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INTRODUCTION

Legislation, policy, and technology over the last decade have been key drivers in transforming the way hospitals operate and deliver care. Hospitals that once used health information technology (health IT) primarily for administrative purposes are advancing its use to support clinical processes. New care delivery models reimburse value over volume of care and rely on vast amounts of data from electronic health records (EHR) to inform decision making. Increased use of health IT makes hospitals more vulnerable to a well targeted attack. Access to electronic health information is appealing to cybercriminals since it has broader utility that can support a range of nefarious activities.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 spurred digitization in health care through Meaningful Use of EHRs. Since 2011, the federal government has generated EHR financial incentives to Maryland hospitals in the amount of roughly $330 million out of a nearly combined total of $22 billion earned by hospitals nationally. By 2014, use of certified EHRs among hospitals was practically universal (Maryland: 100%; Nation: 96%), a significant increase from basic EHR technology in 2009 (Maryland: 16%; Nation: 9%). EHRs are critical infrastructure necessary to support health information exchange (HIE); however, information silos still exist post-HITECH as technology and policy barriers surrounding interoperability have not been resolved.

Lack of interoperability between EHRs impacts care coordination and analytics. HIE is a key component in solving these barriers. HIE organizations range from regional, public entities (including State-Designated entities) to enterprise-wide (large health systems) and vendor-mediated networks (EHRs). HIEs, particularly those that rely on public funds, continue to struggle in developing a sustainable business model. On April 19, 2019, the Office of the National Coordinator for Health Information Technology (ONC) released (draft 2) the Trusted Exchange Framework and Common Agreement (TEFCA) for public comment. TEFCA aims to advance nationwide interoperability through a set of principles designed to facilitate trust among authorized participants, and complement emerging national frameworks (e.g., CommonWell Health Alliance) that support exchange across multiple networks.
Telehealth is considered as an important component of a health IT framework. Supported by EHRs and HIE, telehealth is enabling hospitals to provide clinical care and health information to patients at a distance through applications, such as live (synchronous) video conferencing and remote patient monitoring. Hospitals are increasingly viewing the promise of telehealth as innovative way to curb utilization and address access issues.

Investments in health IT by providers and policy makers have resulted in mixed views regarding its impact on quality and cost. Assessing perceived value of health IT is an important activity to improve its use. Valuing health IT investments are largely subjective; however, it does provide perspective on its ability to facilitate better health outcomes, enhance operating efficiencies, and reduce costs. This is especially important since Maryland has become the first state fully at risk for the total cost of care (TCOC) of Medicare beneficiaries.

ABOUT THE ASSESSMENT

Since 2008, the Maryland Health Care Commission (MHCC) has conducted an assessment of health IT adoption among all acute care hospitals (“hospitals”) in the State. This is the first year that hospitals were asked to respond to survey questions about perceived value of health IT (EHRs, HIE, and telehealth) post-HITECH. Survey questions pertaining to key areas of hospital population health and cybersecurity were also included. The information is intended to inform stakeholders about hospital health IT accomplishments and foster conversations focused on enhancing its use to transform care delivery. Key findings are presented in aggregate; certain data is broken down by health systems and community-based hospitals. Input from hospital Chief Information Officers (CIOs) on a working draft of this report was used to finalize the assessment.

LIMITATIONS

Data was self-reported by hospital CIOs and other senior leadership using an online survey. The majority of survey questions were structured using a Likert scale approach. Likert scales can have an “anchor effect” where respondents gravitate towards more central answers. Survey questions were pre-tested with a small number of hospital respondents; their ability to identify potential challenges with the questions may have varied. The assessment does not track changes in perceived value over time, and not all survey findings are included in the report. National benchmarking data is limited; variation in survey methods may impact gauging Maryland to the nation.
This report presents findings from the assessment using infographic dashboards. A total of 15 dashboards are organized under five key categories: population health, EHRs, HIE, telehealth, and cybersecurity. A snapshot from an infographic dashboard and the accompanying descriptions below provide guidance on how to understand the layout and information presented.

**HOW TO READ THIS REPORT**

* A Snapshot from an Infographic Dashboard
Form and expand clinically integrated networks, partnerships, and infrastructure\textsuperscript{17}

Supports data sharing and analysis\textsuperscript{18}

\textbf{#1 HEALTH IT STRATEGIC FOCUS AREA}

\textbf{POPULATION HEALTH}

71\% Overall

75\% Health System

67\% Community-Based
Improve physician and hospital alignment\(^{19}\)

* Enables continuous collaboration to support value-based care\(^{20}\)

Advance predictive analytics capabilities\(^{21}\)

* Identifies high risk patients\(^{22}\)

Adapt to changing consumer demands and expectations\(^{23}\)

* Addresses the rise of health care consumerism\(^{24}\)

Health System

\[42\%\]

Community-Based

\[25\%\]

\[25\%\] (Equally Ranked)
#3 HEALTH IT STRATEGIC FOCUS AREA

Expand existing telehealth services

Reduces avoidable hospital utilization
Patient medication history viewed highly\textsuperscript{27}

Identifies prescribing discrepancies and reduces errors\textsuperscript{28}

Mixed views on patient generated health information\textsuperscript{31}

Supplements available clinical data\textsuperscript{32}

Interest in socioeconomic information\textsuperscript{29}

Informs treatment interventions and referrals\textsuperscript{30}
Shifts in vendor diffusion

Driving factors include system functionalities and cost

<table>
<thead>
<tr>
<th>Vendor</th>
<th>2014</th>
<th>% Change</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerner</td>
<td>28%</td>
<td>7%</td>
<td>35%</td>
</tr>
<tr>
<td>MEDITECH</td>
<td>36%</td>
<td>-5%</td>
<td>31%</td>
</tr>
<tr>
<td>Epic</td>
<td>19%</td>
<td>10%</td>
<td>29%</td>
</tr>
<tr>
<td>McKesson</td>
<td>6%</td>
<td>7%</td>
<td>13%</td>
</tr>
</tbody>
</table>
Use vendor HIE functionality\textsuperscript{25}

Facilitates information sharing outside the enterprise\textsuperscript{36}

Contributes significantly to interdisciplinary communication across patient care teams\textsuperscript{37}

Improves care coordination\textsuperscript{38}
Reduces adverse medical events\textsuperscript{39}

\textit{Avoidable outcomes that affect patient safety and quality of care}\textsuperscript{40}

Contributes to reductions in unnecessary utilization of services\textsuperscript{41}

\textit{Enables access to patients’ complete health record for more coordinated and efficient care}\textsuperscript{42}
ELECTRONIC HEALTH RECORDS

VIEWS ON LOWERING COSTS AND USER SATISFACTION

Cost-controlling capability not widely evident\(^{43}\)

*Substantiating financial and staff investments are difficult and imprecise\(^{44}\)*

Partially contributes to physician satisfaction\(^{45}\)

*Accessing information can be obscured by system design and documentation requirements, which contribute to burnout\(^{46}\)*
Information sharing across State lines deemed important

Care delivery is more efficient with accurate, available, and current information
HEALTH INFORMATION EXCHANGE

VIEW ON INFORMATION SHARING

**Improves care coordination and transitions of care⁴⁹**

Facilitates comprehensive care management and evaluation of patients⁵⁰

**Increases awareness of primary care services⁵¹**

Enabling early intervention and appropriate treatment⁵²
Satisfied with CRISP HIE services\textsuperscript{53}

Reduces information gaps and facilitates improvement in quality\textsuperscript{54}

CRISP reporting services central to improving quality of care\textsuperscript{58, 59}

Increases access to information from multiple sources, supported by advanced analytic tools\textsuperscript{60}

Emergency departments rely on CRISP\textsuperscript{55, 56}

Provides access to missing or incomplete information\textsuperscript{57}
TELEHEALTH

DIFFUSION

Increasing adoption of telehealth\textsuperscript{61, 62}

\textit{Favorably impacts care delivery and reduces readmissions}\textsuperscript{63}

<table>
<thead>
<tr>
<th>Year</th>
<th>Overall Adoption Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>46%</td>
</tr>
<tr>
<td>2013</td>
<td>61%</td>
</tr>
<tr>
<td>2014</td>
<td>64%</td>
</tr>
<tr>
<td>2015</td>
<td>77%</td>
</tr>
<tr>
<td>2016</td>
<td>88%</td>
</tr>
<tr>
<td>2017</td>
<td>92%</td>
</tr>
</tbody>
</table>

\textit{Compound Annual Growth Rate}\textsuperscript{64} 16%
Implementing telehealth largely an enterprise-wide approach.\textsuperscript{65}

*Improves access to specialty services and enables cost-effective implementation of technology.*\textsuperscript{66}

**Overall**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterprise</td>
<td>77%</td>
</tr>
<tr>
<td>Departmental</td>
<td>21%</td>
</tr>
<tr>
<td>Transitional</td>
<td>9%</td>
</tr>
</tbody>
</table>
Conducting security risk assessments at least annually to guide risk management activities\textsuperscript{67,68} VARIES WIDELY FROM HOSPITAL TO HOSPITAL AND INFLUENCED BY TECHNICAL INFRASTRUCTURE COMPLEXITY, PROBABILITY AND CRITICALITY OF POTENTIAL RISKS, AND COST\textsuperscript{69,70}

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Maryland</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once per year</td>
<td>85%</td>
<td>46%</td>
</tr>
<tr>
<td>Once every six months</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Monthly</td>
<td>11%</td>
<td>19%</td>
</tr>
</tbody>
</table>
Commonality among security risk assessments\textsuperscript{71}

Critical elements of an information security risk management program\textsuperscript{72}

Consistency with including medical devices in security risk assessments\textsuperscript{73}

Unsecured and poorly secured medical devices jeopardize patient safety\textsuperscript{74}
CONCLUSION

The effort by hospitals over the last decade to implement a robust health IT infrastructure is commendable. Work continues to advance use of more innovative health care applications and significant volumes of data, which are key in supporting the shift to quality of care over quantity of services. Federal agencies have ramped up efforts to address technical and policy barriers that limit interoperability (and have been considered outside the scope of HITECH legislation and programs). TEFCA will establish critical policies, procedures, and guidance to bridge information gaps bolstering the work of national frameworks in solving interoperability challenges. Addressing the proliferation of cybersecurity risk remains a top priority for everyone involved in the health IT ecosystem.

Acknowledgments

The Maryland Health Care Commission thanks hospitals for their contributions to this report.
REFERENCES


2. Large repositories of medical records are valuable to cybercriminals as medical records can include Social Security and credit card numbers, patient demographics, addresses, insurance identification numbers, and other medical information, and can sell on the black market for as much as 20 times the cost of a stolen credit card number. Criminals use medical records to fraudulently bill insurance, receive free medical services, or obtain prescription medications.


4. Meaningful Use outlines objectives an eligible hospital must meet to earn financial incentives. Hospitals demonstrate Meaningful Use by successfully attesting through either the Centers for Medicare & Medicaid Services Medicare Attestation System or through a state’s Medicaid Attestation System.


6. A certified EHR meets the technological capability, functionality, and security requirements adopted by the Office of the National Coordinator for Health Information Technology (ONC). The ONC Health IT Certification Program consists of health IT standards, implementation specifications, and certification criteria required to participate in Meaningful Use and most alternative payment models under the purview of federal, state and private entities. For more information, visit: www.healthit.gov/topic/certification-ehrs/about-onc-health-it-certification-program.

7. A basic EHR is classified as minimum use of at least 10 core functions: recording patient demographic information, physician notes, nursing assessments, problem lists, medication lists, discharge summaries, ordering medications and viewing laboratory reports, radiology reports, and diagnostic test results.


9. As of May 2019, nine HIEs are registered in Maryland as required by COMAR 10.25.18.09 *Registration and Enforcement*. More information available at: mhcc.maryland.gov/mhcc/Pages/hit/hit_hie/hit_hie_registration.aspx.


12. Other applications include store-and-forward (asynchronous) and mobile health.

13. The Total Cost of Care Model builds upon the All-Payer Model by expanding beyond hospitals to other care settings and is expected to run from January 1, 2019 through December 31, 2028.

14. For purposes of this assessment, a health system is four or more hospitals connected through common ownership or joint management, with the exception of Levindale Hebrew Geriatric Center and Hospital. See Appendix A for more information, including number of licensed acute beds by hospital.

15. A Likert scale is an ordered scale from which respondents choose one option that best aligns with their view. It is often used to measure respondents’ attitudes by asking the extent to which they agree or disagree with a question or statement.


17. Hospitals were asked to rank their top three strategic areas of focus supported by health IT. Percentages represent hospitals that ranked “Forming or expanding clinically integrated networks, partnerships, and/or infrastructure” as their number one strategic area of focus.


19. Hospitals were asked to rank their top three strategic areas of focus supported by health IT. Percentages represent health systems that ranked “Improving physician-hospital alignment” as their number two strategic area of focus.
Responses were on a five point Likert scale. Percentages reflect the hospitals that indicated “Complete data on patient prescription medication history” is “extremely important” or “moderately important” for enhancing analysis and reporting; hospitals that selected “neutral,” “low importance,” or “not at all important” are not included.

Response were on a five point Likert scale. Percentages reflect the hospitals that indicated “Socioeconomic data (social determinants of health)” is “extremely important” or “moderately important” for enhancing analysis and reporting; hospitals that selected “neutral,” “low importance,” or “not at all important” are not included.

Responses were on a five point Likert scale. Percentages reflect the hospitals that indicated “Patient-generated health data (personal health records)” is “extremely important” or “moderately important” for enhancing analysis and reporting; hospitals that selected “neutral,” “low importance,” or “not at all important” are not included.


Ten hospitals selected more than one vendor. Four hospitals reported using two of the top four vendors.


Responses were on a five point Likert scale. Percentages reflect hospitals that reported using their EHR “almost always (75%+),” “often (50-74%),” or “sometimes (25-49%)” to share data with providers external to the organization; hospitals that selected “rarely (<24%),” “never (0%),” or “N/A” were not included.


Responses were on a five point Likert scale. Percentages reflect hospitals that selected “moderately,” “slightly,” “not at all,” or “unknown” were not included.


Responses were on a five point Likert scale. Percentages reflect hospitals that selected “strongly agree” or “agree” that EHRs reduced adverse medical events; hospitals that selected “neutral,” “disagree,” “strongly disagree,” or “unknown” were not included.

Responses were on a five point Likert scale. Percentages reflect hospitals that selected “almost always (75%+)”, “often (50-74%)”, or “sometimes (25-49%)” that EHRs contribute to reductions unnecessary utilization of hospital services; hospitals that selected “rarely (<24%)”, “never (0%)”, or “unknown” were not included.

Responses were on a five point Likert scale. Percentages reflect hospitals that selected “neutral”, “disagree,” or “strongly disagree,” that EHRs have not delivered on the promise of lower costs; hospitals that selected “strongly agree,” “agree,” or “unknown” were not included.

Responses were on a five point Likert scale. Percentages reflect hospitals that selected “neutral”, “disagree,” or “strongly disagree,” that EHRs have not delivered on the promise of better physician satisfaction; hospitals that selected “strongly agree,” “agree,” or “unknown” were not included.

Responses were on a five point Likert scale. Percentages reflect hospitals that selected “neutral”, “disagree,” or “strongly disagree,” that EHRs have not delivered on the promise of improved emergency department care through faster accessing of patient information and inform care delivery; hospitals that selected “rarely (<24%)”, “never (0%)”, or “unknown” were not included.

Responses were on a five point Likert scale. Percentages reflect hospitals that selected “strongly agree” or “agree” that HIE improves transitions of care by accessing patient information vital to care management and in guiding treatment; hospitals that selected “neutral,” “disagree,” “strongly disagree,” or “unknown” were not included.

Responses were on a five point Likert scale. Percentages reflect hospitals that selected “strongly agree” or “agree” that HIE enhances awareness of primary care services by ensuring relevant patient information is available to the care team at the point of care; hospitals that selected “neutral,” “disagree,” “strongly disagree,” or “unknown” were not included.

Responses were on a five point Likert scale. Percentages reflect hospitals that selected “very true” or “somewhat true” to the question “Overall, our hospital is satisfied with CRISP HIE services”; hospitals that answered “neutral,” “slightly true,” “not true,” or “unknown” were not included.

Responses were on a five point Likert scale. Percentages reflect hospitals that selected “neutral”, “disagree,” or “strongly disagree,” or “unknown” were not included.

Two hospitals do not have an emergency department: Levindale and University of Maryland Orthopaedic and Rehabilitation (n=46).

Responses were on a five point Likert scale. Percentages reflect hospitals that selected “neutral”, “disagree,” “strongly disagree,” or “unknown” were not included.

Two hospitals reported not using CRS and were not included (n=46).

Two hospitals do not have an emergency department: Levindale and University of Maryland Orthopaedic and Rehabilitation (n=46).

Two hospitals reported not using CRS and were not included (n=46).

Two hospitals do not have an emergency department: Levindale and University of Maryland Orthopaedic and Rehabilitation (n=46).

Two hospitals reported not using CRS and were not included.
Compound annual growth rate (CAGR) determined using a beginning value of the number of adopters in 2012 (n=21) and an ending value of number of adopters in 2017 (n=44) over 5 periods. Includes the adopters of telehealth only (n=44).

Health Leaders. 5 Need-To-Know Leaps in Telehealth, September 2018. Available at: www.healthleadersmedia.com/innovation/5-need-know-leaps-telehealth.


Select CIO reviewers stated that while security risk assessments are conducted over multiple stages, the accuracy of responses indicating frequency of monthly security risk assessments is questionable.

HIPAA requires covered entities to conduct periodic risk analysis and ongoing reviews of measures taken to ensure they are still appropriately protecting health information, and make updates to measures to address identified risks, as needed. The standards allows each individual organization to implement these standards in line with their specific needs, risks, and environments. More information is available at: www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads/cms0049f.pdf.


Percentages reflect hospitals that reported the component is included in their security risk assessment.


Percentages reflect the hospitals that reported medical devices in are included in their security risk assessment.

## Appendix A: Licensed Acute Care Beds by Hospital

### Total Licensed Acute Care Beds

<table>
<thead>
<tr>
<th>Health System</th>
<th>Licensed Beds</th>
<th>Community-Based Beds</th>
<th>Licensed Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Howard County General Hospital</td>
<td>245</td>
<td>2.61</td>
<td>Adventist Healthcare Shady Grove Medical Center</td>
</tr>
<tr>
<td>Johns Hopkins Bayview Medical Center</td>
<td>335</td>
<td>3.67</td>
<td>Adventist Healthcare Washington Adventist Hospital</td>
</tr>
<tr>
<td>The Johns Hopkins Hospital</td>
<td>1,114</td>
<td>11.86</td>
<td>Anne Arundel Medical Center</td>
</tr>
<tr>
<td>Suburban Hospital</td>
<td>233</td>
<td>2.48</td>
<td>Atlantic General Hospital</td>
</tr>
<tr>
<td>MedStar Franklin Square Medical Center</td>
<td>347</td>
<td>3.69</td>
<td>Bon Secours Hospital</td>
</tr>
<tr>
<td>MedStar Good Samaritan Hospital</td>
<td>132</td>
<td>1.41</td>
<td>Calvert Health Medical Center</td>
</tr>
<tr>
<td>MedStar Harbor Hospital</td>
<td>129</td>
<td>1.37</td>
<td>Carroll Hospital Center</td>
</tr>
<tr>
<td>MedStar Montgomery Medical Center</td>
<td>117</td>
<td>1.25</td>
<td>Doctors Community Hospital</td>
</tr>
<tr>
<td>MedStar Southern Maryland Hospital Center</td>
<td>176</td>
<td>1.87</td>
<td>Edward W. McCready Memorial Hospital</td>
</tr>
<tr>
<td>MedStar St. Mary’s Hospital</td>
<td>96</td>
<td>1.02</td>
<td>Fort Washington Medical Center</td>
</tr>
<tr>
<td>MedStar Union Memorial Hospital</td>
<td>185</td>
<td>1.97</td>
<td>Frederick Memorial Hospital</td>
</tr>
<tr>
<td>University of Maryland Baltimore-Washington Medical Center</td>
<td>272</td>
<td>2.90</td>
<td>Garrett Regional Medical Center</td>
</tr>
<tr>
<td>University of Maryland Charles Regional Medical Center</td>
<td>98</td>
<td>1.04</td>
<td>Greater Baltimore Medical Center</td>
</tr>
<tr>
<td>University of Maryland Harford Memorial Hospital</td>
<td>82</td>
<td>0.87</td>
<td>Holy Cross Germantown Hospital</td>
</tr>
<tr>
<td>University of Maryland Laurel Regional Hospital</td>
<td>55</td>
<td>0.59</td>
<td>Holy Cross Hospital of Silver Spring</td>
</tr>
<tr>
<td>University of Maryland Medical Center</td>
<td>789</td>
<td>8.40</td>
<td>Levindale Hebrew Geriatric Center and Hospital*</td>
</tr>
<tr>
<td>University of Maryland Medical Center Midtown Campus</td>
<td>97</td>
<td>1.03</td>
<td>Mercy Medical Center</td>
</tr>
<tr>
<td>University of Maryland Prince George’s Hospital Center</td>
<td>238</td>
<td>2.53</td>
<td>Meritus Medical Center</td>
</tr>
<tr>
<td>University of Maryland Rehabilitation &amp; Orthopaedic Institute</td>
<td>3</td>
<td>0.03</td>
<td>Northwest Hospital Center</td>
</tr>
<tr>
<td>University of Maryland Saint Joseph Medical Center</td>
<td>218</td>
<td>2.32</td>
<td>Peninsula Regional Medical Center</td>
</tr>
<tr>
<td>University of Maryland Shore Medical Center at Chestertown</td>
<td>21</td>
<td>0.22</td>
<td>Saint Agnes Hospital</td>
</tr>
<tr>
<td>University of Maryland Shore Medical Center at Dorchester</td>
<td>42</td>
<td>0.45</td>
<td>Sinai Hospital</td>
</tr>
<tr>
<td>University of Maryland Shore Medical Center at Easton</td>
<td>104</td>
<td>1.11</td>
<td>Union Hospital of Cecil County</td>
</tr>
<tr>
<td>University of Maryland Upper Chesapeake Medical Center</td>
<td>149</td>
<td>1.59</td>
<td>Western Maryland Regional Medical Center</td>
</tr>
</tbody>
</table>

**Total** | 5,277 | 56.17 | **Total** | 4,118 | 43.83

**Notes/Sources:**
Data represents number and percent of licensed acute care beds by hospital; includes Levindale Hebrew Geriatric Center and Hospital* since it was an eligible hospital for Meaningful Use and received incentive payments. Figures represent the proportion of total licensed beds (N=9,395) for all hospitals included in MHCC’s assessment. Data is publicly available at: mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/FY2019_Tables_Bed_Designation.pdf and www.lifebridgehealth.org/Main/AcuteRehab.aspx.
For purposes of this report, a health system is defined as four or more hospitals connected through common ownership or joint management, with the exception of Levindale Hebrew Geriatric Center and Hospital.
David Sharp, PhD, Director

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