 out of 9 started prenatal care in 3rd trimester
6 of 7 live births were pre-term (mean gestation age was 28.9 weeks)
6 of 9 weighed less than 1500g
2 deaths occurred post-neonatal due to unsafe sleeping arrangements.

Role of Stress in Infant Mortality

Stress alters physiology much like smoking
- ❖Poverty
- ❖Food insecurity
- ❖Housing insecurity
- ❖Fears about safety (crime & domestic violence)

Racism
- ❖Experienced and anticipated discrimination
- ❖Woven into the cultural fabric of a community

Source: Health Disparities Conference, Infant Mortality: Crisis in Maryland, April 12, 2012

Factors that impact Infant Mortality Rates:

- Births to adolescents
- Late or no prenatal care
- Low Birth Weight (< 2500 grams)
- Pre-term Birth (< 37 weeks gestation)
- Poverty/Unemployment
- Domestic Violence
- Substance Abuse
- Maternal Education Level
- Preconception health status
- Unintended pregnancy
- Maternal Behavior During Pregnancy
- Breastfeeding & Safe Sleep

Preconception Health

Maryland PRAMS* Data from 2001 – 2009 indicates that of women in Dorchester County delivering a live infant:

- 42% smoked during the three months prior to pregnancy
- 19% had at least one episode of binge drinking during the three months prior to pregnancy
- 28% were obese (BMI ≥ 30) just before pregnancy
- 16% were taking a daily multi-vitamin one month prior to pregnancy

*Prenatal Risk Assessment Monitoring System, February 2011 Publication

Based on PRAMS* data collected between 2001 and 2009 for women from Dorchester County delivering a live infant:

- 54% - over half - indicated that the pregnancy was mistimed (compared with 42% statewide)
- 70% initiated First Trimester Prenatal Care
- 87% did not smoke during the last three months of pregnancy
- 98% did not use alcohol during the last three months of pregnancy
- 65% of women initiated breastfeeding (Maryland – 78%)
- 64% placed their babies to sleep on their backs (Maryland – 67%)

Appendix 5: Community Health Needs Assessment Steering Committee

Community Health Needs Assessment Steering Committee

- Michael Silgen (Chair) - VP, Strategic Planning & Business Development
- Aaron Lefort – Data Analyst, Shore Wellness Partners
- Andrew McCarthy, MD
- Bill Roth - Senior Director, Comprehensive Rehab Care
- Chris Parker - Senior Vice President-Patient Care Services, Chief Nursing Officer
- Chris Mitchell MSN, RN, NEA-BC, Director of Emergency and Outpatient Services
- Chris Pettit – Planning Analyst
- Dale Jafari MSN, CRNP, Breast Center Coordinator
- Iris Lynn Giraudo RN,BSN, Readmissions Care Coordinator
- Kathleen McGrath - Director of Strategic Planning & Business Development
- Linda Porter, Patient Access Manager
- Patricia Plaskon - PhD, LCSW-C, OSW-C, Coordinator of Oncology Social Work
- Rita Holley MS, BSN, RN Director of Shore Home Care
- Ruth Ann Jones EdD, MSN, RN, NEA-BC, Director Acute Care
- Sharon Stagg RN, DNP, MPH, FNP-BC, Director of Shore Wellness Partners
- Susan Siford, PharmD, MBA, Director of Pharmacy
- Trish Rosenberry, BSN, RN, Manager of Outpatient Services
- Bee Fish – Director IT, Site Executive
- Deborah Reeder RN, COS-C, Home Health Manager
- Gary Jones, Director, Cardiovascular & Pulmonary Services
- Holly Patronik - Clinical Nutrition Manager
- Jackie Weston, BSN, RN-BC, Nurse Manager for Shore Behavioral Health Services
- Kathy Gootee - Director Clinical Information Management
- Paul Monte, MD
- Terri Ross - Director of Care Coordination

Shore Health participates on the University of Maryland Medical System (UMMS) Community Benefits Workgroup to study demographics, assess community health disparities, inventory resources and establish community benefit goals for both Shore Health System and UMMS. Donna Jacobs, Senior Vice President Government and Regulatory Affairs, chairs this workgroup.

Appendix 6: Mid-Shore Health Improvement Coalition Membership (SHIP)

Mid Shore Health Improvement Coalition Membership (SHIP)

Name	Title	Organization
Community Organizations		
Joe Sheehan	CEO	Choptank Community Health Systems
Janet Fountain	Project Director	Caroline County Minority Outreach Technical Assistance
Donna Hacker	Executive Director	Talbot County Local Management Board
Sandy Wilson	Program Manager	Partnership for Drug Free Dorchester
Margaret Jopp	Family Nurse Practitioner	Caroline County Community Representative
Jeanne Bromwell	Deputy Director	Eastern Shore Area Health Education Cernter
Dora Best	Program Coordinator	Kent County Minority Outreach Technical Assistance
Deanna Harrell	Executive Director	YMCA of the Chesapeake
Sharon Pahlman	Health Educator	University of MD Extension
Hope Clark	Director	Kent County Local Management Board
William Clark	Director	Kent County Department of Juvenile Services
Carolyn Brooks	Member	Coalition Against Tobacco Use
Rev. Mary Walker	Clergy	Mt. Olive AME Church
Holly Ireland	Executive Director	Mid Shore Core Service Agency
Ashyria Dotson	Program Director	Associated Black Charities
Mike Clark	Executive Director	Queen Anne County Housing and Family Services

Health Department Representation		
C. Devadason	Health Officer	Queen Anne County Health Department
Roger Harrell	Health Officer	Dorchester County Health Department
Kathy Foster	Health Officer	Talbot County Health Department
Rebecca Loukides	Deputy Health Officer	Caroline County Health Department
Hospital Representation		
Kathleen McGrath	Executive	Shore Health System
Scott Burleson	Executive Vice President	Chester River Hospital

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