STATE OF MARYLAND

Andrew N. Pollak, MD
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

December 31, 2019

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
State House, H-107
Annapolis, MD 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House
State House, H-101
Annapolis, MD 21401-1991

The Honorable Nancy J. King
Chair, Senate Budget and Taxation Comm.
3 West, Miller Senate Office Building
Annapolis, MD 21401

The Honorable Maggie McIntosh
Chair, House Appropriations Comm.
Room 121, House Office Building
Annapolis, MD 21401

RE: Assessment of Services at the University of Maryland Shore Medical Center as required by Senate Bill 1010 (Chapter 406, 2019) and page 95 of the Joint Chairmen's Report on the Fiscal 2020 State Operating Budget (HB 100) and the State Capital Budget (HB 101) and Related Recommendations

Dear President Miller, Speaker Jones, Chair King, and Chair McIntosh:

The Maryland Health Care Commission (MHCC) and the Maryland Department of Health (Department) would like to request a 30-day extension on the report required under Senate Bill 1010 (2019) and page 95 of the Joint Chairmen's Report (JCR). Senate Bill 1010 requires MHCC and the Office of Health Care Quality (OHCQ) to conduct an assessment of services provided at the University of Maryland Shore Medical Center in Chestertown (UMSHCC). Page 95 of the JCR requires that the Department, in consultation with MHCC, conduct the same assessment. Both reports are due January 1, 2020.

The MHCC, OHCQ (a unit within the Department), and the Health Services Cost Review Commission (HSCRC) are working together to complete this assessment, including engagement of community stakeholders and the leadership at the Shore Regional Health System and completion of extensive data analysis. The assessment has generated considerable public interest on the Eastern Shore. MHCC, OHCQ, and HSCRC have taken time to meet with stakeholders at each stage of the work. This effort has been productive, but has required additional time to investigate stakeholder questions and evaluate suggestions.

MHCC recognizes that the assessment report could answer what happened at UMSHCC, but by itself could not provide information on possible next steps. MHCC has contracted with the

Walsh Center for Rural Health Analysis at NORC at the University of Chicago to develop models for rural health delivery that could work in Chestertown and in rural communities throughout the State. The 30-day extension will allow for a more thorough review by stakeholders, MHCC Commissioners, and others of the report on the statutorily-required assessment and the report on potential future models for rural health delivery.

If you have any questions, or you would like to discuss this request, please contact us directly:

Maryland Health Care Commission
Ben Steffen, Executive Director (Ben.Steffen@maryland.gov, 410-764-3565)
Megan Renfrew, Director, Government Affairs (Megan.Renfrew@maryland.gov, 443-615-1338)

Maryland Department of Health
Robert R. Neall, Secretary (robert.neall@maryland.gov, 410-767-4639)
Tom Andrews, Chief of Staff (thomas.andrews@maryland.gov, 410-767-0136)

Thank you for your consideration of this request.

Best regards,

Ben Steffen
Executive Director
Maryland Health Care Commission

Robert R. Neall
Secretary
Maryland Department of Health

Enclosure

cc: The Honorable Bill Ferguson
The Honorable Delores G. Kelley
The Honorable Shane E. Pendergrass
The Honorable Stephen S. Hershey
Andrew N. Pollak, MD, Chair, Maryland Health Care Commission
Mathew J. Palmer, Deputy Legislative Officer, Governor Hogan
Katie Wunderlich, Executive Director, Health Services Cost Review Commission
Tricia Nay, Executive Director, Office of Health Care Quality
Webster Ye, Director, Office of Governmental Affairs, Maryland Department of Health
Sarah Albert, Department of Legislative Services (5 copies)

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January 29, 2019

The Honorable Bill Ferguson
President of the Senate
State House, H-107
Annapolis, MD 21401-1991

The Honorable Adrienne Jones
Speaker of the House
State House, H-101
Annapolis, MD 21401-1991

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3 West, Miller Senate Office Building
Annapolis, MD 21401

The Honorable Maggie McIntosh
Chair, House Appropriations Comm.
Room 121, House Office Building
Annapolis, MD 21401

RE: Report on Options for Rural Health Care Delivery in Maryland

Dear President Ferguson, Speaker Jones, Chair Guzzone, and Chair McIntosh:

The Maryland Health Care Commission (MHCC) is pleased to submit two reports related to rural health care delivery in Maryland. The report on the *Assessment of Service Changes at the University of Maryland Shore Medical Center at Chestertown* (the "Assessment Report") is submitted under the requirements of 2019 Laws of Maryland, Chapter 406 (Senate Bill 1010) and page 95 of the Joint Chairman's Report (JCR) for Chapter 565 (House Bill 100). The *Final Report: Options for Rural Health Care Delivery in Maryland* (the "Models Report") complements the Assessment Report by providing options for the future of rural health care delivery in Maryland.

To produce the Assessment Report, the MHCC worked closely with the Office of Health Care Quality within the Maryland Department of Health and also consulted with the Health Services Resources Cost Review Commission. For the Models report, MHCC Commission contracted with the Walsh Center for Rural Health Analysis at NORC at the University of Chicago ("Walsh

Center at NORC") to identify delivery system models that could meet the health care needs of residents in rural Maryland (with a focus on Kent and Queen Anne's counties).

The Assessment Report finds that the volume of inpatient services discharges at the University of Maryland Shore Medical Center at Chestertown ("UMSMC at Chestertown") decreased by 32 percent between 2015 and 2018, with further declines in 2019. Inpatient discharge volume also decreased at UMSMC at Easton during this time period (decreasing by 7% 2015 to 2018): both hospitals experienced more decline in inpatient discharges than Maryland hospitals on average. Outpatient service volume is relatively steady at both hospitals. UMSMC at Chestertown is losing market share as patients living in the traditional service area for UMSMC at Chestertown are increasingly seeking care at other hospitals (including UMSMC at Easton and Anne Arundel). *MHCC is not able to discern any formal plan being implemented by Shore Regional Health expressly designed to force a market shift in hospital service provision from Chestertown to Easton.*

The Assessment Report notes that health care quality has improved at UMSMC at Chestertown over the study period – the hospital is now in par with Maryland averages on most quality measures. The improvement in reducing unnecessary admissions related quality measures in one of several factors contributing to the decline in inpatient volume at the hospital. Hospital payments based on global budgets under the Maryland Model moderated the financial impact of these losses in patient volume over the period from 2015 to 2018, but this has resulted in increased charges for patients and payers at UMSMC at Chestertown.

The Models Report describes potential models for rural health delivery in Maryland: 1) acute general hospital (the status quo); 2) Maryland Rural Hospital (Pilot); and 3) Aging and Wellness Center of Excellence (a focus area for the acute general hospital or Maryland Rural Hospital).

To develop this report, the Walsh Center at NORC interviewed representatives from the University of Maryland Shore Regional Health, public officials representing Chestertown and Kent County, business leaders, and community members in developing this report. MHCC, the Walsh Center at NORC, OHCQ, and HSCRC also met with representatives from the University of Maryland Shore Regional Health and the community to present the proposed models while the report was in development to collect feedback. The Walsh Center at NORC also conducted data analysis that is in addition to the data analysis reported in the Assessment Report. MHCC required that the models conform with the requirements of the Total Cost of Care Demonstration Agreement that Maryland signed with the Centers for Medicare and Medicaid Services (CMS) in 2018.

MHCC, OHCQ, and HSCRC are currently analyzing existing statutes, regulations, and payment policies to determine what changes are needed to support the proposed "Maryland Rural Hospital" model and the "Aging and Wellness Center of Excellence". MHCC plans to continue to work with these State agencies, representatives of the University of Maryland Shore Health System, Members of the General Assembly, and community stakeholders on implementing appropriate changes to support health care access in Maryland.

If you have any questions, or you would like to discuss this request, please contact Ben Steffen, Executive Director (Ben.Steffen@maryland.gov, 410-764-3565) or Megan Renfrew, Director, Government Affairs (Megan.Renfrew@maryland.gov, 443-615-1338).

Best regards,

Ben Steffen
Executive Director
Maryland Health Care Commission

Enclosure

cc:
The Honorable Delores G. Kelley
The Honorable Shane E. Pendergrass
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Andrew N. Pollak, MD, Chair, Maryland Health Care Commission
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Katie Wunderlich, Executive Director, Health Services Cost Review Commission
Tricia Nay, Executive Director, Office of Health Care Quality
Webster Ye, Director, Office of Governmental Affairs, Maryland Department of Health
Sarah Albert, Department of Legislative Services (5 copies)

Assessment of Service Changes at the University of Maryland Shore Medical Center at Chestertown

Report required under 2019 Laws of Maryland, Chapter 406 (Senate Bill 1010) and the Conference Report for Chapter 565 (House Bill 100)

January 29, 2020

Maryland Health Care Commission
4160 Patterson Avenue
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MARYLAND HEALTH CARE COMMISSION

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Executive Summary

In 2019, the Maryland General Assembly required that the Maryland Health Care Commission (MHCC), in collaboration with the Office of Health Care Quality (OHCQ) of the Maryland Department of Health (MDH), conduct an "assessment of the types, quality, and level of services provided at the University of Maryland Shore Medical Center in Chestertown (UMSMC at Chestertown).[1] This assessment was required to compare the services currently provided at the hospital with services provided in fiscal year 2015 and identify if any services were reduced or transferred to the University of Maryland Shore Medical Center at Easton after July 1, 2015. This report contains this assessment.

The UMSMC at Chestertown is a general hospital located in Chestertown in rural Kent County on Maryland's Eastern Shore. The hospital is located in "downtown" Chestertown and primarily serves residents of Kent and northern Queen Anne's Counties.

Prior to 2008, UMSMC at Chestertown operated as an independent community hospital, known in that year as Chester River Hospital. In 2008, Chester River Hospital joined the University of Maryland Medical System (UMMS). In 2013, the Chestertown hospital joined the University of Maryland Shore Health System (now Shore Regional Health), which also includes two other general hospitals (UMSMC at Easton and UMSMC at Dorchester), a freestanding medical facility in Queenstown, and a network of outpatient centers.[2] Based on regional strategic planning undertaken by Shore Regional Health in the current decade, residents of Chestertown have been concerned that UMSMC at Chestertown might eventually be closed or converted to a freestanding medical facility. A community group, *Save Our Hospital*, coalesced in opposition to this eventuality. During the 2016 legislative session, legislation passed which prevented this hospital from converting to a freestanding medical facility before July 1, 2020.[3] Subsequently, Shore Regional Health committed to keep UMSMC at Chestertown open through March 2022.

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[1] Senate Bill 1010, 2019

[2] A "freestanding medical facility" (FMF) is a licensed category of health care facility in Maryland that can only be operated by a general hospital. An FMF provides a high-level of emergency service capability similar to that found in a hospital emergency department but does not provide inpatient care. In April 2019, the Maryland Health Care Commission approved the conversion of UMSMC at Dorchester, located in Cambridge, to an FMF and the relocation of inpatient psychiatric hospital beds operated at the Cambridge hospital to UMSMC at Easton. http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/2019_decisions/con_merger_shore_dorchester_decision_Revised_20190418.pdf

[3] See 2016 Md. Law, Ch. 420 (Senate Bill 707). This legislation also established a work group on rural health care delivery, tasked with studying issues related to rural health care access and delivery on the Eastern Shore. Pursuant to the 2016 legislation, the Maryland Health Care Commission convened a workgroup on rural health delivery in 2016 and 2017. In 2017, this work group submitted a report to the Maryland General Assembly which contained a number of recommendations, including the creation of a Mid-Shore Rural Health Collaborative focused on improving health care access on the mid-shore. See *Transforming Maryland's rural healthcare system: A regional approach to rural healthcare delivery*. http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/rural_health/Rural%20Health%20Full%20report%20with%20Appendices_2017.pdf

Senate Bill 1056 in the 2018 legislative session established the recommended Rural Health Collaborative, which has begun work and will submit an initial report to the General Assembly in 2020. (See the Website of the Maryland Rural Health Collaborative, https://health.maryland.gov/mcrhc/Pages/home.aspx)

As of fiscal year 2020, UMSMC at Chestertown is licensed by the State of Maryland to operate 12 acute care hospital beds.[4] By this measure, this hospital is the third smallest hospital in the State.

The UMSMC at Chestertown Service Area, defined by patient origin, is concentrated in Kent County and parts of Queen Anne's County. Kent County's population is small (an estimated 19,383 in 2018) and is not growing. It is a relatively older population and has a relatively high rate of poverty. It has a higher proportion of residents who lack health insurance coverage than most areas of Maryland. These demographic factors suggest that Kent County's population may have a greater than average need for health care services and poorer access to services than most areas of the state. It is also a challenging environment for the generation of hospital income. Most areas of Queen Anne's County, which does not contain a general hospital, do not rely on UMSMC at Chestertown as an important access point for hospital services because travel time from many parts of this jurisdiction to the hospital in Annapolis or in Easton is better or comparable. Queen Anne's County has a larger population (an estimated 50,251 in 2018) and higher incomes than Kent County, and fewer households that lack health insurance coverage or public health benefits.

This assessment evaluated the types of service offered at UMSMC at Chestertown in two ways: types of licensed beds and All Patients Refined Diagnosis Related Groups (APR-DRG) service lines. No changes occurred in the broad licensure categories for beds operated by UMSMC at Chestertown between 2015 and 2018. The hospital only provided general acute medical/surgical/gynecological/addictions (MSGA) services in both 2015 and 2018 and did not provide the other three general hospital acute inpatient services that some hospitals provide; obstetric, pediatric, and acute psychiatric services. About 80% of patients admitted to general hospitals are MSGA patients. MHCC also considered All Patient-Refined Diagnosis Related Group (APR-DRG) service lines in assessing the types of services offered at the hospital. In 2015, services were provided to patients at UMSMC at Chestertown in seven inpatient service lines and one outpatient service line that were not seen in the patient population served in 2018. The service volume for each of these eight inpatient and outpatient service lines was five or fewer discharges in 2015, so the change in the patient population served was small. In addition, services in three inpatient surgery service lines were provided at UMSMC at Chestertown in 2018 that were not observed in 2015, resulting in a total net "loss" of only five service lines. UMSMC at Easton did not add service categories that were removed from UMSMC at Chestertown, although the volume of services provided at the Easton hospital did change. It is important to note that this assessment of service line change is based on the observed patients within a defined service line. A service may be potentially available at the hospital but have a volume of zero patients in a given year because no patient needing that service was treated in the hospital that year.

Between 2015 and 2018, the volume of inpatient service provided at UMSMC at Chestertown declined. The observed decline in inpatient service volume was larger than that observed at other Maryland hospitals. Some of these volume losses are likely due to changes in hospital utilization

[4] Maryland Health Care Commission, Licensed Acute Care Beds by Hospital and Service: Maryland, FY 2020 (effective July 1, 2019), accessed December 17, 2019

https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Licensed_Acute_Care_Beds_by_Hospital_and_Service_%20Maryland_FY2020.pdf

that are occurring throughout the state and nation.[5] During the assessment period, UMSMC at Chestertown successfully reduced certain types of avoidable hospitalizations (see further discussion in the report section on Quality of Services), so that some of the decline in inpatient service volume is a result of patients receiving appropriate care in other settings and, thus, not needing to be hospitalized. Finally, UMSMC at Chestertown has lost market share to other hospitals, notably Anne Arundel Medical Center and UMSMC at Easton during the assessment period (2015-2018). The MHCC does not believe it is possible to determine, based on available data, that inpatient volume has been diverted from UMSMC at Chestertown to UMSMC at Easton for the express purpose of reducing use of the Chestertown hospital.

Some decline in outpatient service volume was also seen at UMSMC at Chestertown in the 2015-2018 time period, but this decline was small compared to the loss of inpatient cases. UMSMC at Chestertown lost less outpatient service volume, proportionally, than all hospitals in Maryland over the assessment time period, reflecting a potential area of strength for the hospital.

Based on quality measures mandated by CMS, overall quality of care, at UMSMC at Chestertown was stable in the 2015 to 2018 period. This hospital's quality of care can be characterized as relatively average among Maryland hospitals.

Some actions by UMSMC at Chestertown's parent, Shore Regional Health are undoubtedly related to the decline in use of this small hospital. The MHCC is not able to discern any formal plan being implemented by Shore Regional Health expressly designed to force a material market shift in hospitalization services from Chestertown to Easton. Only one service identified by *Save Our Hospital* as being transferred from UMSMC at Chestertown to the Easton hospital, sleep lab services, was confirmed by Shore Regional Health as a service it chose to terminate at UMSMC at Chestertown but the system claims that this action was taken on the basis of a recommendation by the now retired pulmonologist providing the service in Chestertown, because of the low volume of sleep studies being conducted there. Ultimately, sleep studies were not actually transferred from Chestertown to Easton. They are now conducted at patients' homes rather than the hospital.

[5] Healthcare Cost and Utilization Project, "HCUP Fast Stats- Trends in Inpatient Stays", Agency for Health Care Research and Quality, https://www.hcup-us.ahrq.gov/. See also Kaiser Family Foundation State Health Facts "Hospital admissions per 1,000 population by ownership type", https://www.kff.org/other/state-indicator/admissions-by-ownership/

See appendix A for detailed tables.

Introduction

This report is the result of a legislative mandate to conduct an assessment of the types, volumes, and quality of services at the University of Maryland Shore Medical Center at Chestertown (UMSMC at Chestertown). This section describes the legislative mandate, the organizations contributing to the report and related data analysis, the methodology and study approach, the history of the UMSMC at Chestertown, and the demographics of Kent and Queen Anne's Counties, which are served by this hospital.

Mandate for the Assessment and Community Concerns

The requirements for this report come from two legislative documents generated in the 2019 General Assembly session: Senate Bill 1010 and 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).

Senate Bill 1010 directs MHCC, in collaboration 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 UMSMC in Chestertown".[6] This assessment must compare current services with services provided in fiscal year 2015 and identify if any services were reduced or transferred to the UMSMC in Easton after July 1, 2015.

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.

Senate Bill 1010 and House Bill 100 both require the submission of the report to the legislature by January 1, 2020. MDH and MHCC submitted a letter requesting a 30 day extension to this deadline.

In September 2018, before the 2019 legislative session, the Maryland Secretary of Health sent a letter to the Chairs of MHCC and the Health Services Cost Review Commission (HSCRC) requesting that the Commissions collaborate to conduct an audit of services at UMSMC at Chestertown. This letter was prompted by a March 2018 request for "regular state-mandated hospital audits" from *Save Our Hospital*, the group representing community leaders and citizens concerned about apparent service reductions at UMSMC at Chestertown and the hospital's long-term viability.[7] The request from *Save Our Hospital* outlined detailed concerns about services, marketing, and facility maintenance at UMSMC at Chestertown.

In response to this request, in late October 2018, the Commissions submitted a letter to the President and CEO of Shore Regional Health asking the health system to respond to the specific items addressed in the request from *Save Our Hospital*. In early November 2018, Shore Regional Health system submitted a response which responded to the specific items in *Save Our Hospital's* letter and reiterated the health system's commitment to maintaining UMSMC at Chestertown as a general hospital through March 2022.

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[6] Senate Bill 1010, 2019

[7] March 22, 2018 letter from Margie Elsberg on behalf of Save Our Hospital to Senator Hershey (see Appendix D).

Organizations Contributing to Report

Maryland Health Care Commission

MHCC is an independent regulatory agency of the State of Maryland whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on accessibility, cost, and quality of services to policy makers, purchasers, providers and the public. The MHCC's vision for Maryland is to ensure that informed consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation. MHCC has 15 commissioners who are appointed by the Governor.

Office of Health Care Quality, Maryland Department of Health

OHCQ is the agency within MDH charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. OHCQ is an agent of the Centers for Medicare and Medicaid Services (CMS) and is the designated State survey agency in Maryland. OHCQ issues State licenses and recommends certification to CMS. A license authorizes a facility or program to do business in Maryland. Certification authorizes a facility to participate in the Medicare and Medicaid programs. OHCQ surveys these facilities and programs to determine compliance with State and federal regulations, which set forth minimum standards for the delivery of care. It is through these activities that OHCQ fulfills its mission to protect the health and safety of Marylanders and to ensure there is public confidence in the health care delivery system.

Health Services Cost Review Commission

The Health Services Cost Review Commission (HSCRC) is an independent State agency with authority to establish hospital rates to promote cost containment, access to care, equity, financial stability and hospital accountability. The goals of the HSCRC are to constrain hospital cost growth, ensure that hospitals have the financial ability to provide efficient, high quality services to all Marylanders, and to increase the equity or fairness of hospital financing

The HSCRC's primary mandates are to review and approve reasonable hospital rates and publicly disclose information on the costs and financial performance of Maryland hospitals. The HSCRC establishes hospital-specific and service-specific rates for all inpatient, hospital-based outpatient and emergency services. In approving hospital rates, the HSCRC is required to assure that the total costs of all services offered by a hospital are reasonable, that aggregate revenues of a hospital are reasonably related to its aggregate costs, and that rates are set equitably among all purchasers of hospital services.

The HSCRC also plays a role in managing the State's responsibilities under the Total Cost of Care Model agreement with the Federal government. Under this agreement, Maryland is attempting to transform care delivery across the health care system with the objective of improving health and quality of care while also controlling cost.

LD Consulting

MHCC contracted with LD consulting[8], a small, Maryland-based, health financial and data analytics firm, to support the data analysis and writing for this report.

Methodology and Study Approach

Data Sources

To assess the types, quality, and level of services provided at UMSMC at Chestertown, the following data sources were used:

1. Publicly available data on the MHCC website[9].
2. Case mix data for inpatient and outpatient hospital visits from HSCRC.[10] HSCRC collects various data sets from all Maryland acute care hospitals and licensed specialty hospitals. Case mix data is self-reported by hospitals and inconsistencies can exist between hospitals for some information due to differences in internal hospital reporting. The outpatient data set includes hospital clinic, outpatient surgery, and emergency room data.
3. Hospital financial data collected by HSCRC including data on revenue, expenses, staff levels (full time equivalents) and volume inpatient admissions and outpatient services for Maryland hospitals.[11]
4. The CMS Virtual Research Data Center's (VRDC) Chronic Conditions Data Warehouse (CCW)[12] was used to compare the services provided at UMSMC at Chestertown to hospitals outside of Maryland. The CCW provides researchers with Medicare and Medicaid beneficiary, claims, and assessment data.[13] Maryland has access to 100% of hospital claims for Medicare fee-for-service claims for all U.S. residents.
5. Virginia rural hospital patient level data sets supplied by Virginia Health Information[14] were used to compare services at Chestertown to rural hospitals in Virginia, regardless of payer source, a useful compliment to the Medicare data provided through the CCW.

[8] https://ldchealth.com/

[9] https://mhcc.maryland.gov/

[10] Case mix data is collected pursuant to COMAR 10.37.04, 10.37.01.08 and 10.37.06, and includes financial and confidential patient-level administrative data. The inpatient and outpatient data sets are abstracted from the medical record of each of the state's approximately 700,000 inpatient discharges and 5.7 million outpatient visits annually. https://hscrc.maryland.gov/Pages/data.aspx

[11] https://hscrc.maryland.gov/Pages/data.aspx

[12] https://www.resdac.org/cms-virtual-research-data-center-vrdc

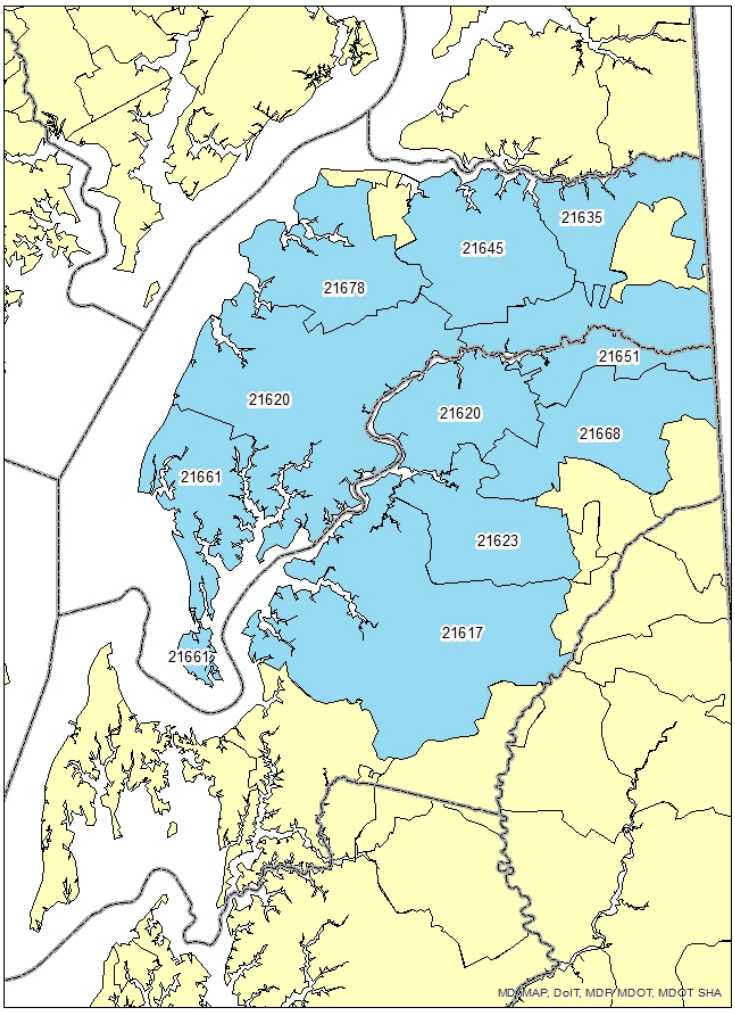
[13] https://www2.ccwdata.org/web/guest/home/

[14] http://www.vhi.org/

Chestertown Hospital Service Area

Some of the analysis included in this report is limited to individuals who reside in the defined service area of UMSMC at Chestertown. For purposes of this report, the service area is defined as the zip code areas that were home to 85 percent (85% relevance) of the hospital discharges from UMSMC at Chestertown in 2011, rank ordered on the basis of frequency of discharges. Use of an 85% relevance index allows for a service area definition that captures most of the zip code areas from which the hospital's patients consistently originate without producing the more diffuse and discontinuous service area that could occur by trying to include a higher cumulative percentage of the hospital's patient discharges. 2011 was selected as a base year for defining the service area because it is not too distant in the past to be relevant to the purposes of this assessment and is a year falling after the acquisition of Chester River Hospital by UMMS but before the incorporation of the hospital into Shore Regional Health.

Figure 1: Chestertown Hospital Service Area



In 2011, the 85% relevance service area for UMSMC at Chestertown included the following nine zip code areas: 21617, 21620, 21623, 21635, 21645, 21651, 21661, 21668, and 21678.[15] These zip code areas represent most of Kent

[15] Kent County contains or is included, in part, in the following zip code areas: 21610-Betterton (not in service area); 21620-Chestertown (in service area); 21635-Galena (in service area); 21645-Kennedyville (in service area); 21650-Massey (not in service area); 21651-Millington (in service area); 21661-Rock Hall (in service area); 21667-Still Pond (in service area); and 21678-Worton (in service area). Queen Anne's County contains or is include, in part, in the following zip code areas: 21607-Barclay (not in service area); 21617-Centerville (in service area); 21619-Chester (not in service area); 21620-Chestertown (in service area); 21623-Church Hill (in service area); 21638-Grasonville (not in service area); 21640-Henderson (not in service area); 21644-Ingleside (not in service area); 21649-Marydel (not in service area); 21651-Millington (in service area); 21657-Queen Anne (not in service area); 21658-Queenstown (not in service area); 21666-Stevensville (not in service area); 21668-Sudlersville (in service area); and 21679-Wye Milles (not in service area).

County (only the Betterton zip code area is not included) and about a third of the zip code areas in Queen Anne's county.

By 2018, only eight of these zip code areas would be included in an 85% relevance service area definition for UMSMC at Chestertown. (Fewer patients from 21645, Kennedyville, eliminated that zip code area from the 85% relevance service area for 2018.)

It is important to note that a service area definition based on patient origin is not equivalent to an area defined on the basis of market share. While 85 percent of patients at this hospital came from the zip code areas outlined above, the service area definition does not tell us about the strength of the commitment to the hospital by patients who reside in those zip code areas. Market share will be discussed later in the report.

Rural Hospitals

For some of the analysis in this assessment, UMSMC at Chestertown is compared to a select set of five other rural hospitals in Maryland with similar characteristics and levels of rurality in the surrounding community. These hospitals are Atlantic General (Worcester County), UMSMC at Dorchester, UMSMC at Easton, Garrett Regional (Garrett County), and Union Hospital (Cecil County).

Limitations

Use of hospitals in Delaware by residents of the defined service area cannot be identified and is not included in market share calculations. Similarly, while there is a District of Columbia hospital discharge data base, this data set was not available for the entire assessment period. Some residents of the UMSMC at Chestertown service area use hospitals in other states and, undoubtedly, Delaware and D.C. hospitals are the two groups of non-Maryland hospitals that account for most of this out-of-state migration. This means that the market shares achieved by Maryland hospitals are somewhat overstated in this report. However, the relative movement of market share among the Maryland hospitals that account for most of the service area population's hospital use is still revealed in a meaningful way.

Background on UMSMC at Chestertown

UMSMC at Chestertown is a general hospital that provides general medical and surgical inpatient and outpatient services located in Chestertown in rural Kent County on Maryland's Eastern Shore. The hospital primarily serves residents of Kent and Queen Anne's Counties. UMSMC at Chestertown is classified as a rural hospital according to the Federal Office of Rural Health Policy (FORHP) definition of rural hospital.[16]

[16] This definition of rural includes all non-metropolitan counties, as defined by the Office of Management and Budget as rural, and uses an additional method of determining rurality called the Rural-Urban Commuting Area (RUCA) codes. Similar to defining Metropolitan Statistical Areas, RUCA codes are based on Census data that is used to assign a code to each Census Tract. Tracts inside Metropolitan counties with the codes 4-10 are considered rural. FORHP has made some exceptions for areas with a RUCA code of 2 to 3 to be classified as rural.

Table 1: Key Acquisitions and Events on the Mid-Shore

2006	UMMS acquires Shore Health System composed of Easton Memorial and Dorchester General Hospitals.
2008	The General Assembly directs MHCC to study the use and performance of FMFs and authorizes establishment of the Queenstown FMF as a pilot project.
	UMMS acquires Chester River Hospital which is renamed the UMMS Medical Center at Chester River.
2010	Queenstown FMF opens.
2013	UMMS Medical Center at Chester River merges with Shore Health System (now Shore Regional Health).
2016	Senate Bill 707 prevents UMSMC at Chestertown from converting to an FMF before July 1, 2020.
2017	University of Maryland Shore Medical Center at Easton is authorized to offer percutaneous coronary intervention services.
2019	MHCC authorizes the conversion of UMSMC at Dorchester to an FMF (anticipated for completion in 2021) and the relocation of inpatient psychiatric services from UMSMC at Dorchester to UMSMC at Easton.
	Shore Regional Health submits a request to MHCC for an exemption from CON review to relocate psychiatric inpatient services to UMSMC at Chestertown (rather than UMSMC at Easton).

Prior to 2008, Chester River Hospital was an independent community hospital. In 2008, the hospital joined UMMS. In 2013, the hospital in Chestertown joined the University of Maryland Shore Health System (now Shore Regional Health), which also includes hospitals in Dorchester and Talbot Counties, an FMF in Queen Anne's County, and a network of outpatient centers.[17] Shore Regional Health serves five counties, the "Mid-Shore" region of the Eastern Shore, with an estimated 2018 population of approximately 172,000. By late 2015, some community members and physicians at UMSMC at Chestertown grew concerned that Shore Regional Health was considering a regional reconfiguration of its health care facility network that would involve converting UMSMC at Chestertown to an FMF or similar outpatient care campus.[18] During the 2016 legislative session, the law was amended to prohibit such a conversion before July 1, 2020.[19]

[17] In April 2019, the Maryland Health Care Commission approved the conversion of the Dorchester hospital located in Cambridge into a freestanding medical facility and the relocation of inpatient psychiatric hospital beds from the Dorchester facility to the University of Maryland Shore Medical Center at Easton.

http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/2019_decisions/con_merger_shore_dorchester_decision_Revised_20190418.pdf

[18] "Freestanding medical facility" is a term in Maryland State law that describes a facility that has a 24/7 emergency service capability but does not provide inpatient hospitalization services

[19] See 2016 Md. Law, Ch. 420 (Senate Bill 707). This legislation also established a workgroup on rural health care delivery, tasked with studying issues related to the rural health care access and service delivery on the Eastern

Subsequently, Shore Regional Health has committed to keep UMSMC at Chestertown open as a general hospital through March 2022.

As of fiscal year 2020, UMSMC at Chestertown is licensed by the State of Maryland to operate 12 acute care hospital beds.[20] In Maryland, licensed bed capacity is annually adjusted as patient census rises or falls at a hospital. This hospital is the third smallest hospital in Maryland, in terms of licensed bed capacity and, thus, the size of its average daily census in the FYE March 31, 2019.

Demographics of Kent and Queen Anne's Counties

The UMSMC at Chestertown service area is concentrated in Kent County and parts of Queen Anne's County. Kent County's population is small (an estimated 19,383 in 2018) and is not growing. It is a relatively older population and has a relatively high rate of poverty. It has a higher proportion of residents who lack health insurance coverage than most areas of Maryland. These demographic factors suggest that Kent County's population may have a greater than average need for health care services and poorer access to services than most areas of the state. It is also a challenging environment for the generation of hospital income. Most areas of Queen Anne's County do not rely on UMSMC at Chestertown as an important access point for hospital services because travel time to the hospital in Annapolis or in Easton is better or comparable. Queen Anne's County has a larger (an estimated 50,251 in 2018) and wealthier population with better access to health insurance. Only a few Queen Anne's County zip code areas are in the UMSMC at Chestertown service area.

Kent County is estimated to have lost population over the past eight years. Queen Anne's County's population is estimated to have grown at a rate similar to Maryland overall between 2010 and 2018.[21]

Shore. Pursuant to the 2016 legislation, MHCC convened a workgroup on rural health delivery in 2016 and 2017. In 2017, this workgroup submitted a report to the Maryland General Assembly which contained a number of recommendations, including the creation of a Mid-Shore Rural Health Collaborative focused on improving health care access on the Mid-Shore. *Transforming Maryland's rural healthcare system: A regional approach to rural healthcare delivery*

http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/rural_health/Rural%20Health%20Full%20report%20with%20Appendices_2017.pdf; Senate Bill 1056 in the 2018 legislative session established the recommended Rural Health Collaborative, which has begun work and will submit an initial report to the General Assembly in 2020. Website of the Maryland Rural Health Collaborative, https://health.maryland.gov/mcrhc/Pages/home.aspx

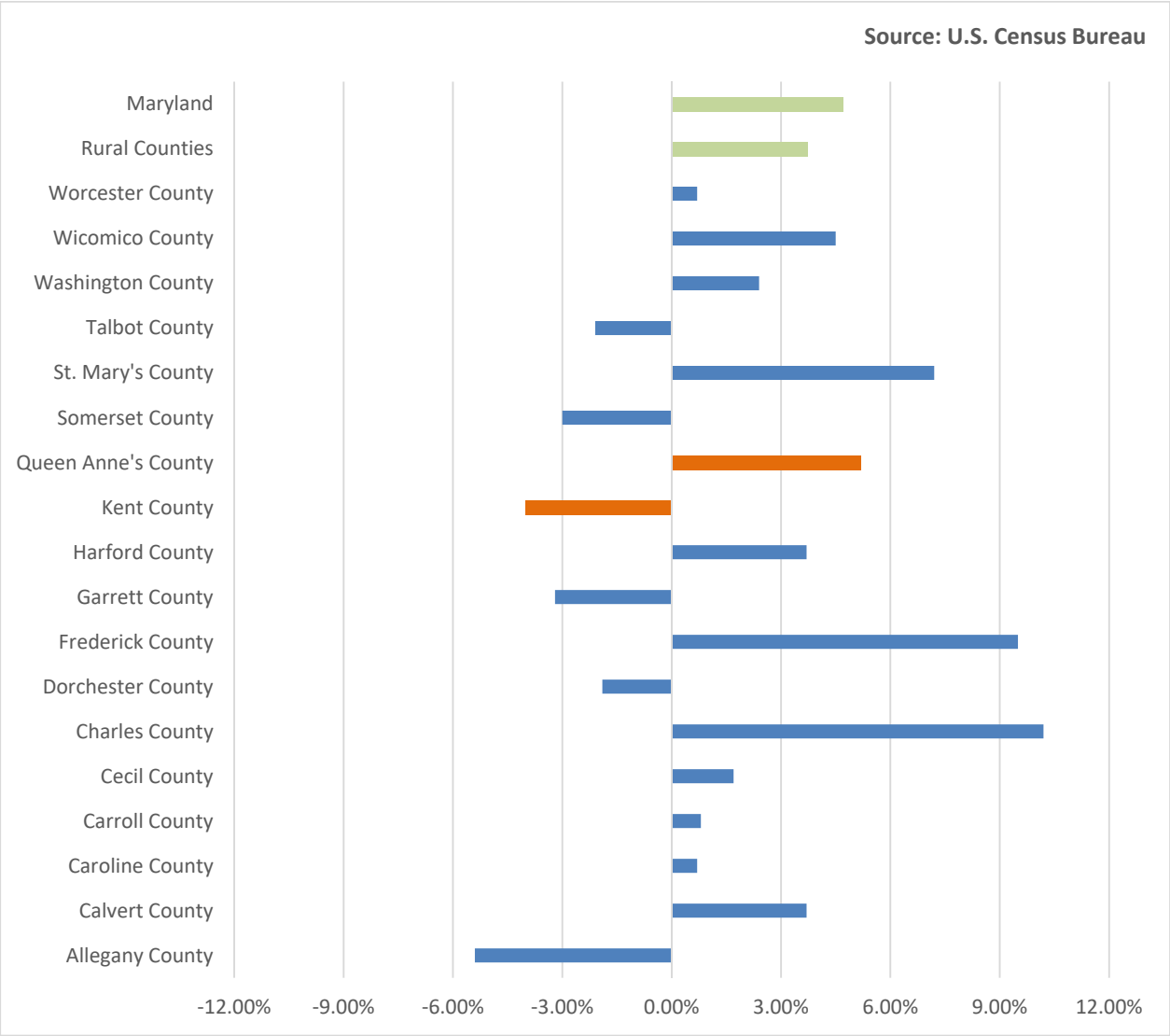
[20] Maryland Health Care Commission, Licensed Acute Care Beds by Hospital and Service: Maryland, FY 2020 (effective July 1, 2019), accessed December 17, 2019

https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Licensed_Acute_Care_Beds_by_Hospital_and_Service_%20Maryland_FY2020.pdf

[21] According to U.S. Census bureau population estimates, Kent County lost four percent of its population between 2010 and 2018 (a loss of approximately 800 individuals) while Queen Anne's County's population grew by 5.2 percent (an approximate gain of 2,500 individuals). For comparison, the population of Maryland grew by 4.7% over that time period and the population in rural counties in Maryland grew by 3.7 percent. Six rural counties are estimated to have lost population over this time period and the only county estimated to have lost population at a faster rate than Kent County is Allegany County, in Western Maryland, which is estimated to have shrunk by 5.4 percent between 2010 and 2018. U.S. Census Bureau Quick Facts, accessed December 17, 2019

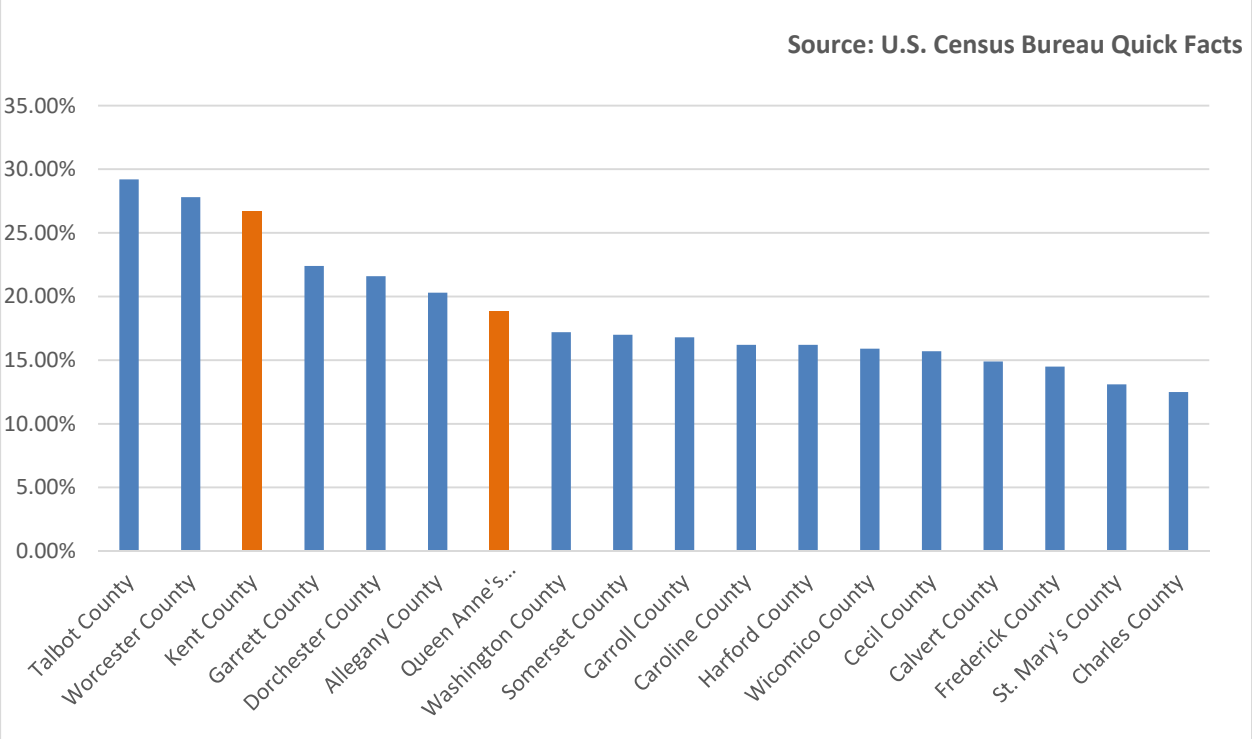
https://www.census.gov/quickfacts/fact/table/US/PST045218

Figure 2: Percent Change in Populations of Rural Counties in Maryland, April 1, 2010- July 1, 2019



Both Kent and Queen Anne's County have older populations than most Maryland jurisdictions. Twenty-seven (27) percent of Kent County's population is aged 65 or older. Of rural counties in the state, only Talbot and Worcester County have older populations. Almost 19 percent of Queen Anne's County's population is aged 65 or older.

Figure 3: Population Age 65 Years and Over as a Percent of Total Population, Rural Counties of Maryland, 2018



The populations of Kent and Queen Anne's Counties are predominantly White Non-Hispanic/Latino (78% in Kent County and 86% in Queen Anne's, compared to 51% for Maryland). The next largest racial/ethnic group is African American (15% in Kent County and six percent in Queen Anne's). About four percent of the population in both counties is Hispanic or Latino and about four percent of the population in both counties is foreign born. In Kent County, approximately six percent of the population speaks a language other than English at home; in Queen Anne's, approximately five percent. [22]

The proportion of individuals with a disability is slightly higher than the State average in these counties (Maryland, 7.4%; Queen Anne's County, 7.8%; Kent County 8.2%).[23] The proportion of veterans in these counties is similar to that seen in other Maryland rural counties.[24]

With the Medicaid expansion and availability of subsidized private market insurance beginning in 2014, the uninsured rate in Maryland has dropped in the past five years. In Maryland in 2018 the uninsured rate for non-elderly individuals was estimated at 6.9%. Queen Anne's County has a higher rate of health insurance coverage, with only 5.4% of the non-elderly population estimated

[22] U.S. Census Bureau Quick Facts, accessed December 17, 2019 https://www.census.gov/quickfacts/fact/table/US/PST045218

[23] Percent of population under age 65 with a disability 2013-2017, U.S. Census Bureau.

[24] MHCC analysis of U.S. Census Bureau data.

to lack health insurance. By comparison, Kent County, the primary source of patients for UMSMC at Chestertown, is estimated to have an uninsured rate of 8.4%.[25]

Poverty is a key social determinant of health status. The poverty rate in Kent County is approximately 13% (i.e. one in eight residents of the county live in poverty). This is a higher poverty rate than Maryland overall (9%). Queen Anne's County has a lower poverty rate (6.5%).[26]

Table 2: Income and Poverty for Kent County, Queen Anne's County, and Maryland[27]

	Median household income (in 2017 dollars), 2013-2017	Per capita income in past 12 months (in 2017 dollars), 2013-2017	Persons in poverty, percent (2018)
Kent County	$56,638	$32,217	12.9%
Queen Anne's County	$89,241	$40,553	6.5%
Maryland (All Counties)	$78,916	$39,070	9.0%

Home computer and internet access is relevant to health care for a number of reasons. It allows consumers access to information about their health, health care, and providers. It also allows for the implementation of home-based telehealth solutions that allow for in-home monitoring of patients. Among the 18 rural counties in Maryland, Kent County has fewer households with a computer (81.7% in 2013-2017) and fewer households with a broadband internet subscription (72.6% in 2013-2017).[28] Queen Anne's County has higher rates of computer ownership and broadband access, and is one of only four rural counties that exceed the state-wide rates on these measures.[29]

Table 3: Home Access to Computers and Broadband for Kent County, Queen Anne's County, and Maryland[30]

	Households with a computer, percent, 2013-2017	Households with a broadband Internet subscription, percent, 2013-2017
Kent County, MD	81.7%	72.6%
Queen Anne's County, MD	90.6%	84.6%
Maryland (All Counties)	90.2%	82.8%

Appendix A contains additional demographic data for reference.

[25] U.S. Census Bureau

[26] U.S. Census Bureau

[27] U.S. Census Bureau

[28] Allegany, Garrett, and Somerset County had lower rates of households without a computer. Five counties (Allegany, Garrett, Somerset, Dorchester, and Washington Counties) had lower rates of households with broadband subscriptions. Source: U.S. Census Bureau Quick Facts.

[29] Source: U.S. Census Bureau Quick Facts. The four rural counties with higher than average computer and internet access are Queen Anne's, Harford, Frederick, and Calvert.

[30] U.S. Census Bureau

Assessment of Changes in the Type (Category) of Services Provided at UMSMC at Chestertown, 2015-2018

Senate Bill 1010 (2019) directs MHCC to compare the "types" of services offered at UMSMC at Chestertown, providing a comparison between services provided in fiscal year 2015 and 2018, and services that were transferred to Easton.

This assessment evaluated the change in types of services in two ways. No change was found in the broad licensure categories for inpatient beds operated at UMSMC at Chestertown. The hospital provided general acute medical/surgical/gynecological/addiction (MSGA) services in both 2015 and 2018. In addition to bed licensure categories, the assessment considered APR-DRG service lines represented by patients. In 2015, services were provided to patients at UMSMC at Chestertown in seven inpatient service lines and one outpatient service line that were not seen in the patient population in 2018. The service volume for each of these service lines was five (5) or fewer patients in 2015, so the change was small. In addition, services in three inpatient surgery service lines were provided at UMSMC at Chestertown in 2018 that were not observed in 2015, resulting in a total net "loss" of only five service lines. The UMSMC at Easton did not add service categories that were removed from UMSMC at Chestertown, although the volume of services provided at Easton did change.

Licensed Bed Types

Maryland designates four types of acute care service at general hospitals and allows general hospitals to allocate licensed bed capacity among these categories of service so long as the hospital is authorized to provide the service. These categories are: 1) MSGA services; 2) obstetric services; 3) pediatric services; and 4) acute psychiatric services.

In 2015, UMSMC at Chestertown provided a single category of inpatient service, MSGA services, and it continued to provide that single inpatient service in 2018. UMSMC at Chestertown also allocated a single licensed bed to pediatric services during this period. However, the hospital had no reported patient days for patients aged 0-14 in 2018. Pediatric hospitalizations are relatively rare, and only a handful of Maryland hospitals with pediatric surgical capability handle the great bulk of demand for hospitalization of children. UMSMC at Chestertown did not provide obstetric or acute psychiatric services during this time period.[31]

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[31] The obstetrics unit at the hospital in Chestertown closed in 2012. As of 2011, the hospital had the lowest number of births of any hospital in Maryland (183), compared to 1,000 at Easton and 5,000 at Anne Arundel in the same time period. https://chestertownspy.org/2012/02/15/chester-river-hospital-to-close-obstetrics-april-1/. For residents of the UMSMC at Chestertown service area, obstetrics accounts for 16% of total inpatient discharges (or approximately 560). The majority of these visits occur at Anne Arundel Medical Center. Chestertown has two practicing obstetricians with an office location in Chestertown. These providers are not associated with Shore Regional Health and they deliver newborns at Anne Arundel Medical Center. https://www.myaamg.org/chester-river-ob-gyn The University of Maryland Shore Medical Group has two obstetrician/gynecologists and a nurse practitioner focused on women's health who hold office hours in Chestertown two days a month.https://www.umms.org/shore/locations/smg-womens-health-chestertown.

In 2018, only 135 births were generated by residents of Kent County at any location. The comparable number for residents of Queen Anne's County was 477. https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Jurisdictional/2018_Births/TableKent.pdf ; https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Jurisdictional/2018_Births/TableQueenAnnes.pdf. A national 2018 OB-GYN workforce study found a national average of 100 births per OB-GYN (with a range

In both 2015 and 2018, UMSMC at Easton provided both MSGA and obstetric services, as well as allocating licensed bed capacity to pediatric services (156 patients age 0-14 were served in Easton in 2018).

UMSMC at Easton is currently authorized to provide acute psychiatric services after UMSMC at Dorchester converts to a free-standing medical facility. However, Shore Regional Health has a request under review to replace this authorization with approval to introduce acute psychiatric services at UMSMC at Chestertown rather than Easton.[32]

APR-DRG Service Lines

UMSMC at Chestertown provided services in fewer service line categories in 2018 than in 2015. However, these were low volume services (less than 5 discharges in each service line) in 2015.

Table 4: APR-DRG Service Lines with Volume Greater Than Zero for UMSMC at Chestertown, UMSMC at Easton, and All Maryland Hospitals[33]

	U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau
Inpatient Medical Services	Chestertown	26	21	-5
	Easton	32	31	-1
	All Maryland Hospitals	32	32	0
Inpatient Surgery[34]	Chestertown	8	9	1
	Easton	17	17	0
	All Maryland Hospitals	23	22	-1
Outpatient	Chestertown	20	19	-1
	Easton	22	22	0
	All Maryland Hospitals	22	22	0
All service lines (Inpatient & Outpatient, Medical and Surgery)	***Chestertown***	***54***	***49***	***-5***
	Easton	***71***	***70***	***-1***
	All Maryland Hospitals	***77***	***76***	***-1***

from 32-247 in the 50 largest metro areas).https://s3.amazonaws.com/s3.doximity.com/press/OB-GYN_Workload_and_Potential_Shortages_2018.pdf.

This means that Kent County's demand for OB-GYN services is likely being fully met by the existing providers. However, a 2018 MHCC workforce study suggests that the supply of OB-GYN physicians practicing in Kent and Queen Anne's County is likely to fall below the level of demand by 2030.

[32] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con_merger_consolidation.aspx

[33] LC Consulting analysis of HSCRC Case-Mix data

[34] Because of a change in DRG classifications during the time period of the Assessment, the service related to injuries/complications of surgery was dropped in all hospitals during this time period.

To look at a more discrete level of changes in the types of services, MHCC looked at the All Patient Refined Diagnosis Related Group (APR-DRG) service line descriptions for inpatient services. APR-DRG codes are a set of standardized codes that categorize an inpatient stay based on a specific set of diagnoses and the medical or surgical services used to treat the patient. Sets of APR-DRG codes are categorized into service lines. For example, a knee replacement would have one APR-DRG code and a hip replacement would have another APR-DRG code but both codes will roll up to the Orthopedic Surgery APR-DRG service line. MHCC used the HSCRC patient-level administrative data (referred to as "case mix data") to determine the APR-DRG service line description. A hospital was determined to have a particular service category if the hospital had at least one reported APR-DRG code related to the service category reported in the service year reviewed. Outpatient service levels were identified using outpatient revenue codes.

UMSMC at Chestertown had a net decline of five service lines (compared to a net decline of one service line at UMSMC at Easton). Each of the services that was not provided to patients at UMSMC at Chestertown in 2018 had a very low volume of utilization in 2015 (less than five patients served in 2015).

Summary Perspective on Changes in the Type of Services Provided at UMSMC at Chestertown

During the study period, UMSMC at Easton did not add service line categories that were observed at UMSMC at Chestertown in 2015 but not reported in 2018, although the volume of services provided at Easton did change (and will be discussed in the next section). Additional tables on service types are contained in Appendix A.

Assessment of Changes in Volume of Services at UMSMC at Chestertown

Senate Bill 1010 (2019) directs MHCC to compare the "volume" of services offered at UMSMC at Chestertown in 2015 with 2018 volume and to identify any related "transfers" of services to UMSMC at Easton.

This assessment of changes in volume of service has been considered in terms of inpatient service and outpatient service. Inpatient services are broken down as medical or surgical in nature. A patient receiving inpatient services is admitted to the hospital for a stay of at least one night. Outpatient services are services that are provided at the hospital or on the campus of the hospital without any physician order for admission of the patient to the hospital. Outpatient services include emergency department services that do not result in a hospital admission, observation services, outpatient surgery, and an array of other diagnostic and treatment services, such as lab tests and diagnostic imaging procedures. A patient receiving outpatient services may stay overnight at the hospital as an "observation" patient.[35]

[35] "Observation services are hospital outpatient services given to help the doctor decide if" a patient needs "to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the hospital". https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf. The distinction between inpatient and outpatient services is important from a regulatory perspective, and is also important for payers, patients, and other types of health facilities, as different payment rules apply. For example, Medicare Part A covers inpatient care, while Medicare Part B covers outpatient care, which in turn has different cost-sharing implications for patients. In addition, federal Medicare rules require a 3-day inpatient hospital admission before Medicare will cover payments to a nursing home. Time spent in outpatient observation care

Between 2015 and 2018, inpatient service volume at UMSMC at Chestertown declined, as it did at most Maryland hospitals. These reductions in admissions were relatively larger than those seen at other Maryland Hospitals. Some of these volume losses are likely due to changes in hospital utilization that follow national and statewide trends.[36] During the assessment period, UMSMC at Chestertown reduced certain types of avoidable hospitalizations (see further discussion in section on Quality of Services), so that some decrease in inpatient volumes is a result of patients receiving appropriate care in other settings and not needing to be hospitalized. UMSMC at Chestertown lost inpatient market share to other hospitals, including Anne Arundel Medical Center and UMSMC at Easton during the assessment period MHCC does not believe it is possible to determine, based on the data available, that inpatient service volume declines at UMSMC at Chestertown were the result of diversion of patients to UMSMC at Easton, on a planned basis.

A decline in outpatient service volume was also seen at UMSMC at Chestertown in the 2015-2018 time period, but these changes were small compared to the changes in inpatient service volume. On a relative basis, UMSMC at Chestertown lost less outpatient service volume than seen for all hospitals in Maryland over the assessment period.

Inpatient Services at UMSMC at Chestertown

This section provides data on the volume of inpatient service provided at UMSMC at Chestertown for the assessment period. Data is presented both for all patients that used UMSCMC at Chestertown (and comparable hospitals), as well as data on the inpatient service use of residents of the hospital's service area.

Hospital Inpatient Service Volume

Data from UMSMC at Chestertown shows a decline in inpatient service volume, both for medical services and for surgical services. Hospital utilization has been broadly declining in Maryland and throughout the United States in recent years. Some of the reductions in volume at UMSMC at Chestertown are consistent with this trend.[37] During the assessment period, UMSMC at Chestertown has successfully reduced certain types of avoidable hospitalizations (see further discussion in section on Quality of Services), further reducing inpatient service utilization at UMSMC at Chestertown during the assessment period (i.e. some of the decrease in inpatient volume is a result of patients receiving appropriate care in other settings and not needing to be hospitalized). Finally, UMSMC at Chestertown lost market share to other hospitals, including Anne Arundel Medical Center and UMSMC at Easton during the assessment period. Inpatient surgery cases declined by 25 percent at UMSMC at Chestertown, compared to a two percent decline at UMSMC at Easton. During this time period, some surgeries that previously require

doesn't count towards the three-day admission. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SNF3DayRule-MLN9730256.pdf

[36] Healthcare Cost and Utilization Project, "HCUP Fast Stats- Trends in Inpatient Stays", Agency for Health Care Research and Quality, https://www.hcup-us.ahrq.gov/. See also Kaiser Family Foundation State Health Facts "Hospital admissions per 1,000 population by ownership type", https://www.kff.org/other/state-indicator/admissions-by-ownership/.

[37] Healthcare Cost and Utilization Project, "HCUP Fast Stats- Trends in Inpatient Stays", Agency for Health Care Research and Quality, https://www.hcup-us.ahrq.gov/. See also Kaiser Family Foundation State Health Facts "Hospital admissions per 1,000 population by ownership type", https://www.kff.org/other/state-indicator/admissions-by-ownership/. See appendix A for detailed tables.

hospitalization were increasingly done on an outpatient basis (either at a hospital or at an ambulatory surgical center). This is reflected in a nine percent decline in inpatient surgery services at all Maryland Hospitals between 2015 and 2018. UMSMC at Easton's decline in inpatient surgery volume is likely lower than all Maryland Hospitals because UMSMC added percutaneous coronary intervention (PCI) services in 2017 (PCI is a form of invasive cardiology procedure that tends to be "coded" as a surgical service even though it does not take place in an operating room). The hospital in Easton reported 126 PCI cases in 2018. This service category had not previously been provided at UMSMC at Easton[38] and its introduction at Easton did not pull any case volume away from Chestertown, which has never provided PCI services.

Table 5: Volume of Inpatient Medical Discharges at UMSMC at Chestertown, UMSMC at Easton, and All Maryland Hospitals, 2015 & 2018[39]

	2015	2018	Nominal Change	Percentage Change
UMSMC at Chestertown	1,545	1,029	(516)	-33%
UMSMC at Easton	7,084	6,491	(593)	-8%
All Maryland Hospitals	473,458	454,805	(18,653)	-4%

Table 6: Volume of Inpatient Surgical Discharges at UMSMC at Chestertown, UMSMC at Easton, and All Maryland Hospitals, 2015 & 2018[40]

	2015	2018	Nominal Change	Percentage Change
UMSMC at Chestertown	236	176	(60)	-25%
UMSMC at Easton	1,604	1,569	(35)	-2%
All Maryland Hospitals	150,036	135,998	(14,038)	-9%

The data examined in this assessment contains some evidence that individuals who can choose to use another hospital for a scheduled inpatient medical or surgical service are doing so, although the reasons for those choices cannot be definitively determined. Eighty-nine percent (89%) of inpatient discharges (both medical and surgical) at UMSMC at Chestertown were delivered to individuals admitted through the emergency department (as opposed to scheduled direct admissions), compared to less than 60 percent of admissions at other Maryland hospitals. More than 90 percent of inpatient medical admissions at UMSMC at Chestertown resulted as a consequence of a patient presenting at the hospital's ED, compared to around 65% of admissions for other Maryland hospitals. At UMSMC at Chestertown, more than 55 percent of surgical patient admissions came from patients initially assessed in the emergency department, compared to

[38] PCI was not provided at UMSMC at Chestertown at any time in the study period.

[39] LD Consulting analysis of HSCRC Case Mix Data

[40] LD Consulting analysis of HSCRC Case Mix Data

approximately 30 percent for all Maryland hospitals. UMSMC at Easton's data on ED to admitted patient conversion closely resembles that data of all other Maryland hospitals.

TABLE 7: PERCENT OF INPATIENT ADMISSION ORIGINATING IN THE EMERGENCY DEPARTMENT AT UMSMC AT CHESTERTOWN, UMSMC AT EASTON, AND ALL MARYLAND HOSPITALS, 2015 & 2018

	UMSMC at Chestertown		UMSMC at Easton		All Maryland Hospitals	
Service Category	2015	2015	2015	2015	2015	2015
Inpatient Medical	92%	95%	66%	61%	65%	64%
Inpatient Surgery	56%	57%	27%	32%	31%	30%
Total Inpatient	**87%**	**89%**	**59%**	**55%**	**57%**	**56%**

Other rural hospitals in Maryland have an ED to inpatient conversion rate that is between the rate for all Maryland hospitals and the rate for UMSMC at Chestertown. About 75% of inpatient medical admissions at these hospitals originated in the ED and about 38% of inpatient surgical admission originated in the ED.

Hospital Service Area Inpatient Service Volume

Another perspective on this data involves a look at the residents of the UMSMC-Chestertown service area (i.e. the nine zip code areas defined as the hospital's 85% relevance service area, described earlier in this report). For the most part, the residents of this service area obtain inpatient hospital services at five hospitals: UMSMC at Chestertown; Anne Arundel Medical Center; UMSMC at Easton; University of Maryland Medical Center; and The Johns Hopkins Hospital.[41]

Total inpatient hospital discharges for residents of this service area declined by 445 discharges between 2015 and 2018, an 11 percent drop. Discharges from UMSMC at Chestertown declined by 521 (32%) between 2015 and 2018, while discharges of service area residents increased by 168 (32%) at UMSMC at Easton and by 23 (3%) at Anne Arundel Medical Center. Other hospitals in Maryland (including the University of Maryland Medical Center and The Johns Hopkins Hospital, both in Baltimore City, saw declines in inpatient hospitalizations from residents of the service area.

[41] Inpatient visits from these five hospitals make up 89% of all inpatient visits for Chestertown hospital service area residents.

Table 8: Number of Inpatient Hospital Discharges for Top Five Hospitals by Hospital Discharge Volume for Residents of Chestertown Hospital Service Area, 2015 & 2018

Hospital Name	2015	2018	Nominal Change	Percentage Change
UMSMC at Chestertown	1,609	1,088	-521	-32%
Anne Arundel Medical Center	897	920	23	3%
UMSMC at Easton	529	697	168	32%
University of Maryland Medical Center	309	280	-29	-9%
Johns Hopkins Hospital	130	129	-1	-1%
Other Maryland Hospitals	465	380	-85	-18%
Total Inpatient Discharges	**3,939**	**3,494**	**-445**	**-11%**
Proportion of discharges at top five hospitals	**88%**	**89%**		

Table 9: 2015 and 2018 Inpatient Services Market Share for Top Five Hospitals used by Residents of Chestertown Hospital Service Area

Hospital Name	2015 IP Market Share	2018 IP Market Share
UMSMC at Chestertown	41%	31%
Anne Arundel Medical Center	23%	26%
UMSMC at Easton	13%	20%
University of Maryland Medical Center & Shock Trauma	8%	8%
Johns Hopkins Hospital	3%	4%
Other Maryland Hospital	12%	11%

During the assessment period, UMSMC at Chestertown lost service area market share to other hospitals. In 2015, 41% of the inpatient hospitalizations for residents of the UMSMC at Chestertown service area occurred at UMSMC at Chestertown. AAMC had a market share in the service area of 23% and UMSMC at Easton achieved a 13% market share. By 2018, only 31% of the total Maryland hospital discharges from the service area were from UMSMC at Chestertown. In that same year, Anne Arundel Medical Center accounted for 26% of the discharges from the service area and UMSMC at Easton accounted for 20%.

There are a number of factors that influence which hospital a patient chooses. Such factors include services offered at the hospital facility (for example, UMSMC at Chestertown does not have obstetric services, certain cardiac services, or a trauma center), patient choice, and specialty or primary care physician recommendations and referrals.

Transfers to other Hospitals

One concern that has been raised by some community members is that patients are being transferred from UMSMC at Chestertown to other hospitals. In 2018, 28% of inpatient admissions

(medical and surgical) at UMSMC at Easton of service area residents were the result of transfers from another hospital. In 2015, only 9 percent of admissions at UMSMC at Easton were the result of transfers from another hospital. It is not possible to identify the source hospital in the data (i.e. MHCC cannot determine how many of these transfers are from UMSMC at Chestertown in the administrative data set).

Emergency medicine services (EMS) personnel routinely transport a patient to the nearest hospital equipped to treat that patient's condition. An emergency medical services (EMS) diversion allows hospitals in the State to inform EMS of capacity issues within the hospital or the ED that could have an impact on the timeliness of patient care. For example, a "red alert" communicates that a hospital has no ECG monitored beds available for critical care or telemetry. A "yellow alert" is a request from an emergency department to EMS to bypass the hospital with all patients in need of urgent medical care. Patients that bypass the hospital because of a red or yellow alert would not be captured in the transfer data discussed above, because EMS transports the patients directly from the site of the EMS call to another hospital.

Yellow alerts, the most relevant diversion for this assessment were not major contributors to EMS bypasses that may have occurred at UMSMC in Chestertown in either 2015 or 2018. In 2015, UMSMC at Chestertown was on yellow alert 24 hours (less than 1% of total ED hours) over that year and in 2018, the hospital was on yellow alert a mere eight hours.[42] UMSMC at Easton had more hours on yellow alert but it experienced a decline in yellow alert hours from 312 (about 4% of total ED hours) in 2015 to 140 in 2018.

Average Daily Census, Length of Stay, and Licensed Beds

UMSMC at Chestertown saw a decrease in the average daily census (ADC) for inpatient services in each year over the study period. The ADC for UMSMC at Chestertown, a function of both discharges and average length of stay, declined 36% from 2015 to 2018 and the ADC for UMSMC at Easton increased 15% over the same time period (however, the ADC for UMSMC at Easton has declined since 2018). The overall average daily census for all Maryland hospitals decreased 2.6% from 2015 to 2018. The overall average daily census for all Maryland rural hospitals decreased 11% from 2015 to 2018 (a decrease of nine percent if UMSMC at Chestertown is excluded).

Licensed bed capacity at UMSMC at Chestertown fell from 31 beds in FY 2015 to 26 beds in FY 2018 (16 percent). Licensed bed capacity has fallen to 12 beds as of FY 2020 (a decrease of 61 percent compared to 2015). Licensed bed capacity for acute care hospitals in the State of Maryland is dynamic, calculated annually based on average daily acute care inpatient census. The average daily census (ADC) of acute care patients for each hospital for the 12-month period ending with the first quarter of each year is calculated and total licensed acute care bed capacity is established for the next fiscal year at 140% of the hospital's average daily census during that period. This licensure approach reflects an assumption that an average annual occupancy rate of approximately 71% for acute care hospital beds is an appropriate benchmark for determining the maximum

[42] MHCC analysis of the CHATS Region I, II, IV - County/Hospital Alert Tracking System at https://www.miemssalert.com/chats/Default.aspx?hdRegion=124&hdReportRegion=IV&hdReport=Hospital%20Summary%20Report accessed on January 10, 2020

number of beds an acute care hospital needs to operate without an excessive number of days occurring in which all bed capacity is full.[43]

Table 10: Licensed Bed Capacity, FY 2015-FY 2020

	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	Percent Change, 2015-2020
UMSMC at Chestertown	31	30	26	26	21	12	-61%
UMSMC at Easton	112	112	112	120	104	97	-13%
All Maryland Hospitals	**9,804**	**9,800**	**9,555**	**9,611**	**9,355**	**9,401**	**-4%**

Outpatient Service Volume Changes at UMSMC at Chestertown

Use of outpatient services for all patients at the Chestertown hospital declined during the 2015-2018 assessment period, but at a much lower rate than the rate of decline experienced in inpatient service. UMSMC at Chestertown saw a five percent decline in outpatient service volume between 2015 and 2018. Hospitals in Maryland, on average, saw a six percent volume reduction during this time period, so the Chestertown hospital is retaining more of its historic volume of outpatient services than many other Maryland hospitals. Easton saw two percent growth in outpatient service volume over this time period.

Table 11: Visit Volume - Outpatient Care, 2015 & 2018

	2015	2018	Net Change, 2015 -2018	Percent change, 2015-2018
UMSMC at Chestertown	77,833	74,240	-3593	-5%
UMSMC at Easton	141,209	143,695	2,486	2%
All Maryland Hospitals	13,568,384	12,709,474	(858,910)	-6%

Outpatient Service Volume for Residents of the UMSMC at Chestertown Service Area

Focusing on the geographic service area, residents of this area frequently choose UMSMC at Chestertown for outpatient services. Of the outpatient service visits provided to residents of this service area, 66 percent were provided at UMSMC at Chestertown, a percentage that has changed very little during the assessment period.

The total number of outpatient service visits at any hospital provided to residents of the UMSMC at Chestertown service area increased about one percent over the assessment period. This is the same increase in outpatient service visits seen at UMSMC at Chestertown during the assessment period. The volume of outpatient service visits delivered to service area residents also increased at UMSMC at Easton, Johns Hopkins Hospital, and the University of Maryland Medical Center. Outpatient services delivered at the FMF in Queen Anne's County declined during this period.

43 https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Annual_Rpt_Hosp_Services_FY2018.pdf

Table 12: Outpatient Service Visit Market Share for UMSMC at Chestertown Service Area Residents: Top Five Hospitals by Visit Volume		
	2015 Market Share	2018 Market Share
UMSMC at Chestertown	67%	66%
Anne Arundel Medical Center	9%	8%
UMSMC at Easton	6%	7%
University of Maryland Medical Center	6%	7%
Johns Hopkins Hospital	3%	4%
Other Maryland Hospitals	9%	8%

Table 13: Outpatient Service Visits Provided to UMSMC at Chestertown Service Area Residents				
	2015	2018	Net Change, 2018 -2015	Percent change, 2018-2015
UMSMC at Chestertown	31,051	31,301	250	1%
Queen Anne's Freestanding Medical Facility	3,968	3,595	-373	-9%
Anne Arundel Medical Center	3,022	3,244	222	7%
UMSMC at Easton	2,976	3,237	261	9%
Johns Hopkins Hospital	1,560	2,023	463	30%
Other Maryland Hospitals	4,077	3,793	-284	-7%
Total OP Visits	**46,654**	**47,193**	**539**	1%

Observation Stays

Table 14: Average Daily Census of Observation Patients				
	FY 2015	FY 2016	FY 2017	FY 2018
UMSMC at Chestertown	2.5	2.0	1.3	1.8
UMSMC at Easton	3.0	3.0	2.0	2.0

Observation services are those services furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible inpatient admission.[44] Observations services are outpatient services. However, these services may be

[44] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Annual_Rpt_Selected_Hospital_Services_FY2017.pdf

provided in a hospital room and bed, and so the patient may not be aware of the status of the services. The status of the services makes a difference to patient's cost-sharing responsibility both for the time in the hospital and for subsequent stays in a long-term care facility, depending on the patient's source of insurance. It appears that use of this outpatient service declined at both UMSMC at Chestertown and UMSMC at Easton over the assessment period.

Summary Perspective on Changes in Service Volume at UMSMC at Chestertown

UMSMC at Chestertown experienced a larger decline in admissions during the assessment period and a larger decline in admissions after 2018 than would be expected, in light of the broad decline in hospitalization seen across the state in recent years. The basis for this decline is two-fold. UMSMC at Chestertown was and still is experiencing a higher level of admission of patients discharged from a hospital within the 30 days preceding admission, referenced as "readmissions," than most hospitals. It was and still is experiencing a higher level of Prevention Quality Indicators (PQI) admissions (a measure of potentially avoidable hospitalizations for ambulatory care sensitive conditions) than most hospitals. It has made progress in reducing the number of such potentially preventable admissions but this has exacerbated the overall decline in use of its inpatient facilities. Secondly, the hospital has lost significant inpatient market share in its shrinking service area to the two other hospitals that draw the most patients from this service area. The patient choices underlying this trend and physician influence on those choices cannot be definitively characterized by MHCC in a manner that allows for any meaningful finding on why inpatient care is migrating away from UMSMC at Chestertown. It seems likely that some actions of Shore Regional Health, taken in response to the declining use of the hospital in Chestertown and the reductions in demand for service at this hospital have exacerbated the declines. However, MHCC is not able to discern any formal plan being implemented by Shore Regional Health expressly designed to force a market shift in hospitalization services from Chestertown to Easton.

Assessment of Changes in the Quality of Care Provided by UM Shore Medical Center at Chestertown, 2015 – 2018

Three types of data are examined to assess the quality of services provided at SMC-Chestertown and how quality and performance measures for this hospital have changed in recent years.

The first set of measures are those related to broad categories of hospital use and measures of timely and effective hospital care. Characteristically, they have been used, e.g., in the case of readmissions and PQI admissions, in Maryland's regulatory model to track and reward reductions in hospital use that can be prevented through improvements in care delivery and coordination. The measures include: the ratio of "readmissions" to total admissions; the ratio of "Prevention Quality Indicator" (PQI) admissions to total admissions; and the time inpatients originating from the hospital emergency department (ED) wait in the ED prior to admission.

Hospital Use

Readmissions" are admissions of patients that occur within 30 days of the same patient being discharged from a hospital stay. (Transfers of patients from one hospital to another for longer-term care are not readmissions.) Readmissions were reduced at SMC-Chestertown in the years shown in the table, declining at a faster rate (38%) between 2015 to 2018 than total admissions (31%). The observed rate in 2018 was comparable to the average seen for Maryland's rural hospitals (12%). The overall readmission rate for all Maryland hospitals in 2018 was 8.9%.

Table 15: Readmissions and Total Admissions, UMSMC at Chestertown						
	2015	2016	2017	2018	Nominal Change 2015-18	Average Annual Change 2015-2018
Readmissions	245	247	249	152	-38.0%	-11.3%
Total Admissions	1,829	1,581	1,712	1,262	-31.0%	-8.9%
Readmissions/Total Admissions	13.4%	15.6%	14.5%	12.0%		

The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates. (AHRQ). In 2018, 10.2% of SMC-Chestertown admissions included PQI, a significant improvement when compared with 2015's PQI rate of 22.7%. The 2018 PQI rate for SMC-Chestertown is slightly higher than the average rate for Maryland rural hospitals (9.5%). The gap between the SMC-Chestertown rate and the state average (7.3%) is higher.

Table 16: PQI Admissions and Total Admissions, UMSMC at Chestertown						
	2015	2016	2017	2018	Nominal Change 2015-18	Average Annual Change 2015-2018
PQI Admissions	415	331	279	129	-68.9%	-25.3%
Total Admissions	1,829	1,581	1,712	1,262	-31.0%	-8.9%
PQI Admissions/Total Admissions	22.7%	20.9%	16.3%	10.2%		

From 2015 to 2018, SMC-Chestertown reduced the median time patients spent in the hospital's ED prior to admission by over 1.5 hours, an impressive achievement when compared with statewide experience, where this measure (in terms of a simple average time) actually worsened slightly in those same years. Despite the improvement, the median time spent by patients at SMC-Chestertown in 2018 was longer than that observed for the two nearest Eastern Shore general hospitals and Anne Arundel Medical Center, by approximately an hour to 1.5 hours and was substantially longer compared to the border state rural hospital average and almost 20 minutes longer than the overall statewide average

Table 17: Median Time (Minutes) in ED Prior to Admission, UMSMC at Chestertown and Selected Other Hospitals						
Hospital	2015	2016	2017	2018	Nominal Change 2015-18	Average Annual Change 2015-2018
UMSMC at Chestertown	512	493	407	418	-18.4%	-4.9%

UMSMC at Easton	306	325	335	350	14.4%	3.4%
Union Hospital of Cecil County	352	369	339	330	-6.3%	-1.6%
Anne Arundel Medical Center	372	352	333	330	-11.3%	-2.9%
University of Maryland Medical Center	635	-	662	688	8.3%	2.0%
Rural Hospitals in Border States (Simple Average)	227	232	232	233	2.5%	0.7%
All Maryland Hospitals (Simple Average)	391	383	391	399	2.1%	0.5%

Hospital Performance Evalation Guide

A second set of measures are those that MHCC has used in its Maryland Hospital Performance Evaluation Guide (MHPEG), which can be accessed on the MHCC web site at: https://www.marylandqmdc.org/Article/View/d1c578b9-afab-45c2-b88a-df65e1c46fc2

A number of measures in the MHPEG are not reported for UMSMC at Chestertown because utilization is too low to yield meaningful performance results. A review of the measures is summarized below.

Timely and Effective Care

The following table provides 2018 values for CMS Hospital Compare timely and effective care measures as available SMC-Chestertown, the two other Shore Regional Health hospitals (combined) and Anne Arundel Medical Center. The measures of timely and effective care, also known as process measures, show how often or how quickly hospitals provide care that research shows gets the best results for patients with certain conditions.

The substantive "findings" from this set of measures are:

- The reported median time from ED arrival to ED departure for discharged ED patients increased from 178 minutes in 2017 to 406 minutes in 2018. This is only based on two available data points.
- Colonoscopy care appears to be improving. Both measures for this procedure showed significant improvement between 2016 and 2018. .Both were new measures in 2015.

Complications, Deaths, and Imaging Measures

With respect to this set of complication and death measures, no changes in complications or mortality measures occurred. All measures with enough data are found to be "No different than the national rate"

No clear change trends in imaging measures are apparent.

Table 18: Selected Measures of Timely and Effective Care, UM Shore Medical Center at Chestertown and Selected Other Hospitals in 2018					
Service Type/ Condition	Measure	Measure Value	SMC-Chestertown	SMC-Easton & SMC-Dorchester	Anne Arundel Medical Center
Emergency Department	Median time from arrival in ED to departure for admitted ED patients	Minutes	330	330	418
	Median time in ED after decision to admit	Minutes	102	111	207
	Median time in ED – all outpatients (not admitted)	Minutes	128	153	189
	Median time from arrival in ED to ED departure – all patients	Minutes	406	285	430
	Left without being seen	Percentage of total ED patients	1%	3%	1%
Heart Attack or Chest Pain	Median time to ECG	Minutes	7	7	4
Colonoscopy Care	Appropriate follow-up interval for normal colonoscopy in average risk patient	Compliance Percentage	40%	78%	94%
	Colonoscopy interval for patients with a history of adenomatous polyps-avoidance of inappropriate use	Compliance Percentage	89%	82%	100%
Sepsis Care	Appropriate care for severe sepsis and septic shock	Compliance Percentage	34%	38%	69%
Immunization for Influenza	Immunization for influenza following patient assessment	Compliance Percentage	97%	99%	99%
Health Care Worker Influenza Vaccination	Health care workers immunized for influenza	Compliance Percentage	99%	99%	95%

Infections

UMSMC at Chestertown does not have results for all but one of the hospital-acquired infection types tracked by the Centers for Disease Control, because of insufficient data or, in the case of cardiac surgery, because it does not provide the service. Small amounts of data are not compatible with precision issues in the National Healthcare Safety Network calculations of comparative performance. Clostridium difficile is the only infection type that is consistently scored for UMSMC at this hospital. The standardized infection ratio (SIR) is consistently above 1 (below 1 is better), but the SIR is considered no different than the national benchmark and there have been no changes in this finding since 2015.

Patient Experience

Finally, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) data set was reviewed. CAHPS surveys are funded and overseen by the Agency for Healthcare Research and Quality (AHRQ). The surveys ask patients to report on their health care experiences and are available to the public. They focus on health care quality aspects that patients find important and are capable of assessing. The surveys measure patient experience with various measures that 'should' happen with each medical encounter, such as understandable communication with doctors, nurses and pain management during a patient's hospital or clinic visit or end of life care. More information of CAPHS survey information can be accessed at: (https://www.ahrq.gov/cahps/news-and-events/podcasts/measure-patient-experience-podcast.html)

The following table provides a composite star rating based on HCAPHS patient surveys for five years for five hospitals, for border state rural hospitals and for all hospitals in Maryland. The five-star rating system combines data gathered from questions on ten topics: nurse communication; doctor communication; responsiveness of hospital staff; communication about medicines; discharge information; care transition; cleanliness of hospital environment; quietness of hospital environment; hospital rating; and willingness to recommend hospital. As can be seen, over the five years shown, SMC-Chestertown's average composite score was 2.6, the lowest star rating among the two nearest alternative general hospitals on the Eastern Shore (SMC-Easton and Union), and also lower than the average maintained by Anne Arundel Medical Center and University of Maryland Medical Center. Over the years shown, SMC-Chestertown composite star rating was similar to the average for all Maryland hospitals.

Table 19: CMS 5-Star Composite Hospital Ratings 2014-2018

Hospital	2014	2015	2016	2017	2018
UMSMC at Chestertown	3	2	2	3	3
UMSMC at Easton	3	3	3	3	3
Union Hospital at Cecil County	3	3	3	3	2
Anne Arundel Medical Center	3	3	4	3	4
University of Maryland Center	3	3	3	3	3
Rural Hospitals in Border States (Simple Average)	**3.2**	**3.2**	**3.4**	**3.2**	**3.3**
All Maryland Hospitals (Simple Average)	**2.6**	**2.6**	**2.6**	**2.7**	**2.8**

Summary Perspective on Changes in Quality at UMSMC at Chestertown

Substantive changes in the overall quality of care at SMC-Chestertown are not evident in the 2015 to 2018 period based on the quality of care and performance measures considered. This hospital certainly does not stand out has a top performer among Maryland hospitals nor does the profile indicate that the hospital is notable for producing very bad outcomes or significantly unhappy patients.

As previously noted, SMC-Chestertown has reduced readmissions or potentially preventable or avoidable admissions at a faster pace than the state's hospitals as a whole but started the period with a high proportion of such admissions and its levels are still relatively high despite its success. This "success" is a substantive factor in the inpatient volume slide that has occurred at SMC-Chestertown, as previously discussed in this report.

Assessment of the Causes for the Observed Changes at UMSMC at Chestertown, 2015 to 2018

A key basis for this report was the distribution in 2018 of a list of grievances by the *Save Our Hospital* organization that has established itself in Chestertown. Those complaints were directed at Shore Regional Health and primarily addressed changes in personnel and services at UMSMC at Chestertown that, in the view of the Chestertown group, constituted neglect, inaction, or purposeful actions by Shore Regional Health that degraded the availability of services in Chestertown, the quality of managerial oversight applied in Chestertown, or, in the case of psychiatric services, a poor level of policy consideration and decision-making related to the conversion of the Cambridge hospital to an FMF and the alternatives for relocation of this service.

Appendix D includes correspondence itemizing the specific grievances identified by *Save Our Hospital* and the response of Shore Regional Health.

As outlined in the body of this report, UMSMC at Chestertown is a small rural hospital providing general medical/surgical inpatient services that has not seen any changes in recent years in its fundamental service mix or quality of care but has experienced a precipitate decline in demand for hospitalization. As noted in the report, one basis for the decline in inpatient service volume is UMSMC at Chestertown's history of hospitalizing patients of questionable appropriateness. As would be expected under Maryland's new payment model, these high levels of readmissions and PQI admissions are falling. This is a positive development that has placed a difficult strain on this small hospital. Secondly, as overall use of hospitals declines, as a result of reductions in inappropriate hospitalization but also as a result of changes in clinical practice, UMSMC at Chestertown is also seeing its market position erode. It is reasonable to expect that Shore Regional Health will try to deploy staff and clinical resources where they can be used most frequently and most efficiently. As activity levels at the hospital in Chestertown shrink, perceptions of the hospital as a reliable and proficient provider of services by physicians and patients may lead to more migration to other hospitals or health care facilities for service. It is difficult to know with certainty, but it is possible that a "downward spiral" of decline may be at play.

To reiterate the report's summary perspective on the volume decline, the choices underlying this trend cannot be definitively characterized by MHCC in a manner that allows for any meaningful finding on why inpatient care is migrating away from UMSMC at Chestertown. Some actions by Shore Regional Health which, at least in part, are a response to the declining demand for service in Chestertown, have exacerbated the decline. However, MHCC is not able to discern any formal

plan being implemented by Shore Regional Health expressly designed to force a market shift in hospitalization services from Chestertown to Easton.

Some actions by UMSMC at Chestertown's parent, Shore Regional Health are undoubtedly related to the decline in use of this small hospital. MHCC did not identify any formal plan being implemented by Shore Regional Health expressly designed to force a material market shift in hospitalization services from Chestertown to Easton. Only one service identified by "*Save Our Hospital*" as being transferred from UMSMC at Chestertown to the Easton hospital, sleep lab services, was confirmed by Shore Regional Health to have made this transfer by choice of SRH but the system claims that this action was taken on the basis of a recommendation by the now retired pulmonologist providing the service in Chestertown, because of the low volume of sleep studies being conducted.

Financial Performance of UM Shore Medical Center at Chestertown

While not requested as a specific element of this report, context for the information about changes at UMSMC at Chestertown provided in the report, revenues and expenses from Maryland hospitals' annual Statement of Revenue and Expenses (schedule RE) were reviewed to summarize the change in revenue and expenses from fiscal year 2015 to 2018 at the UMSMC at Chestertown.[45] The schedule RE summary includes data from regulated revenue, unregulated revenue[46] and the combined total revenue.

In total (combining both regulated and unregulated revenue), UMSMC at Chestertown generated positive margins from fiscal year 2015 through 2018. In 2015 the hospital's "profit" (excess revenues over expenses) margin was $1.2 million (2% of net revenue) and steadily increased to $8.1 million in 2018 (15% of net revenue). It is worth noting that the hospital accrued a significant $6.8 million deduction to patient revenue in 2015 that impacted financial performance. This accrual was related to a payback to CMS that spanned multiple years but was realized in 2015. Had this $6.8 million deduction not been realized in 2015 the profit margin in 2015 would have been more consistent with that seen in 2018, approximately $8 million. The positive margin is attributable to inpatient and outpatient services. The hospital did not generate a positive margin from unregulated revenue generated from 2015 through 2018. Like UMSMC at Chestertown, the total gross profit margin for all Maryland Hospitals was positive in both 2015 (3.9% of net revenue) and 2018 (5.7% of net revenue). However, the profits experienced at the Chestertown hospital as a percentage of net revenue exceeded the rate of profit for all Maryland hospitals and also exceeded profit as a percentage of net revenue for Maryland rural hospitals (4.8% of net revenue).

In the regulated inpatient and outpatient services, gross patient revenue at UMSMC at Chestertown declined from $64.5 million in 2015 to $59.4 million in 2018. The reduction is seen primarily in the gross revenues from daily hospital services and inpatient ancillary services. There was an increase in revenue from ambulatory services while outpatient ancillary service revenue remained

[45] Maryland hospital audited financial statements are available on the HSCRC website. https://hscrc.maryland.gov/pages/hsp-afs.aspx. Schedule RE is used by Maryland Hospitals to provide an annual statement of revenue and expenses to the HSCRC. The schedule RE summary includes data from regulated revenue, unregulated revenue, and the combined total revenue.

[46] Unregulated revenue includes physician services and other Medicare Part B services that hospitals provide but are not subject to HSCRC rate setting.

relatively flat from 2015 to 2018. The $5 million drop in patient revenue from 2015 to 2018 was offset by reductions in expenses (primarily wage and benefit expenses) which was reported as $18.6 million in 2015 and only $12.1 million in 2018. However, there was a $3.2 million increase from 2015 to 2018 reported under "other expenses." Shore Regional Health stated that the increase in other expenses is related to an increase in recruitment and additional practice support. In the above-mentioned letter to Senator Hershey from *Save Our Hospital*, concerns were addressed regarding service and staff reductions and the transition of the Chestertown hospital into a de facto FMF. The decline in daily hospital and inpatient ancillary services and the increase in ambulatory and outpatient ancillary service revenue suggests that there is a transition during this period away from inpatient care to ambulatory care. To further review the reduction of salary and wage expenses and how that might relate to the alleged reduction in staffing, the UMSMC at Chestertown Schedule C was reviewed.[47] Schedule C includes the hospital's reported wages and benefits by general service center as well as the hospital's reported full time-equivalent staffing by general service area.

As reported on Schedule C, UMSMC at Chestertown reported a total of $8.2 million in wage and benefit expenses in 2015. The wage and benefits reported in 2018 declined by 56% to $3.6 million. Expense reductions were reported across all service areas but were most notable in hospital administration which was reported at $1.8 million in 2015 and dropped to $72,000 in 2018. There were eight hospital administration FTEs reported in 2015 and six in 2018. The patient accounts service area contributed significantly to the overall wage decline. This service area previously had $990,000 allocated in wages in 2015 and dropped to $0 allocated in wages in 2018. Shore Regional Health stated that the decline in hospital administration and patient accounts expenses was a result of regionalizing positions at Chestertown. *Save Our Hospital* expressed concerns over administration and a lack of on-site leadership at the hospital in Chestertown.

Nursing administration saw a significant decline (57%) in wages and FTEs from 2015 to 2018. In 2015, $1.4 million (12 FTEs) were allocated in wages for nursing administration versus $596,000 (six FTEs) in 2018. *Save Our Hospital* expressed concerns over nursing shortages as well as an understaffed transitional nurse navigator program and a lack of nurses with specialized care such ostomy and wound care nursing. *Save Our Hospital* alleges that such nursing shortages resulted in the transfer of patients to Easton. In the above-mentioned Shore Regional Health response letter to *Save Our Hospital* allegations (see Appendix D), administration and nursing shortages were addressed. The letter confirms that positions such as the medical records supervisor and the joint commission director are regional positions and states that such positions do not require full time, on-site staffing at the Chestertown hospital. The letter also addresses the concerns over alleged nursing shortages stating that nurse staffing at UMSMC at Chestertown is managed within an appropriate range for the patient demand experienced and standardized nurse to patient ratio targets. Additionally, the use of telemedicine to consult ostomy and wound nursing was referenced in Shore Regional Health's response. The reduction in expenses, wages, and FTEs associated with hospital and nursing administration found in the financial reports (schedule RE and schedule C), as well as the feedback provided by Shore Regional Health, confirms the impact on staffing levels

[47] Schedule C "General Service Center" is used by hospitals to report fiscal year overhead expenses (Wage, Salary, Fringe Benefit and Other Expenses), and FTEs for the general service centers. Detailed instruction of the report and description of the general service centers included in this schedule can be found on HSCRC web site at https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-500-FINAL-03-01-18.pdf

and expenses related to "regionalization." The extent to which that reduction in staff resulted in consequential shortages in Chestertown and/or transfers to Easton cannot be determined in the schedule RE and Schedule C financial reports. The reduction in gross patient revenues is indicative of declining service volume. However, to further review and confirm any reduction in services, the UMSMC at Chestertown Schedule V5 was reviewed.[48] The Schedule V5 includes the hospital's reported inpatient and outpatient volume of visits and the number of days that a patient was hospitalized. The information found in schedule V5 comprises information found in Schedules V1, V2, and V3 and is available by service center.[49]

As reported on Schedule V5, UMSMC at Chestertown reported a total of 7,770 inpatient days in 2015. Patient days reported in 2018 represented a decline of 38% (4,853 days). The overall volume of inpatient admissions also declined 33% from 2015 (a reported 1,859 admissions) to 2018 (a reported 1,254 admissions). Additionally, outpatient visits reported on Schedule V5 declined by 4% over the same time frame. Hospital discharges and patient days for the hospital in Chestertown declined but this decline was outstripped by the 50% rate of reduced nursing staff. However, it would not be clinically accurate to assume that the nurse to patient ratio is directly related to the rate of inpatient/outpatient visits. The lower rate of visits could however correlate to fewer patients and thus fewer nurses needed to maintain the standard nurse to patient ratio. Additionally, we can see in Schedule V5 that the average length of stay related to the Intensive Care Unit (service center "MIS") dropped from 6.4 days in 2015 to 1.3 days in 2018. The lower length of stay required by patients may be an indication of a lower acuity of patients or, potentially, the lower length of stay is a result of a nurse vacancy in the ICU unit in 2018 – as referenced in the Shore Regional Health response letter to *Save Our Hospital*'s allegations. In the Shore Regional Health response letter to *Save Our Hospital*'s allegations it was noted that the vacancy (and active recruitment to fill that vacancy) may result in possible ICU patient transfers. Patient transfers from UMSMC are addressed in the section of this report on the "Assessment of Changes in Volume of Services at UMSMC at Chestertown". As noted in that section of the report, in 2015, 9% of admissions at UMSMC at Easton were the result of transfers from another hospital, while in 2018, 28% of admissions at UMSMC at Easton were the result of transfer from another hospital. The source hospital for these transfers could not be identified.

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[48] Schedule V5 "Equivalent Inpatient Days and Admissions" is used by hospitals to express outpatient visits and inpatient days as equivalent inpatient days (EIPD) and outpatient visits and inpatient admissions as equivalent inpatient admissions (EIPA). Detailed instruction of the report can be found on HSCRC web site HSCRC web site at https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-500-FINAL-03-01-18.pdf

[49] Schedule V1 "Routine Service Volumes and Patient Days" is used by hospitals to report certain inpatient statistics, including admissions (discharges) and patient days for daily hospital service centers.

Schedule V2 "Ambulatory Visits" is used by hospitals to report units of service (visits and relative value units) for inpatient and outpatient for ambulatory service centers.

Schedule V3 "Ancillary Service Units" is used by hospitals to report units of service for inpatient and outpatient for ancillary service centers.

Detailed instructions for each of these schedules can be found on HSCRC web site HSCRC web site at https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-500-FINAL-03-01-18.pdf

For regulated inpatient and outpatient revenue, Chestertown hospital net operating revenues increased 8.5% or an annual average of 2.8%. However, the hospital's operating expenses declined by 5.9% or an annual average decline of 2.0%. The main driver for the reduction in operating expenses is the decline in expenses in the "Salaries, Wage, and Benefit" category. The expense for this category declined 35% in the period for an annual average decline of 13.4%. The following table profiles changes in net operating revenue, operating expenses, and total margin in the regulated and unregulated space.

Table 20: Percent Changes in Regulated Operating Revenue and Operating Expenses between FY 2015 and FY 2018

	Percent Change in Net Operating Revenue		Percent Change in Operating Expenses	
Hospitals	Nominal Change	Average Annual Change	Nominal Change	Average Annual Change
UMSMC at Chestertown	8.5%	2.8%	-5.9%	-2.0%
Shore Regional Health Hospitals	7.1%	2.3%	7.3%	2.4%
Maryland Rural Hospitals	6.8%	2.2%	9.3%	3.0%
Maryland – All Hospitals	8.4%	2.7%	8.0%	2.6%

Table 21: Changes in Unregulated Operating Revenue and Operating Expenses between FY 2015 and FY 2018

Hospitals	Change in Net Operating Revenue		Change in Operating Expenses	
	Nominal Change	Average Annual Change	Nominal Change	Average Annual Change
UMSMC at Chestertown	-24.4%	-8.9%	-8.7%	-3.0%
Shore Regional Health Hospitals	21.9%	6.8%	2.3%	0.8%
Maryland Rural Hospitals	20.1%	6.3%	25.9%	8.0%
Maryland – All Hospitals	24.3%	7.5%	25.6%	7.9%

In summary, the sharp decline in service volume experienced by UMSMC at Chestertown between 2015 and 2018 did not result in a commensurate negative impact on the hospital's financial performance over this period, a result deriving from the Maryland hospital payment model's moderating influence, over the short-term, on how service volume changes are reflected in revenue changes and the hospitals ability to trim expenses.

It should be noted that the accelerated decline in service volume that has occurred after the end of the study period, 2018, especially with respect to inpatient service volume, has resulted in more recent performance that more closely aligns with what the trends of recent years have appeared to portend. The table below profiles net patient service revenue, total operating expenses, and operating income (loss) as reported in audited financial statements for the University of Maryland

Medical System for FY 2015 to FY 2019. These statements can be viewed on the HSCRC web site at https://hscrc.maryland.gov/Pages/hsp-AFS.aspx

Table 22: Revenue, Expenses and Income from Audited Financial Statements – UMSMC at Chestertown, FY 2015 to FY 2019 (all figures in $000s)

	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Net Patient Service Revenue	$50,443	$53,306	$51,811	$53,243	$43,864
Total Operating Expenses	$49,362	$48,612	$45,571	$46,259	$51,275
Income (Loss) from Operations	$1,340	$4,949	$6,643	$7,494	($7,411)

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

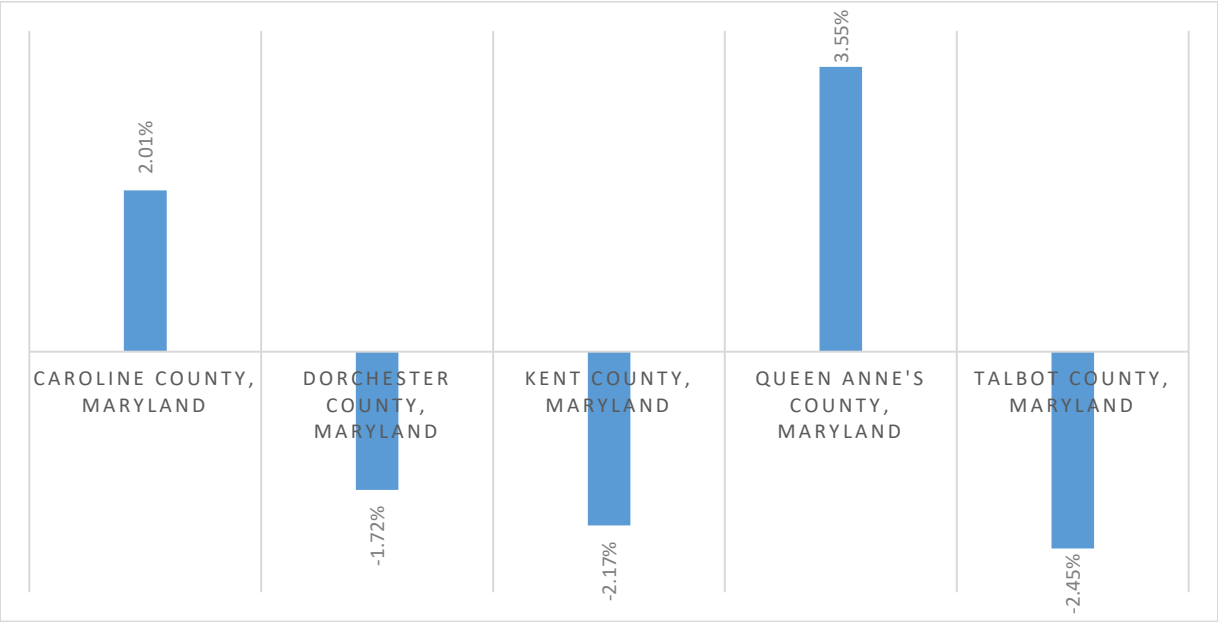
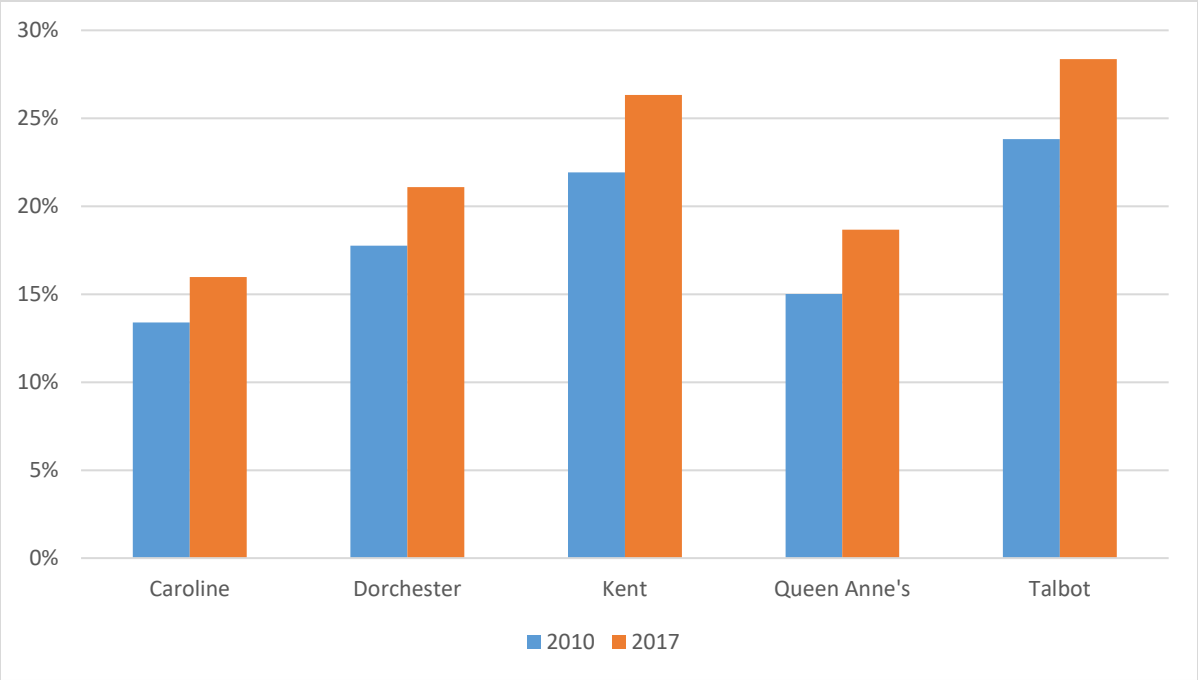


Figure 2: Percent of Population Change Age 65 and Older, Five Eastern Shore Counties, 2010 & 2017



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.

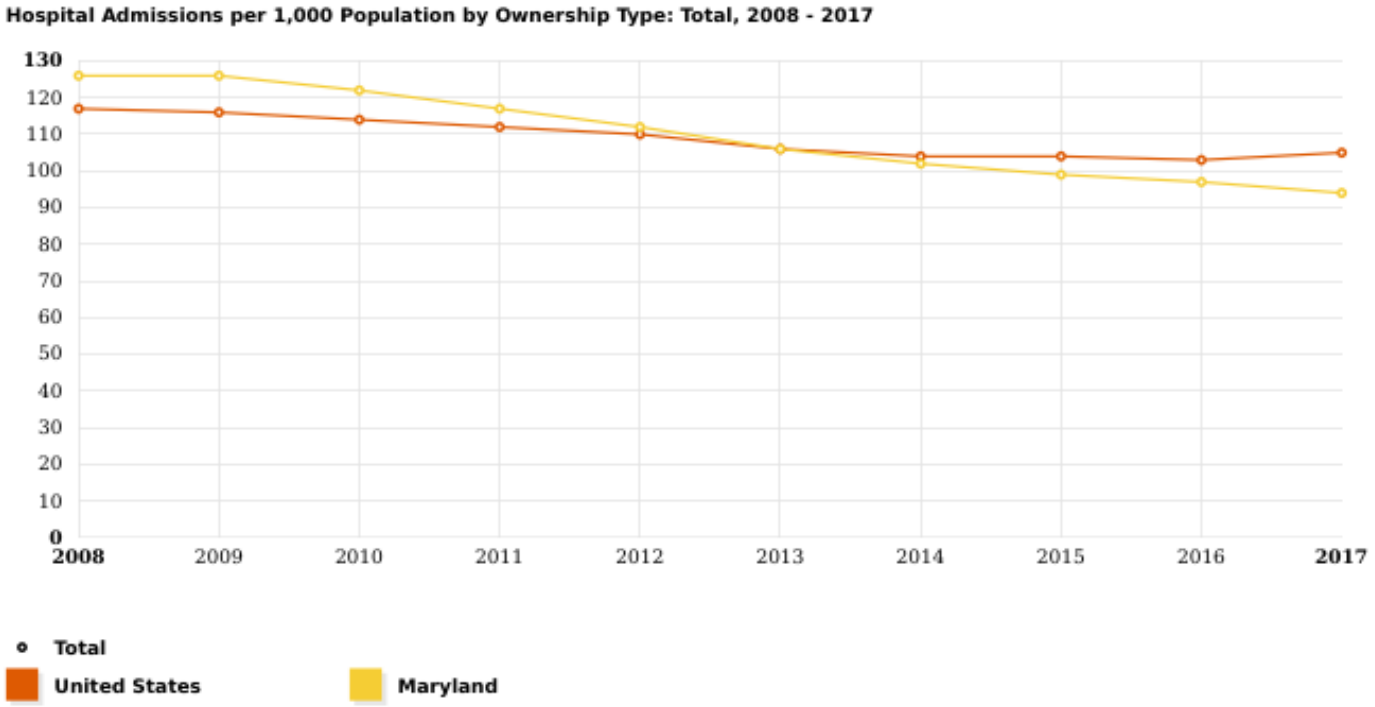
[2] Ibid.

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

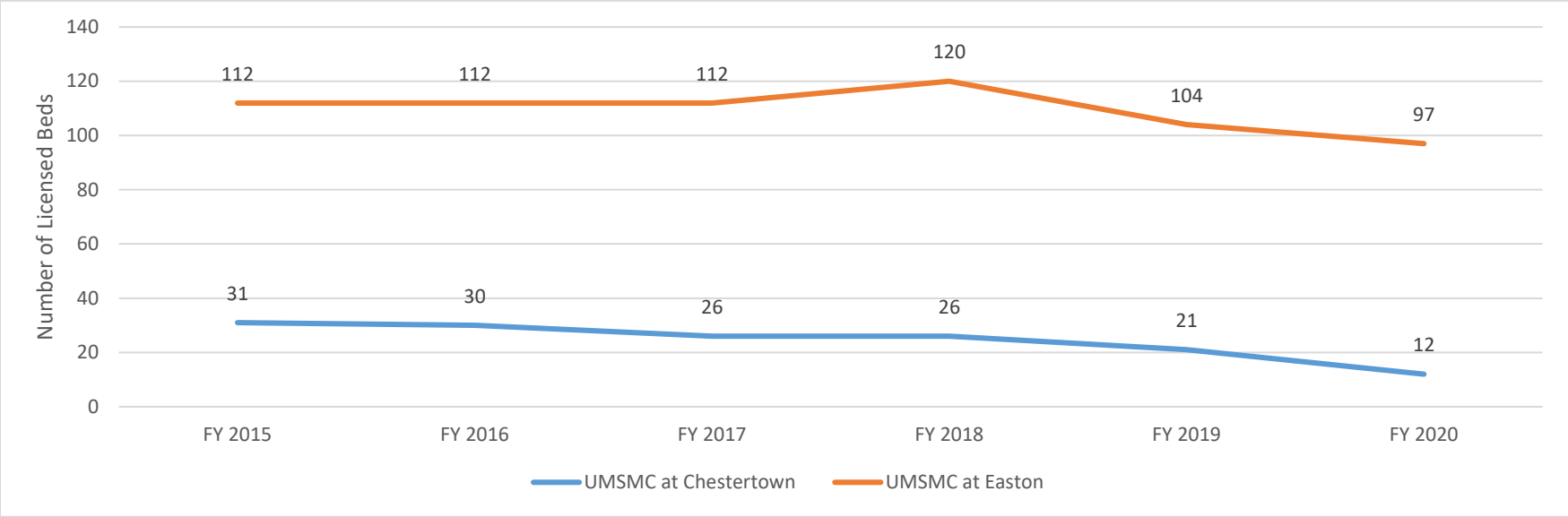


Figure 5: Licensed Bed Capacity, All Maryland Hospitals, Fiscal Year 2015 to Fiscal Year 2020

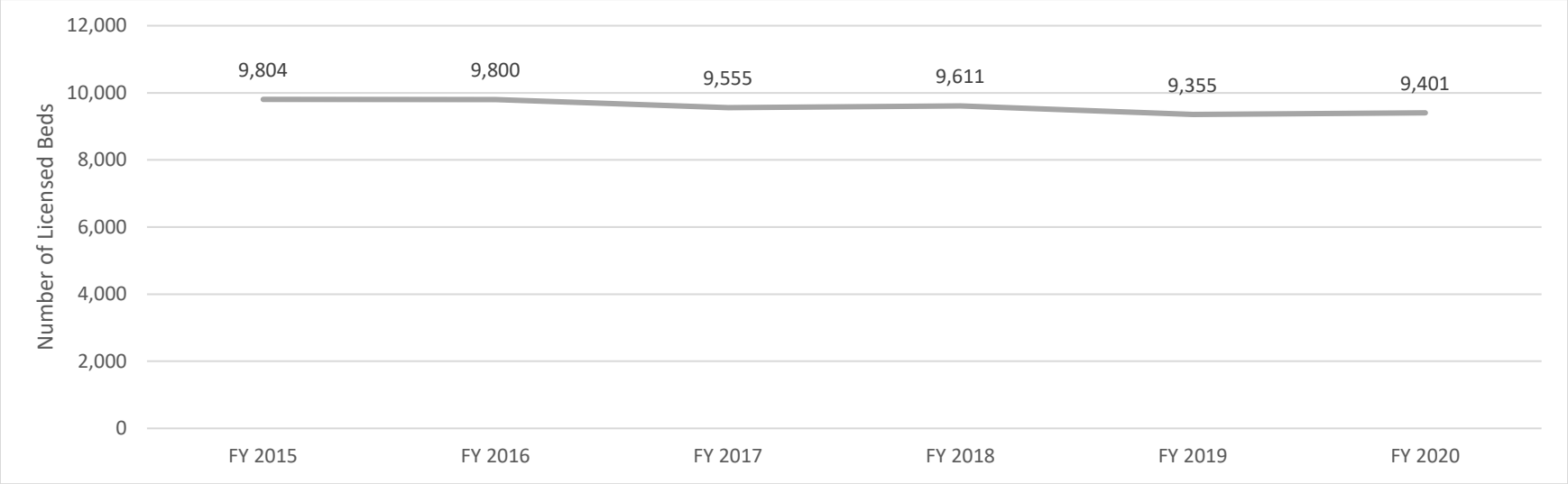


Figure 6: UMSMC at Chestertown Monthly MSGA Discharges, Calendar Year 2017 and 2018

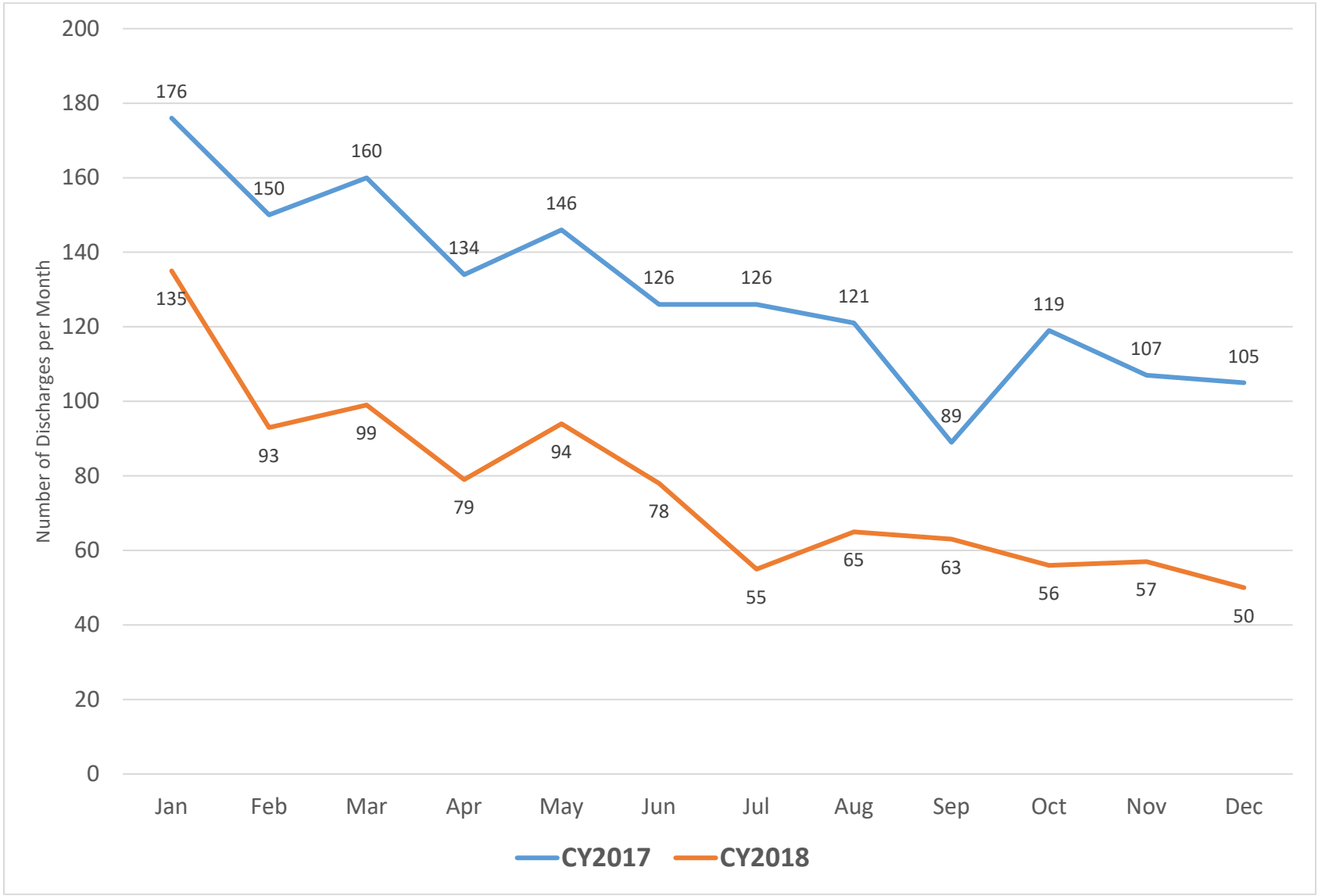


Table 8: Shore Health System Hospital MSGA Discharges by County of Residence, CY2011 - CY2018										
		MSGA Discharges								
Hospital	County/*State*	CY2011	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	Percent Change 2018 - 2011
UMSMC at Chestertown	Kent County, MD	1,623	1,787	1,506	1,482	1,335	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