Appendix A: Additional Tables and Figures

This Appendix contains tables and figures related to the Assessment of the types, volume, and quality of services at the UMSMS at Chestertown that provide additional detail not included in the body of the report.

Demographic Information

This section includes a table of population estimates for rural counties in Maryland and a table showing the percent of population in each rural county in Maryland that is under age 18 and age 65 and older.

Table 1: Population in Rural Counties in Maryland, 2018 and 2010

Source: U.S. Census Bureau Quick Facts

County	Population estimates, July 1, 2018, (V2018)	Population estimates base, April 1, 2010, (V2018)	Population, percent change - April 1, 2010 (estimates base) to July 1, 2018, (V2018)
Allegany County	70,975	75,047	-5.40%
Calvert County	92,003	88,739	3.70%
Caroline County	33,304	33,078	0.70%
Carroll County	168,429	167,142	0.80%
Cecil County	102,826	101,102	1.70%
Charles County	161,503	146,565	10.20%
Dorchester County	31,998	32,623	-1.90%
Frederick County	255,648	233,391	9.50%
Garrett County	29,163	30,139	-3.20%
Harford County	253,956	244,826	3.70%
Kent County	***19,383***	***20,195***	***-4.00%***
Queen Anne's County	***50,251***	***47,789***	***5.20%***
Somerset County	25,675	26,470	-3.00%
St. Mary's County	112,664	105,143	7.20%
Talbot County	36,968	37,777	-2.10%
Washington County	150,926	147,430	2.40%
Wicomico County	103,195	98,733	4.50%
Worcester County	51,823	51,451	0.70%
Rural Counties	**1,750,690**	**1,687,640**	**3.74%**
Maryland	**6,042,718**	**5,773,798**	**4.70%**

Table 2: Population by Age, Rural Counties, Maryland, 2018		
Source: U.S. Census Bureau Quick Facts		
	Persons under 18 years, percent	Persons 65 years and over, percent
Allegany County	17.40%	20.30%
Calvert County	23.20%	14.90%
Caroline County	23.70%	16.20%
Carroll County	21.70%	16.80%
Cecil County	22.60%	15.70%
Charles County	24.00%	12.50%
Dorchester County	21.10%	21.60%
Frederick County	23.10%	14.50%
Garrett County	18.60%	22.40%
Harford County	22.20%	16.20%
Kent County	***15.80%***	***26.70%***
Queen Anne's County	***21.50%***	***18.80%***
Somerset County	17.10%	17.00%
St. Mary's County	24.20%	13.10%
Talbot County	18.20%	29.20%
Washington County	21.80%	17.20%
Wicomico County	22.00%	15.90%
Worcester County	17.20%	27.80%
Maryland (All Counties)	**22.20%**	**15.40%**

Figure 1: Percent of Population Change, Five Eastern Shore Counties, July 2013-July 2018

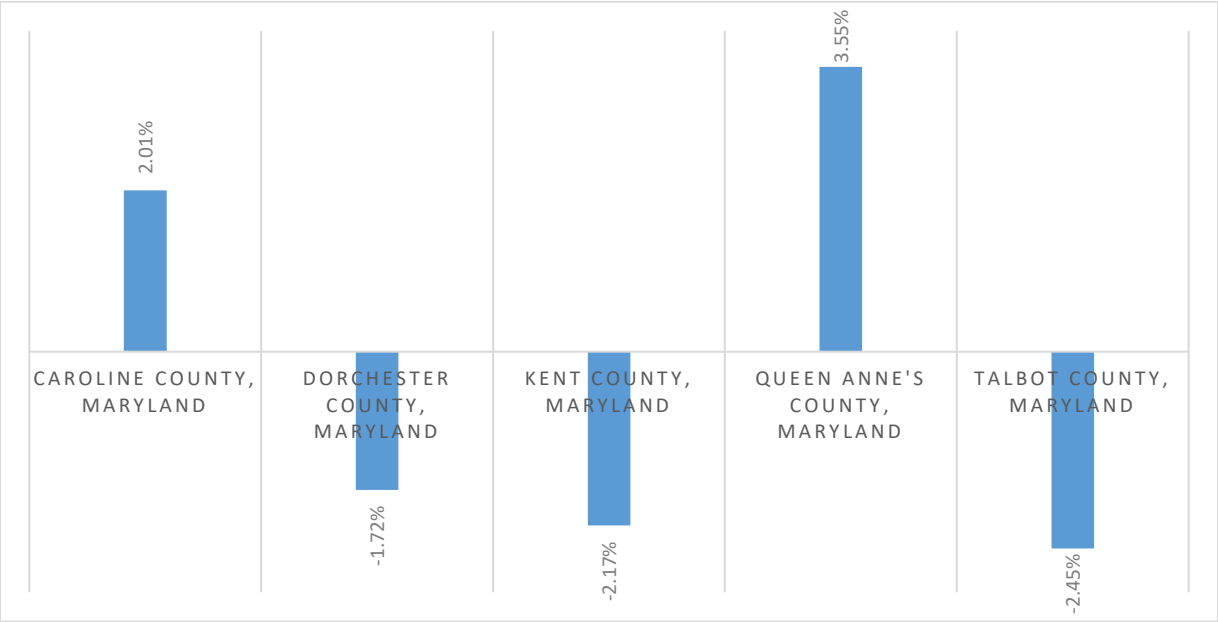
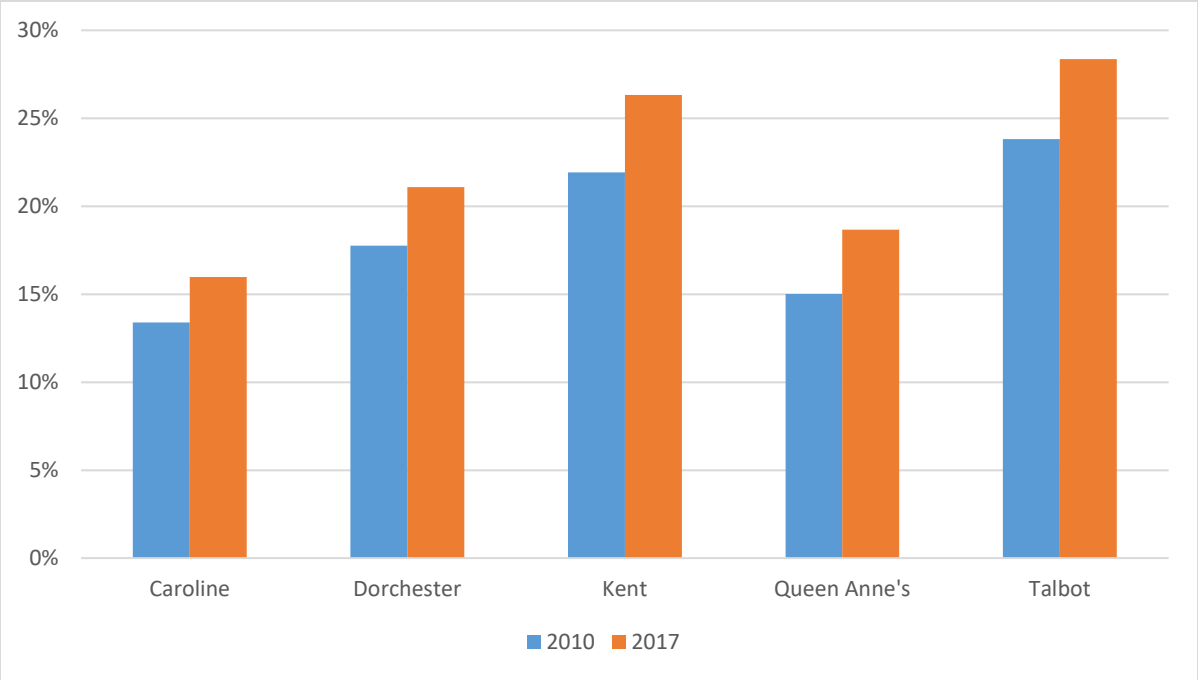


Figure 2: Percent of Population Change Age 65 and Older, Five Eastern Shore Counties, 2010 & 2017



Types of Services

This section contains tables related to the Assessment of the Types of Services provided at the UMSMC at Chestertown.

Table 3: Inpatient Surgery APR-DRG Service Categories with zero volume in 2015 and a volume of at least 1 in 2018, UMSMC at Chestertown		
Service Category	Service Provided to at least 1 patient in 2015	Service Provided to at least 1 patient in 2015
Vascular Surgery	NO	YES
Trauma	NO	YES
Ep/Chronic Rhythm Mgmt	NO	YES

Table 4: Inpatient Surgery APR-DRG Service Categories with zero volume in 2015 and a volume of at least 1 in 2018, USMC at Easton		
Service Category	Service Provided to at least 1 patient in 2015	Service Provided to at least 1 patient in 2015
Invasive Cardiology	NO	YES
Vascular Surgery	NO	YES

Table 5: Inpatient Medical APR-DRG Service Categories with positive volume in 2015 and a volume of zero in 2018, UMSMC at Chestertown		
Service Category	Service Provided to at least 1 patient in 2015	Service Provided to at least 1 patient in 2015
General Surgery	YES	NO
Injuries/Complic. Of Prior Care	YES	NO
Ophthalmology	YES	NO
HIV	YES	NO
Dental	YES	NO
Cardiothoracic Surgery	YES	NO
Injuries/Complic. Of Prior Care[1]	YES	NO
Other	YES	NO

Table 6: Inpatient Medical APR-DRG Service Categories with positive volume in 2015 and a volume of zero in 2018, UMSCM at Easton		
Service Category	Service Provided to at least 1 patient in 2015	Service Provided to at least 1 patient in 2015
Rehabilitation	YES	NO
Thoracic Surgery	YES	NO
Injuries/Complic. Of Prior Care[2]	YES	NO

[1] Inpatient surgery services related to "Injuries/Complication of Prior Care" were dropped in 2018 for all Maryland hospitals. The DRGs included in this service category were listed as "Other Complications Of Treatment" in prior years. The drop in this service category is a result of annual changes to the DRG classification.

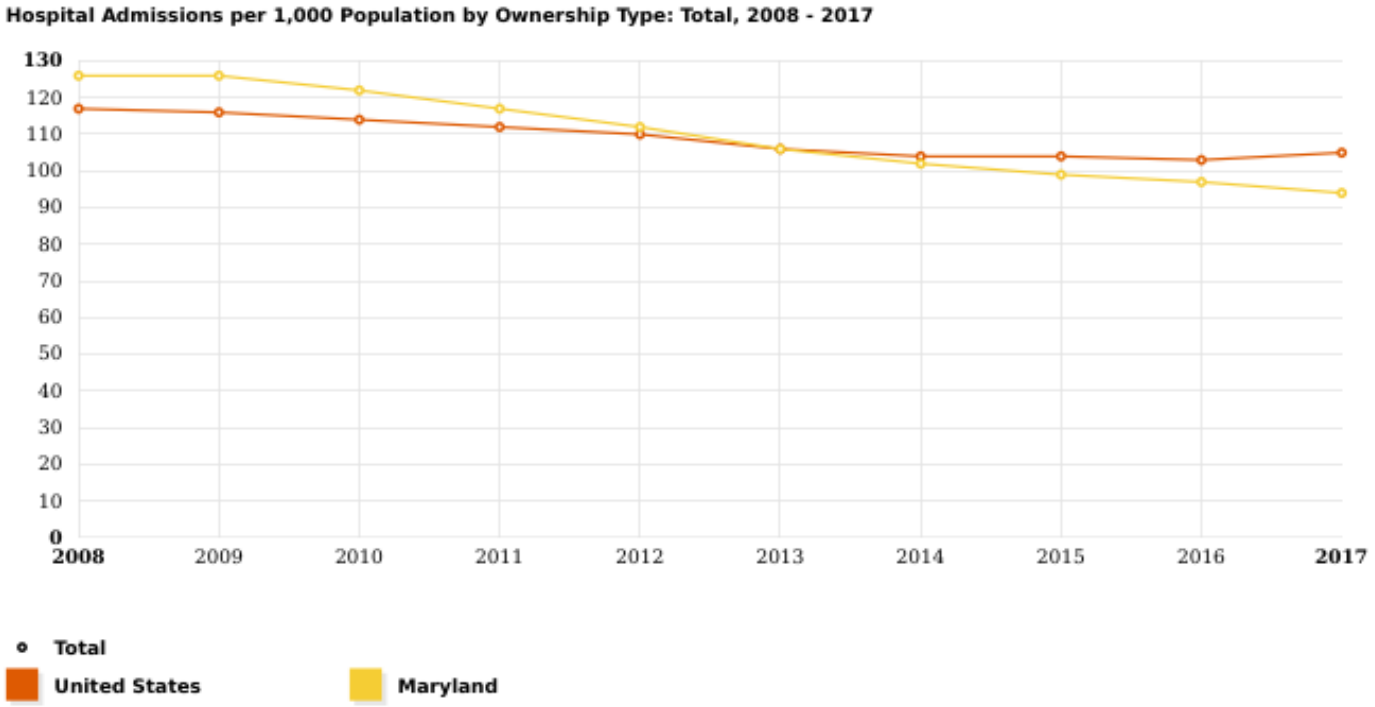
[2] Ibid.

Table 7: Available of Services were not provided in UMSMC at Chestertown in 2015 or 2018 at UMSMC at Easton					
		Chestertown		Easton	
Service Category		Provided in 2015	Provided in 2018	Provided in 2015	Provided in 2018
Inpatient Medical	Newborn	NO	NO	YES	YES
	Obstetrics/Delivery	NO	NO	YES	YES
	Neonatology	NO	NO	YES	YES
	Rehabilitation	NO	NO	YES	NO
	Other Obstetrics	NO	NO	YES	YES
	Invasive Cardiology	NO	NO	YES	YES
	General Surgery	YES	NO	YES	YES
	Injuries/Complic. Of Prior Care	YES	NO	YES	YES
	Ophthalmology	YES	NO	YES	YES
	HIV	YES	NO	YES	YES
	Dental	YES	NO	YES	YES
Inpatient Surgery	Obstetrics/Delivery	NO	NO	YES	YES
	Invasive Cardiology	NO	NO	NO	YES
	Vascular Surgery	NO	YES	NO	YES
	Urological Surgery	NO	NO	YES	YES
	Cardiothoracic Surgery	YES	NO	YES	YES
	Thoracic Surgery	YES	YES	YES	NO
	Spinal Surgery	NO	NO	YES	YES
	Trauma	NO	YES	YES	YES
	Ep/Chronic Rhythm Mgmt	NO	YES	YES	YES
	Ent Surgery	NO	NO	YES	YES
	Oncology	NO	NO	YES	YES
	Ventilator Support	NO	NO	YES	YES
	Transplant Surgery	NO	NO	NO	NO
	Ophthalmologic Surg	NO	NO	NO	NO
	Other Obstetrics	NO	NO	YES	YES
	Injuries/Complic. Of Prior Care	YES	NO	YES	NO
	General Medicine	NO	NO	NO	NO
	Neonatology	NO	NO	NO	NO
Outpatient	RadiationTherapy	NO	NO	YES	YES
	LaborDelivery	NO	NO	YES	YES
	Other	YES	NO	YES	YES

Volume of Services

Tables and figures in this section relate to the assessment of the volume of services provided at UMSMC at Chestertown.

Figure 3: Hospital admissions per 1,000 Population by Ownership Type, All hospital Types, United States and Maryland, 2008-2017



SOURCE: Kaiser Family Foundation's State Health Facts.

[3]

[3], https://www.kff.org/other/state-indicator/admissions-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Data are for community hospitals (nonfederal, short-term general, and specialty hospitals whose facilities and services are available to the public), which represent 85% of all hospitals nationwide. Data source:1999 - 2017 AHA Annual Survey, Copyright 2018 by Health Forum, LLC, an affiliate of the American Hospital Association. Special data request, 2018. Available at http://www.ahaonlinestore.com.

Figure 4: Licensed Bed Capacity at UMSMC at Chestertown and UMSMC at Easton, FY 2015-2020

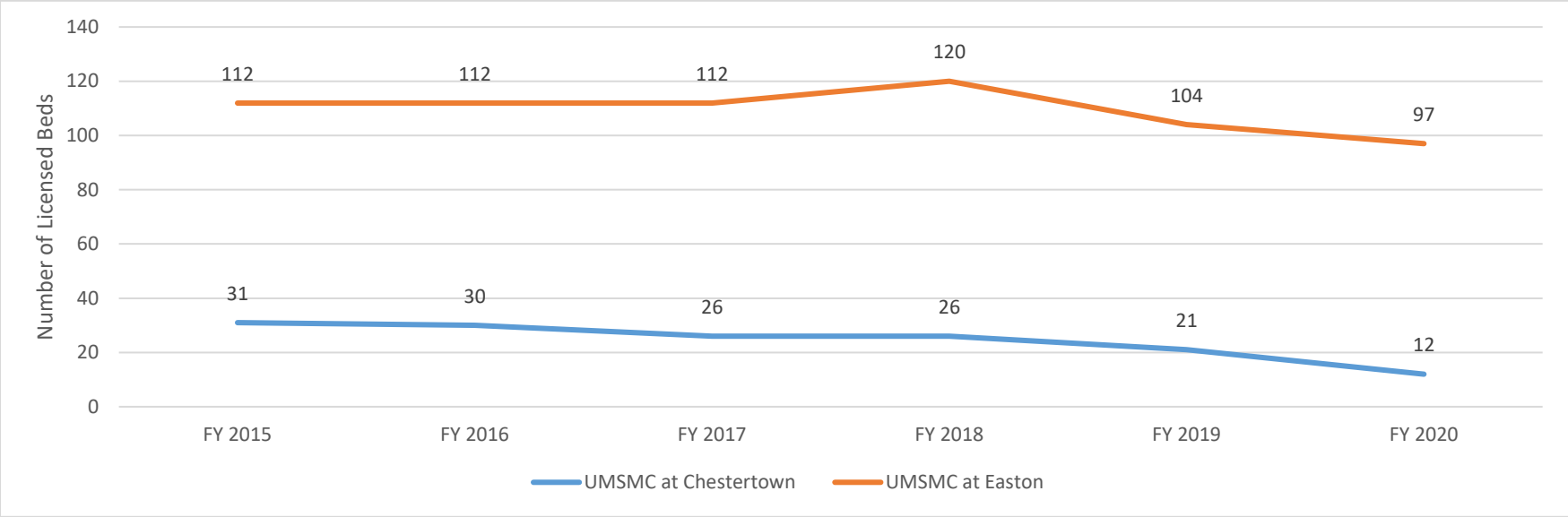


Figure 5: Licensed Bed Capacity, All Maryland Hospitals, Fiscal Year 2015 to Fiscal Year 2020

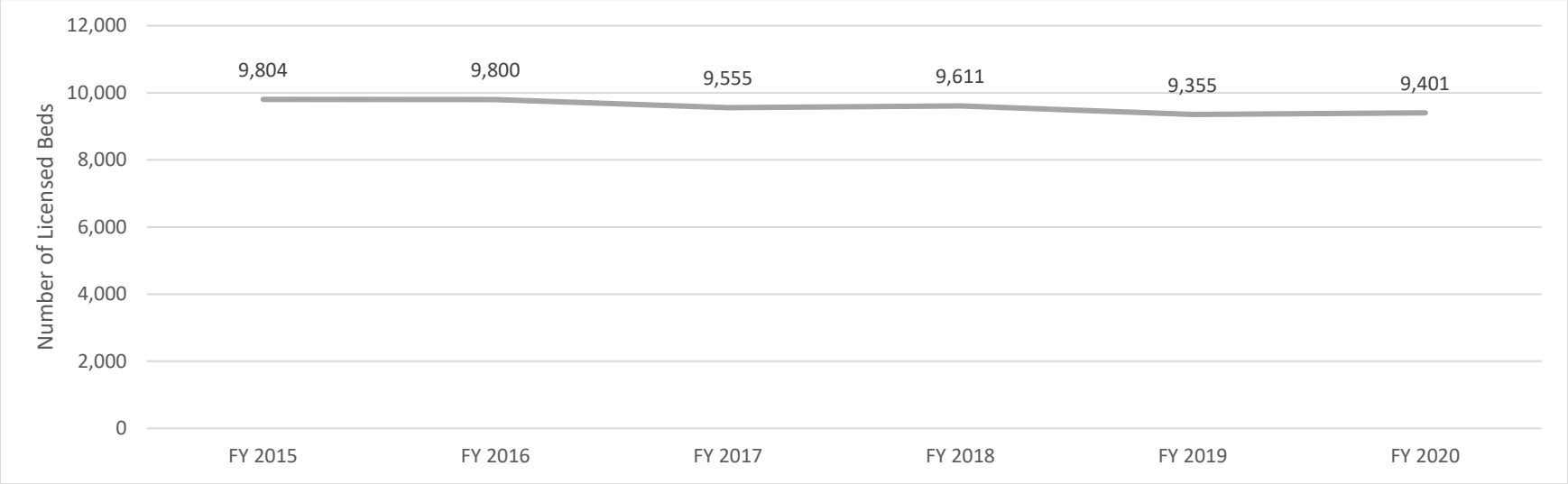


Figure 6: UMSMC at Chestertown Monthly MSGA Discharges, Calendar Year 2017 and 2018

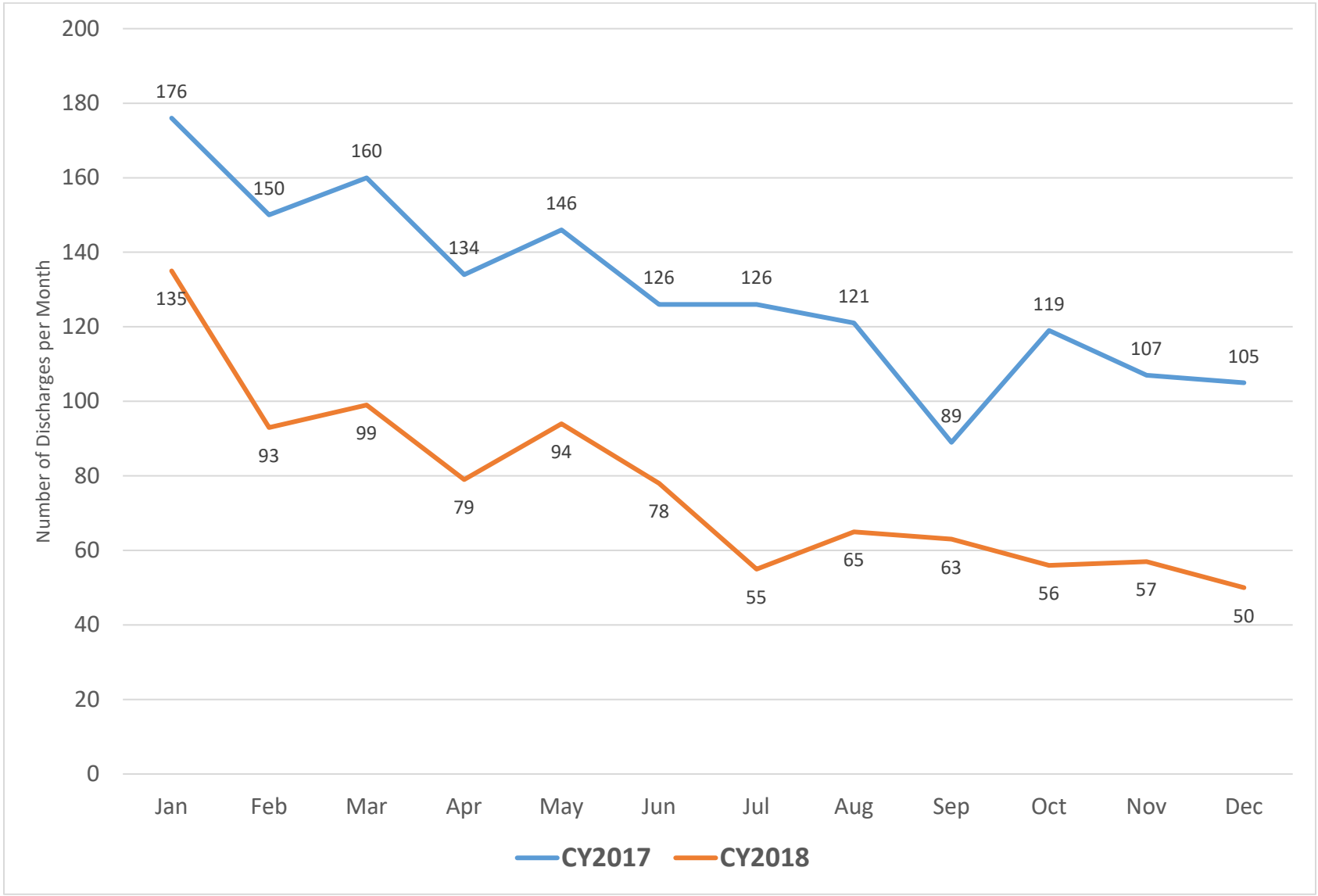


Table 8: Shore Health System Hospital MSGA Discharges by County of Residence, CY2011 - CY2018										
		MSGA Discharges								
Hospital	County/*State*	CY2011	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	Percent Change 2018 - 2011
UMSMC at Chestertown	Kent County, MD	1,623	1,787	1,506	1,482	1,335	1,226	1,188	725	-55%
	Queen Anne's County, MD	639	406	319	281	256	236	247	148	-77%
	Caroline County, MD	97	92	62	60	35	44	42	20	-79%
	All Other Places	106	93	76	62	74	80	82	31	-71%
	Total	*2,465*	*2,378*	*1,963*	*1,885*	*1,700*	*1,586*	*1,559*	*924*	*-63%*
UMSMC at Dorchester	Dorchester County, MD	2,134	1,789	1,605	1,669	1,628	1,590	1,522	1,080	-49%
	Talbot County, MD	90	66	52	83	69	55	64	43	-52%
	Caroline County, MD	58	50	59	52	58	61	50	46	-21%
	All Other Places	132	99	110	92	79	98	105	86	-35%
	Total	*2,414*	*2,004*	*1,826*	*1,896*	*1,834*	*1,804*	*1,741*	*1,255*	*-48%*
UMSMC at Easton	Talbot County, MD	2,974	2,725	2,645	2,697	2,567	2,528	2,222	1,981	-33%
	Caroline County, MD	2,086	1,920	1,795	1,683	1,680	1,629	1,649	1,339	-36%
	Dorchester County, MD	636	661	654	717	812	781	779	821	29%
	Queen Anne's County, MD	866	738	702	694	670	810	687	697	-20%
	Kent County, MD	99	152	147	131	176	202	281	279	182%
	Delaware	65	71	67	60	49	57	62	45	-31%
	Wicomico County, MD	39	41	49	63	51	58	61	46	18%
	All Other Places	182	157	152	142	177	160	164	161	-12%
	Total	*6,947*	*6,465*	*6,211*	*6,187*	*6,182*	*6,225*	*5,905*	*5,369*	*-23%*

Table 9: MSGA Discharges by County of Residence, Kent and Dorchester County, 2011- 2018										
County	Hospital	CY2011	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	Percent Change 2018 - 2011
Dorchester County	UMSMC at Dorchester	2,134	1,789	1,605	1,669	1,628	1,590	1,522	1,080	-49%
	UMSMC at Easton	636	661	654	717	812	781	779	821	29%
	University of Maryland Medical Center	228	282	253	248	206	172	178	186	-18%
	Anne Arundel Medical Center	48	57	50	57	55	55	58	59	23%
	UMSMC at Chestertown		2	4	7	1	3	4		
	All Other Maryland Hospitals	621	591	621	581	642	560	621	571	-8%
	Total	*3,667*	*3,382*	*3,187*	*3,279*	*3,344*	*3,161*	*3,162*	*2,717*	*-26%*
Kent County	UMSMC at Chestertown	1,493	1,787	1,506	1,482	1,335	1,226	1,188	725	-51%
	UMSMC at Easton	72	152	147	131	176	202	281	279	288%
	Anne Arundel Medical Center	122	143	131	174	139	162	187	163	34%
	University of Maryland Medical Center	258	262	246	218	165	170	135	121	-53%
	UMSMC at Dorchester	1		4	3	5	4	6	11	
	All Other Maryland Hospitals	249	206	233	194	216	185	258	270	8%
	Total	*2,195*	*2,550*	*2,267*	*2,202*	*2,036*	*1,949*	*2,055*	*1,569*	*-29%*

Table 10: MSGA Discharges by County of Residence, Queen Anne's And Talbots Counties, 2011- 2018										
County	Hospital	CY2011	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	Percent Change 2018 - 2011
Queen Anne's County	Anne Arundel Medical Center	1,441	1,557	1,459	1,456	1,420	1,380	1,410	1,244	-14%
	UMSMC at Easton	866	738	702	694	670	810	687	697	-20%
	University of Maryland Medical Center	346	339	270	251	195	181	190	174	-50%
	UMSMC at Chestertown	639	406	319	281	256	236	247	148	-77%
	UMSMC at Dorchester	16	9	19	15	12	10	15	8	-50%
	All Other Maryland Hospitals	484	415	360	430	386	338	406	399	-18%
	Total	3,792	3,464	3,129	3,127	2,939	2,955	2,955	2,670	-30%
Talbot County	UMSMC at Easton	2,974	2,725	2,645	2,697	2,567	2,528	2,222	1,981	-33%
	University of Maryland Medical Center	427	365	389	331	255	247	214	214	-50%
	Anne Arundel Medical Center	140	157	212	220	223	236	211	190	36%
	UMSMC at Dorchester	90	66	52	83	69	55	64	43	-52%
	UMSMC at Chestertown	5	1	7	6	5	9	14	6	20%
	All Other Maryland Hospitals	386	373	352	388	336	375	394	372	-4%
	Total	4,022	3,687	3,657	3,725	3,455	3,450	3,119	2,806	-30%

Table 11: MSGA Discharges by County of Residence, Five Mid-shore Counties, 2011-2018									
Hospital	CY2011	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	Percent Change 2018 - 2011
UMSMC at Easton	6,634	6,196	5,943	5,922	5,905	5,950	5,618	5,117	-23%
Anne Arundel Medical Center	1,918	2,111	2,059	2,090	2,033	2,026	2,067	1,840	-4%
UMSMC at Dorchester	2,299	1,914	1,739	1,822	1,772	1,720	1,657	1,188	-48%
UMSMC at Chestertown	2,234	2,288	1,898	1,836	1,632	1,518	1,495	899	-60%
University of Maryland Medical Center	1,578	1,512	1,438	1,307	1,051	980	905	870	-45%
All Other Maryland Hospitals	2,082	1,882	1,837	1,898	1,930	1,760	2,053	1,945	-7%
Total	16,745	15,903	14,914	14,875	14,323	13,954	13,795	11,859	-29%

Table 12: Average Length of Stay and Average Daily Census, Shore Health System Hospitals, CY2011 - CY2018									
	Average Length of Stay (Days)								
	CY2011	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	Percent Change 2018 - 2011
UMSMC at Dorchester	3.4	3.6	3.7	4.3	4.3	4.3	4.3	4.3	26%
UMSMC at Chestertown	4.5	4.4	4.3	4.2	4.1	3.9	4.0	3.9	-12%
UMSMC at Easton	3.9	3.9	4.2	4.2	4.2	4.4	4.3	4.2	9%
	Average Daily Census								
	CY2011	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	Percent Change 2018 - 2011
UMSMC at Dorchester	23	20	18	22	22	21	21	15	-35%
UMSMC at Chestertown	30	29	23	22	19	17	17	10	-67%
UMSMC at Easton	74	70	71	71	71	76	69	62	-16%

Hospital Finances

Table 13: Summary of Finances at UMSMC at Chestertown, in thousands

	Regulated Revenue					Unregulated Revenue			
	2015	2018	Nominal Change 2018 to 2015	Percent Change 2018 to 2015		2015	2018	Nominal Change 2018 to 2015	Percent Change 2018 to 2015
Gross Patient Revenues	***64,477***	***59,412***	***-5,065***	***-7.90%***		***3,756***	***4,312***	***555***	***14.80%***
Total Deductions from Revenue	***18,889***	***8,734***	***-10,154***	***-53.80%***		***185***	***1,871***	***1,686***	***909.70%***
Uncompensated Care Fund	1,285	125	-1,160	-90.30%		0	0	0	
Net Patient Revenues	***46,873***	***50,803***	***3,930***	***8.40%***		***3,571***	***2,440***	***-1,131***	***-31.70%***
Other Operating Revenues	32	81	49	150.80%		227	429	202	89.20%
Net Operating Revenues	***46,906***	***50,884***	***3,979***	***8.50%***		***3,798***	***2,869***	***-929***	***-24.40%***
Total Operating Expenses	***43,026***	***40,472***	***-2,554***	***-5.90%***		***6,336***	***5,788***	***-549***	***-8.70%***
Operating Margin	***3,880***	***10,412***	***6,533***	***168.40%***		***-2,538***	***-2,918***	***-380***	***15.00%***
Total Margin	***3,880***	***10,412***	***6,533***	***168.40%***		***-2,705***	***-2,277***	***428***	***-15.80%***
Margin As Pct of Net Op Rev	***8.27%***	***20.46%***				***-71.23%***	***-79.36%***		

	Total Revenue			
	2015	2018	Nominal Change 2018 - 2015	Percent Change 2018 - 2015
Gross Patient Revenues	***68,234***	***63,724***	***-4,510***	***-6.60%***
Total Deductions from Revenue	***19,074***	***10,606***	***-8,469***	***-44.40%***
Uncompensated Care Fund	1,285	125	-1,160	-90.30%
Net Patient Revenues	***50,444***	***53,244***	***2,799***	***5.50%***
Other Operating Revenues	259	510	251	96.80%
Net Operating Revenues	***50,704***	***53,754***	***3,050***	***6.00%***
Total Operating Expenses	***49,362***	***46,259***	***-3,103***	***-6.30%***
Operating Margin	***1,341***	***7,494***	***6,153***	***458.80%***
Total Margin	***1,174***	***8,135***	***6,961***	***592.80%***
Margin As Pct of Net Op Rev	***2.32%***	***15.13%***		

Table 14: Summary of Finances at UMSMC at Chestertown, UMSMC at Dorchester, and UMSMC at Easton, combined, in thousands									
	Regulated Revenue					**Unregulated Revenue**			
	2015	**2018**	**Nominal Change 2018 to 2015**	**Percent Change 2018 to 2015**		**2015**	**2018**	**Nominal Change 2018 to 2015**	**Percent Change 2018 to 2015**
Gross Patient Revenues	***313,316***	***321,453***	***8,137***	***2.6%***		***52,389***	***53,417***	***1,028***	***2.0%***
Total Deductions from Revenue	***60,696***	***49,766***	***-10,931***	***-18.0%***		***32,018***	***29,766***	***-2,252***	***-7.0%***
Uncompensated Care Fund	1,285	462	-823	-64.0%		0	0	0	
Net Patient Revenues	***253,904***	***272,149***	***18,245***	***7.2%***		***20,372***	***23,651***	***3,279***	***16.1%***
Other Operating Revenues	767	627	-140	-18.3%		2,731	4,518	1,787	65.4%
Net Operating Revenues	***254,671***	***272,776***	***18,105***	***7.1%***		***23,103***	***28,169***	***5,066***	***21.9%***
Total Operating Expenses	***219,133***	***235,228***	***16,094***	***7.3%***		***31,003***	***31,728***	***725***	***2.3%***
Operating Margin	***35,538***	***37,549***	***2,010***	***5.7%***		***-7,900***	***-3,559***	***4,342***	***-55.0%***
Total Margin	***35,538***	***37,549***	***2,010***	***5.7%***		***-8,318***	***4,477***	***12,795***	***-153.8%***
Margin As Pct of Net Op Rev	***13.95%***	***13.77%***				***-36.00%***	***15.89%***		

	Total Revenues			
	2015	**2018**	**Nominal Change 2018 to 2015**	**Percent Change 2018 to 2015**
Gross Patient Revenues	***365,705***	***374,870***	***9,164***	***2.5%***
Total Deductions from Revenue	***92,714***	***79,531***	***-13,183***	***-14.2%***
Uncompensated Care Fund	1,285	462	-823	-64.0%
Net Patient Revenues	***274,276***	***295,800***	***21,524***	***7.8%***
Other Operating Revenues	3,498	5,145	1,647	47.1%
Net Operating Revenues	***277,774***	***300,945***	***23,171***	***8.3%***
Total Operating Expenses	***250,137***	***266,956***	***16,819***	***6.7%***
Operating Margin	***27,638***	***33,990***	***6,352***	***23.0%***
Total Margin	***27,220***	***42,025***	***14,805***	***54.4%***
Margin As Pct of Net Op Rev	***9.80%***	***13.96%***		

Table 15: Summary of Finances at Rural Hospitals in Maryland (Atlantic General, Garrett, McCready, Union of Cecil, Dorchester, Chestertown, and Easton)									
	Regulated Revenue					**Unregulated Revenue**			
	2015	**2018**	**Nominal Change 2018 to 2015**	**Percent Change 2018 to 2015**		**2015**	**2018**	**Nominal Change 2018 to 2015**	**Percent Change 2018 to 2015**
Gross Patient Revenues	***632,466***	***672,972***	***40,507***	***6.4%***		***145,221***	***169,907***	***24,686***	***17.0%***
Total Deductions from Revenue	***109,914***	***105,619***	***-4,295***	***-3.9%***		***83,952***	***98,552***	***14,599***	***17.4%***
Uncompensated Care Fund	2,294	1,025	-1,270	-55.3%		0	0	0	
Net Patient Revenues	***524,846***	***568,378***	***43,532***	***8.3%***		***61,269***	***71,355***	***10,086***	***16.5%***
Other Operating Revenues	6,517	-722	-7,239	-111.1%		6,880	10,477	3,597	52.3%
Net Operating Revenues	***531,362***	***567,655***	***36,293***	***6.8%***		***68,148***	***81,832***	***13,683***	***20.1%***
Total Operating Expenses	***463,327***	***506,628***	***43,301***	***9.3%***		***101,471***	***127,725***	***26,254***	***25.9%***
Operating Margin	***68,036***	***61,028***	***-7,008***	***-10.3%***		***-33,323***	***-45,894***	***-12,571***	***37.7%***
Total Margin	***68,036***	***61,028***	***-7,008***	***-10.3%***		***-31,831***	***-30,558***	***1,272***	***-4.0%***
Margin As Pct of Net Op Rev	***12.80%***	***10.75%***				***-46.71%***	***-37.34%***		

	Total Revenues			
	2015	**2018**	**Nominal Change 2018 to 2015**	**Percent Change 2018 to 2015**
Gross Patient Revenues	***777,686***	***842,879***	***65,192***	***8.4%***
Total Deductions from Revenue	***193,867***	***204,171***	***10,304***	***5.3%***
Uncompensated Care Fund	2,294	1,025	-1,270	-55.3%
Net Patient Revenues	***586,114***	***639,733***	***53,619***	***9.1%***
Other Operating Revenues	13,396	9,754	-3,642	-27.2%
Net Operating Revenues	***599,511***	***649,487***	***49,976***	***8.3%***
Total Operating Expenses	***564,798***	***634,353***	***69,556***	***12.3%***
Operating Margin	***34,713***	***15,134***	***-19,579***	***-56.4%***
Total Margin	***36,205***	***30,469***	***-5,736***	***-15.8%***
Margin As Pct of Net Op Rev	***6.04%***	***4.69%***		

Table 16: Summary of Finances at all Maryland Hospitals									
	Regulated Revenue					Unregulated Revenue			
	2015	2018	Nominal Change 2018 to 2015	Percent Change 2018 to 2015		2015	2018	Nominal Change 2018 to 2015	Percent Change 2018 to 2015
Gross Patient Revenues	***16,282,065***	***17,444,227***	***1,162,162***	***7.1%***		***1,771,914***	***2,111,052***	***339,138***	***19.1%***
Total Deductions from Revenue	***2,740,335***	***2,714,807***	***-25,528***	***-0.9%***		***936,770***	***1,085,670***	***148,900***	***15.9%***
Uncompensated Care Fund	117,663	96,560	-21,103	-17.9%		0	0	0	
Net Patient Revenues	***13,659,393***	***14,825,980***	***1,166,587***	***8.5%***		***835,143***	***1,025,382***	***190,238***	***22.8%***
Other Operating Revenues	211,298	215,469	4,170	2.0%		654,424	826,798	172,375	26.3%
Net Operating Revenues	***13,870,691***	***15,041,448***	***1,170,757***	***8.4%***		***1,489,567***	***1,852,180***	***362,613***	***24.3%***
Total Operating Expenses	***12,694,932***	***13,705,202***	***1,010,270***	***8.0%***		***2,100,381***	***2,638,075***	***537,693***	***25.6%***
Operating Margin	***1,175,759***	***1,336,246***	***160,488***	***13.6%***		***-610,815***	***-785,895***	***-175,080***	***28.7%***
Total Margin	***1,175,759***	***1,336,246***	***160,488***	***13.6%***		***-610,610***	***-436,574***	***174,036***	***-28.5%***
Margin As Pct of Net Op Rev	***8.48%***	***8.88%***				***-40.99%***	***-23.57%***		

	Total Revenues			
	2015	2018	Nominal Change 2018 to 2015	Percent Change 2018 to 2015
Gross Patient Revenues	***18,053,979***	***19,555,279***	***1,501,300***	***8.3%***
Total Deductions from Revenue	***3,677,106***	***3,800,477***	***123,371***	***3.4%***
Uncompensated Care Fund	117,663	96,560	-21,103	-17.9%
Net Patient Revenues	***14,494,536***	***15,851,361***	***1,356,825***	***9.4%***
Other Operating Revenues	865,722	1,042,267	176,545	20.4%
Net Operating Revenues	***15,360,258***	***16,893,628***	***1,533,370***	***10.0%***
Total Operating Expenses	***14,795,314***	***16,343,277***	***1,547,963***	***10.5%***
Operating Margin	***564,944***	***550,351***	***-14,593***	***-2.6%***
Total Margin	***565,149***	***899,672***	***334,524***	***59.2%***
Margin As Pct of Net Op Rev	***3.68%***	***5.33%***		

Table 17: The impact of GBR on per visit charges when volume changes (patient acuity-adjusted for all patients--Private insured, Medicare, Medicaid, Uninsured)								
	UMSMC-Chestertown		UMSMC-Easton		Garrett Regional Medical Center		Anne Arundel Hospital	
	2015	2018	2015	2018	2015	2018	2015	2018
Medical Admissions	1,545	1,029	7,084	6,491	1,601	1,775	21,262	21,722
Charge Per Visit	$15,680	$15,060	$ 13,618	$14,037	$ 11,577	$ 9,908	$ 10,369	$ 10,527
Surgical Admissions	236	176	1,604	1,569	530	543	9,041	7,994
Charge Per Visit	$ 16,513	$19,793	$11,809	$11,591	$9,960	$10,165	$9,874	$10,494

- A hospital is permitted to adjust its GBR by +- 5% in a given year without HSCRC approval and by +-10% with HSCRC approval
- Significant savings for payers if SMC-Chestertown average charges per surgical admission was the same as that at Garrett or Anne Arundel
- The use of global budgeted revenue (GBR) for charge regulation in Maryland means that rates per discharge or visit go up when volume declines
    - SMC-Chestertown's declining volume makes it a high charge hospital, reducing its appeal to payers,
- **the GBR can delay the fiscal impact of "good" volume declines, it cannot eliminate the impact**

Table 18: The impact of GBR on charges for 4 conditions when volume changes (patient acuity adjusted for all patients--Private insured, Medicare, Medicaid, Uninsured)

	UMSMC-Chestertown		UMSMC-Easton		Garrett Regional Medical Center		Anne Arundel Hospital	
	2015	**2018**	**2015**	**2018**	**2015**	**2018**	**2015**	**2018**
Medical Admissions	109	75	184	353	115	167	835	977
Septicemia & Disseminated Infections	$15,341	$13,563	$14,108	$12,680	$12,928	$9,271	$11,363	$10,650
Intestinal Obstruction	$11,835	$18,347	$12,899	$13,545	$11,786	$9,600	$9,715	$9,874
Surgical Admissions	69	66	346	255	161	211	1,425	1,000
Knee Joint Replacement	$17,887	$25,268	$10,013	$10,436	$10,007	$9,950	$10,938	$12,582
Laparoscopic Cholecystectomy	$15,694	$16,021	$12,838	$13,312	$11,125	$9,311	$8,386	$9,340

Note: This table is included for illustrative purposes. These four conditions may not be representative of charges for all conditions at these hospitals.

Appendix B: Senate Bill 1010

Text of Chapter 406, Laws of Maryland, 2018 (Senate Bill 1010).

Senate Bill 1010 directs MHCC, in conjunction with the Office of Health Care Quality (OHCQ), a division of the Maryland Department of Health (MDH) that licenses health care facilities, to conduct an "assessment of the types, quality, and level of services provided at the University of Maryland Shore Medical Center in Chestertown".[1] This assessment must compare current services with services provided in fiscal year 2015 and identify if any services were reduced or transferred to the University of Maryland Shore Medical Center in Easton after July 1, 2015.

[1] Senate Bill 1010, 2019

Chapter 406

(Senate Bill 1010)

AN ACT concerning

Maryland Health Care Commission – Assessment of Services at the University of Maryland Shore Medical Center in Chestertown

FOR the purpose of requiring the Maryland Health Care Commission, in conjunction with the Office of Health Care Quality, to conduct a certain assessment of services provided at the University of Maryland Shore Medical Center in Chestertown; specifying the requirements of the assessment; requiring the Commission to report, on or before a certain date, to the General Assembly on the findings of the assessment; and generally relating to an assessment of services at the University of Maryland Shore Medical Center in Chestertown.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) The Maryland Health Care Commission, in conjunction with the Office of Health Care Quality, shall conduct an assessment of the types, quality, and level of services provided at the University of Maryland Shore Medical Center in Chestertown.

(b) The assessment under subsection (a) of this section shall, at a minimum:

(1) compare the services currently provided to the services provided in fiscal 2015; and

(2) identify whether, on or after July 1, 2015, any services from the University of Maryland Shore Medical Center in Chestertown were reduced or transferred to the University of Maryland Shore Medical Center in Easton.

(c) On or before January 1, 2020, the Maryland Health Care Commission shall report to the General Assembly, in accordance with § 2–1246 of the State Government Article, the findings of the assessment required under subsection (a) of this section.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2019.

Approved by the Governor, May 13, 2019.

Appendix C: Joint Chairman's Report on the Fiscal 2020 State Operating Budget (HB 100) and the State Capital Budget (HB 101) and Related Recommendations (page 95)

Text of page 95 of the Joint Chairman's Report on the Fiscal 2020 State Operating Budget (HB 100) and the State Capital Budget (HB 101) and Related Recommendations (page 95).

The Joint Chairmen's Report withholds $500,000 in appropriations for MDH pending MDH, in consultation with MHCC, conducting an assessment and submitting a report covering the same topics addressed in Senate Bill 1010 (see Appendix A).

Budget Amendments

OFFICE OF THE SECRETARY

M00A01.01 Executive Direction

Add the following language to the general fund appropriation:

, provided that $500,000 of this appropriation made for the purpose of administration may not be expended until the Maryland Department of Health, in consultation with the Maryland Health Care Commission, conducts an assessment of, and submits an accompanying report on, the types, quality, and level of services provided at the University of Maryland Shore Medical Center in Chestertown. This assessment shall include a comparison of the services currently provided to the services provided in fiscal 2015 and identify whether, on or after July 1, 2015, any services from the University of Maryland Shore Medical Center in Chestertown were reduced or transferred to the University of Maryland Shore Medical Center in Easton. The report shall be submitted by January 1, 2020, and the committees shall have 45 days to review and comment. Funds restricted pending the receipt of the report may not be transferred by budget amendment or otherwise and shall revert to the General Fund if the report is not submitted.

Explanation: This language restricts funding in the Office of the Secretary until the Maryland Department of Health (MDH), in consultation with the Maryland Health Care Commission, undertakes an assessment on the services offered at the University of Maryland Shore Medical Center in Chestertown, including the change of services offered since fiscal 2015, and submits a report on those findings.

Information Request	Author	Due Date
Services provided at the University of Maryland Shore Medical Center	MDH	January 1, 2020

Appendix D: Letters related to 2018 Save Our Hospital Request for Audit

This Appendix contains a series of letters. The first letter is a March 22, 2018 letter from Margie Elsberg on behalf of the Save our Hospital group, detailing a number of concerns about the University of Maryland Shore Medical Center at Chestertown. The other included letters are related to that letter. Included correspondence is listed below:

Document Description	**Date**
Letter from Margie Elsberg to Senator Hershey on behalf of Save our Hospitals	March 22, 2018
Letter from Secretary Neall to MHCC Chair Moffit and HSCRC Chair Sabatini	September 24, 2018
Letter from MHCC Chair Moffit and HSCRC Chair Sabatini to Secretary Neall	October 18, 2018
Letter for Ken Kozel, University of Maryland Shore Health System CEO, from Katie Wunderlich, Executive Director of HSCRC, and Ben Steffen, Executive Director of MHCC	October 26, 2018
Response to Allegations of Service Reductions by Save Our Hospital Group on 3/22/2018 from University of Maryland Shore Health System	November 8, 2018
Letter from Renee Webster, Deputy Director at OHCQ, to Ben Steffen, Executive Director at MHCC	December 6, 2019

March 22, 2018

Save the Chestertown Hospital!

Senator Stephen S. Hershey, Jr.
James Senate Office Building - Room 420
11 Bladen Street
Annapolis, Maryland 21401

Dear Senator Hershey,

I'm writing because our community needs your help, and we need it now.

We need your strong support for enactable, enforceable legislation that will return the Chestertown hospital to long-term health. Our doctors are concerned that recent service reductions are turning our hospital into a de facto Freestanding Medical Facility. With waning public confidence in the hospital, the new cutbacks leave us to believe that it won't be long before there won't be a hospital to save.

These are serious concerns that need addressing now. Our doctors tell us that Shore Regional Health refuses to assign Easton-based cardiologists and orthopedic surgeons to work in Chestertown when we have no local doctors on call. As the Chestertown hospital limps along without full cardiology or orthopedic surgery coverage, frail and seriously injured patients who should be cared for close to home are inevitably transferred to Easton.

What's more, recent reductions in the amount of time that supervisors, technicians, nurses, lab staffers and others are scheduled to work in Chestertown compounds the number of transfers and delayed procedures, and in at least one case, raises concerns about patient and staff safety.

A revised list of service reductions since the spring of 2016 is attached.

Our community needs a trusted and robust inpatient hospital, and we need legislative relief to make that happen. We believe that regular state-mandated hospital audits, paired with clear consequences for un-repaired deficits, will motivate those who operate our hospital to recruit much-needed physicians and surgeons, return staffing and services to appropriate high-quality levels, and run community outreach and public relations campaigns aimed at raising community confidence.

A state-mandated hospital audit regimen and follow-up oversight need not be costly, but we believe it will provide the ingredient that is currently missing: the will to provide our community with high quality hospital services.

We implore you to keep the promises that you and Senator Middleton made in 2016 to the people of Kent and northern Queen Anne's Counties. It's what you promised, and what we trust you will do.

Sincerely,

Margie Elsberg
On behalf of Save Our Hospital

Save Our Hospital

Chestertown Physician Concerns
Service reductions at the Chestertown hospital
March 22, 2018

Though inpatient services have remained open in Chestertown—required until 2020 under the law known as SB707—our doctors are setting off alarms once again, listing physician, service, staff, facilities and equipment eliminations and reductions.

Current physician comments:

"There is a general animosity toward us from the entire regional administration and staff."
"This is not benign neglect. It is malignant neglect."
"They're doing irreparable damage to the hospital's reputation."
"As Shore cuts back services, people go elsewhere for care and develop new relationships with those doctors. I don't know if those people will ever return to our hospital."
"This is not really a regional medical staff even though the physicians are employed by Shore Regional Health System. They are allowed to refuse to cover Chestertown."
"No successor physicians means no future for the hospital."
"Death by a thousand cuts."
"The hospital is being slowly bled to death."

All services on this list were reduced after early 2016.

- **HALF-TIME CARDIOLOGY COVERAGE SINCE LATE 2017**
  Since late 2017, there has been no cardiologist on-call in Chestertown one-third of the time. Off and on for more than two years, Chestertown has had only one full-time cardiologist, and though the service has often been supplemented with locums and for a brief period, by a doctor who had planned to move here (but changed his mind), local primary physicians say it has been difficult to cope with the lack of consistent cardiology services.

  When the Chestertown cardiologist went on a long-planned vacation recently, Shore Regional Health and the NINE-MEMBER cardiology group in Easton/Dorchester refused to assign a cardiologist to Chestertown. (However, when two interventional cardiologists in Easton took a vacation recently, two equally qualified cardiologists from UMMS in Baltimore were sent to Easton to cover the service.)

  Though the Easton/Dorchester cardiologists are employed by Shore Regional Health, they are never assigned to Chestertown. It is common for Chestertown to transfer cardiac patients to Easton because there is no cardiologist on call in Chestertown.

- **PART-TIME STRESS TEST TECHNICIAN**
  The hospital no longer has a full-time stress test technician. Inpatients are sent to Easton for stress tests when the part-time technician is not in Chestertown.

- **LACK OF CONSISTENT ORTHOPEDIC SURGERY COVERAGE SINCE 2017**
  There has not been 24/7 Orthopedic Surgery coverage since the retirement of one of Chestertown's orthopedic surgeons in mid-2017. Since then, there are several days each month

when there is no orthopedic surgeon on call, so patients with hip fractures, for instance—common among the elderly—cannot be operated on close to home. There are SEVEN orthopedic surgeons based in Easton, but Shore Regional Health System's Chief Medical Officer, Dr. William Huffner, refers to them as "our orthopedic surgeons" and refuses to assign them to Chestertown. What's more, transfers to Easton are not automatic for orthopedic surgery patients, unless a member of the orthopedic group accepts the patient, and acceptance is not automatic. (The Easton-based orthopedic surgeons regularly see patients at Shore's Queenstown facility.)

- **NO CHESTERTOWN FACILITY MANAGER NEGATIVE PRESSURE PATIENT ROOM – 2017-2018**
  Chestertown no longer has a Facility Manager, whose job is to ensure that the facility is in good repair. The Regional Facility Manager in Easton is responsible for Chestertown facilities, but this system sometimes leads to a lack of repair and poor communications, according to the doctors.

  Chestertown has two Isolation rooms with negative pressure systems, designed to ensure that contaminated air does not infiltrate common areas. When the rooms "stopped working" in early December of 2017, no one in Easton informed the Chestertown nursing staff. As a result, patients were cared for in those rooms (at least one may have had TB) "for extended stays." The Chestertown staff was informed of the situation in early February.

- **INTENSIVE CARE UNIT OPENED IN APRIL, 2016 – TWO ROOMS NOT USEABLE**
  Two of the six ICU patient beds are not used because they are not equipped with telepathy equipment that links the ICU to UMMS' tele-medicine center in Baltimore, a service that is used during the night. The two rooms also are not equipped with bathrooms and lift equipment. Because of this, some patients in need of ICU care are transferred to Easton.

- **NO ELECTIVE OR EMERGENT CARDIOVERSION**
  This non-emergency procedure is implemented to return a patient's heart rhythm to normal. It is no longer done in Chestertown. (Yes, the hospital staff performs emergency defibrillation.)

- **NO SLEEP LAB**
  The Sleep Lab that used to be part of the Chestertown service has been removed and is now in Easton.

- **NO EMERGENCY DEPARTMENT MANAGER as of mid-2017**
  This position was considered necessary until about nine months ago, when the long-time ED Manager resigned. She has never been replaced.

- **NO OSTOMY NURSE**

- **NO WOUND CARE NURSE**
  Shore has no wound care specialist on staff in the Chestertown hospital, but there is a specially trained technician in Chestertown who is nearly always available to respond when there is a wound care need in the hospital.

- **NO TJC (Joint Commission) DIRECTOR**
  This specialist helps all departments ensure successful passage of rigorous Joint Commission inspections. This service has been regionalized and is based in Easton.
- **INTERVENTIONAL RADIOLOGY – lack of service after expected physician retirement**
  One of Chestertown's two radiologists, the only radiologist who performs interventional procedures, will soon retire. When he leaves, patients requiring interventional radiology will have to be transferred to Easton.

- **RADIOLOGY MANAGER / RADIOLOGY SCHEDULING - 2018**
  The long-time full-time Chestertown Radiology Manager was recently rescheduled for two days a week in Chestertown and three in Easton.

- **PATHOLOGY CUT BACK TO TWO MORNINGS A WEEK**
  Pathology services have been cut back to two mornings a week. Chestertown surgeons have requested tele-pathology services, whereby pathologists in Easton could diagnose, for instance, whether there is cancer in a tissue sample, but the service has been refused.

- **NO CYTOLOGY SERVICE**

- **NURSE SHORTAGES**
  It is becoming more common to transfer patients to Easton because of nurse shortages. The scheduling of nurses is so minimal that sometimes new inpatients cannot be accepted in the second floor nursing unit because of rules governing nurse-patient ratios.

  ICU NURSING STAFF SHORTAGE
  Intensive Care patients are sometimes transferred because there are not enough ICU nurses.

- **NO MEDICAL RECORDS SUPERVISOR**
  Primary physicians say they no longer receive surgery reports on their patients unless they call to request them. Another primary physician says he almost never gets patient histories and discharge reports from the emergency department—something that was normal when Dr. Deborah Davis was the Emergency Department Director.

- **TRANSITIONAL NURSE NAVIGATOR PROGRAM – reinstated in 2017 but understaffed**
  This robust Chestertown program, which was eliminated in 2013, was reinstated with only one Nurse Navigator in 2017. Because this program serves patients with complicated medical needs, helping them transition out of the hospital, doctors feel that one staffer is not enough. Under the pre-2013 program Nurse Navigators reduced patients' length of hospitalization, prevented readmissions, reduced hospital-acquired conditions, decreased penalties and increased financial rewards for meeting and exceeding hospital regulators' goals was dismantled in 2013.

- **PHYSICIAN RECRUITMENT—RETIREMENT OF EXEC. DIR. SCOTT BURLESON**
  Four of Chestertown's Primary Care physicians are over 67 and both general surgeons are in their 60s. Chestertown administrators and local physicians have warned for many years that physician recruitment is a critical need. Our understanding is that there was no recruitment effort by Shore's administration until Scott Burleson was named Chestertown's Executive Director in late 2016, in response to an outcry from Save Our Hospital physicians.

Mr. Burleson worked tirelessly on recruitment. As the result, Chestertown now has two new full-time primary care doctors and one part-time family physician. We are told that Shore is recruiting a cardiologist who will work part-time in Chestertown—which means there will continue to be care gaps—but to our knowledge, there are no orthopedic surgery or general surgery recruitment efforts, and no plans to recruit an interventional radiologist to succeed the radiologist who plans to retire soon.

NOTE: Shore is currently recruiting one general surgeon, two gastroenterologists, one or two endocrinologists, one neurologist and numerous Physicians' Assistants (PAs) and Nurse Practitioners. When hired, all will become highly-paid members of Shore physician groups. We expect that they will not be assigned to see patients in Chestertown.

- **UMMS & UM MEDICAL SCHOOL LACK RURAL MEDICINE/PRIMARY CARE RESIDENT TRACKS**
  While several states, including North Carolina, have robust rural residency programs, the University of Maryland Medical School and UMMS have failed to offer rural primary care programs. If residents are regularly scheduled to work in Shore Regional facilities, the lack of coverage in Chestertown and the need to hire expensive physicians from out of state will dramatically decrease. A rural residency program was strongly recommended by the Legislative Workgroup.

- **PARKING LOT "GOLF CART" SHUTTLE**
  The parking lot golf cart shuttle in Chestertown is not a medical service, but it is a much-used convenience that eliminates an uphill walk and relieves the stress of getting frail seniors and young children across the street to the hospital entrance. In a cost-cutting measure, the shuttle drivers were fired in July of 2017 and the service was terminated. In spite of scores of angry phone calls and letters to the editor from people who felt that the cutback was thoughtless and disrespectful, there was no golf cart service for more than four months; the service was restored in November. A similar parking lot valet service in Easton was never interrupted.

- **LACK OF PUBLIC RELATIONS; LOSS OF "MARKET SHARE"**
  Physicians and area residents complain that there has been an almost total lack of positive public relations about the Chestertown hospital, its services and staff, since Shore Regional Health was created in 2013 and public relations functions were consolidated in Easton. Promised news stories are slow to materialize or never appear in local media. At least one physician offered to write a regular column for the local newspaper and to do radio interviews, but he was denied permission. News stories about Easton physicians and services are common in Talbot County media.

  As a result of media- and conversation-driven news about diminished services (no maternity, no pediatrics, no ENT for five years, loss of a cardiologist and an orthopedic surgeon, etc.) and the uncertain future of inpatient services in Chestertown, many area residents who have their own transportation have sought and found specialists, emergency and hospital services in non-UMMS facilities, primarily in Annapolis, Christiana and Elkton. As they share their decisions to abandon the Chestertown hospital and physicians with neighbors, more area residents follow suit. When the inpatient census falls, regulators may conclude that the hospital is not needed.

- **ADMINISTRATION CONCERNS – EXECUTIVE DIRECTOR SCOTT BURLESON'S RETIREMENT**
  The sudden and unexpected retirement in late February of the highly qualified Scott Burleson as Executive Director at Chestertown in 2016 is an enormous disappointment; his dedication to physician recruitment and to the staff and operation of the hospital was the single greatest improvement we have seen since Chestertown was merged into the Shore Regional System.

  We have reason to be concerned about Chestertown administration plans for the future. Inexplicably, there was no dedicated supervisor in Chestertown for Shore Regional Health's first three years, until Mr. Burleson was named Executive Director, and the hospital suffered from a lack of on-site leadership. During those years, instead of installing a single administrator, five different Shore Health administrators (vice presidents of HR, Finance, Public Relations, etc.) had been assigned to supervise the hospital on one day of each week. Chestertown employees reported that some had never or rarely been seen in the hospital.

  The Interim Executive Director is the Director of Nursing for the Chestertown hospital and for the Queenstown FMF.

- **A CHESTERTOWN PSYCHIATRIC UNIT PROPOSAL – a missed opportunity**
  The Shore Regional Health System board recently voted to close the Dorchester hospital as soon as possible. The system decided to move the Behavioral Health Unit (about 20 beds) as well as the 40-some Med-Surg beds to Shore's Memorial Hospital in downtown Easton. An administrative area of Memorial Hospital will be converted to use as the Behavioral Health Unit.

  When it was suggested that Chestertown's third floor (which has 17 vacant patient rooms) would be a perfect location for the Behavior Health Unit, Shore administrators dismissed the idea, even though conversion would be minimal (rather than nearly $1 million in Easton). The concern, ostensibly, is to avoid inconveniencing physicians who live in the Easton area. It seems more likely that there is no interest in turning part of the Chestertown hospital into a facility that would offer services that are desperately needed in Maryland, and which would give the hospital long-term viability.

  (Note that Compass Regional Hospice recently rented a four-room section of Chestertown's third floor for a new hospice facility. We have been assured that the new hospice facility could be moved readily to the former Maternity Unit on Chestertown's second floor, leaving all 17 rooms and the nursing station available for use as a Behavioral Health Unit.)

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

September 24, 2018

The Honorable Robert E. Moffit, PhD, Chairman
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

The Honorable Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairmen Moffit and Sabatini:

I am writing you regarding the University of Maryland Medical Center at Chestertown. I have received many inquiries from concerned citizens and community leaders in Kent County who have raised issues regarding the level of care received, alleged reduction of staff, and the alleged diversion of patients to surrounding hospitals by the Medical Center.

Governor Hogan and the Maryland Department of Health (MDH) are committed to ensuring access to quality healthcare services in the Mid-Shore region and have allocated a total of $325,000 in state funds to the Rural Health Collaborative Pilot. This Collaborative, which will have its first meeting shortly, and which is being governed by health care stakeholders from the four Mid-Shore Counties will lead the development of health services assessments for rural regions when it is fully operational and is expected to allow for a gap analysis to understand what resources are needed to serve populations such as Chestertown. Senator Hershey spearheaded the legislative effort in the most recent General Assembly session to create the Collaborative.

While this approach will be useful in the long term, I am concerned, as are the residents of Kent County, that this will not meet their more immediate need of assessing the services provided by the Chestertown Medical Center. To that end, I am asking your Commissions to consider collaborating on an audit of the current services provided at the Medical Center. This audit should look at what services are being provided, how those services have changed in the past year, and whether they are meeting the needs of the citizens of the Mid-Shore. The Maryland Health Care Commission has done the similar assessments through the Certificate of Need process, and the Health Services Cost Review Commission would be able to review and assess current conditions and practices. I think your Commissions are much more capable and well equipped than the MDH to conduct the requested health services audit.

I hope you will consider undertaking this review and look forward to speaking with both of you about this matter. I have also attached a letter that I received earlier this year regarding these issues from a group of residents of Kent County for your information and my earlier response.

Sincerely,

Robert R. Neall
Secretary

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

October 18, 2018

The Honorable Robert R. Neall
Secretary, Maryland Department of Health
201 W. Preston Street
Baltimore, MD 21201

Dear Secretary Neall:

Thank you for your letter dated September 24, 2018, addressed jointly to the Health Services Cost Review Commission ("HSCRC") and the Maryland Health Care Commission ("MHCC") relaying the concerns reported by citizens and community leaders regarding the level of care delivered by the University of Maryland Medical Center at Chestertown ("UM-Chestertown"). We understand the importance of assuring Kent County and mid-Shore residents' access to quality health care services at the hospital. This letter confirms the intent of both Commissions to conduct a thorough inquiry of the inpatient and outpatient services offered through the University of Maryland Medical Center at Chestertown.

The MHCC and HSCRC are well qualified to oversee this inquiry. The MHCC reviews the need for certain regulated health facilities (and a limited number of specialized services) through the Certificate of Need process and recently organized a workgroup to study rural health care delivery in response to legislation expanding Freestanding Medical Facilities. The HSCRC is tasked with establishing hospitals' global budgets and monitoring hospital financial viability, the movement of services, as well as the reasonableness of rates related to costs for purchasers of care at a hospital. HSCRC has access to financial reports from each of the State's acute care and specialty hospitals. Thus, the HSCRC can provide a financial analysis of the hospital and services that are offered at the hospital. Together, MHCC and HSCRC, therefore, are well equipped to review and assess current conditions and practices at Chestertown.

In conducting this inquiry, the Commissions' staff will immediately first meet with representatives of Shore Health to review the alleged serious concerns that have been raised and

recommend any remedial courses of action necessary. If warranted, the Commissions will engage the services of a contractor to conduct an audit of the facility that will include review of data and documents. These will include, among other things, the 2016 legislation protecting the status of UM-Chestertown through 2020, the several reports by University of Maryland Medical System and its affiliates addressing the health care system on the Mid-Shore dating from 2014 forward, and the numerous communications from Mid-Shore residents regarding services at UM-Chestertown. We will also assess utilization of services and financial performance of the UM-Chestertown compared to similar Maryland hospitals using data held by the Commissions. We anticipate completion of such an audit by January 2019.

Please feel free to contact Ben Steffen, Executive Director of MHCC, or Katie Wunderlich, Executive Director of HSCRC, for additional information.

Sincerely,

Robert E. Moffit, Ph.D.
Chair, MHCC

Nelson Sabatini
Chair, HSCRC

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

October 26, 2018

By E-Mail and USPS

Kenneth Kozel, M.H.A., F.A.C.H.E.
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington Street
Easton, Maryland 21601

Dear Mr. Kozel:

On September 24th the Chairs of the Maryland Health Care Commission and the Health Services Cost Review Commission received a request from Secretary of Health Robert Neall asking the Commissions to examine alleged reductions in services at the University of Maryland Shore Health Medical Center at Chestertown (UM-Chestertown). The Secretary asked the Commissions to "look at what services are being provided [at UM-Chestertown], how those services have changed in the past year, and whether they are meeting the needs of the citizens of the Mid-Shore.". The Commissions responded to the Secretary's request on October 18th.

The Commissions outlined a two-step process for reviewing and assessing conditions at UM-Chestertown. In this first step, the Commissions request that Shore Health (Shore) respond by November 9th to the allegations raised in Save Our Hospital's March 22nd, 2018 letter, which was an enclosure in Secretary Neall's letter. The Commissions will meet with Shore leadership approximately one week later at a time mutually agreeable to Shore leadership and the Commissions' staffs to review Shore's responses and discuss the second step, which could include a formal review of the alleged reductions at UM-Chestertown by an independent third party.

Please respond to each of the service reduction claims in the enclosed Save the Hospital letter. Complete responses to the claims will enable to the Commissions to complete the request from the Secretary of Health in an expeditious manner.

Please feel free to contact Ben Steffen, Executive Director of MHCC, or Katie Wunderlich, Executive Director of HSCRC, for additional information.

Sincerely,

Katie Wunderlich
Executive Director, HSCRC

Ben Steffen
Executive Director, MHCC

Attachments:

Secretary Neall letter
Save Our Hospital Letter
MHCC-HSCRC Letter to Secretary Neall

cc: Nelson Sabatini, Chair of HSCRC
Robert Moffit, PhD, Chair of MHCC

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

November 8, 2018

RESPONSE TO ALLEGATIONS OF SERVICE REDUCTIONS BY SAVE OUR HOSPITAL GROUP ON 3/22/18 CHESTERTOWN, MD

On October 2, 2018, I received a copy of the March 22, 2018 letter sent to Senator Steve Hershey by Margie Elsberg of the Save Our Hospital group. Attached to that letter, also dated March 22, 2018, was a purported summary of "service reductions at the Chestertown hospital since 2016." As requested by MHCC Executive Director Ben Steffen and HSCRC Executive Director Katie Wunderlich, via a letter to me dated October 26, 2018, I am responding on behalf of University of Maryland Shore Regional Health (UM SRH) to each item in the summary with the current status and, where necessary, an explanation of the actual circumstances that, in some instances, have been misconstrued or misunderstood.

The overarching facts are these:

1. UM SRH remains committed to keeping inpatient beds at UM SMC Chestertown through March, 2022.

2. Health care and hospitals are dynamic and changing, with an abundance of factors that are not within control of the industry or an individual hospital, such as physician and provider decisions (recruitment, retirements, concierge-based practice conversions, inpatient care, relocation), patient choice, team member choice, achieving patient volumes sufficient to provide quality outcomes, technology changes, facility needs and the challenges of reducing utilization and costs.

3. Given these factors, it is impractical and impossible to freeze an organization in time and to insist that "nothing can change." Changes occur and a prudent organization must responsibly adapt.

4. None of these factors, however, has impacted our commitment to maintaining inpatient beds through March, 2022. Neither the University of Maryland Medical System (UMMS) nor UM SRH is inflicting "death by a thousand cuts," as alleged. Positions are being filled, equipment is being repaired, physicians are being recruited and essential services are being provided. Public relations and marketing on behalf of the hospital in Chestertown are more robust in 2018 than they ever were in the years prior to the hospital's affiliation with the Easton and Dorchester hospitals in 2013.

In the response to the Save Our Hospital allegations that follow, please note that for purposes of clarity, we have categorized each of the complaints into one of four categories:

1. Facility Operations
2. Staff Recruitment
3. Physician/Provider Recruitment
4. Clinical and Support Services

The first two categories (Facility Operations and Staff Recruitment) comprise the bulk of the complaints and are easily answered. Physician/Provider Recruitment and Clinical and Support Services do present significant challenges in this rural and sparsely populated region of Kent and northern Queen Anne's counties, and we recognize both the community's interest and your inquiry.

Despite these challenging issues, and despite allegations to the contrary, UM SRH has had notable success in bringing new providers and services to the community and stabilizing practices that were feeling the weight of challenges such as (i) transition to an electronic medical record system; (ii) office management and expense pressures; (iii) recruitment and retirement planning; (iv) handling call time and vacations as solo community providers; and (v) building and maintaining referrals.

Providers have been added to or stabilized in the community in the following specialties:

1. Primary Care
2. OB/GYN
3. Cardiology
4. Urology
5. Uro-gynecology/Continence
6. Women's Health
7. Diabetes and Endocrinology
8. Neurology
9. Pulmonology
10. Sleep Medicine
11. Breast Surgery
12. Ear Nose and Throat/Otolaryngology

We are actively recruiting for general surgery and for additional primary care providers, since our primary care practices are filling quickly due to two very active community-based physicians who recently moved to concierge medicine and the retirement of another primary care physician in September. There will always be more work to do in the vexing arena of rural provider recruitment and these recruitments come with a hefty price tag in time and expense. Each newly recruited physician, provider and practice is introduced by UM SRH to the community, marketed thoroughly and connected with his or her colleagues in the Kent County medical field.

Additionally, with the use of telemedicine, we have brought pediatric and psychiatry consults in real time to the Emergency Department at Chestertown (and indeed, to all four of our Emergency Departments throughout the mid-Shore) and we are using telemedicine to provide regional palliative care services at the bedside, saving families travel and time in discussing their loved ones' plans of care.

In summary, and as a preface to the responses that follow, UM SRH has remained true to its 2013 commitments when Chester River and Shore Health affiliated. We work diligently every day to provide care for the people who count on us for their health care in Kent and northern Queen Anne's counties. Despite the challenges we face there—not the least of which is the mistrust of some very vocal citizens—UM SRH and UMMS place a high value on continuing necessary services that are patient focused, high quality and efficient.

Thank you for your interest and I welcome the opportunity for further discussion with you.

Kenneth D. Kozel
President and CEO
UM Shore Regional Health

Facility Operations

ICU Negative Pressure Room Alarm: During the time when the negative pressure alarm system was inactive, waiting for behind the wall construction and repair, ICU nursing and facilities maintained meticulous testing and logs of effective negative pressure. Staff and patients were never at risk. The alarm system in the ICU negative pressure room is repaired and both negative pressure rooms at Chestertown are fully functioning.

ICU Rooms Useable: The average daily census (ADC) of ICU patients is 0.67 at Chestertown. Four ICU telemedicine beds and the available bathrooms and lifts are sufficient for Chestertown's ICU ADC. Decisions to transfer patients are clinical in nature and every transfer from Chestertown is reviewed by physicians for appropriateness.

Parking Lot Shuttle: This service was discontinued to save costs. The service shuttles people during daytime hours. Any anticipated savings were overshadowed by public discontent and the service has been reinstituted after recruitment of new staff.

Staff Recruitment

Emergency Department Manager: Position filled

Facility Manager: Position filled

Executive Director: Position filled

Radiology Manager: Position has been a shared position between hospitals. With the retirement of our Regional Director for Radiology, our Radiology Manager has temporarily filled the director role. The shared Radiology Manager position will be re-filled when the permanent Radiology Director is hired.

Stress Testing Technician: Full time stress technician on site; tests performed when cardiologist present

Ostomy Nurse: This has never been a budgeted position at Chestertown; care is standardized in nursing; telemedicine consults support ostomy and wound services

Wound Nurse: This has never been a budgeted position at Chestertown; care is standardized in nursing; telemedicine consults support care

Medical Records Supervisor: This is a regional department that does not require a full-time on-site supervisor; the Medical Records responsibilities for Chestertown are covered by a UM SRH Regional Supervisor.

Joint Commission Director: System-wide Joint Commission activities are overseen by a Regional Director who serves all UM SRH locations, including our Chestertown campus.

Cytology Technologist: This position did not exist in the past; volumes are very low and testing is absorbed in the regional lab with no delays in patient care

Transitional Nurse Navigators (TNN): This service did not exist at Chestertown in 2013. The TNN has been full time at Chestertown since 2016.

Nursing Shortages, ICU and Med-Surg: Nurse staffing at Chestertown is managed in the appropriate ranges for patient demand and standardized nurse/patient ratios. Staffing is reviewed a minimum of three times a day at bed huddles to determine needs. There have been no transfers due to staffing on Med Surg unit. Every effort is made to staff the ICU with competent ICU nurses; however, we are actively recruiting for a current vacancy and ICU patient transfers may be necessary during recruitment.

Physicians/Provider Recruitment

Cardiology: The independent cardiologist in Chestertown takes call on a sporadic basis. Because he did not wish to recruit another provider to his practice, with the support of the Chestertown Physician's Council, UM SRH recruited and employed an additional cardiologist. The new cardiologist has established a practice in Chestertown. The monthly call schedule is supplemented by telephonic coverage from the Easton based cardiology group. Whether to transfer a patient is determined by each patient's clinical needs. All patient transfers are routinely reviewed by the Chestertown Physicians Council to insure that transfers were appropriate.

> *The Chestertown Physicians Council (CPC) is a CEO-chaired council that includes six long-standing Chestertown medical staff providers (Drs. Ross, Peimer, Noble, O'Conner, Panas, and Kareiva), the CEO and members of the SRH senior team. Meeting agenda items typically include establishing recruitment priorities and providing recruitment effort updates, transfer data review, operations issues discussions and marketing/public relations plan review.*

Orthopedics: There are two independent orthopedic surgeons at Chestertown, following a retirement in 2016. The two surgeons declined to replace the third, citing low volumes, and the decision not to recruit and employ our own orthopedist was upheld by the Chestertown Physicians Council. The two orthopedic surgeons cover most call, supplemented by telephonic coverage by the Easton based orthopedic group. Emergent hip fractures are performed at Chestertown by the Chestertown orthopedic surgeons or may be stabilized, managed for pain and depending upon patient needs, taken for operative repair to our Chestertown operating suite the next day. Transfer of patients is determined by a patient's clinical needs. All patient transfers are reviewed by the Chestertown Physicians Council to insure that transfers were appropriate.

Interventional Radiology: While there has never been a room equipped for interventional radiology at the Chestertown hospital, one of the two radiologists there did perform certain infrequent interventional procedures such as simple biopsies. When the sole radiologist who performed interventional procedures retired, some interventional radiology procedures such as lumbar punctures and hip injections have been continuously performed by some radiologists at Chestertown on request. Comprehensive Interventional radiology services are performed at the hospital in Easton, where technology, facilities and volumes are sufficient to insure quality outcomes for patients.

Pathology: With retirement of the Chestertown pathologist in 2016, the pathology group based in Easton met with surgeons at Chestertown in order to schedule effectively for surgical pathology needs and to meet those needs in timely and flexible ways. The Chestertown surgeons worked with pathology to create, approve and implement this plan. It is in place and meeting current needs.

Clinical and Support Services

Sleep Lab: Before the retirement of the Chestertown pulmonologist who provided sleep lab services, only three sleep studies were conducted per month. The retiring pulmonologist recommended that these low volumes and the migration of sleep studies to home testing did not warrant the continuation of a sleep lab at Chestertown. The new pulmonologist recruited in 2016 provides for home sleep testing through his Chestertown office practice.

Cardioversion: Our cardiology clinicians do not remember a time when *elective* cardioversions were offered in the Chestertown hospital. The independent cardiologist resigned the privilege due to infrequent occurrence and malpractice costs.

Marketing and Public Relations: The Chestertown hospital has 47 percent of the inpatient market share for its primary service area. Largely the result of a shift in physician referral patterns and patient choice, this market share represents a 12 percent decline since 2015. During the same period of time, UM SRH increased marketing, special events and community relations activities, which more than doubled previous efforts and campaigns, specifically on behalf of the Chestertown hospital. These efforts, along with provider recruitment and retention, are expected to help stabilize and likely grow market share at UM Shore Medical Center at Chestertown.

Physician Recruitment: Advocacy for physician and provider recruitment is not the work of one executive but all UM SRH executives, in partnership with our providers and with UMMS and the UM School of Medicine. While successful recruitment and retention of providers in this rural community present special financial challenges, due to salaries, call coverage, benefits and productivity, UM SRH has the dedicated skill and support of the Chestertown Physicians Council, the Executive Director, and the full complement of the executive team and Medical Staff Office for recruitment in Chestertown.

Rural Physician Residencies: To be undertaken and sustained, such expensive residencies – as a recruitment tool-- are more a matter of public policy and resources than they are independent decisions of any school of medicine. The Rural Study recommended an exploration of such residencies, a recommendation that we support. UM SRH will continue to advocate for expansion of residency programs to the rural Eastern Shore.

Behavioral Health Unit at Chestertown: The location of clinical services must be determined by community need for, and appropriate access to, those services, not merely by what may be viewed as "available space." As such, the study of the possible relocation of the behavioral health unit from UM SMC at Dorchester to UM SMC at Easton, and ultimately to the new regional medical center, indicated that both the geographic distribution of our patients and the need for enhanced hospital services for acute behavioral health patients make it necessary for that service to be located in Easton.

The hospice suite located within the Chestertown hospital is functioning well in its new location where it is discreet from inpatient medical care.

MARYLAND
Department of Health
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Office of Health Care Quality
7120 Samuel Morse Drive
Columbia MD 21046

December 6, 2019

Mr. Ben Steffen, Executive Director
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore MD 21215

Dear Mr. Steffen,

Per your request, staff of the Office of Health Care Quality again reviewed the "Save our Hospital" document dated March 22, 2018, for evidence of possible regulatory violations. The document outlines a series of concerns about services that the University of Maryland Shore Medical Center at Chestertown no longer provides or provides at a reduced level of services.

Regulations set minimum requirements for hospitals. The regulations are designed to allow for various types, sizes and localities of hospital facilities under the umbrella of one set of regulations. Maryland hospitals are governed under COMAR 10.07.01 and under the Medicare Conditions of Participation 42CFR 482. Both require processes and systems to address the services provided and the flexibility to address oversight of very large hospitals to small rural hospitals including teaching hospitals and community hospitals. The regulations only stipulate that hospitals provide a specific sets of services with additional requirements based on the complexity of the health care services provided.

A review of the "Save our Hospital" letter identifies many services that are no longer available at University of Maryland Shore Medical Center at Chestertown. Most of the services identified in the letter are not required by regulation or can be provided on a limited basis

without being out of compliance with the regulations. It is also permissible for some management staff to be shared between hospitals if consistent with all personnel and credentialing requirements. In those cases, this office would expect that the hospital management is providing the required services in accordance with State and federal regulations at both hospitals. Therefore, the sole fact that certain services are no longer provided, without evidence that the loss of or reduced level of services has resulted in adverse outcomes for hospital patients, would not alone serve as a basis for a citation of non-compliance with hospital regulations.

The "Save our Hospital" document also addresses concerns related to nurse staffing. Neither Maryland nor the Centers for Medicare and Medicaid Services mandate staffing ratios for nurses. When required, the Office of Health Care Quality evaluates the adequacy of nurse staffing by reviewing care provided to patients. The Office of Health Care Quality has received only two complaints over the past nine years on University of Maryland Shore Medical Center at Chestertown. However, the allegations in those complaints were not related the lack of or quality of nursing services provided at the hospital.

The Office of Health Care Quality is prepared to investigate complaints related to the care at University of Maryland Shore Medical Center at Chestertown if there is evidence of possible non – compliance and should be contacted by any citizens or agencies that may have concerns. Thank you for allowing me to address your questions about the oversight of University of Maryland Shore Medical Center at Chestertown.

Sincerely,

Renee B. Webster
Deputy Director

Appendix E: Office of Health Care Quality Letter on UMSMC Accreditation and Licensure Status and Complaints

This Appendix contains a letter from the Office of Health Care Quality describing UMSMC's accreditation and licensure status and describing the number of complaints that have been received related to UMSMC at Chestertown during the period covered by the assessment.

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Office of Health Care Quality 7120
Samuel Morse Drive
Second Floor
Columbia, MD 21046

November 8, 2019

Ben Steffen
Executive Director
Maryland Health Care Commission
Patterson Ave'.
Baltimore MD 21215

Dear Mr. Steffen,

The Office of Health Care Quality has made a review of our survey records for University of Maryland Shore Medical Center at Chestertown.

The hospital was last surveyed by The Joint Commission on November 7, 2018 and was granted accreditation.

The complaint records indicate that the hospital has received two complaints over the past year both complaints related to care in the Emergency Department. The most recent complaint was received in early October and the investigation has not yet been completed. The previous complaint was received in January 2, 2019 and resulted in no deficiencies. Prior to the January 2019 complaint, the last complaint received was in 2010.

The hospital remains accredited by the Joint Commission, certified for Medicare and is in good standing under its licensure.

Sincerely,

Renee B. Webster

Renee B. Webster
Deputy Director