UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

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

Community Health Needs Assessment & Implementation Plan

FY2020-FY2022

Approved by: Shore Regional Health Board of Directors
5/22/2019

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Executive Summary

Overview

University of Maryland Shore Regional Health (UM SRH) is a regional, nonprofit, medical delivery care network serving the Mid-Shore region, which includes Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. In addition to its three hospitals — University of Maryland Shore Medical Center at Chestertown (SMC at Chestertown), the University of Maryland Shore Medical Center at Dorchester (SMC at Dorchester), and the University of Maryland Shore Medical Center at Easton (SMC at Easton) — Shore Regional Health's diverse health care network includes: UM Shore Emergency Center at Queenstown; UM Shore Medical Pavilions at Chestertown, Easton, Denton, Dorchester and Queenstown; the Regional Cancer Center; the Clark Comprehensive Breast Center; UM Shore Home Care; UM Chester River Home Care; a broad array of outpatient diagnostic, surgery and rehabilitation centers; and medical practices under the umbrella of University of Maryland Shore Medical Group.

As the regional health care network serving Caroline, Dorchester, Kent, Queen Anne's and Talbot counties on Maryland's Eastern Shore, University of Maryland Shore Regional Health (UM SRH) provides inpatient and outpatient health care services for residents in this predominantly rural, 2,000 square mile region. With more than 2,500 employees, board members and volunteers, and a medical staff that includes 359 credentialed medical staff members, UM SRH works with various community partners to provide quality health care and to fulfill the organization's mission of Creating Healthier Communities Together.

In FY2018, UM SRH provided care for 11,560 inpatient admissions, 8,873 outpatient surgical cases, and 71,481 emergency department visits. UM SRH is licensed for 194 acute care beds. Beyond Shore Regional Health Medical Center facilities in FY2018, UM SRH provided over 18,000 hours of community health services through education and outreach programs, screenings, support groups, and other initiatives that meet community health care needs. In addition, UM SRH

provides a community outreach section on the UM SRH public web site to announce upcoming community health events and activities in addition to posting the triennial Community Health Needs Assessment (CHNA).
/www.umms.org/shore/-/media/files/um-shore/community/community-health-needs-

Our Mission and Vision

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

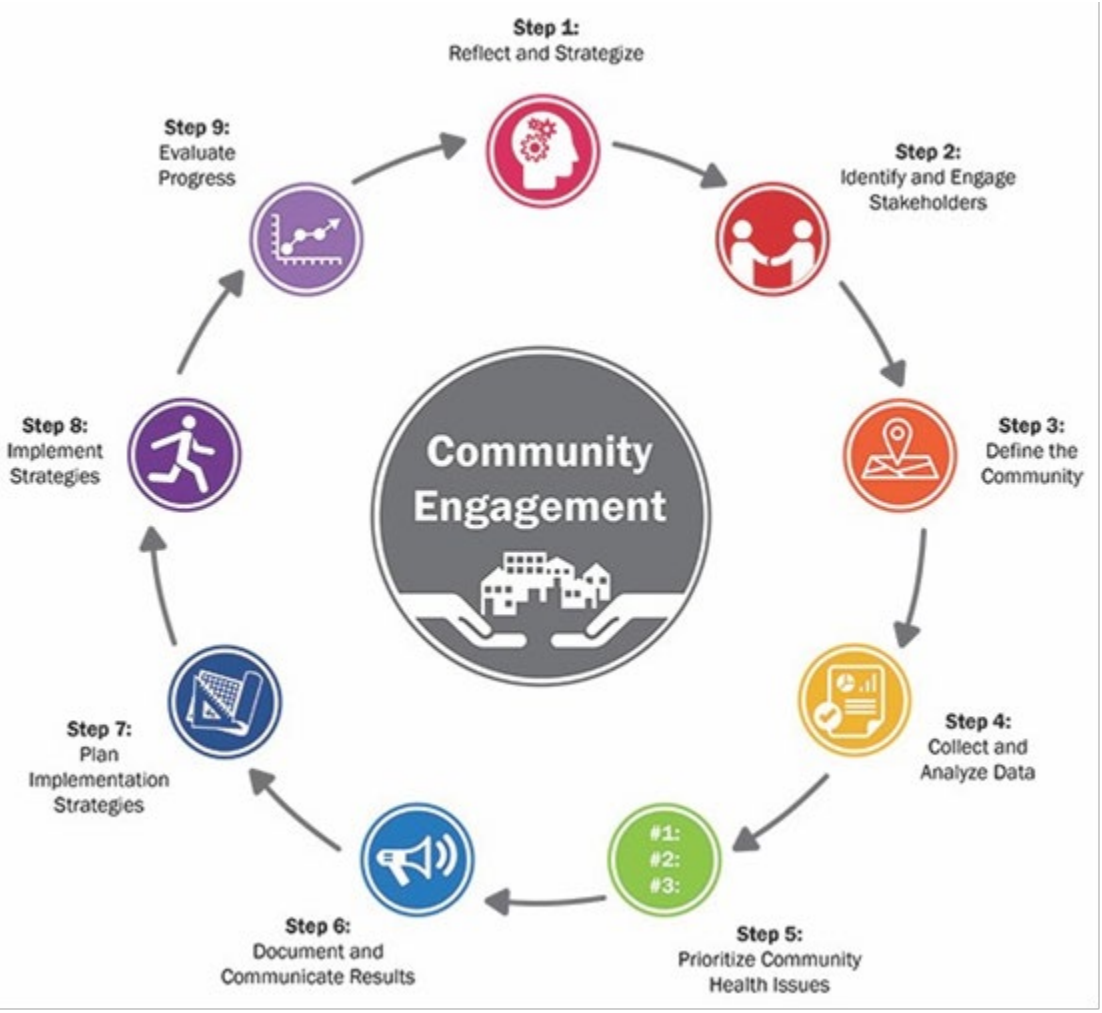
The Strategic Plan supports our **Mission**, **Creating Healthier Communities Together**, and our **Vision**, to be the **region's leader in patient centered health care**. Our goal is to provide quality health care services that are comprehensive, accessible, and convenient, and that address the needs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

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) 9-step Community Health Assessment Process was utilized as an organizing methodology. The UM SRH Community Health Planning Council served as the lead team to conduct the Community Health Needs Assessment (CHNA) with input from UM SRH Strategic Planning Committee, The University of Maryland Medical System (UMMS) Community Health Improvement Committee, community leaders, the public, health experts, and the five health departments that serve the Mid-Shore. The UM SRH Community Health Planning Council adopted the following ACHI 9-step process (See Figure 1) to lead the assessment process and the additional 5-component assessment (See Figure 2) and engagement strategy to lead the data collection methodology.

Figure 1 - ACHI 9-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 – 5-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 document. UM SRH participates in a wide variety of local coalitions including, several sponsored by Local Health Departments (Caroline, Dorchester, Kent, Queen Anne's, Talbot Counties), Cancer Coalition, Tobacco Coalition, Opioid Taskforce, Rural Health Collaborative, Rural Health Association as well as partnerships with many community- based organizations like American Cancer Society (ACS), Susan G. Komen Foundation, American Diabetes Association (ADA) and American Heart Association (AHA), to name a few.

II. Defining the Purpose and Scope

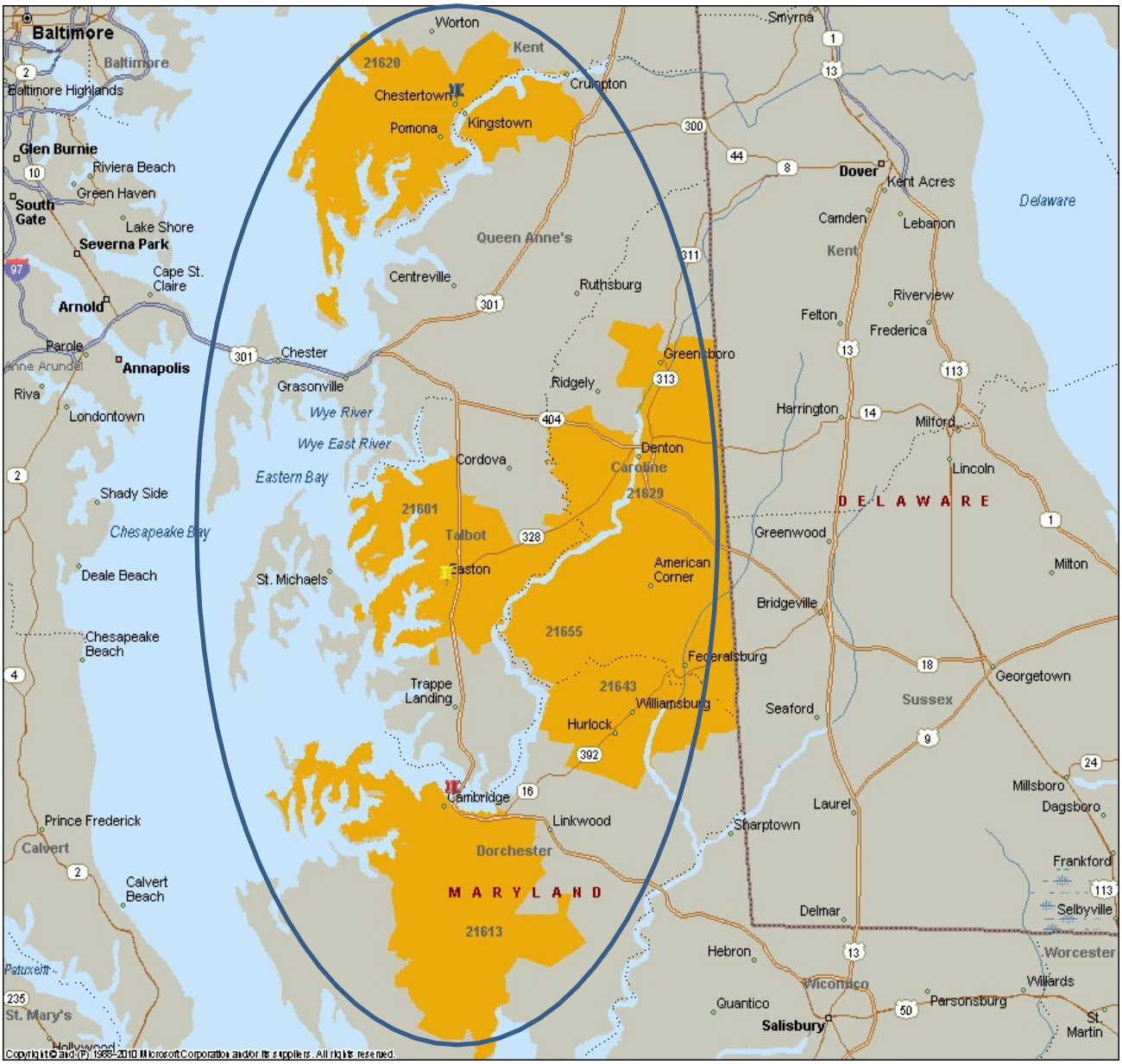
Primary Community Benefit Service Area

For purposes of community benefits programming and this report, Shore Regional Health's Community Benefit Service Area is defined as the Mid-Shore, the Maryland counties of Caroline, Dorchester, Kent, Queen Anne's and Talbot. (See Figure 3).

Figure 3 – 5 County UM SRH Community Benefit Service Area (CBSA)

- Caroline, Dorchester, Kent, Queen Anne's, Talbot Counties

The primary (CBSA) for UM SRH is the geographic area of the Mid-Shore and includes the zip codes that comprise 80% of all admissions



Orange Highlighted ZIP Codes – Top 65% of Market Discharges; Top 80% Circled in Blue

Zip Codes included in CBSA

Hospital	ZIP Code
SMC at Chestertown	21620 - Chestertown
	21661 - Rock Hall
	21678 - Worton
	21651 - Millington
	21617 - Centreville
SMC at Dorchester	21613 - Cambridge
	21643 - Hurlock
	21631 - East New
	21601 - Easton
	21664 - Secretary
	21835 - Linkwood
	21632 - Federalsburg
	21673 - Trappe
SMC at Easton	21601 - Easton
	21613 - Cambridge
	21629 - Denton
	21632 - Federalsburg
	21655 - Preston
	21643 - Hurlock
	21639 - Greensboro
	21663 - Saint Michaels
	21617 - Centreville
	21660 - Ridgely
	21673 - Trappe
	21625 - Cordova
	21620 - Chestertown

III. Collecting and Analyzing Data

Using the above framework (Figures 1 & 2), data was collected from multiple sources, groups, and individuals and integrated into a comprehensive document which was utilized at the planning session of the Community Health Planning Council held on April 2, 2019 During that strategic planning session, priorities were identified using the collected data and an adapted version of a widely used and referenced quantitative tool (The Hanlon method) to rank the health-related needs based on four selected and weighted criteria:

- Importance to our community- 40% weight
- Capacity to address the need - 25% weight
- Alignment with organizational and statewide goals- 25% weight
- Strength of existing intervention/collaborations- 10% weight

The identified priorities were then validated by UM SRH Strategic Planning Committee meeting on April 17, 2019.

UM SRH used primary and secondary sources of data as well as quantitative and qualitative data and consulted with numerous individuals and organizations during the CHNA, including community leaders, community partners, the University of Maryland Medical System Community Health Improvement Committee, the general public, local health experts, and the Health Officers representing the five counties of the Mid-Shore.

Additionally, UM SRH reviewed the data and findings of two recent and comprehensive studies focused on rural health care delivery and rural health care needs of the Mid-Shore.

- **Maryland Mid-Shore Rural Health Study,** November 2017

  Purpose:

  To help better meet health care needs in the Mid-Shore region and provide recommendations that could be applied to other Maryland rural areas, the

Maryland Health Care Commission (MHCC) and the Department of Health established a workgroup on rural health care delivery to oversee a study, hold public hearings and recommend policy options.

The report's recommendations for restructuring and enhancing the health care delivery system on the Mid-Shore were based on:

- focus groups with residents;
- interviews with community leaders;
- analyses of claims and primary care physician workforce data;
- review of literature and national models; and
- input from the Workgroup, and its advisory groups and public hearings.

"Health Matters: Navigating an Enhanced Rural Health Model for Maryland, Lessons Learned from the Mid-Shore Counties" is the executive summary and report detailing the findings of the group's studies. The data and recommendations from the Mid-Shore Rural Health Study were utilized to inform the Shore Regional Health Strategic Planning Committee and Community Health Planning Council in the development of implementation strategies to improve the access and delivery of health services in the region.

- **Maryland Rural Health Plan**, October 2018

Purpose:

The updated Maryland Rural Health plan is a comprehensive examination of the rural health care needs of Maryland conducted by the Maryland Rural Health Association. The 2018 Maryland Rural Health Plan examined existing county health plans and Community Health Needs Assessments (CHNA), the Maryland State Health Improvement Process (SHIP) data, results from a state appointed study on Maryland's Eastern Shore. Data was aggregated by topic and themes identified from multiple data sources emerged as key priorities.

Findings were collated for the state, with county profiles highlighting their specific results. The Maryland Rural Health Plan documents the health needs for the Mid-Shore as well as serves as a roadmap to develop actionable and practical strategies.
https://mdruralhealthplan.org/

The following describes the individual data collection strategies with the accompanying results for each requisite stakeholder component of the CHNA:

A) Community Perspective

The community's perspective was obtained through a widely-distributed survey offered to the public via several methods throughout the Mid-Shore. The survey queried residents to identify their top health concerns and barriers in accessing health care. (See Appendix 1 for the survey tool and resident comments)

Methods

The survey was distributed in FY2019 using the following methods:

- The link for the online survey was circulated to over 78,000 households within the CBSA via a community health newsletter ***Maryland Health Matters***
- Online survey posted to UM SRH website
- Health fairs and events in neighborhoods within UM SRH's CBSA

The data from the two Rural Health Studies was also examined and considered:
Focus group findings from:

- Maryland Rural Health Plan, October 2018
- Maryland Mid-Shore Rural Health Study, November 2017

Results

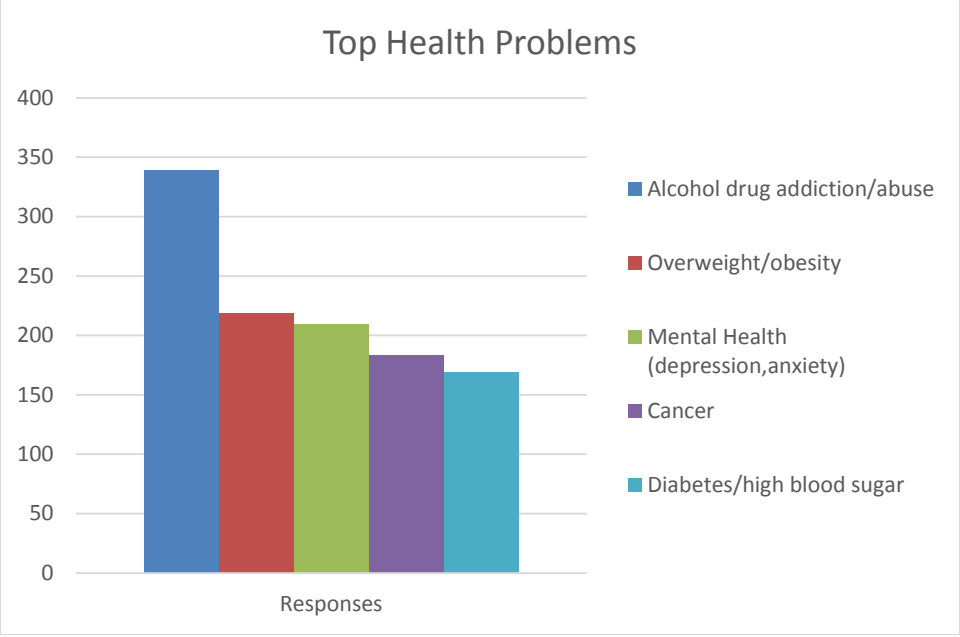
- Top 5 Health Concerns from survey (See Chart 1 below)
    1. Alcohol drug addiction/abuse
    2. Overweight/obesity

3. Mental Health (depression, anxiety)
4. Cancer
5. Diabetes/high blood sugar

Analysis by CBSA targeted zip codes, revealed the same top health concerns and top health barriers bore little deviation from the overall DHMH State Health Improvement Process (SHIP) data which reports state and county level data on critical health measures.

Chart 1 - Community's Top Health Concerns

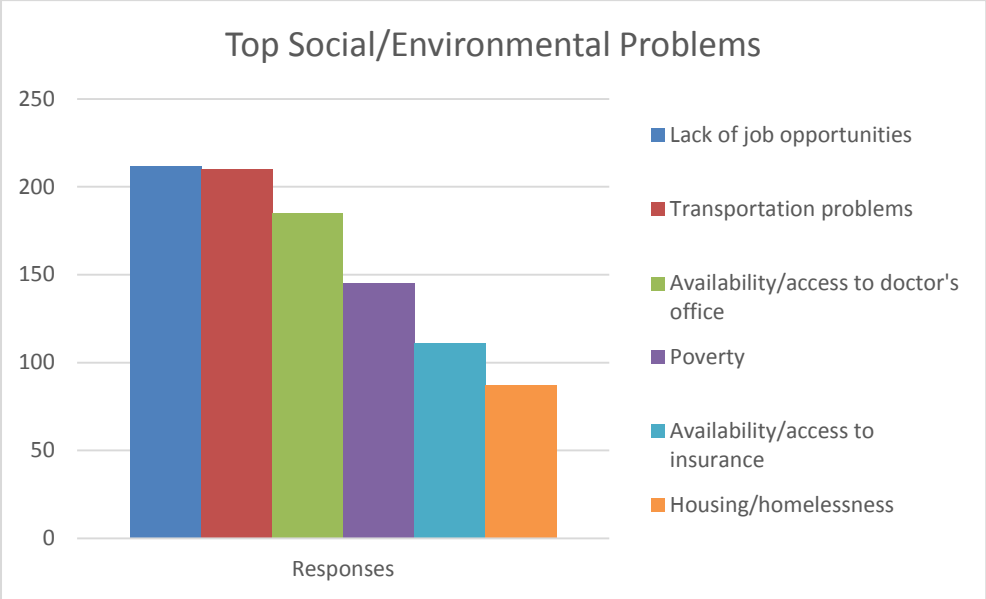
Question: What are the three most important health problems that affect the health of your community?



THE SAMPLE SIZE WAS 506 MID-SHORE RESIDENTS FROM THE IDENTIFIED CBSA.

Chart 2 - Community's Top Health Concerns

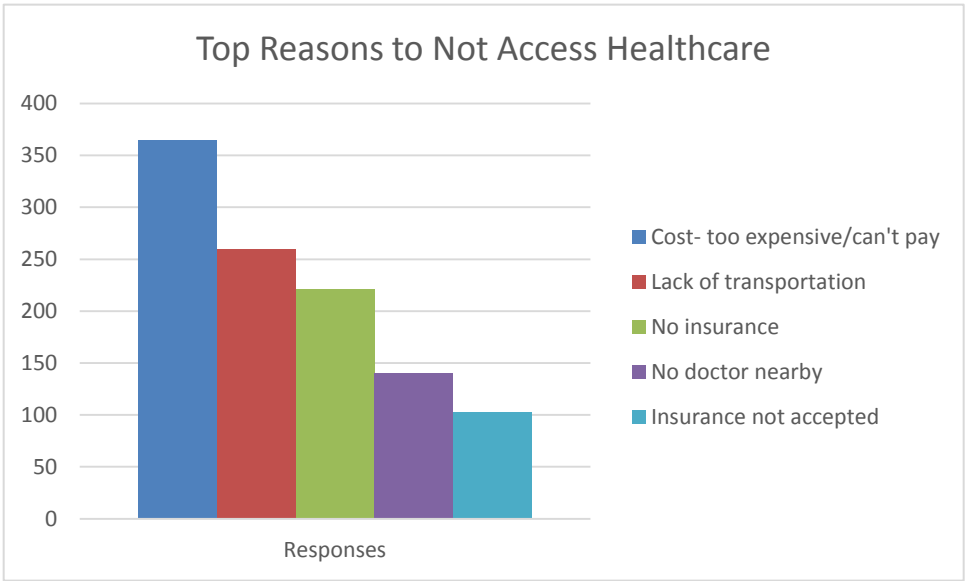
Question: What are the three most important social/environmental problems that affect the health of your community?



THE SAMPLE SIZE WAS 507 MID-SHORE RESIDENTS FROM THE IDENTIFIED CBSA

Chart 3 – Community's Top Barriers to Healthcare

Question: What are the three most important reasons why people in your community do not get health care?



THE SAMPLE SIZE WAS 504 MID-SHORE RESIDENTS FROM THE IDENTIFIED CBSA

- **Focus group findings from the Maryland Mid-Shore Rural Health Study:**

  Technical Report 1- Residents' View

  As part of the Maryland Mid-Shore Rural Health Study, the University Of Maryland School Of Public Health, in partnership with the Walsh Center for Rural Analysis at NORC at the University of Chicago, conducted five focus groups — one in each county of the Mid-Shore. Residents shared their perceived ideas of the strengths and weaknesses of the current healthcare delivery system. Generally speaking, residents in the Mid-Shore region recognize that healthcare systems need to accommodate culturally diverse populations and the growing number of vulnerable residents, including elders with chronic health conditions. The residents also feel that in order to improve the healthcare delivery system, recommendations must address social determinants of health. Residents support an integrated care delivery system across a continuum of care with services as close to home as possible.

  Top concerns identified by the Rural Health Study focus groups:

  - Health insurance and costs: cost and coverage difficulties
  - Specialty care lacking or far away
  - Mental, behavioral and substance use care: access and affordability
  - Need for care coordination, case management and patient navigation

- **Focus group findings from the Maryland Rural Health Plan**

  Top 5 barriers to accessing care:

  - Transportation
  - Health Insurance
  - Overbooked providers
  - Hours of Service
  - Lack of care coordination

  Gaps in service:

  - Lack of specialists and oral health services
  - Lack of behavioral health providers

B) Health Experts

Methods

- Reviewed and included National Prevention Strategy Priorities, Maryland State Health Improvement Plan (SHIP) indicators, findings from the Maryland Mid-Shore Rural Health Study and Maryland Rural Health Plan, Robert Wood Johnson County Rankings and Roadmaps, and Hospital Inpatient Readmissions and High Utilizer data.
- Healthcare providers' perspective was obtained through a survey distributed to the medical staff of UM SRH. The survey queried providers of care to identify the community's top health concerns and top barriers in accessing health care.

Results

- National Prevention Strategy – 7 Priority Areas
    - Tobacco Free Living
    - Preventing Drug Abuse and Excessive Alcohol Use
    - Healthy Eating
    - Active Living
    - Injury and Violence Free Living
    - Reproductive and Sexual Health
    - Mental and Emotional Well Being
- SHIP: 39 Objectives in 5 Focus Areas for the State (Figure 4), includes targets for Caroline, Dorchester, Kent, Queen Anne's, Talbot counties:
  - While progress has been made since 2016 - each county's progress varies widely on meeting the identified targets at the state level. Wide disparities exist within the CBSA territory. (See Appendix 2 for SHIP data by county)

  Results for Mid-Shore SHIP Measures:
    - Caroline County has met 14 of 39 SHIP goals
    - Dorchester County has met 7 of 39 SHIP goals
    - Kent County has met 12 of 39 SHIP goals
    - Queen Anne's has met 18 of 39 SHIP goals
    - Talbot County has met 18 of 39 SHIP goals

  Goals not met for the following areas for at least 4 of the 5 counties of the Mid-shore:
    - Life expectancy
    - Cancer mortality rate
    - Adults who currently smoke
    - Obesity -Adolescents who have obesity/Adults who are overweight or obese

- Emergency Department visit rates due to:
  - *Diabetes*
  - *Hypertension*
  - *Mental Health Conditions*
  - *Asthma*
  - *Addictions Related Conditions*

■ Analysis of provider surveys revealed the same top health concerns and top health barriers with little deviation from the community (consumer survey) and overall DHMH State Health Improvement Process.

■ **Maryland Rural Health Plan:**

Feedback from health care professionals for the Mid-Shore:
Top 5 barriers to accessing care:

- Transportation
- Stigma and culture
- Insurance coverage and affordability
- Awareness of services
- Health literacy and health insurance literacy

Gaps in service:

- Lack of specialists and oral health services
- Lack of stable funding

C) Community Leaders

Methods

■ A series of structured interviews/focus groups were conducted to obtain input from those with knowledge of specific communities, focus areas or disease states (January – February 2019)

Results

- Top Health Priorities and Concerns:

  Access to care:
  - Lack of public transportation system with difficulty accessing health services
  - Health workforce shortage that includes primary care, behavioral health and specialty care
  - The lack of care coordination and connectivity to integrate patient care and services
  - Limited number of non-profits and private organizations as stakeholders to help share in filling gaps for vulnerable populations

  Sustainable funding:
  - Caught in transition between payment for value versus payment for volume (GBR versus fee-for-service)
  - Shift in health departments from direct service delivery to programs with limited capacity to bill for services

- **Maryland Mid-Shore Rural Health Study:**

  <u>Technical Report 1- Community Leaders' Perspectives</u>

  Community leaders reported challenges/concerns about:

  - Hospital care availability
  - Lack of primary care providers and specialists
  - Limited public and medical transportation
  - Needs of vulnerable populations.

  The community leaders voiced the need for innovation and flexibility in promoting rural health.

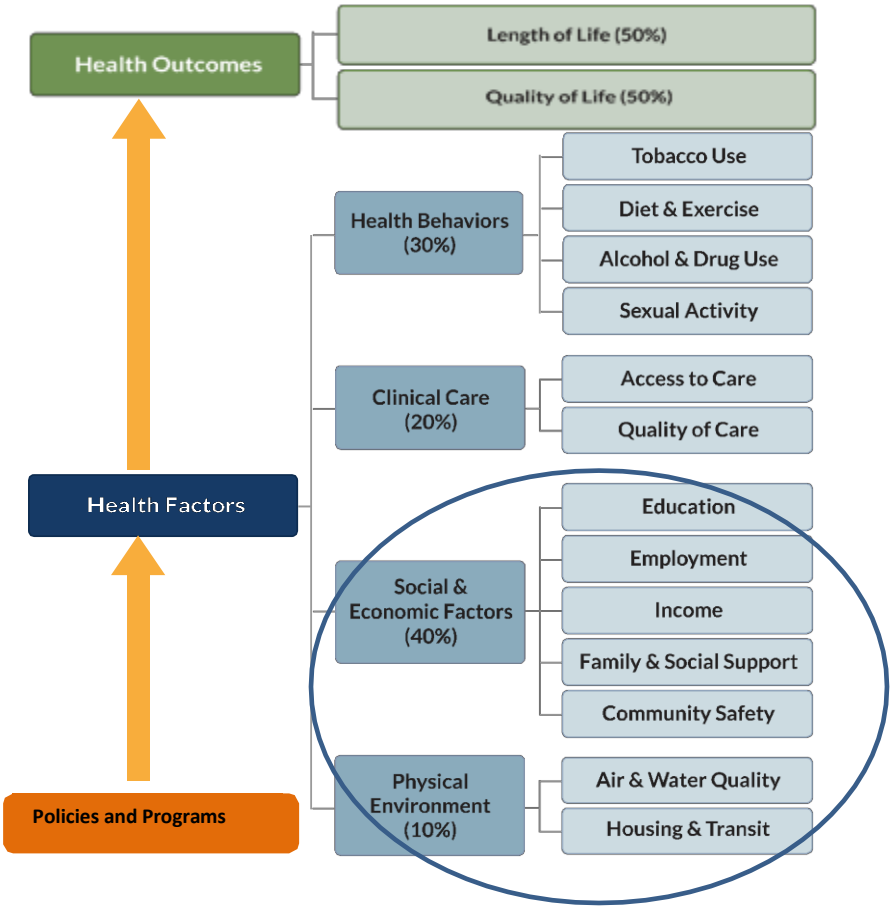
D) Social Determinants of Health

(SDoH) Methods

- Reviewed SHIP data from Maryland Health Department's MDH data (Appendix 2)
- Reviewed data from Robert Wood Johnson Foundation, County Health Rankings & Roadmaps. (See Appendix 3)

Results

The *County Health Rankings & Roadmaps* report explores the wide gaps in health outcomes throughout Maryland and what is driving those differences. The report finds health status is influenced by every aspect of how and where we live. Access to affordable housing, safe neighborhoods, job training programs and quality early childhood education are examples of important changes that can put people on a path to a healthier life even more than access to medical care. But access to these opportunities varies county to county. This limits choices and makes it hard to be healthy.



- Top SDoHs impacting health on the Mid-Shore as reported in the Robert Wood Johnson County Health Rankings & Roadmaps 2018 report are:
  - Low Education Attainment (Dorchester and Caroline)
  - High Poverty Rate (Dorchester 15.4%, Caroline 16.5%, Kent (13.2%)
  - Children in Poverty (Dorchester 29%, Caroline 22%, Kent, 20%)
  - High Unemployment Rate (Dorchester 5.7%)
  - Severe Housing Problems (Caroline 19%, Dorchester 19%)

Local Health Context

- 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
  - 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:
  - Subpopulations within counties have higher uninsured, unemployed, and low income residents
  - 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

Methods

Review annually and for this triennial survey the following:

- **Local data sources:**
  - MDH SHIP data
  - Maryland Chart book of Minority Health and Minority Health Disparities Data

- **National trends and data:**
  - Healthy People 2020
  - Robert Wood Johnson County Health Rankings
  - Centers for Disease Control reports/updates

Results

- Robert Wood Johnson County Health Data

County Rankings: position out of 23 counties plus Baltimore City

	Caroline	Dorchester	Kent	Queen Anne's	Talbot
Health Outcomes	**22**	**21**	**16**	**9**	**10**
Length of Life	**23**	**19**	**14**	**11**	**9**
Clinical Care	**24**	**23**	**19**	**10**	**4**
Social & Economic Factors	**19**	**22**	**13**	**6**	**11**
Physical Environment	**19**	**15**	**10**	**4**	**2**

Poor health indicators exist in the following areas for at least 4 of the 5 counties of the mid-shore:

Health Behaviors

- Adult smoking
- Adult Obesity

Clinical Care

- Preventable hospital stays
- Uninsured
- Provider shortages
  - Primary care physicians
  - Dentists
  - Mental health providers

- Outcomes Summary for CBSA territory

Top 3 Causes of Death on the Mid-Shore in rank order:

1. Heart Disease
2. Cancer
3. Stroke

IV. Selecting Priorities

Analysis of all quantitative and qualitative data described in the above section identified these top five 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. These priorities were identified and approved by the Community Health Planning Council (See Appendix 6) and validated with the UM SRH Strategic Planning Committee.

- **Results**: Prioritization- with one being the greatest need:
  1. Access to Care
  2. Preventable ER visits
  3. Chronic disease management
  4. Mental Health/substance abuse
  5. Cancer

V. Documenting and Communicating Results

The completion of this community health needs assessment marks a milestone in community involvement and participation with input from the community stakeholders, the general public, UM SRH, and health experts. This report will be posted on the UM SRH website under the Community Health Needs section, https://www.umms.org/shore/community/assessment-implementation-plan Highlights of this report will also be documented in both the Community Benefits Annual Report filed with the Health Services Cost Review Commission and the UMMS Community Health Improvement Report. 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 Community Health Planning Council developed the Community Health Implementation Plan (CHIP), made publicly available June 2019. This plan is a living document that provides concrete actionable strategies for addressing the health needs of the Mid-Shore. UM SRH will track and evaluate progress towards achieving long-term outcome objectives measured through Maryland's Department of Health (MDH) SHIP metrics. Short-term programmatic objectives, including process and outcome metrics will be measured annually by UM SRH 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.

Because UM SRH serves the Mid-Shore region, 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.

UM SRH 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, national, and international disasters, i.e. civil unrest, terrorist attack, weather disasters – earthquake, blizzards
- **Urgent Response -** Urgent response to episodic community needs, i.e. H1N1/Flu response
- **Sustained Response -** Ongoing response to long-term community needs, i.e. 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. All community benefits reporting will occur annually to meet state and federal reporting requirements.

B) Unmet Community Needs

Several additional topic areas were identified by the Community Health Planning Council during the CHNA process including: transportation and workforce development. While UM SRH will focus the majority of our efforts on the identified priorities, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while significantly important to the health of the community, will be met through other health care organizations with our assistance as available.

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Community Health Implementation Plan, FY2020-FY2022

The Community Health Implementation Plan (CHIP) is a list of specific goals and strategies that demonstrate how UM SRH plans to address the most significant needs identified in the CHNA while also being aligned with UMMS community health improvement initiatives and national, state and local public health priorities.

Our Annual Operating Plan, which is derived from our strategic plan, includes community benefit and population health improvement activities.

Based on qualitative and quantitative data collected and analyzed during the CHNA process, UM SRH's Implementation Plan remains committed to the goals and strategies identified in the 2016 CNHA. Although some of the focus areas have changed in their order of priority per community feedback, the overall needs remain the same as reported in the 2016 CHNA.

Health Priorities FY2020-2022

The top five priorities:

1. Access to care
2. Preventable ER visits
3. Chronic Disease management
4. Mental health/substance abuse
5. Cancer

Overarching theme for addressing health priorities:

1. Reduce barriers to care
2. Improve care coordination
3. Focus on health outreach and education

UM SRH is engaged in numerous programs addressing the identified needs of the Mid-Shore. The UM SRH hospitals — SMC at Chestertown, SMC at Dorchester, and SMC at Easton work to

strategically allocate scarce resources to best serve the communities, increase trust and build stronger community partnerships.

The CHIP items which follow provide action plan strategies and examples of ongoing initiatives that address the identified needs. Strategies emphasize clinical and community partnership development and improved coordination of care. All identified key community needs are addressed either directly through designation as a prioritized key community need or incorporated as a component of a prioritized key community need.

HEALTH NEED 1: ACCESS TO CARE			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Improve access to care for medically underserved and vulnerable groups of all ages and populations	**Strategy 1**: Increase capacity by addressing the recruitment, retention, accessibility, competency of providers	• Medical Staff assessment-identify shortages • Provide/fund physician subsidies to meet identified community needs • Establish physician/resident training programs	• University of Maryland School of Medicine and UMMC • Eastern Shore Area Health Education Center (AHEC)
	Strategy 2: Enhance and Expand Telemedicine Opportunities	• Increase total consults • Identify and implement new consult services: Dermatology and Child/Adolescent Psychiatry currently under negotiation	University of Maryland Medical Center, University of Maryland Faculty Physicians, (FPI) University of Maryland School of Medicine (SOM)
	Strategy 3: Reduce transportation barriers and enhance awareness of available services	• Number of transportation vouchers • Resource information distribution • Participate Mid-Shore Rural Health Collaborative Transportation Workgroup	• Delmarva Community Transit (DCT) and Queen Anne's County Ride cover Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties • Rural Health Collaborative
	Strategy 4: Connect uninsured to private insurance, Medicaid, or other available coverage	• Number of insured residents	• Maryland Health Exchange

ACTIVITIES/INITIATIVE:

Recruit additional health care providers and specialists to the region. Provide subsidies to increase the availability of health care providers in order to best meet identified patient and community needs related to the availability of health care services.

Telehealth services Expand existing programs to outlying facilities as much as possible, increase the number of specialties providing telehealth consultations.

Transportation- Work to mitigate transportation barriers by assisting/arranging transportation for patients to travel to medical appointments

Uninsured/underinsured care -Inform patients and family members of UM SRH Financial Assistance Policy, assist with application for financial assistance, and provide financial assistance to eligible patients. Work with patients to determine eligibility for medical assistance, e.g. Medicaid, and other social services.

HEALTH NEED 2: Preventable ER Visits			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Help patients obtain "The Right Care, at the Right Place, at the Right Time"	**Strategy 1**: Provide community health education to improve understanding of appropriate use of primary care, urgent care, and emergency department in terms of medical capability and patient needs	• Decrease in unnecessary emergency department visits • Increase health in literacy	• Payers • Community media outlets
	Strategy 2: Improve care coordination, info sharing protocols to achieve safer, more effective care	• Protocols developed • Chronic disease management	• Community providers • five county health departments • social services • EMS agencies • Aging agencies

ACTIVITIES/INITIATIVES:

Educational topics include:

- How to understand Medicare, Medicaid and commercial health insurance plan benefits (e.g. copays, coinsurance, in and out of network providers)
- How to choose where to seek health care services (e.g. primary care, urgent care, Emergency Department)
- How to access community resources that can help prevent and manage chronic conditions

Rural Health Collaborative: UM SRH participates as a member on the Integrating Clinical and Social Support Services Workgroup. This workgroup supports the Rural Health Collaborative in determining actions that can be taken within the five Mid-Shore counties and throughout the Mid-Shore region to better integrate clinical and social support services. The Workgroup is charged with:

- Articulating the overarching problem to be addressed
- Identifying the current status of clinical and social support services and the resources supporting those services (including the components being added by the Maryland Total Cost of Care Waiver beginning January 2019)
- Determining the optimal availability and integration of clinical and social support services
- Deciding what is feasible to achieve by 2023 to better integrate clinical and social support services and steps to take to do so
- Recommending actions for improving integration of clinical and social support services to the Care Transformation Organizations and/or the Care Managers assigned to Primary Care Providers.

HEALTH NEED 3: Chronic Disease Management			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Prevent, detect, and manage chronic diseases	**Strategy 1**: Work with community organizations, congregational networks, and individuals to improve care, management and prevention of chronic diseases	• Number of health education/outreach encounters provided to community-based organizations and churches • Number of participants in health events and number of screenings performed • Number of outreach programs	• Health Departments • Faith based organizations • Homeports • Department(s) of Aging • YMCA • Area Schools
	Strategy 2: Screen for barriers/social needs of patients with chronic conditions during transitions to improve ability of patient to manage condition	• Increased transition support available to patients with chronic disease • Number of patients connected to services addressing social needs	• Home care providers • Faith based organizations • Department(s) of Social Services • Pharmacies • Meals on Wheels • Mobile Integrated Community Health

	Strategy 3: Provide specialized health information, "physician to physician" education regarding diabetes treatment and management.	• Number of provider outreach education sessions for primary care offices and medical staff	• Community providers

ACTIVITIES/INITIATIVES EXAMPLES:

Outreach: Education, screenings and support groups offered on the following topics/conditions: high blood pressure and heart disease; diabetes; cancer, stroke; hospice services and palliative care; obesity, exercise and nutrition; depression and anxiety

Engage targeted communities on healthy lifestyles: Through sponsorship or provision of:
- Community-wide education
- Store Tours
- Community Screenings & Referrals (Blood pressure, BMI/Weights, & Cholesterol)
- Exercise Demonstrations

Chronic Disease: To address chronic disease-related emergency department visits, The Transitional Nurse Navigator (TNN) Program provides continued care coordination for high-risk patients from the beginning of their hospital stay through up to 30-days after discharge. The scope of the discharge planning process has been expanded to include the broader, holistic needs of patients. Caseworkers and transitional nurse navigators help patients anticipate what their care needs will be in their home environment, connect with the patient's primary care provider to ensure proper follow-up, and provide links to needed community resources offering services such as transportation, home care, meals, home technologies and social support.

Physician Outreach: Provide education to community physicians who manage patients with complex chronic conditions

HEALTH NEED 4: BEHAVIORAL HEALTH			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Improve access and integration/ coordination of mental health and substance abuse services	**Strategy 1**: Provide individual, group, medication assisted treatment, and other mental health services, including prevention and support services	• Decrease re-hospitalization • Number of patients who accept treatment following an overdose • Number of adults who utilize services • Increase family and patient understanding of mental health treatments.	• Eastern Shore Crisis Response • Queen Anne's, Talbot, and Dorchester County Health Departments • Shore Medical Group Bridge Clinic

	Strategy 2: Expand program(s) to support ED patients waiting for outpatient mental health and/or substance use disorder treatment	• Number of patients served by the Bridge Clinic • Number of follow-up phone calls and outreach to patients who have experienced an overdose	• Corsica River Mental Health Center • Community Behavioral Health • Marshy Hope Mental Health
	Strategy 3: Improve care coordination for mental health and substance abuse co-occurring conditions through facilitation of direct hand-offs to the next level of care	• Number of patients referred between systems • Improve access by providing education regarding available resources and services	• Mid-Shore Behavioral Health System • Eastern Shore Crisis Response • Physician practices • Local Health Depts.

ACTIVITIES/INITIATIVES EXAMPLES:

Behavioral Health Bridge Clinic. The Bridge Clinic serves patients discharged from the behavioral health inpatient unit who are unable to access psychiatric care from community due to shortage of psychiatric providers.

Continue to provide: (1) medication administration assistance to complement counseling services currently being offered and to assist post discharge overdose patients; (2) injection support/education clinic to promote use of long acting psychotropic medications

The Bridge Clinics family group meeting. Community supporters of patients and in particular patients' family members receive education and support regarding mental health and treatment strategies. Assist families in maintaining positive support for their loved ones.

Education: To improve access to mental health care, programs are offered on a quarterly basis to the community providing up to date information on available mental health resources and services.

Regional Opioid Task Force: The task force — which includes representatives of county health departments and emergency services, and emergency and behavioral health physicians and nurses, and hospital officials — is led by Dr. Walter Atha, regional director of emergency medicine for UM Shore Regional Health, and Dorchester County Health Officer Roger Harrell. The task force is working to coordinate and standardize the medical community's response among Mid-Shore counties tackling the heroin and opioid epidemic

Education/Awareness: Cosponsor the series "Not All Wounds Are Visible": A Community Conversation. The community events are facilitated by University of Maryland Medical System and the University of Maryland, Baltimore– to help community members engage with experts and gain valuable tools on how to lead a healthy life - mentally and physically.

HEALTH NEED 5: Cancer			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Reduce cancer mortality rate	**Strategy 1**: Provide increased and improved screening and prevention services for breast, skin, prostate and colorectal cancer and evaluate adding cervical screening.	• Number of health education/outreach encounters provided to community • Number of participants in health events and number of screenings performed • Number of outreach programs	• University of Maryland Medical Center • County Health Departments • Specialty practices
	Strategy 2: Continue to educate the community about Lung Cancer Screening Program and support programming to reduce use of tobacco products	• Earlier detection of lung cancer • Improve survival rates • Work with Talbot County HD to develop a formal pathway for smoking cessation.	• County Health Departments • Community Providers

ACTIVITIES/INITIATIVES:

WELLNESS FOR WOMEN ACCESS TO CARE PROGRAM

The program serves as a point of access into care for age and risk specific mammography screening, clinical breast exam, and genetic testing for breast cancer.

Offers **no cost mammograms** to eligible women: those under the age of 40 and over 65 who have no insurance. Those women needing further diagnostic tests or who need treatment for breast cancer are enrolled in the State of Maryland Diagnosis and Treatment Program through the case manager.

LUNG CANCER EARLY SCREENING PROGRAM

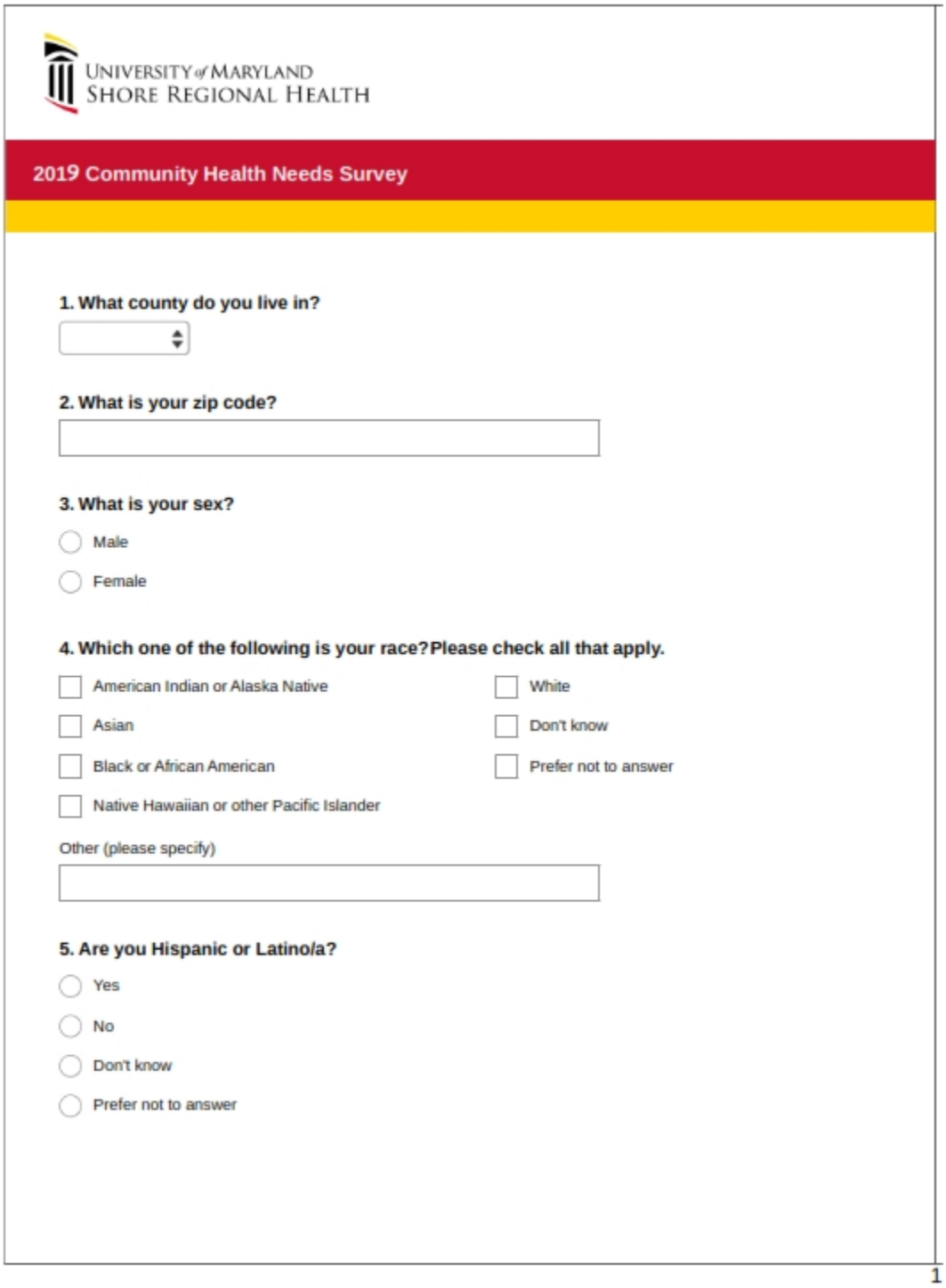
The low dose computed tomography (LDCT) screening program promotes earlier detection of lung cancer. Eligible patients are the high-risk groups which include those who have smoked a pack of

cigarettes daily for two or three decades, who are currently smokers, or those who quit smoking less than 15 years ago to have them screening for lung cancer. Earlier detection promotes better treatment and survival rates.

ANNUAL PROSTATE SCREENING

Public screening for males who are $\geq$ 40 years of age for a baseline screening, African American men, men with a family history of disease, and males > 55-74 for yearly screening.

Appendix 1 – Community Survey



UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

2019 Community Health Needs Survey

1. What county do you live in?

2. What is your zip code?

3. What is your sex?

- Male
- Female

4. Which one of the following is your race? Please check all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Don't know
- Prefer not to answer

Other (please specify)

5. Are you Hispanic or Latino/a?

- Yes
- No
- Don't know
- Prefer not to answer

1

6. On how many days during the past 30 days was your mental health not good?Mental health includes stress, depression and problems with emotions. Please write number of days.

- ◯ Zero days
- ◯ Prefer not to answer
- ◯ Don't know

Days

7. What are the three most important health problems that affect the health of your community? *Please check only three*

- ☐ Alcohol/Drug addiction
- ☐ Alzheimer's/dementia
- ☐ Cancer
- ☐ Diabetes/high blood sugar
- ☐ Heart disease/blood pressure
- ☐ HIV/AIDS
- ☐ Infant death
- ☐ Lung disease/asthma/COPD
- ☐ Mental health (depression, anxiety)
- ☐ Overweight/obesity
- ☐ Smoking/tobacco use
- ☐ Stroke
- ☐ Don't know
- ☐ Prefer not to answer

8. What are the three most important social/environmental problems that affect the health of your community? *Please check only three*

- ☐ Availability/ access to doctors' office
- ☐ Availability/access to insurance
- ☐ Child abuse/neglect
- ☐ Domestic violence
- ☐ Housing/homelessness
- ☐ Lack of affordable child care
- ☐ Lack of job opportunities
- ☐ Limited access to healthy food
- ☐ Limited places to exercise
- ☐ Neighborhood safety/violence
- ☐ Poverty
- ☐ Race/ethnicity discrimination
- ☐ School dropout/poor schools
- ☐ Transportation problems
- ☐ Don't know
- ☐ Prefer not to answer

9. What are the three most important reasons why people in your community do not get health care? *Please check only three*

- ☐ Cost- too expensive/can't pay
- ☐ Cultural/religious beliefs
- ☐ No doctor nearby
- ☐ No insurance
- ☐ Insurance not accepted
- ☐ Lack of transportation
- ☐ Language barrier
- ☐ Wait is too long
- ☐ Don't know
- ☐ Prefer not to answer

10. What ideas or suggestions do you have to improve health in your community?

11. To be entered into the $100 Amazon Gift Card Raffle, please leave your contact information below (Optional)

Name

Email Address

Phone Number

3

Survey Question 10: What ideas or suggestions do you have to improve health in your community?

Caroline County Comments

- Putting in a hospital or have urgent care open 24/7! People in Denton should have access to urgent care all the time!
- Free healthcare for all.
- More programs geared towards the older people, meals, transportation, local activities, checking on the isolated, and loneliness - dental care, neighbor watch, and neighbors helping neighbors.
- More accessible, quality providers. Everything should not be centered in Easton.
- Most people in the county have to drive 20 minutes or more to get to a physician's office, which translates to several hours of work. If anything is truly wrong at the doctor's office, the closest facility is in the next county. The closest ER is in the next county as well. There should be a place to get diagnostic imaging and consultations with specialists in the county that won't require a full day of missed work and travel to plan
- Educate - let resident know what is available Offer resources, how to care for self
- Wellness day at a local facility
- I do not know
- Healthy low cost meal awareness, low cost exercise places.
- Go the gym three times a week
- Healthcare needs to be more affordable.
- I don’t know
- We need more outreach help. Also a need for Public transportation
- Increase on-demand transportation options for medical appointments. Increase availability of behavioral health treatment and continue to improve integration of behavioral health into primary care practices. Work to address systemic poverty. Increase interventions for children with high ACEs scores.
- Public transportation, mobile addiction treatment, better public outreach...go to where the problems are, more trauma based therapy for youth.
- Better mental health care Access- someone to tell you how to find services out there
- Education
- No clue. Until people are able to get better jobs with health care or more affordable health care I don't see any way to improve health.
- It would be nice to have other doctors come to county for office hours. It would be nice to offer wellness and educational programs in Caroline County instead of always driving to Easton.

- Lower taxes to attract more businesses and residents! poor county / highest taxes ?!?!? go hand in hand!!
- More bus routes that are easier to use and less restrictive as far as "who" can ride, and with less wait times.
- Need transportation for the elderly who do not have Medicaid; our Veterans do not have transportation to Cambridge or across the bridge; better mental health programs for Veterans that are accessible in County. Transportation is desperately needed for non-Medicaid people over 55 to go to the store (grocery) pharmacy and local physicians. More cost-effective medical programs for this population. Our County has a very high level of Medical Assistance residents and the "gray-area" people do without the programs they need.
- - keep and expand community health service like family planning, preventive health screenings, cancer screenings - Promote community education on health promotion, disease prevention (topics like diabetes, pre diabetes, obesity, tobacco/nicotine/Juling, nutrition, physical activity) - We need an indoor pool -- place for kids to learn to swim and for families and individuals to exercise - transportation barriers need addressed - encourage and offer incentives for doctors, especially specialists to practice on the shore and stay
- More dr's are needed for this area
- Free Healthcare to the elderly (65 years and older)
- TRANSPORTATION, EXERCISE AWARENESS SUCH AS PUBLIC ACTIVITIES
- Weekend dr hours outside of urgent care. Traveling dr would be amazing that does house calls
- Increase the amount of specialists available: OB/GYN, Pediatricians, Primary Care, ENT, GI
- access to mental health providers
- We need to develop a true system of transit. We have services in some of the town centers but getting to them is challenging.
- School based health care centers with mental and behavioral intervention support; more access to drug and alcohol treatment.
- Free health care, without financial limits
- enhanced transportation, local specialists, in county ob/gyn
- Transportation is a real issue. Use of MA Transportation is riddled with rules that impede actual use for our most vulnerable residents-- if someone has a car in their name, they can't use it (think about when the person has a setback in health and they are unable to drive for a period of time-- they would either have to sell their car, which doesn't make sense, or they just can't access MA Transportation at all-- even if they have proof that they are unable to drive and they have straight MA). Many clients simply stop going to the doctors because they don't have a reliable way to get to appts-- this leads to premature institutionalization when health declines and diseases are exacerbated due to lack of medical monitoring and treatment.
- To motivate people to take it upon themselves to have good health. "You can lead a horse to water but you can't make him drink"

- Don't know
- More outreach needs to be done for the community. I work for the Medicaid Department at the
- County Health Department and a lot of the community do not know that we are available to help them sign up for health insurance.
- Mobile health unit, outpt clinics, with scheduled transportation
- TRANSPORTATION TO HEALTH CARE FROM A PATIENT S HOME. SECONDARY INSURANCE FOR MEDICARE WITH PRE EXISTING HEALTH PROBLEMS.
- More Primary Care practices. Let's look in to Holistic & Naturopathic. So many issues that could be corrected by holistic health means- improved mental health, obesity etc.
- CLINICS AT THE HEALTH DEPT
- More availability of providers & not being put on a waiting list. More flexible transportation Understanding of conditions/diagnosis
- Need Behavioral Health services

Dorchester County Comments

- Increase transportation options, more physicians
- More resources for Diabetes/ High Blood Pressure patients. Increased accessibility to informational and exercise programs.
- I would talk with Church leaders to have an exercise or activity program. Go walking with your neighbor. Be aware of the health content of products "Read everything"
- The suggestion I have is better transportation, have several different times throughout the day that a medical bus can be taken to doctor offices with different pick up and drop off areas where patient can get bus from and bus should make stops to all medical doctors in Cambridge.
- More accessible health care and more providers. New construction for medical offices.
- More options to eat healthy at reasonable cost
- More job opportunities. Increased community services.
- Promote more of what we have to offer now.
- To move forward with the Shore Health new building and access to doctors in one area
- More availability to teledoctors or satellite clinics. Health Dept. to expand services to assist the public in guiding people to needed services and offer classes/education (cpr, nutrition, stds, family planning, etc.). Additional staff & area to expand clinic so more people can be seen.
- Our community needs more specialist in the area. To go to a specialist, we need to travel to other counties and transportation is an issue for many residents.
- Not Sure

- Make insurance affordable, especially for seniors.
- Improve transportation to include weekend transportation
- At this time, I think it would be important to have more access to a physicians in the local community.
- 1) I don't know if this is still a problem, but 3.5 years ago, there was no availability of in-home speech and occupational therapy services that accepted United Healthcare insurance; my husband could only get in-home physical therapy and skilled nursing services even though he had a great need for continuation of OT and speech therapy services that he had been receiving while in-patient. 2) Shore Rehab only offers 40 minute therapy sessions while other PT providers in the area offer 1 hour sessions. Since our insurance covers the 1 hour sessions, but is limited to number of days of therapy, it is more beneficial for a patient to seek PT services elsewhere, even though the staff is great at Shore Rehab.
- Shore home health care need to more helpful
- A community pool in northern co
- No idea- awareness campaigns for eating healthy, no smoking, it's just a very poor place in general with many homeless who probably prefer not to be seen or participate in any programs. Education and employment opportunities and/or a willingness to work at jobs migrant workers previously held, who are now prohibited from entering the US to fill. It's a generational thing around here, sadly.
- More and better jobs. More and better education. More and better access to health care.
- Stop all the drug use
- Affordable health insurance, medical provider in Hurlock, safe place for senior citizens to walk.
- Do not get rid of facilities Many citizens live 45-60 minutes away from Cambridge and adding a 20 minutes' drive to Easton or 40 minutes' drive to Salisbury would jeopardize their health care
- There is a group of ladies that go with people to the doctors and help them learn about their health and they use to be ABC but I am not sur if the name now because it changed to Eastern Shore something, but their program is really helpful because me and my mom were able to work with them and now my mom is off of her High Blood Pressure Meds and I have lost 34 pounds through their program.
- Establish high performance heath call center for system to include all physician medical groups - including independent groups.
- Collaborate with EMS services to include screening & preventive services and establish referral process to outpatient services such as CP Rehab & Diabetes Center.
- Increase access to community education and health screening & preventative services.
- Creative solutions like mobile healthcare
- Need physicians in local doctor offices, vs. Nurse practitioners.
- We desperately need more facilities to help those with mental illness and addiction.
- Higher wages for techs to get a better pool of people to apply
- Effective ways of fighting disparities in people of color, which is another way of saying color discrimination in health care

- Affordable public transportation other than MA, due to the fact that it's an all-day process and becomes difficult with parents that have other children and lack of support.
- Transportation available to & from doctor's office to be made more convenient & available at very low cost or free.
- Stricter alcohol & tobacco sales (check ID on everyone).
- People need to start helping themselves also
- Educate the people here to care about their health and increase nutritional classes
- I think that healthcare should be free for all.
- More specialists having hours in Dorchester County; more flexible public transportation
- More farmer's markets and more availability to them in season. Obesity from poor eating choices is a huge issue but I honestly don't know how to address it; it is now a generational issue.
- Safer places to walk without having to run from dogs. Having access to the Cambridge Bridge. More sidewalks on side streets to give neighborhoods access to walking.
- I think if we make patients medication more affordable and physicians are able to spend more time with their patients we would have less readmissions and less patients going to the Emergency Room instead going to PCP.
- Partner with pharmacies more
- Correct items listed above (survey questions)
- Education
- Have more minority and culturally competent professionals and staff. Individuals with compassion and empathy and are willing to learn and understand the culture of those in this community.
- Not sure at the moment
- More support groups and seminars to the general public with information on fighting poverty
- I find that a lot of people that live in Hurlock do not have transportation... So having monthly farmer markets or resource health fairs would be nice. Also the teenage population middle and high school do not have anything recreational to do that would improve their health and keep them out of trouble.
- Awareness of ACES - Adverse Childhood Experiences and their impact on health; tougher child welfare laws so children are truly protected; more mental health services available in schools; trauma informed schools
- Access to Free or Reduced cost Mental Health
- More Prevention for Children (mentors, character counts)
- Anonymous Mental Health
- Free or Reduce Health Care Clinic
- Better programs to address obesity.

- More access to mental health programs.
- Develop a health food store that has lower costs (Similar to Superfresh or Whole Foods), allow individuals who have Medicare and Medicaid to use their health insurance benefits towards the cost of healthy foods to improve their health, increase door to door transportation for individuals who have disabilities or limited mobility; give health-related business incentives and tax deductions for moving to Dorchester County, improve the communication with County and the City of Cambridge to help senior citizens and individuals who have disabilities navigate necessary services within the community; and give employers incentives for becoming disability friendly.
- Mobile screening trailers, education in schools and health fairs
- MORE DRUG ADDICTION RESOURCES AND EDUCATION
- Medical uber
- More diabetes education during the day. Some people can't drive at night
- Make hours more convenient. People that work cannot take off 8-4:30. Need later hours 2-3 days a week. This goes for doctors and physical therapy. Maybe until 6-6:30.
- Provide additional services to small business owners, provide programs and services to those middle income bracket families not just those in poverty, better school system discipline to not tolerate disruptions to other students.
- Educate /motivate people to get jobs as opposed to trying to work the system to stay at home and live off the government and hand-outs. Understand there are people in need, but many who just prefer not to work.
- Education, Healthy Lifestyles that are affordable.
- Need more primary care options
- It is estimated that in the next 20-30 years the number of people with Alzheimer's disease and related Dementias will triple. Our community will be significantly impacted by this because of a vast percentage of our population being 65+. More work needs to be done to educate the community about cognitive impairments and how to care for those suffering from them.
- Help people with no insurance and help to get healthy food cost down
- Universal healthcare

Kent County Comments

- Keep our regional hospital
- That Chestertown have a hospital serving the needs of the community and county. You are NOT providing adequate health care to Kent County!!!
- Keep the hospital open!
- More comprehensive services at the local hospital like 25/7 emergency cardiac care. Closer access to trauma services, transportation, better access to GOOD specialists.

- Keep the hospital open as full care facility.
- Give more educational programs at a time and location that people can attend
- If going to make current hospital an emergency room only then have Dr who look like Dr. Not sloppily dressed and appears to be dirty like the one who treated my brother in law last month.
- Free day care.
- This is a fairly affluent community, obesity a problem in some areas. Information is not readily accessible
- more doctors
- Keep the hospital open and viable. Make access to specialists possible to people who do not have transportation to urban areas and teaching hospitals.
- Better education and communication
- More health expos, and doctors' seminars on public health issues.
- Mental health awareness, pediatric specialist for mental health
- Adult fitness facility.
- Stop the downgrading of the hospital in Chestertown. Only a glorified emergency room and not much else (too few inpatient beds and backup services for them and the ER) are not acceptable, with the situation downright dangerous. For the first time in my 65+ years I have no primary-care provider as there are only waiting lists for the creditable ones (internists esp.). Traveling 35 miles or so for one is not realistic.
- Retain inpatient and outpatient care at the hospital and open an urgent care clinic
- We need more doctors in and nearer to Kent County.
- Keep our hospital. Many seniors move here because of availability of community hospital. They bring $s and intellect via volunteering and participation.
- Clearly you have skewed these questions to reach a foregone conclusion. The real problem in County revolves around the downgrading of our hospital from an excellent facility to one to be avoided. Patients did not used to be shipped to Baltimore to get basic services, now they are. Patients did not used to travel to Middletown, De to see a doctor, now it is commonplace. Patients did not travel to Christiana Hospital for care except in special circumstances, now they must just to get basic hospital services.
- A viable hospital that plays an integral role in the community's health.
- Keep hospital in Chestertown.
- Keep our Hospital providing quality inpatient care. Encourage new Primary Care Physicians to come to town.
- Prioritize prevention through the Health Departments.
- Maryland state support of the hospital in Chestertown to ensure it will always provide inpatient care, including ICU; increased telemedicine (nephrology, behavioral, neurology, gerontology); 24/7 on-call cardiology, general surgery, orthopedic surgery; 911 responders to evaluate medical, mental, dietary,

housing, transportation & other needs of frequent Emergency Dept. patients & hospital inpatients; increased availability inpatient addiction services.

- Reinstate pediatrics at the hospital in Chestertown. More PCPs in/near County. More mental health providers, including prescribers in/near County.
- more doctors
- Provide financial incentives for medical professionals to locate to rural areas to county. There is currently a lack of general practitioners as well as specialists. Wait times are often very long. The local hospital is a must. We need a place to get prolia for our aging population. The UMMCG offices in Chestertown and Denton and Centreville should be able to provide this service in their office. My mother fell and broke her hip because she hasn't been able to get her shot in over a year due to constraints in transportation to Easton to get it. This is ridiculous
- We need more primary care doctors that are accepting new patients. So many of the established practices aren't available to new residents or those who've changed insurance, etc.
- We need an urgent care facility
- Urgent care center, open to those with or without insurance with same care quality to both.
- Consider a partnership of care with the Elkton Hospital. In addition, satellite offices for routine care and surgical follow ups, at minimum 2 times a week. A few young mothers would like to see a certified mid-wife clinic for pre-natal care. Note: there is no pediatric emergency care in Chestertown.
- More accessible mental health nearby and need for walk in clinic to handle non-emergent health situations
- More job opportunities as well as safe things for kids to do when not in school
- Encourage healthier eating and weight management. Obesity a huge issue.
- There needs to be an urgent care nearby. I have to drive an hour with sick kids when they wake up sick or get sick on the weekend.
- Chestertown needs to retain in-patient beds and bring more doctors to the area
- Keep our hospital open, and run it as a full hospital not like an ER! ! !
- Stop prohibiting reasonable growth of the economy with new jobs - jobs here mean money stays here which means people can afford to pay for doctors. Also great for mental health.
- Keep access to specialists/hospital/ER in Chestertown Increase availability of primary care in Chestertown
- Urgent Care in Chestertown
- Revitalize Chester River Hospital. Clean it up and paint it. Recruit more specialists.
- Please keep our hospital open. We desperately need a hospital here.
- Walk in Clinics

- Unsure, only have been here less than two years. However, my health declined after we moved and I was fortunate to have the hospital here where I received a timely diagnosis of acute PE and DVT that likely saved my life.
- Please have more specialists come to Chestertown from Easton! Indoor walking area and/or place to exercise as not everyone can afford Aquafit.
- Identify people who are not getting health promotion and illness care and the reasons. Public education through the school system, community center, health fairs, other public gatherings. Blood pressure screenings. Home monitoring of patients with chronic disease, free transportation to doctors, clinics, etc.
- Keep the Chestertown hospital open for inpatient care.
- Get people to move, more than just to the next meal
- Education 2.) Gov't assisted healthcare or discounted healthcare services to those who qualify 3.) Health Club Membership supplied by business, education circulated to employees, incentives to practice good health, nutrition & exercise
- More and better employment affording better access to health care.
- Recruit more doctors to the area.
- More doctors or nurse practitioners throughout the counties.
- Keep Chestertown inpatient hospital open permanently
- Need more primary care providers.
- need more PCP's accepting new patients, need reliable public transportation, increase ways for people to get more exercise...better walkability
- SRH put more money into recruiting physicians
- Shore Regional Health is destroying our hospital, bit by bit. Rather than assigning doctors and services to the County area, it is systematically moving these to Easton. This in turn destroys our community and our future economic development. This is the big problem!
- Put the hospital back as a full service acute hospital with inpt beds and an icu
- Better access to mental health services
- Keep the hospital open and provide universal healthcare
- Keep the Chestertown hospital open as a real hospital, not just as a glorified emergency room. Attract general practice and specialty doctors to the community. I no longer have a doctor because mine opted recently for a VIP practice that costs a ridiculous amount annually on top of what I already pay for insurance. Other doctors aren't taking new patients.
- More public education, more preventive medicine, more specialists in town.
- Improve interaction with the black community. Bring businesses in that will increase job opportunities.
- There needs to be more health education during school for kids as after school for the parents. Health starts at home and if parents are not educated, that means their children are not and then unhealthy habits continue to form.

- Outdoor health awareness Fair in Rock Hall
- There is a problem with affordable healthcare and access to medical care.
- The local hospital in Chestertown has cut back on basic services and in house. People have to go to Easton, Annapolis or Baltimore for hospital care. Transportation is a problem. We need our hospital to restore the level of services that it once had. We have a college in town and a high percentage of seniors and working people.
- Keep the local hospital - in Chestertown - open
- Keep our hospital open, with full service so we don't have to leave area for another provider.
- Improve public education to help break the cycle of poverty.
- Recruit more doctors for the county. Keep the hospital in Chestertown open for inpatients since we are an aging county, including all the residents of Heron Point Assisted Living.
- Keep local hospital open for emergency, outpatient and acute care services. 2. Provide more outreach programs and education. 3. Utilize part or hospital as inpt rehab. 4. Utilize hospital as inpatient drug/ behavioral health rehab. 5. Recruit more family practice physicians. 6. Use hospital as teaching hospital for med school residents.
- Through the community organizations determine the greater need, then focus that need for ways to improve, then take the next need.
- Better mental health services and addiction services on the eastern shore.
- Keep Chestertown Hospital open and fully functional, i.e., maintain inpatient hospital beds, hire more physicians to replace those who have retired or moved from the area.
- We need gerontologist!! We have a very large retiree population. We need dialysis, midwife (at least), labor/delivery, ER, inpatient, in addition to what is already offered....all at a minimum.
- More general practice doctors. Advertise hours and availability of specialist.
- Transportation schedules posted in more areas.
- For the State of Maryland to support financially keeping the Chester River Medical Center a hospital with inpatient beds, an ICU, surgery services.
- Should be general practitioners and medical specialists in the community and a viable hospital.
- Keep inpatient beds in Chestertown
- Improve medical availability of County Hospital.
- More services/Doctors in Chestertown so people do not have to DRIVE to Easton! The community transportation is a joke!!
- Education from birth until death.
- Keep Chestertown hospital inpatient care.
- More robust hospital services and access to specialists

- Lower cost healthcare, more specialty physicians here in County, and an emergency room where you can actually get help.
- expand and improve the hospital the rest will follow
- More jobs with health insurance; many jobs are with small businesses and their health care supplements are very expensive for their employees
- Keep the Hospital.
- We need a real hospital and access to specialist
- Make sure the hospital in Chestertown remains open.
- Get/keep doctors at the Chestertown hospital. Require UMMS Residents to rotate to C'town. Some may actually enjoy living here. Set up medical school loan forgiveness program and allow docs to live in the houses the hospital bought for free for a period of time.

Talbot County Comments

- Have professional doctors address problems just as well as they do in the big cities.
- Need a paramedic on the ambulance crew in Oxford, MD
- none
- Have affordable healthcare options available for everyone. Healthcare is very expensive for most people.
- one of the problems in addition to those checked off above has to do with attitude and compliance on the part of the community members - see so much of noncompliance
- Transportation and awareness of how to access it.
- Improved access to affordable housing and healthy food. Equitable health practices would be a good start to address racial inequities and discrepancies.
- Give us more doctors, not just PA's who are here only temporarily. I have had 2 in the last 6 months and Mother has had 2 also. The reason we left our primary doctors in the first place was because we went with your Health Advantage Plan. Which did us a lot of good since you dropped the plan anyway leaving us hanging and stuck with Medicare only.
- Improved transportation
- Need more GP's
- Aggressive programs focused on people under the age of 30 in terms of healthy lifestyle, diets, and habits.
- With the exception of the poor and impoverished, I believe most people in County manage to receive health care though there seem to be very few doctors accepting patients, particularly those with Medicare.

- -coordinated behavioral health services / improved SUD screenings at ER -community health interventions focused on achieving health equity - increased health education programs on chronic disease prevention (stress importance of cancer screenings) Increase rates of adults insured -STI prevention -improve food environment -More culturally competent care
- Educating the poorer public
- Thankfully a community health care facility was opened in the elementary school on the island -- a huge help for the aging population and others without transportation. That was a big factor, in my opinion.
- More urgent care offices and available transportation to them. The availability of seeing a doctor over the internet instead of going into an office.
- Make it easier to obtain treatment for drug addiction. Have clinics for those with no health insurance.
- Have enough culturally sensitive primary care providers accepting new patients and accepting all insurances. Have the UM system run a bus daily to transport people to and from appointments (or send an Uber)
- Don't know
- Have affordable health care facilities available 24 hours a day other than the Emergency Room. Have area transportation options.
- Affordable public transportation for every neighborhood locally
- Education and incentives to improve diet and quit smoking.
- Free health clinics
- More Family physicians
- Health prevention education, nutrition education, community fitness challenge

Queen Anne's County Comments

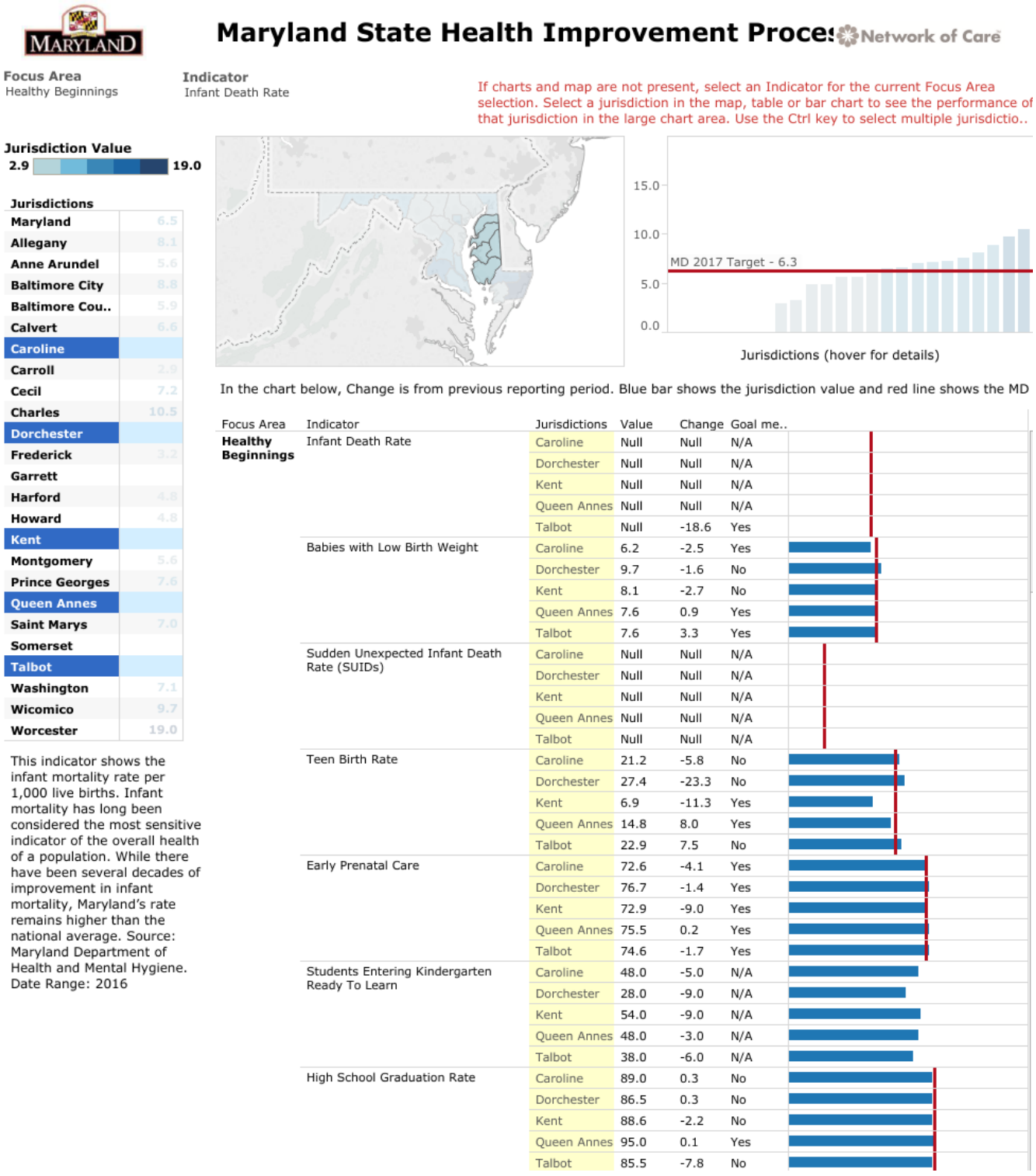
- more LOCAL doctors in 21620 Not an hour away
- Make Chestertown Hospital a true center for treatment of all medical problems of the community from prenatal to geriatrics.
- Offer more clinics at the Health Dept. (i.e. Diabetes management/ education, weight management/ access to weight loss programs at low to no cost). Also, increase funding for senior services.
- Access to maternity care. Access to specialists. Inpatient hospital beds. With a college, a senior community, and minority population, serious consideration for all aspects of health care.
- rural health clinics that could do routine healthcare, education of public on value of midwife/douma as
- alternative to hospital delivery

- An independent urgent care center would be life changing
- Need to recruit more primary care physicians to the area & promote health care programs. More Health fairs should be scheduled
- need urgent care
- Keep Chestertown Hospital
- Open the Chestertown hospital
- More health fairs. More Doctors with practices here on Kent Island
- Seeking better health and wellness planning.
- Have a hospital that is functioning as it used to. My 1 depression day was due to none responsiveness of
- Community scheduling. Also was unable to talk to an operator at hospital as machine had a message no one called back from either place although I left my name and phone number as directed.
- Bring health care down make it affordable I don't mean that stupid Obama plan either that was highway robbery. Talk about being stabbed in the back that was a criminal act. Can afford insurance and then got fined anyway. So then my children went without insurance and paid the fine because that was cheaper.
- No ideas
- Walk, socialize
- Lower cost of in-hospital care (i.e. $2,000 for "OR “expense alone for routine colonoscopy is far too high.
- Better water drainage
- More free health assessments given through schools or churches in area.
- Keep the Chester River Hospital open as a functioning hospital. ..not just an Emergency Hospital....more specialists, neurologists, cardiologists, surgeons.
- Safer sidewalks for outdoor walking, a health food store, and organized walking groups. Place to walk indoors would be wonderful.
- Don't have any right now
- Keep the hospital in Chestertown
- Public transportation
- More quality physicians.
- More affordable public health insurance. More access to mental health services on the Eastern Shore.
- Need a walk in after hour walk in clinic.
- Keep doctors… need geriatricians, cardiologists, primary care providers
- Please hire doctors for our hospital in Kent Co. You are closing a vital need for us.
- Develop easier access to food pantries that have fresh foods and heart healthy options.

- Develop transportation specifically for health care related visits.
- Better transportation for those who need public transportation.
- Mental health events for stress and anxiety.
- Stress and anxiety free zones/socials
- Affordable health care
- Increase availability of PCP in QAC
- More doctors accepting Priority Partners and Maryland Smile.
- Make sure the local hospital is not closed.
- Lower Rx costs. Transparent and published fee schedules to allow comparative shopping.
- Better transportation for people to get to/from dr appts. 2. Expansion of the cardiopulmonary rehab program at hospital
- Add community health clinics in the local health department. There are few local physicians and even fewer specialty care providers in County.
- More mental health service providers that accept patients with and without insurance, using sliding scale where necessary More awareness raising (advertising, awareness days, open houses, community events) re mental health services Chesapeake College is good location, larger venues in designated zip codes. Awareness raising campaigns of the value of exercise wherever and however you can find it - walking, dog walking, parking further away, reduced screen time exchanged for movement, convey the idea that you don't have to join a club or pay a fee to get movement in your day, raise awareness of improving nutrition - more home cooked food, what is a good grocery list, how to keep costs down when grocery shopping,
- Continued efforts to meet people on their 'turf'. Bi lingual contact needs to be improved
- Clinics or options that are on a sliding fee scale for those with little income and poor or no insurance.
- I know that there is a focus on affordable housing, but the continued development of high density housing without any supporting infrastructure is a serious issue effecting all aspects of life.
- none
- Access to high quality healthcare. Drs, specialist, etc have no reason to move to this area.
- Invest in the local hospital so that people in outlying areas have reasonable access. Bring obstetrics back to Chestertown. Refer people who call looking for healthcare to doctors closest to their zip codes. Give signing bonuses to new doctors to practice in outlying areas to make care as easily available as AAMC does, so our patients stay within the system. I hear ALOT of complaints about our ER staff, the rudeness, lack of caring, long waits(which I know are unavoidable at times), but I think we should do more to improve our ER situation and we should have care available for pediatric patients, as I hear a lot of complaints and now hear everyone say "I'll just take them to AAMC", they feel the kids are disregarded and not properly cared for, so I think we should think about a neonatologist on staff, or a small pediatric ER.

- In general, I think we now have the technological ability to do doctor's visits for simple ailments through phone or Internet. This should be both cheaper in the long term, and result in more care, where I might ordinarily wait till offices open back up, or not go at all. For us, living on Kent Island, we are close enough to major hospitals to have our more serious medical needs cared for.
- There seems to be plenty of doctors' offices in the area. Insurance, or lack thereof, has been a limiting factor for myself and my family in the past.
- Bring back services that aren't currently available at the local hospital (Chestertown).
- More activities for children and families to engage in positive, quality time together!

Appendix 2: State Health Improvement Process (SHIP) Measures



Maryland State Health Improvement Proces

Network of Care

Focus Area
Healthy Beginnings

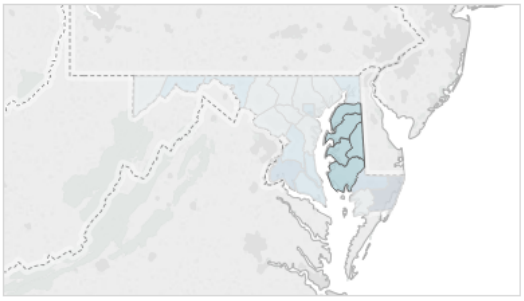
Indicator
Infant Death Rate

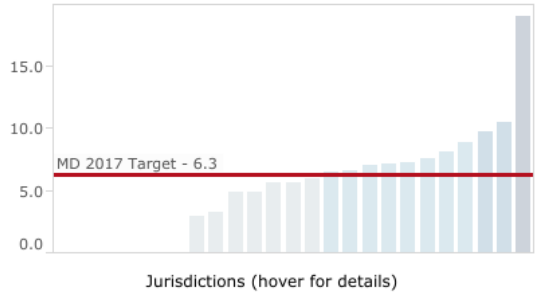
If charts and map are not present, select an Indicator for the current Focus Area selection. Select a jurisdiction in the map, table or bar chart to see the performance of that jurisdiction in the large chart area. Use the Ctrl key to select multiple jurisdictio..

Jurisdiction Value
2.9 — 19.0

Jurisdictions	
Maryland	6.5
Allegany	8.1
Anne Arundel	5.6
Baltimore City	8.8
Baltimore Cou..	5.9
Calvert	6.6
Caroline	
Carroll	2.9
Cecil	7.2
Charles	10.5
Dorchester	
Frederick	3.2
Garrett	
Harford	4.8
Howard	4.8
Kent	
Montgomery	5.6
Prince Georges	7.6
Queen Annes	
Saint Marys	7.0
Somerset	
Talbot	
Washington	7.1
Wicomico	9.7
Worcester	19.0

This indicator shows the infant mortality rate per 1,000 live births. Infant mortality has long been considered the most sensitive indicator of the overall health of a population. While there have been several decades of improvement in infant mortality, Maryland's rate remains higher than the national average. Source: Maryland Department of Health and Mental Hygiene. Date Range: 2016





Jurisdictions (hover for details)

In the chart below, Change is from previous reporting period. Blue bar shows the jurisdiction value and red line shows the MD ..

Focus Area	Indicator	Jurisdictions	Value	Change	Goal me..
Healthy Beginnings	Children Receiving Blood Lead Screening	Caroline	70.7	1.2	Yes
		Dorchester	61.4	1.7	No
		Kent	50.9	-4.0	No
		Queen Annes	61.4	5.2	No
		Talbot	73.4	3.1	Yes
Healthy Living	Adults Who Currently Smoke	Caroline	27.9	4.4	No
		Dorchester	25.7	5.9	No
		Kent	18.0	Null	No
		Queen Annes	16.5	-0.7	No
		Talbot	13.6	Null	Yes
	Adolescents Who Use Tobacco Products	Caroline	19.5	-6.6	No
		Dorchester	25.8	0.9	No
		Kent	20.4	-2.5	No
		Queen Annes	20.7	-3.6	No
		Talbot	16.7	-4.9	No
	HIV Incidence Rate	Caroline	7.3	-3.8	Yes
		Dorchester	36.7	0.0	No
		Kent	5.7	0.0	Yes
		Queen Annes	4.8	2.4	Yes
		Talbot	3.1	-9.2	Yes
	Chlamydia Infection Rate	Caroline	360.1	30.6	Yes
		Dorchester	561.7	-240.2	No
		Kent	326.2	138.2	Yes
		Queen Annes	293.8	45.7	Yes
		Talbot	319.3	33.8	Yes
	Life Expectancy	Caroline	76.1	0.0	No
		Dorchester	76.8	-0.8	No
		Kent	79.6	0.1	No
		Queen Annes	79.4	-0.2	No
		Talbot	81.1	0.3	Yes
	Increase Physical Activity	Caroline	51.8	12.8	Yes
		Dorchester	38.7	6.7	No
		Kent	49.7	8.3	No
		Queen Annes	51.2	1.5	Yes
		Talbot	53.4	4.4	Yes

Maryland State Health Improvement Proces

Network of Care

Focus Area
Healthy Beginnings

Indicator
Infant Death Rate

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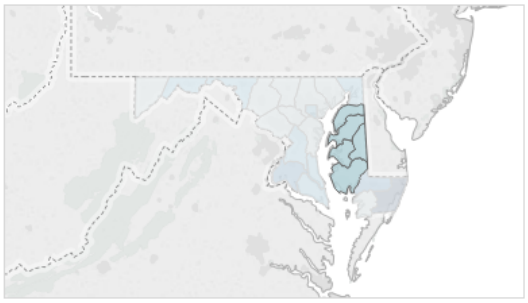
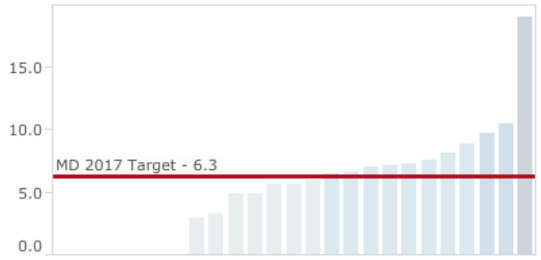
Jurisdiction Value
2.9 — 19.0





Jurisdictions (hover for details)

Jurisdictions	
Maryland	6.5
Allegany	8.1
Anne Arundel	5.6
Baltimore City	8.8
Baltimore Cou..	5.9
Calvert	6.6
Caroline	
Carroll	2.9
Cecil	7.2
Charles	10.5
Dorchester	
Frederick	3.2
Garrett	
Harford	4.8
Howard	4.8
Kent	
Montgomery	5.6
Prince Georges	7.6
Queen Annes	
Saint Marys	7.0
Somerset	
Talbot	
Washington	7.1
Wicomico	9.7
Worcester	19.0

This indicator shows the infant mortality rate per 1,000 live births. Infant mortality has long been considered the most sensitive indicator of the overall health of a population. While there have been several decades of improvement in infant mortality, Maryland's rate remains higher than the national average. Source: Maryland Department of Health and Mental Hygiene. Date Range: 2016

In the chart below, Change is from previous reporting period. Blue bar shows the jurisdiction value and red line shows the MD ..

Focus Area	Indicator	Jurisdictions	Value	Change	Goal me..
Healthy Living	Adolescents Who Have Obesity	Caroline	16.0	2.1	No
		Dorchester	18.6	1.4	No
		Kent	14.4	1.6	No
		Queen Annes	11.1	-0.6	No
		Talbot	12.0	1.7	No
	Adults Who Are Not Overweight Or Obese	Caroline	26.0	4.8	No
		Dorchester	28.6	3.0	No
		Kent	39.9	12.7	Yes
		Queen Annes	34.1	1.2	No
		Talbot	32.5	-8.3	No
Healthy Communities	Child Maltreatment Rate	Caroline	13.5	0.3	N/A
		Dorchester	17.2	1.2	N/A
		Kent	8.0	-1.7	N/A
		Queen Annes	3.0	0.1	N/A
		Talbot	4.3	-1.9	N/A
	Suicide Rate	Caroline	Null	Null	N/A
		Dorchester	Null	Null	N/A
		Kent	Null	Null	N/A
		Queen Annes	Null	Null	N/A
		Talbot	Null	Null	N/A
	Domestic Violence	Caroline	350.1	-31.0	Yes
		Dorchester	632.4	43.0	No
		Kent	268.6	-74.5	Yes
		Queen Annes	329.0	19.6	Yes
		Talbot	136.8	-78.4	Yes
	Children With Elevated Blood Lead Levels	Caroline	0.3	-0.3	Yes
		Dorchester	0.3	0.1	Yes
		Kent	Null	Null	N/A
		Queen Annes	0.3	Null	Yes
		Talbot	0.3	0.1	Yes
	Fall-Related Death Rate	Caroline	Null	Null	N/A
		Dorchester	Null	Null	N/A
		Kent	Null	Null	N/A
		Queen Annes	Null	Null	N/A
		Talbot	Null	Null	N/A

Maryland State Health Improvement Proces

Network of Care

Focus Area
Healthy Beginnings

Indicator
Infant Death Rate

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2.9 — 19.0

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Baltimore Cou..	5.9
Calvert	6.6
Caroline	
Carroll	2.9
Cecil	7.2
Charles	10.5
Dorchester	
Frederick	3.2
Garrett	
Harford	4.8
Howard	4.8
Kent	
Montgomery	5.6
Prince Georges	7.6
Queen Annes	
Saint Marys	7.0
Somerset	
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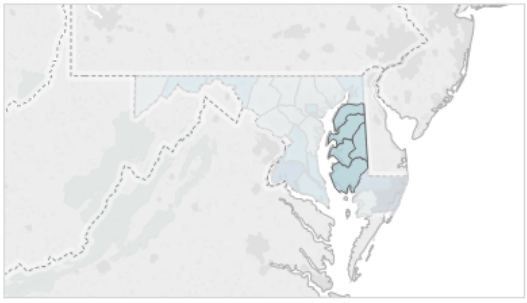

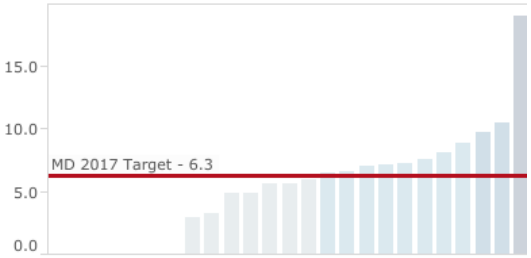

Jurisdictions (hover for details)

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Focus Area	Indicator	Jurisdictions	Value	Change	Goal me..
Healthy Co mmunities	Pedestrian Injury Rate On Public Roads	Caroline	Null	Null	N/A
		Dorchester	Null	Null	N/A
		Kent	Null	Null	N/A
		Queen Annes	Null	Null	N/A
		Talbot	Null	Null	N/A
	Affordable Housing	Caroline	79.0	2.0	Yes
		Dorchester	64.8	-1.6	Yes
		Kent	56.5	5.6	Yes
		Queen Annes	38.2	5.6	No
		Talbot	38.9	-0.6	No
Access to Health Care	Adolescents Who Received A Wellness Checkup In The Last Year	Caroline	63.5	-0.9	Yes
		Dorchester	59.1	-3.6	Yes
		Kent	48.4	-1.7	No
		Queen Annes	51.5	-0.7	No
		Talbot	61.8	-1.4	Yes
	Children Receiving Dental Care In The Last Year	Caroline	68.9	-3.2	Yes
		Dorchester	66.3	-2.4	Yes
		Kent	72.1	0.2	Yes
		Queen Annes	68.4	-1.5	Yes
		Talbot	72.1	-1.1	Yes
	Persons With A Usual Primary Care Provider	Caroline	88.8	6.0	Yes
		Dorchester	83.6	-5.4	No
		Kent	94.2	-1.3	Yes
		Queen Annes	89.6	1.0	Yes
		Talbot	85.5	-8.6	Yes
	Uninsured ED Visits	Caroline	7.1	0.3	Yes
		Dorchester	6.1	-0.7	Yes
		Kent	4.0	-0.7	Yes
		Queen Annes	5.8	0.7	Yes
		Talbot	6.6	0.0	Yes
Quality Preventive Care	Emergency Department Visit Rate Due to Diabetes	Caroline	244.2	33.3	No
		Dorchester	455.4	86.4	No
		Kent	209.4	-140.9	No
		Queen Annes	154.2	28.4	Yes
		Talbot	276.4	52.1	No

Maryland State Health Improvement Proces

Network of Care

Focus Area
Healthy Beginnings

Indicator
Infant Death Rate

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Frederick	3.2
Garrett	
Harford	4.8
Howard	4.8
Kent	
Montgomery	5.6
Prince Georges	7.6
Queen Annes	
Saint Marys	7.0
Somerset	
Talbot	
Washington	7.1
Wicomico	9.7
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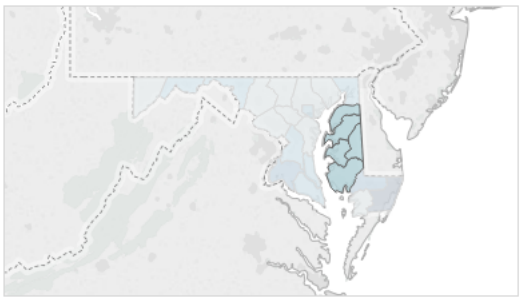
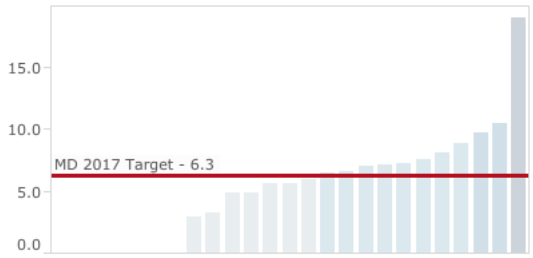
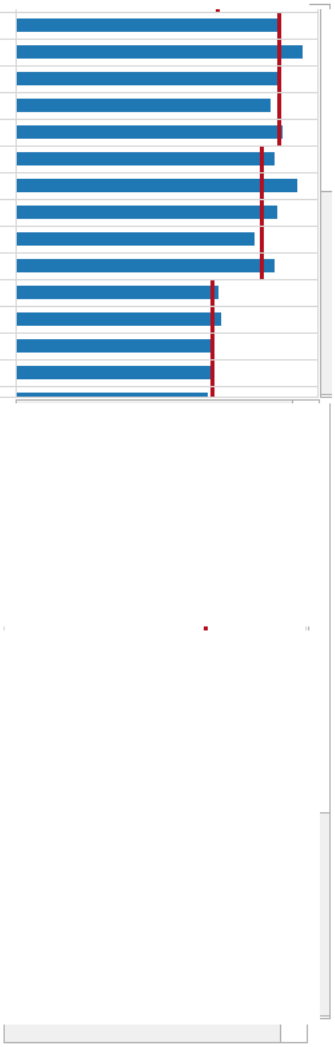




Jurisdictions (hover for details)

In the chart below, Change is from previous reporting period. Blue bar shows the jurisdiction value and red line shows the MD ..

Focus Area					
Quality Preventive Care	Emergency Department Visits for Addictions-Related Conditions	Caroline	1311.1	38.5	Yes
		Dorchester	3120.7	869.5	No
		Kent	1538.3	-3.6	No
		Queen Annes	1048.9	-92.4	Yes
		Talbot	1587.6	41.5	No
	Emergency Department Visit Rate For Dental Care	Caroline	1225.2	56.1	No
		Dorchester	2659.4	13.1	No
		Kent	1359.6	-216.1	No
		Queen Annes	624.9	-61.5	Yes
		Talbot	1246.3	198.0	No
	Cancer Mortality Rate	Caroline	178.3	4.8	No
		Dorchester	196.9	1.7	No
		Kent	147.8	-1.9	No
		Queen Annes	152.4	-8.0	No
		Talbot	127.9	-15.9	Yes



Appendix 3: Social Determinants of Health

County Health Rankings & Roadmaps

	Maryland	Caroline (CR),	Dorchester (DO), MD	Kent (KE), MD	Queen Anne's (QA),	Talbot (TA), MD X
Health Outcomes		**22**	**21**	**16**	**9**	**10**
Length of Life		**23**	**19**	**14**	**11**	**9**
Premature death	6,500	9,500	8,000	7,000	6,700	6,200
Quality of Life		**20**	**22**	**19**	**6**	**9**
Poor or fair health	14%	18%	18%	14%	11%	12%
Poor physical health days	3.1	3.9	3.6	3.1	2.9	3.1
Poor mental health days	3.5	4.6	4.0	3.7	3.4	3.7
Low birthweight	9%	8%	10%	11%	7%	7%
Health Factors		21	22	13	6	7
Health Behaviors		**22**	**21**	**12**	**7**	**5**
Adult smoking	14%	21%	20%	14%	14%	12%
Adult obesity**	29%	37%	35%	30%	29%	28%
Food environment index**	9.1	8.5	7.4	8.9	9.3	8.7
Physical inactivity**	22%	29%	33%	26%	23%	21%
Access to exercise opportunities	93%	39%	72%	61%	81%	75%
Excessive drinking	17%	16%	15%	16%	20%	18%
Alcohol-impaired driving deaths	30%	41%	27%	60%	27%	36%
Sexually transmitted infections**	459.3	292.0	635.4	176.6	202.9	201.9
Teen births	21	29	43	12	14	19
Clinical Care		**24**	**23**	**19**	**10**	**4**
Uninsured	7%	9%	9%	9%	6%	8%
Primary care physicians	1,140:1	2,710:1	2,940:1	1,100:1	2,720:1	1,100:1
Dentists	1,320:1	1,930:1	1,790:1	2,470:1	2,720:1	1,240:1
Mental health providers	460:1	2,530:1	470:1	580:1	1,060:1	240:1
Preventable hospital stays	47	75	81	59	49	49
Diabetes monitoring	85%	86%	85%	86%	89%	89%
Mammography screening	64%	63%	69%	68%	63%	75%
Social & Economic Factors		**19**	**22**	**13**	**6**	**11**
High school graduation**	87%	89%	86%	93%	95%	93%
Some college	69%	44%	55%	59%	65%	61%
Unemployment	4.3%	4.7%	6.0%	4.7%	3.8%	4.1%
Children in poverty	13%	22%	29%	20%	9%	16%
Income inequality	4.6	4.2	4.7	4.7	3.7	5.0
Children in single-parent	34%	39%	45%	36%	24%	38%
Social associations	8.9	11.4	11.1	14.7	8.2	13.1
Violent crime**	465	317	466	314	218	229
Injury deaths	64	91	71	88	71	54
Physical Environment		**19**	**15**	**10**	**4**	**2**
Air pollution - particulate matter	9.5	9.1	8.8	9.5	9.4	8.9
Drinking water violations		Yes	Yes	Yes	No	No
Severe housing problems	17%	19%	20%	16%	14%	18%
Driving alone to work	74%	83%	79%	68%	79%	80%
Long commute - driving alone	49%	47%	38%	34%	55%	31%

Technical Notes and Glossary of Terms

What is health equity? What are health disparities? And how do they relate?

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Health disparities are differences in health or in the key determinants of health such as education, safe housing, and discrimination, which adversely affect marginalized or excluded groups.

Health equity and health disparities are closely related to each other. Health equity is the ethical and human rights principle or value that motivates us to eliminate health disparities. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? And What Difference Does a Definition Make? Robert Wood Johnson Foundation. May 2017

How do we define racial/ethnic groups?

In our analyses by race/ethnicity we define each category as follows:

- Hispanic includes those who identify themselves as Mexican, Puerto Rican, Cuban, Central or South American, other Hispanic, or Hispanic of unknown origin.
- American Indian/Alaskan Native includes people who identify themselves as American Indian or Alaskan Native and do not identify as Hispanic. This group is sometimes referred to as Native American in the report.
- Asian/Pacific Islander includes people who identify themselves as Asian or Pacific Islander and do not identify as Hispanic.
- Black includes people who identify themselves as black/African American and do not identify as Hispanic.
- White includes people who identify themselves as white and do not identify as Hispanic.

All racial/ethnic categories are exclusive so that one person fits into only one category. Our analyses do not include people reporting more than one race, as this category was not measured uniformly across our data sources.

We recognize that "race" is a social category, meaning the way society may identify individuals based on their cultural ancestry, not a way of characterizing individuals based on biology or genetics. A strong and growing body of empirical research provides support for the notion that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

How did we compare county ranks and racial/ethnic groups for length and quality of life?

Data are from the same data sources and years listed in the table on page 15. The mean and standard deviation for each health outcome measure (premature death, poor or fair health, poor physical health days, poor mental health days, and low birthweight) are calculated for all ranked counties within a state. This mean and standard deviation are then used as the metrics to calculate z-scores, a way to put all measures on the same scale, for values by race/ethnicity within the state. The z-scores are weighted using CHR&R measure weights for health outcomes to calculate a health outcomes z-score for each race/ethnicity. This z-score is then compared to the health outcome z-scores for all ranked counties within a state; the identified-score calculated for the racial/ethnic groups is compared to the quartile cut-off values for counties with states. You can learn more about calculating z-scores on our website under Rankings Methods.

How did we select evidence-informed approaches?

Evidence-informed approaches included in this report represent those backed by strategies that have demonstrated consistently favorable results in robust studies or reflect recommendations by experts based on early research. To learn more about evidence analysis methods and evidence-informed strategies that can make a difference to improving health and decreasing disparities, visit What Works for Health.

Technical Notes:

- In this report, we use the terms disparities, differences, and gaps interchangeably.
- We follow basic design principles for cartography in displaying color spectrums with less intensity for lower values and increasing color intensity for higher values. We do not intend to elicit implicit biases that "darker is bad".
- In our graphics of state and U.S. counties we report the median of county values, our preferred measure of central tendency for counties. This value can differ from the state or U.S. overall values.

2018 County Health Rankings for Maryland: Measures and National/State Results

Measure	Description	US	MD	MD Minimum	MD Maximum
HEALTH OUTCOMES					
Premature death	Years of potential life lost before age 75 per 100,000 population	6,700	6,500	3,700	12,500
Poor or fair health	% of adults reporting fair or poor health	16%	14%	9%	22%
Poor physical health days	Average # of physically unhealthy days reported in past 30 days	3.7	3.1	2.4	4.5
Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	3.8	3.5	2.8	4.6
Low birthweight	% of live births with low birthweight (< 2500 grams)	8%	9%	6%	12%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	% of adults who are current smokers	17%	14%	7%	21%
Adult obesity	% of adults that report a BMI ≥ 30	28%	29%	21%	45%
Food environment index	Index of factors that contribute to a healthy food environment, (0-10)	7.7	9.1	6.1	9.5
Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	23%	22%	16%	33%
Access to exercise opportunities	% of population with adequate access to locations for physical activity	83%	93%	39%	100%
Excessive drinking	% of adults reporting binge or heavy drinking	18%	17%	14%	20%
Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	29%	30%	20%	60%
Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	478.8	459.3	141.5	1,080.3
Teen births	# of births per 1,000 female population ages 15-19	27	21	8	44
CLINICAL CARE					
Uninsured	% of population under age 65 without health insurance	11%	7%	4%	11%
Primary care physicians	Ratio of population to primary care physicians	1,320:1	1,140:1	3,220:1	510:1
Dentists	Ratio of population to dentists	1,480:1	1,320:1	2,720:1	680:1
Mental health providers	Ratio of population to mental health providers	470:1	460:1	2,530:1	240:1
Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	49	47	29	81
Diabetes monitoring	% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring	85%	85%	81%	90%
Mammography screening	% of female Medicare enrollees ages 67-69 that receive mammography screening	63%	64%	59%	75%
SOCIAL AND ECONOMIC FACTORS					
High school graduation	% of ninth-grade cohort that graduates in four years	83%	87%	70%	96%
Some college	% of adults ages 25-44 with some post-secondary education	65%	69%	37%	85%
Unemployment	% of population aged 16 and older unemployed but seeking work	4.9%	4.3%	3.2%	9.0%
Children in poverty	% of children under age 18 in poverty	20%	13%	6%	32%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	5	4.6	3.5	6.3
Children in single-parent households	% of children that live in a household headed by a single parent	34%	34%	21%	64%
Social associations	# of membership associations per 10,000 population	9.3	8.9	5.9	18.2
Violent crime	# of reported violent crime offenses per 100,000 population	380	465	130	1,389
Injury deaths	# of deaths due to injury per 100,000 population	65	64	33	126
PHYSICAL ENVIRONMENT					
Air pollution – particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	8.7	9.5	8.3	11.1
Drinking water violations	Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation.	NA	NA	No	Yes
Severe housing problems	% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities	19%	17%	12%	24%
Driving alone to work	% of workforce that drives alone to work	76%	74%	60%	85%
Long commute – driving alone	Among workers who commute in their car alone, % commuting > 30 minutes	35%	49%	19%	64%

2018 County Health Rankings: Ranked Measure Sources and Years of Data

	Measure	Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Premature death	National Center for Health Statistics – Mortality files	2013-2015
Quality of Life	Poor or fair health	Behavioral Risk Factor Surveillance System	2016
	Poor physical health days	Behavioral Risk Factor Surveillance System	2016
	Poor mental health days	Behavioral Risk Factor Surveillance System	2016
	Low birthweight	National Center for Health Statistics – Natality files	2010-2016
HEALTH FACTORS			
HEALTH BEHAVIORS			
Tobacco Use	Adult smoking	Behavioral Risk Factor Surveillance System	2016
Diet and Exercise	Adult obesity	CDC Diabetes Interactive Atlas	2014
	Food environment index	USDA Food Environment Atlas, Map the Meal Gap	2015
	Physical inactivity	CDC Diabetes Interactive Atlas	2014
	Access to exercise opportunities	Business Analyst, Delorme map data, ESRI, & US Census Files	2010 & 2016
Alcohol and Drug Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2016
	Alcohol-impaired driving deaths	Fatality Analysis Reporting System	2012-2016
Sexual Activity	Sexually transmitted infections	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2015
	Teen births	National Center for Health Statistics – Natality files	2010-2016
CLINICAL CARE			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2015
	Primary care physicians	Area Health Resource File/American Medical Association	2015
	Dentists	Area Health Resource File/National Provider Identification file	2016
	Mental health providers	CMS, National Provider Identification file	2017
Quality of Care	Preventable hospital stays	Dartmouth Atlas of Health Care	2015
	Diabetes monitoring	Dartmouth Atlas of Health Care	2014
	Mammography screening	Dartmouth Atlas of Health Care	2014
SOCIAL AND ECONOMIC FACTORS			
Education	High school graduation	EDFacts	2014-2015
	Some college	American Community Survey	2012-2016
Employment	Unemployment	Bureau of Labor Statistics	2016
Income	Children in poverty	Small Area Income and Poverty Estimates	2016
	Income inequality	American Community Survey	2012-2016
Family and Social Support	Children in single-parent households	American Community Survey	2012-2016
	Social associations	County Business Patterns	2015
Community Safety	Violent crime	Uniform Crime Reporting – FBI	2012-2014
	Injury deaths	CDC WONDER mortality data	2012-2016
PHYSICAL ENVIRONMENT			
Air and Water Quality	Air pollution – particulate matter*	Environmental Public Health Tracking Network	2012
	Drinking water violations	Safe Drinking Water Information System	2016
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2010-2014
	Driving alone to work	American Community Survey	2012-2016
	Long commute – driving alone	American Community Survey	2012-2016

*Not available for AK and HI.

Appendix 4: Community Partner Interviews

UM SRH completed interviews with community partners throughout the region to gain a better understanding of community health needs from the perspective of organizations and agencies that have a deep understanding from their day-to-day interactions with populations in greatest need.

I**nterview questions focused on:**

- Identifying the challenges to improving health and health care for the residents of your community
- Identify opportunities for improving current programs and services, as well as highlight service and program gaps.
- Share ideas for how to improve services and relationships in the community

HEALTH CONDITIONS

1. Substance Use disorders and the increasing risk of Hepatitis C and HIV with intravenous injection of illegal drugs
2. Mental health problems and lack of providers, but especially for children
3. The behavioral, physical, economic and social problems resulting from Adverse Childhood Experiences
4. Obesity and its contributions to multiple chronic conditions such as heart disease, hypertension, cardiovascular disease, renal failure
5. Chronic conditions – co-occurring for more complex management problems
6. Aging and its contributions to chronic conditions and decline of cognitive function
7. Increasing incidence of latent and infectious tuberculosis with immigrant population

LACK of SERVICES THAT IMPACT HEALTH

1. Lack of early appropriate prevention services; lack of utilization when available by some
2. Lack of primary care providers for basic clinical services (prevention and chronic disease management plus acute care services in timely manner)
3. Lack of primary care providers attention to detecting and early management of behavioral health problems
4. Lack of pediatric attention to detecting and early management of behavioral health and developmental problems
5. Lack of access for young children with co-occurring developmental, behavioral and learning disorders to a comprehensive multidisciplinary team for diagnosis and care plans
6. Lack of behavioral health services for all ages but especially for providers that work with parents and children in order to modify child's behavior
7. Lack of obstetric services and ability to access if uninsured in first trimester
8. Lack of integration and coordination of clinical services; lack of integration and coordination of social services; lack of integration and coordination of clinical with social services
9. Gaps in socio-economic support services that impact health: inability to afford medications or primary care co-pays
10. Lack of transportation for medical appointments

11. Lack of interpreter services at some healthcare sites

WHAT WE CAN DO ABOUT IT?

Recurring comments in these conversations included the need to ensure quality of care, build trust with community residents and partners, leverage existing programs, and support innovation.

1. Support Rural Health Collaborative efforts – Social/Clinical Integration of services
2. Support health professions education of local residents ("growing our own")
3. Continue work of the Opioid Taskforce
4. Continue to expand use of telemedicine

Interviews: Jan.-Feb 2019				
Participants Name	Title	Organization	Email	Phone
Mary O'Brien	Program Director	Talbot County Health Dept.	mary.obrien@maryland.gov	410-819-5656
Fredia Wadley	Health Officer	Talbot County Health Dept.	fredia.wadley@maryland.gov	410-819-5606
Kate Stinton	AERS and Care Coordinator	Talbot County Health Dept.	kate.stinton@maryland.gov	410-819-5631
Sarah Cloxtan	TCAP Director	Talbot County Health Dept.	sarah.cloxtone@maryland.gov	410-8195696
Angela Mercier	Health Education Program Manager	Dorchester County Health Dept.	angela.mercier@maryland.gov	410-901-8126
Casey Scott	Deputy Health Officer	Dorchester County Health Dept.	casey.scott@maryland.gov	410-228-3825
Beth Spencer	Social Work Program Administrator	Dorchester County Health Dept.	beth.spenser@maryland.gov	410-901-8177
Roger Harrell	Health Officer	Dorchester County Health Dept.	roger.harrell@maryland.gov	410-228-3223
Nicole Riddleberger	WIC Director	Caroline County Health Dept.	Nicole.riddleberger@maryland.gov	410-479-8091
Linda Adair	Alcohol Specialist	Caroline County Health Dept.	Linda.adair@maryland.gov	410-479-3800
Kat Varga	Intern	Caroline County Health Dept.	Kiv29@cornell.edu	
Leigh Marquess	Director of Wellness	Caroline County Health Dept.	leigh.marquess@maryland.gov	410-479-8080
Edna Garlic	Director of Medical Adult Daycare	Caroline County Health Dept.	Edna.garlic@maryland.gov	410-479-8030
Scott Leroy	Health Officer	Caroline County Health Dept.	scott.leroy@maryland.gov	410-4798030
Jennifer Knapp	Nursing Supervisor Maternal Child Health	Caroline County Health Dept.	Jennifer.knapp@maryland.gov	410-479-8185
Pam Eberhard	CRUP PP/CD	Caroline County Health Dept.	pam.eberhard@maryland.gov	410-479-8124
Don Wilson	Director Environmental Health	Caroline County Health Dept.	don.wilson@maryland.gov	410-479-8049
Joseph Ciotola	Health Officer	Queen Anne's County Health Dept.	jciotola@qac.org	
William Webb	Health Officer		william.webb@maryland.gov	

Susan Johnson	VP of Quality Assurance and Population Health	Choptank Community Health	SMJohnson@choptankhealth.org	
Ashyrra Dotson	President & CEO	Eastern Shore Wellness Solutions	adotson@easternshorewellness.org	410- 221-0795
Katie Dilley	Executive Director	Mid Shore Behavioral Health	kdilley@midshorebehavioralhealth.org	410-770-4801

Appendix 5: Prioritization Process

Prioritization Process

Analysis of the qualitative community data revealed a list of pressing health needs. The next step is to prioritize needs that will be the focus of our community health improvement initiatives. A widely used and referenced quantitative tool (The Hanlon method) was chosen to rank the health-related needs based on select weighted criteria. The goal of this method is to identify and compare the list of community-defined needs in a relative framework, as equally as possible, and in a somewhat objective manner.

Step 1
Committee members receive initial list of community defined needs
Step 2
Members rank community needs individually using set criteria
Step 3
Community Health Planning Council engages in a group prioritization activity to select priorities
Step 4
Results will be used to prioritize needs that will be the focus of our community health improvement plan

Prioritization Criteria

Organizational capacity – hospital has the capacity to address the issue.
Alignment with vision/mission – hospital has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.
Existing collaboration – there are established relationships with community partners to address the issue and existing resources are committed to the issue.

Health Need* (A)	Importance to community* (B) weight 40%	Capacity to address (C) weight 25%	Alignment with vision/mission (D) weight 25%	Existing collaboration/ interventions (E) weight 10%	Final Score (F) Max=100
Score each criterion 0 (very low agreement) to 10 (very strong agreement)					
Access to care	10				Leave blank-Will be calculated
Chronic disease conditions	9				
Preventable ER visits	9				
Mental health/ substance abuse	10				
Care coordination	8				
Overweight/obesity	10				
Preventive/wellness programs	8				
Smoking	9				
Cancer	9				

*These two columns are populated in accordance with the qualitative analysis findings.

Appendix 6: Community Health Planning Council

- Patti Willis – Regional Senior Vice President, Strategy and Communications
- Kathleen McGrath – Regional Director of Outreach & Business Development
- William Huffner, MD – Chief Medical Officer
- Walter Atha, MD – Regional Director of Emergency Medicine
- Brian Leutner – Vice President of Clinical and Ambulatory Services
- Diane Murphy, RN – Vice President/Chief Quality Officer
- Timothy Shanahan, DO – Medical Director University of Maryland Shore Medical Group
- Jeanie Scott, – Manager of Oncology Services
- Rita Holley, RN – Director of Shore Home Care
- Kevin Chapple, Pharm.D – .Director of Pharmacy Operations
- Trish Rosenberry, RN, – Director of Clinical & Ambulatory Services
- Jackie Crawford, RN, – Nurse Manager for Shore Behavioral Health Services
- John Mistrangelo, ACSW, LCSW-C – Director, Shore Behavioral Health Services
- Cheryl Ruff – Director of Operations University of Maryland Community Medical Group
- Kathy Elliott, RN – Executive Director, Shore Medical Center Chestertown
- Luanne Satchell, RN – Manager, Women's & Children's Services
- Anna D'Acunzi – Manager, Financial Decision Support
- Trena Williamson– Regional Director, Communications and Marketing
- Nannette Bedell, RN – Director, Population Health
- Teresa Blem – Director, Comprehensive Rehab Care

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