UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Community Benefit Narrative Report

Fiscal Year 2015

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

On January 10, 2014, the Center for Medicare and Medicaid Innovation (CMMI) announced its approval of Maryland's historic and groundbreaking proposal to modernize Maryland's all-payer hospital payment system. The model shifts from traditional fee-for-service (FFS) payment towards global budgets and ties growth in per capita hospital spending to growth in the state's overall economy. In addition to hitting aggressive quality targets, this model must save at least $330 million in Medicare spending over the next five years. The HSCRC will monitor progress overtime by measuring quality, patient experience, and cost. In addition, measures of overall population health from the State Health Improvement Process (SHIP) measures will also be monitored (see Attachment A).

To succeed, hospital organizations will need to work in collaboration with other hospital and community based organizations to increase the impact of their efforts in the communities they serve. It is essential that hospital organizations work with community partners to identify and agree upon the top priority areas, and establish common outcome measures to evaluate the impact of these collaborative initiatives. Alignment of the community benefit reporting with these larger delivery reform efforts such as the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system.

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), the IRS defines a CHNA as a:

Written document developed for a hospital facility that includes a description of the community served by the hospital facility: the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

The written document (CHNA), as provided in the ACA, must include the following: A description of the community served by the hospital and how it was determined;

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe **information gaps** that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. If a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties;

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility, (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions ("LHIC's)[see: http://dhmh.maryland.gov/healthenterprisezones/Documents/Local_Population_Health_Improvement_Contacts_4-26-12.pdf] schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted.

In addition, the report must identify any individual providing input, who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and

A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

Examples of sources of data available to develop a CHNA include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments.

In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the public and adopt an implementation strategy to meet the health needs identified by the CHNA by the end of the same taxable year.

The IMPLEMENTATION STRATEGY, as provided in the ACA, must:

a. Be approved by an authorized governing body of the hospital organization;

b. Describe how the hospital facility plans to meet the health need, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and

c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. **Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. (Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).**

Table I

Bed Designation	**Inpatient Admissions**	**Primary Service Area Zip Codes**	**All other Maryland Hospitals Sharing Primary Service Area**	**Percentage of Uninsured Patients, by County**	**Percentage of Patients who are Medicaid Recipients, by County**
Primary Service Area (Top 60% of discharges)					
Harford Memorial Hospital (HMH) (Provider #21-0006): Licensed beds: 84	HMH: 4,174	HMH: 21001 21078 21903 21904 21040	St. Joseph Health Center Greater Baltimore Medical Center	HMH & UCMC: •Baltimore County 3.3% •Cecil County 1.5%	HMH & UCMC: •Baltimore County 26.8% •Cecil County 8.1%
Upper Chesapeake Medical Center (UCMC) (Provider #21-0049):	UCMC: 11,259	UCMC: 21014 21040 21015 21009 21001	Franklin Square Union of Cecil	•Harford County 1.6%	•Harford County 15.90

Licensed beds: 183		21050 21085			

2. **For purposes of reporting on your community benefit activities, please provide the following information:**

   a. **Describe in detail the community or communities the organization serves. Based on findings from the CHNA, provide a list of the Community Benefit Service Area (CBSA) zip codes. These CBSA zip codes should reflect the geographic areas where the most vulnerable populations reside. Describe how the CBSA was determined, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.**

   The following information is reflective of the just completed 2015 CHNA. However, Table III will reflect the community benefit initiatives that were identified in the 2012 CHNA for the period July 2012 through June 2015.

   The Harford County CHNA includes all 21 Harford County zip codes. This included the zip codes where our most vulnerable populations reside.

   The demographic profile of the respondents who completed the online survey is as follows: approximately 56% of all respondents reside in zip codes 21014, 21015, 21009, 21001, and 21078. The later three zip codes have been identified as geographic areas that contain concentrated areas of poverty. An additional 12.6% of respondents live in an "Other" zip code, the most common of which are 21901, 21921, and 21903. Of the total 1,549 respondents, 85.6% are female and 14.4% are male. Whites comprise 83.2% of study participants and Blacks/African-Americans represent 12.3%. Approximately 3% of all respondents identify as Latino/Hispanic. Approximately 53% of all respondents are between the ages of 45 and 64 years. An additional 35.4% of all respondents are between the ages of 25 and 44 years.

   The marital status, education level, employment status, and income level was also assessed for each respondent. Similar to the secondary data findings for Harford County, the majority of respondents (65.2%) are married. Approximately 13% of respondents are single (never married) and 11% are

divorced. Less than 2% of respondents attained less than a high school diploma or GED. One-third (33.1%) of respondents attained some college, technical school or nursing school and 51.9% of respondents have an undergraduate degree or higher.

The majority (72.7%) of respondents are currently employed and working full-time. In addition, half of respondents have an annual household income of $75,000 or more. Less than 11% of respondents have an income less than $25,000.

A high proportion of respondents have health care coverage (98.2%) and at least one person who they think of as their personal doctor or health care provider (91.4%). In addition, 70.8% of respondents had a routine checkup within the past year and 17.7% had one within the past two years.

Please follow link below for CHNA:
http://umuch.org/~/media/systemhospitals/uchs/pdfs/about-us/community-health-needs-assessment-2015-final-pdf.pdf?la=en

b. **In Table II, describe the population within the CBSA, including significant demographic characteristics and social determinants that are relevant to the needs of the community and *include the source of the information in each response*. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, transportation, education and healthy environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).**

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its Area Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf), The Maryland State Department of Education (The

Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Table II

Median Household Income within the CBSA (US Census Bureau: 2009-2013) http://quickfacts.census.gov/qfd/states/24/24025.html	$80,622
Percentage of households with incomes below the federal poverty guidelines within the CBSA (US Census Bureau: 2011-2013) http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_3YR_DP03&prodType=table	8.4% (Individuals) 6.8% (All Families) 10.9% (Families w/ related children under 18 years) 8.9% (Families w/related children under 5 years only) 22% (Families with female householder, no husband present) 28.4% (with related children under 18) 44.8% (w/related children under 5 years only)
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml (US Census Bureau: 2011-2013) http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_3YR_DP03&prodType=table	6.1% Civilian Non-institutionalized Population 3.0% Civilian Non-institutionalized Population (under 18)
Percentage of Medicaid recipients by County within the CBSA. (US Census Bureau: 2011-2013) http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_3YR_DP03&prodType=table	26.0%

Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: (SHIP 2011-2013) http://dhmh.maryland.gov/ship/SitePages/Home.aspx	Black: 77.7 White: 79.6
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). (SHIP 2011-2013) http://dhmh.maryland.gov/ship/SitePages/Home.aspx (SHIP 2007-2013)	Represented per 100,000 population Age-Adjusted Mortality Rate from Cancer – 167.9 White: 171.7 Black: 174.5 Age-Adjusted Mortality Rate from Heart Disease – 171.6 White:173.9 Black:168.4 Stroke – 38.2 CLRD – 40.7 Unintentional Injury – 30.6 Diabetes – 18.1
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	• Amongst Harford County Youth 5.8% are not eating any fruit, & 5.6% are not eating any vegetables. (HS YRBSS, 2013), There are no official food deserts based on Federal HUD regulations, but there are noted food insecure areas due to lack of supermarkets and public transportation. These areas are in the northern rural areas of the county, i.e. Dublin, Darlington, Whiteford, etc. (Harford County Community Services report). • Harford is primarily rural and

	suburban with a strong car culture. Traffic speed and limited safe bike and pedestrian infrastructure has a severe impact on walking and biking as a means of transportation. Although the majority of public transit routes are located in areas with the highest concentration of low to moderate income families, along the route 40 corridor in the southern portion of the county, public transportation (i.e. busing) is limited in both routes and scheduling. Due to these restrictions work opportunities are limited and given the restricted scheduling it would be challenging for someone solely dependent on public transportation to work a full 8 hour day. All Harford County transit buses, however, are now equipped with bike racks to support multimodal transportation. (Harford County, Community Services Department). • Harford County Public Schools have a significant number of military families that struggle with extended deployments and frequent moves. Other youth health indictors include high minority obesity rate, high smoking rate, high rate of substance abuse and behavioral health issues that result in suicide. (DHMH SHIP - LHIC) • Homeownership in Harford County is at 79.2% with a median value of $276,300 for owner

	occupied housing units. There is an average of 2.7 people per household. (2011-2013 US Census ACS). 47.8% of Harford County households earn less than $75,000 and the inventory for affordable housing is limited. The high average housing price pushes many low and moderate income people out of the housing market, and there is an underreported population of families doubling up and children remaining in parent's household after graduation and marriage. There is only one public housing complex in the county and section 8, low, and moderate income renters must all compete for the limited affordable housing which is often concentrated in the poorer areas. • The US Army Aberdeen Proving Grounds (APG) is located in the southern part of Harford County and for most of the 20th and 21st centuries APG has been a site of manufacturing, testing and disposal of hazardous chemicals including Anticholinesterase nerve agents, mustard gas, and other chemical weapons. The area surrounding APG are some of the most impoverished in our community. Harford County due to a number of factors including its geographical location and its proximity to Rt. I-95 has the second worst air quality in the State of Maryland.

Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx (ACS 2008-2012) http://www.usa.com/harford-county-md-population-and-races.htm	• Primary Language Spoken ○ English: 89.21% ○ Other than English: 10.79% (34% of which is Spanish)
Adult Obesity (Percentage of adults that report BMI >30) (County Health Rankings 2015) http://www.countyhealthrankings.org/app/maryland/2015/rankings/harford/county/outcomes/3/snapshot	Harford: 30 MD: 28%
Diabetes (percentage of adults aged 20 and above with diagnosed diabetes) (County Health Rankings 2015) http://www.countyhealthrankings.org/app/maryland/2015/rankings/harford/county/outcomes/overall/additional	Harford: 10%; MD: 10%
Physical Activity (number of persons who reported at least 150 minutes of moderate physical activity or at least 75 minutes of vigorous physical activity per week) (SHIP 2013) http://www.dhmh.maryland.gov/ship/SitePages/Home.aspx	White/Non-Hispanic – Harford: 47.6; MD 51.5 Black – Harford: 43.9; MD: 45.4
Percentage of Adults who currently smoke (SHIP 2013) http://www.dhmh.maryland.gov/ship/SitePages/Home.aspx	White/Non-Hispanic – Harford: 20.7, MD: 16.8 Black – Harford: 4.7, MD: 17.4

Adolescents Who Use Tobacco Products (percentage of adolescents who used any tobacco in the last 30 days) (SHIP 2013) http://www.dhmh.maryland.gov/ship/SitePages/Home.aspx	White/Non-Hispanic – Harford: 20.3, MD: 19.0 Black – Harford: 19.0, MD: 14.1 Hispanic – Harford 26.8; MD: 18.9
Cancer Mortality (per 100,000 population) (SHIP 2011-2013) http://www.dhmh.maryland.gov/ship/SitePages/Home.aspx	White/Non-Hispanic – Harford: 171.7, MD: 164.8 Black – Harford: 174.5, MD: 186.7
Annual Average unemployment rate (COUNTY HEALTH RANKINGS 2015) Rankingshttp://www.countyhealthrankings.org/app/maryland/2015/rankings/harford/county/outcomes/overall/snapshot	Harford: 6.6%; MD: 6.6%
Rate of Suicides per 100,000 population (VSA 2011-2013) http://dhmh.maryland.gov/vsa/Documents/13annual.pdf	Harford: 10.7; MD: 9.0
Rate of drug induced death per 100,000 population (SHIP 2011-2013) http://dhmh.maryland.gov/ship/SitePages/Home.aspx	Harford: 17.9; MD: 13.3
Health Disparities Infant Mortality Rate (per 1,000 live births) (VSA 2013) Percentage of births that are low birth weight (per 1,000 live births) (VSA 2013) http://dhmh.maryland.gov/vsa/Documents/13annual.pdf Percentage of births that are low birth weight (per 1,000 live birth) (COUNTY HEALTH RANKINGS 2015) http://www.countyhealthrankings.org/app/maryland/2015/rankings/harford/county/outcomes/overall	 White/Non-Hispanic – 3.5% Black – 13% White/Non-Hispanic – 5.9% Black – 12.1% Hispanic – 5.0% 7.6%

/snapshot Rate of hospital encounters for newborns with maternal drug/alcohol exposure (rate exposed per 1,000 newborns) (HSCRC Hospital Data 2000-2013)	35.8 Has increased by 45% from 2000-2013.
Emergency Department Visits related to domestic violence per 100,000 population Diabetes Hypertension Mental Health Asthma Addictions related conditions (SHIP 2014) http://dhmh.maryland.gov/ship/SitePages/Home.aspx	 White/Non-Hispanic – 126.1 Black – 361.6 White/Non-Hispanic – 125.1 Black – 536.3 White/Non-Hispanic – 2661.6 Black – 2908.6 White/Non-Hispanic – 28.3 Black – 117.8 White/Non-Hispanic – 1629.6 Black – 1862.8
Education Percentage of population graduating high school (US CENSUS 2009-2013) http://quickfacts.census.gov/qfd/states/24/24025.html Bachelor's Degree or higher (US CENSUS 2009-2013) http://quickfacts.census.gov/qfd/states/24/24025.html	 92.4% (percentage of persons age 25+) 32.7% (percentage of persons age 25+)
Percentage of children in poverty Children in single parent households (COUNTY HEALTH RANKINGS 2015) http://www.countyhealthrankings.org/app/maryland/2015/rankings/harford/county/outcomes/overall/snapshot	10% 27%

Other	

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. **Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?**

__X__Yes
____ No

Provide date here. Posted 06/30/2015 (mm/dd/yy). Data collected November 2014 through January 2015.

If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

http://umuch.org/~/media/systemhospitals/uchs/pdfs/about-us/community-health-needs-assessment-2015-final-pdf.pdf?la=en

2. **Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?**

__X__Yes 06/23/2015 (mm/dd/yy) Enter date approved by governing body here:
___No

If you answered yes to this question, provide the link to the document here.

http://umuch.org/~/media/systemhospitals/uchs/pdfs/about-us/community-benefit-plan-2015.pdf?la=en

III. COMMUNITY BENEFIT ADMINISTRATION

1. **Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital? (*Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b.)***

   a. **Is Community Benefits planning part of your hospital's strategic plan?**

   __X__Yes
   ____No

If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

Data collected in the 2015 CHNA is being used to determine, develop, and implement collaborative population health initiatives between University of Maryland Upper Chesapeake Health, the Harford County Health Department and Healthy Harford.

The following was abstracted from the FY16 UM UCH's strategic plan:

Population Health

Population Health – Care Continuum Partnerships

1. Enhance Post-Acute Care collaboration
   a. Development of preferred partner relationships along care continuum including Home Health, Palliative and Skilled Nursing Facility
2. High Risk Patient Population Management
3. Continue to develop community partnerships

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. _X_ CEO
2. _X_ CFO
3. Other (please specify):
   a. Senior VP of Medical Staff Affairs
   b. Senior VP Corporate Strategy/Development
   c. VP of Population Health and Clinical Integration

Describe the role of Senior Leadership.

- Reviews and approves the Community Benefit Report and the Implementation Plan.
- Executive sponsor and link to Board.
- Responsible for the development of the annual Operating Plan including Population Health initiatives.
- Provides oversight for the implementation of the Operating Plan and community benefit activities.

ii. Clinical Leadership

1. _X_ Physician
2. _X_ Nurse
3. ___ Social Worker
4. ___ Other (please specify):

Describe the role of Clinical Leadership

- The Senior VP of Medical Affairs (Physician) is involved in the development of the annual Operating Plan which addresses the population health initiatives.
- Provides leadership and oversight for the community benefit process for the organization.
- Develops and provides oversight of implementation of community benefit activities.
- Provides clinical knowledge and context for needs assessment and programming.
- Develops and approves protocols for health screenings
- Insures regulatory compliance.
- Provides oversight to health screenings and education programs.

iii. Community Benefit Operations

1. _X_ Individual (2 FTE)
    a. Vickie Bands, Director of Community Outreach – direct oversight for community benefit to include both the annual Community Benefit Report and the CHNA.
    b. Kimberly Theis, Community Benefits/CHI Business Manager – monitors data collection of community benefit to insure accurate and timely reporting; works in collaboration with Director of Community Outreach to generate the required comprehensive community benefit report and CHNA.
2. X Committee (please list members)

    Community Benefit Reporting Advisory Board - The Community Benefit Reporting Advisory Board is responsible for identifying hospital related activity that is aimed at addressing the needs of those communities where there are disproportionate unmet health needs. The committee consists of representatives from those departments within the organization that are identified as contributing to Community Benefit.

    a. Vickie Bands, Director - Community Outreach

i. Committee Chair – provides oversight for advisory board activities.

b. Nathaniel Albright, Director – Ortho/Neuro/Spine
c. Patsy Astarita, Manager – Oncology Supportive Care Services
d. Barbara Cysyk, Manager – Primary Stroke Center
e. Charles Elly – Finance
f. Elizabeth English - Marketing
g. Karen Hensley, Director – Women and Children's Services
h. Gary Hicks, Director - Education
i. Mark Lewis, Director – Heart and Vascular Institute
j. Debra Ostrowski, Nurse Education – Diabetes and Endoctrine Center

3. _X_ Department (please list staff) – HealthLink Community Outreach – born out of the vision to create the healthiest community in Maryland, HealthLink offers health programs that are either free of charge or have a nominal fee.
    a. Vickie Bands, Director Community Outreach - direct oversite for community outreach and community benefit to include both the annual Community Benefit Report and the CHNA.
    b. Tracey Long, Clinical Nurse Manager
    c. Bari Klein, Grants Administrator
    d. Kimberly Theis, Community Benefits/CHI Business Manager
    e. Judy Lauer, Events Coordinator
4. ___ Task Force (please list members)

5. _X_ Other (please describe)
    a. 1.1 FTE: 35 PRN RN's who perform the community screenings and provide community educational programs.

Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?)

Spreadsheet	_X_ yes ____ no
Narrative	_X_ yes ____ no

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

After completion, the narrative and the spreadsheet are reviewed by the Community Health Improvement/Community Benefit Business Manager and the Director of Community Outreach. Final review is completed by the UMMS SVP for Government & Regulatory Affairs. After completion, the Spreadsheet is reviewed by the UMMS SVP for Government & Regulatory Affairs.

d. Does the hospital's Board review and approve the FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet	_X_ yes ____ no
Narrative	_X_ yes ____ no

Reviewed and approved in December.

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

___X__Other hospital organizations
___X__Local Health Department
___X__ Local health improvement coalitions (LHICs)
___X__ Schools
___X__Behavioral health organizations
___X__Faith based community organizations

___X__ Social service organizations

b. **Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)**

Organization	**Name of Key Collaborator**	**Title**	**Collaboration Description**
Harford County Health Department	Susan Kelly	Health Officer	Strategic Leadership, member of the Strategic Planning Session, and member of Key Leadership Focus Group
	Russell Moy, MD	Deputy Health Officer	Strategic Leadership, member of the Strategic Planning Session, and member of Key Leadership Focus Group
Department of Community Services	Sharon Lipford	Deputy Director	Strategic Leadership, member of the Strategic Planning Session, and member of Key Leadership Focus Group
Harford County	Amber	Director: Local	Member of the

Government	Shrodes	Government Official	Strategic Planning Session
UM UCH and Harford County Health Department	Bari Klein	Grants Administrator	Strategic Leadership, member of the Strategic Planning Session, and member of Key Leadership Focus Group
UM UCH	Colin Ward	Vice President: Population Health & Clinical Integration	Member of the Strategic Planning Session
Faith Based Community	Reverend Doctor Baron D. Young	Faith Based Community Representative	Member of the Strategic Planning Session, member of Key Leadership Focus Group, and provided input regarding community minority faith leaders perspectives on health priorities
Federally Qualified Health Center – Beacon Health	Mark J. Rajkowski	CEO of West Cecil Health (parent organization) CEO of two Federally Qualified Health Centers	Member of the Key Leadership Focus Group, Community

			Health Center Representative
LASOS – Linking All So Others Succeed	Melynda Velez	Founder & Executive Director	Member of the Key Leadership Group, Minority Group Representative
UM UCH Communtiy Benenfit Advisory Board	Barb Cysyk	Primary Stroke Center Manager	Member of the Key Leadership Group
	Charles Elly	Manager of Cost Reporting & Regulatory Compliance	Member of the Key Leadership Group
	Debbie Ostrowski	Diabetes RN Education	Member of the Key Leadership Group
	Karen Hensley	Director of Women's & Children's Service	Member of the Key Leadership Group
	Kimberly Theis	Community Health Improvement/Community Business Manager	Member of the Strategic Planning Session, and member of Key Leadership Focus Group
	Liz English	Marketing Coordinator	Key Leadership Group

	Mark Lewis	Director, Heart and Vascular Institute	Member of the Strategic Planning Session and Key Leadership Group
	Nate Albright	Director, Ortho/Neuro/ Spine Service Line	Key Leadership Group
	Patsy Astarita	Manager, Oncology Support Care Services	Key Leadership Group
	Vickie Bands	Director of Community Outreach	Strategic Leadership, member of the Strategic Planning Session, and member of Key Leadership Focus Group

c. **Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?**

__X__yes ____no

- Vickie Ensor Bands, Director of Community Outreach - Tobacco Workgroup for LHIC
- Bari Klein, Grants Administrator – Community Engagement Workgroup for LHIC

d. **Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?**

__X__yes ____no

Kimberly Theis, Community Health Improvement/Community Benefit Business Manager
Kristie Willats, ED Diversion Patient Navigation Assistant
Pat Thompson, Director of Behavioral Health
Mark Lewis, Director, Heart and Vascular Institute
Karen Goodison, Director, Respiratory
Robin Stokes-Smith, HealthLink, Minority Outreach
Vickie Ensor Bands, Director of Community Outreach
Bari Klein, Grants Administrator

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

This Information should come from the implementation strategy developed through the CHNA process.

1. **Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached example of how to report.**

   For example: for each principal initiative, provide the following:

   a. 1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations. 2. Please indicate whether the need was identified through the most recent CHNA process.

   b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following link: http://www.thecommunityguide.org/)
   (Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

c. Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?

d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?

e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results.

f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.

h. Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.

    - What were the measurable results of the initiative?
    - For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.

j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:
A. What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.

B. Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

2. **Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.**

   Behavioral Health (mental health/substance abuse) has been identified as a health priority in our community. UM UCH works collaboratively through the Local Health Improvement Coalition (LHIC) which consists of the following partners:

   Harford County Health Department
   Addictions Department
   Office on Mental Health – Core Services Agency
   Department of Community Services
   Office of Drug Control Policy

   The priority of the LHIC is to improve the coordination of mental health and addiction services within the county.

3. **How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)**

   UM UCH's Community Benefit activities are directly geared towards addressing the State's initiatives for improvement in population health. UM UCH team members are part of a concerted effort to work beyond the hospital walls to create a true population care model, integrating community health with medical care. UM UCH community benefit work links residents to preventative care, works with community benefit organizations (CBO) and faith based organizations to improve health literacy and help direct patients towards appropriate levels of care (pharmacy, social workers, primary care physician, home health aide, instead of emergency department), and partners with the Office on Aging, Local Health Department, Office of Drug Control Policy, local FQHC, the Office on Mental Health/Core Mental Health Agency, and others community support agencies to increase the capacity of local agencies to address the health care needs of both individuals and the community as a whole.

   UM UCH team members chair the three Local Health Improvement Coalition workgroups: Obesity, Tobacco, and Behavioral Health, helping to create a community centered patient care model that creates policy, systems, and environmental change to improve somatic and psyco/social support.

UM UCH leads a population health team, comprised of stakeholders from both Harford and Cecil Counties, that is developing programmatic standards and administrative structures to monitor and improve the health of patients by creating a CRISP based continuum of care model for emergency department high utilizers. The concept will integrate supportive community care into medical discharge services, extending the monitoring and support of high utilizers from 30 days post discharge through hospital care, to monitoring and support 60 days post discharge through community based services.

STATE INNOVATION MODEL (SIM)
http://hsia.dhmh.maryland.gov/SitePages/sim.aspx
MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
HEALTH CARE INNOVATIONS IN MARYLAND
http://www.dhmh.maryland.gov/innovations/SitePages/Home.aspx
MARYLAND ALL-PAYER MODEL http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/
COMMUNITY HEALTH RESOURCES COMMISSION
http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

VI. PHYSICIANS

1. **As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.**

   UM UCH does not experience a specialty shortage.

2. **If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.**

   Physician subsidies at UM UCH consist of the cost of on call coverage for physicians who would not work there unless compensated by the hospital. The amounts reported for 2015 include:

UCMC ED:	$1,408,859
UCMC Anesthesiology:	$1,046,684
HMH ED/BHU:	$ 604,716
HMH Anesthesiology:	$ 448,579
TOTAL	$3,508,838

VII. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):
    a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's FAP. (label appendix I)

    For ***example***, state whether the hospital:

    - Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
        - in a culturally sensitive manner,
        - at a reading comprehension level appropriate to the CBSA's population, and
        - in non-English languages that are prevalent in the CBSA.
    - posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
    - provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
    - provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
    - includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
    - discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

    b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).
    c. Include a copy of your hospital's FAP (label appendix III).
    d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions:

http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

2. Attach the hospital's mission, vision, and value statement(s) (label appendix V).
Attachment A

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) SELECTED POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers
- Reduce the % of youth using any kind of tobacco product
- Increase the % vaccinated annually for seasonal influenza
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- Reduce hospital ED visits from asthma
- Reduce hospital ED visits related to behavioral health
- Reduce Fall-related death rate

TABLE III

a. 1. Identified Need	Chronic Disease – Heart Disease, Blood Pressure and Cholesterol Initiatives. Direct measurement from 2009 Vital Statistics suggests 210.7 heart disease deaths in Harford County per 100,000 population; 7.4% of adult residents in Harford County diagnosed with heart disease according to the 2012 CHNA (2010 CHAP). Direct measurement from 2012 CHNA (2010 CHAP) suggests 29.7% adults in Harford County report having or have had high blood pressure; 96% of adults in Harford County have had their blood pressure screened within the past 2 years. Direct measurement from 2012 CHNA (2010 CHAP) suggests 25.9% adults in Harford County report having or have had high cholesterol; 93.1% of adults in Harford County have had their cholesterol screened within the past 2 years.
2. Was this identified through the CHNA process?	Yes this was identified through the CHNA Process (FY12 and FY15).
b. Hospital Initiative	We addressed this need with more than one initiative: • Heart disease education through targeted educational programs, risk assessments, and dissemination of health information county wide. • Blood pressure screenings in Harford County with a focus on the senior and underserved populations. • Cholesterol screenings through monthly wellness centers, as well as through specific requests from businesses, the faith community, and other community groups. • Cardiovascular Health Seminar – offered cardiopulmonary screenings and expert information on many heart problems as well as obstructive sleep apnea. Harford County residents learned how to control, treat and prevent these conditions. • Cardiac Risk Assessments were provided throughout the county at various events and locations. • Via Ask-a-Doc column in the local newspaper The Aegis, Upper Chesapeake Health (UCH) cardiologists and vascular surgeons addressed clinical questions from the community. • Cardiac and Pulmonary Rehabilitation Team presented on specific cardiac and/or pulmonary and related topics at a Fall Seminar at UCMC. • Monthly STEMI Process Action Team meetings – discussed topics related to improvement of the procedures followed to care for the STEMI patient.

	Included discussion of pre-hospital issues and involved representatives from Cecil, Harford, and Baltimore Counties EMS, as well as representatives from Hart to Heart, and the University of Maryland Express Care ambulance services. • Coordination of efforts and participation in the Greater Baltimore American Heart Association (AHA) Heart and Stroke Walk, raising funds for research and education regarding reducing heart disease risk and mortality. • Annual spring trauma symposium for Harford and Cecil County EMS personnel. Education was provided on specific diseases and/or clinical issues of interest and need for EMS to remain available and trained to handle any emergency they may come upon. • Heart Club - Monthly educational and support meetings for cardiac patients.
c. Total Number of People Within the Target Population	249,215 in Harford County (County Health Ranking) 76.7% in Harford County = 191,127 adults, >18 years (County Health Rankings) 361 adults die annually from heart disease in Harford County (2013 Vital Statistics) 3% of Harford County adults diagnosed with heart disease annually = 5,538 adults
d. Target Number of People Reached by the Initiative Within the Target Population	• 46 adults were reached as a result of the Cardiovascular Health Seminar • 3 adults had a Cardiac Risk Assessment at one of community events • 126 Harford County EMS, as well as representatives from Hart to Heart, and the University of Maryland Express Care ambulance service attended monthly STEMI Process Action Team meetings to discuss topics related to improvement procedures followed to care for the STEMi patient, including discussion of pre-hospital issues. • 18 adults educated with Heart Risk display. • 21 adults attended Heart Club Support Group to learn more about heart disease and how to live a healthier lifestyle. • 3,427 adults had a blood pressure screening • 587 adults received Halt the Salt education • 347 adults had a cholesterol screening • Ask a Doc column in the Aegis has a distribution reach of 34,985 Harford County resident.
e. Primary Objective of the Initiative	To decrease the number of heart disease deaths per 100,000 in Harford County to 190.1. To decrease the percentage of adults diagnosed with heart disease in Harford County to 6.76%.

	To decrease the number of reported high blood pressures to 28.2%. To increase the number of adults that have had their blood pressure screened within the past 2 years to >95%. To decrease the number of individuals who report they have been told by a doctor that they have/had high cholesterol to 24.6%. To increase the number of adults who have had their cholesterol screened within the past two years to 95%.
f. Single or Multi-Year Initiative – Time Period	Multi-Year
g. Key Collaborators in Delivery of the Initiative	UM UCH UM UCH Community Outreach Harford County Office on Aging Inner County Outreach Harford Mall Klein's ShopRite Baltimore Counties EMS Hart to Heart University of Maryland Express Care ambulance services Harford County Public Libraries Ripkin Stadium Somerset Manor Harford County Detention Center
h. Impact/Outcome of Hospital Initiative?	3,427 adults had their blood pressure taken at a community event, 28.4% were found to have a blood pressure reading >139/89. 182 adults who presented with an elevated pressure reading were referred to the HealthLink Referral Line or to the Beacon Health Center due to not having a Primary Care Physician. 347 adults had a cholesterol screening, of which 32% had a cholesterol reading of >200. 100% of these adults received individual counseling on their cholesterol number and what that number means, as well as nutritional information and the importance of exercise to lower their risk. We believe that this showed success because the rate of deaths due to heart disease among adults of the target population continues to trend down.
i. Evaluation of Outcomes:	2013 Vital Statistics show a reduction in rate of deaths due to heart disease from 210.7 per 100,000 in 2009 to 171.6 per 100,000.

	2015 CHNA shows a reduction in the percentage of adults diagnosed from heart disease from 7.4% to 3%. 2015 CHNA shows a slight increase in the percentage of adults who reported having high blood pressure from 29.7% (CHNA 2012/CHAP 2010) to 29.8%. BRFSS 2006-2012 shows a slight increase in the percentage of adults who report having high blood pressure from 30.2% (BRFSS 2005-2011) to 30.8% 2015 CHNA shows an increase in the percentage of adults who reported having high cholesterol from 25.9% (CHNA 2012/CHAP 2010) to 28.9%.	
j. Continuation of Initiative?	Yes, although there has been a reduction in the rate of deaths due to heart disease among adults in Harford County, there continues to be a need to address and screen high blood pressures among adults in Harford County.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $40,332 of dollars	B. Direct Offsetting Revenue from Restricted Grants

a. 1. Identified Need	Chronic Disease – Stroke Stroke is the number three cause of death in Harford County. Direct measurement from 2009 Vital Statistics suggests 41.8 stroke deaths in Harford County per 100,000 population; 2.5% of adult residents in Harford County diagnosed with stroke according to the CHNA 2012 (2010 CHAP).
2. Was this identified through the CHNA process?	Yes this was identified through the CHNA process.
b. Hospital Initiative	We addressed this need with more than one initiative: • Stroke education educational programs, risk assessments, and dissemination of health information, with an emphasis on the African American population. • Senior population targeted for risk assessment and education during stroke month at Harford County senior centers and independent senior housing. • Annual Dining Stroke Presentation • At least 2 community education programs per year

	• Monthly Stroke Support Group • American Heart Association's Power to End Stroke Program to address racial disparity • Stroke education to Harford Community College Nursing program and Harford and Cecil counties EMS providers • Maryland Stroke Center Consortium • MIEMSS Quality Improvement Committee	
c. Total Number of People Within the Target Population	249,215 in Harford County (County Health Ranking) 76.7% in Harford County = 191,127 adults, >18 years (County Health Rankings) 66 adults die annually from stroke in Harford County (2013 Vital Statistics) 1.7% of Harford County adults diagnosed with stroke annually = 3,138 adults	
d. Total Number of People Reached by the Initiative Within the Target Population	• 213 adults had a Stroke Risk Assessment at one of our community events • 130 adults received Stroke Education • 160 adults attended Stroke Club Support Group to learn more about stroke and new treatment options to live a healthier lifestyle. • 150 individuals participated in the Maryland Stroke Consortium.	
e. Primary Objective of the Initiative	To decrease number of stroke deaths per 100,000 in Harford County to 39.3. To decrease the number of adult residents that are diagnosed with stroke to 2.35%	
f. Single or Multi-Year Initiative – Time Period	Multi-Year	
g. Key Collaborators in Delivery of the Initiative	UM UCH Community Outreach UM UCH Primary Stroke Center Harford County Office on Aging	
h. Impact/Outcome of Hospital Initiative	213 adults had a Stroke Risk Assessment at one of community events; 17 presented at high risk, 32 at moderate risk, and 43 at low risk. We believe that this showed success because the stroke rate of the target population continues to trend down. The death rate due to stroke has decreased from the number 2 cause to number 5 in Harford County.	
i. Evaluation of Outcome:	2013 Vital Statistics show a reduction in rate of deaths due to stroke from 41.8 per 100,000 in 2009 to 34.3 per 100,000. 2015 CHNA shows a reduction in the percentage of adults diagnosed with stroke from 2.5% (CHNA 2012/CHAP 2010) to 1.7%.	
j. Continuation of Initiative?	Yes, UM UCH is a certified Primary Stroke Center and we will continue to focus community benefit efforts on reducing the current rate of deaths due to stroke among adults in Harford County.	
k. Total Cost of Initiative for	A. Total Cost of Initiative	B. Direct Offsetting Revenue from

Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	$8,614 of dollars	Restricted Grants

a. 1. Identified Need	Chronic Disease – Diabetes Diabetes is the sixth leading cause of death in Harford County. Direct measurement from CHNA 2012 (2010 CHAP) suggests 11.4% of adults in Harford County report having been told by a practitioner that they have or had diabetes; 15.1% male, 8.1% female. 89% of adults have been tested for diabetes within the past 2 years; and according to HSCRC 2010, 285.5 ED visits for diabetes per 100,000 in Harford County.
2. Was this identified through the CHNA process?	Yes this was identified through the CHNA process.
b. Hospital Initiative	We addressed this need with more than one initiative: • Diabetes education through targeted educational programs, risk assessments, and dissemination of health information. • Support to patients of the HealthLink Primary Care clinic through one-on-one diabetic counseling. • Support to Senior and Hispanic diabetics through support groups and presentations at senior centers. • Diabetes Health Fairs
c. Total Number of People Within the Target Population	249,215 in Harford County 76.7% in Harford County = 191,127 adults, >18 years 10% of adults age 20 and above in Harford County have been diagnosed with diabetes = 17,145 (Source: County Health Rankings) 34 adults in Harford County die annually from diabetes (2013 Vital Statistics)
d. Total Number of People Within the Target Population	• 78 adults had a Diabetes Risk Assessment completed • 136 adults attended a Diabetes Health Fair • 185 adults received a Hemoglobin A1C screening • 253 adults attended a Diabetes Support Group (7 non English speaking Hispanic participants attended a monthly support group).

e. Primary Objective of the Initiative	To decrease the number of adults who have been told by a practitioner that they have or had diabetes to 10.8%. To increase the number of adults who have been tested for diabetes within the past 2 years to >85%.	
f. Single or Multi-Year Initiative – Time Period	Multi-Year	
g. Key Collaborators in Delivery of the Initiative	UM UCH Community Outreach UM UCH Diabetes & Endocrine Center Harford County Office on Aging	
h. Impact/Outcome of Hospital Initiative?	78 adults had a Diabetes Risk Assessment completed, of which 60% presented with a reading of >5. 185 adults received a Hemoglobin A1C screening, of which 17% had a reading of >6.5. We believe both outcomes show success because the number of adults with diabetes and deaths due to diabetes continues to trend down in Harford County. We believe that the Hispanic support group was successful because we provided a Spanish interpreter which allowed the participants to gain a clear understanding of their disease and prevention opportunities.	
i. Evaluation of Outcomes:	2015 CHNA shows a decrease in the percentage of adults who reported having diabetes from 11.4% to 7.7%. BRFSS 2011-2013 shows a decrease in the number of diabetes deaths per 100,000 in Harford County from 17.8 (BRFSS 2007-2013) to 15.6.	
j. Continuation of Initiative?	Yes, UM UCH has a Center of Excellence for Diabetes and we will continue to focus our community benefit initiatives to reduce the number of newly diagnosed diabetics and pre-diabetics in Harford County.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $7,124 of dollars	B. Direct Offsetting Revenue from Restricted Grants

a. 1. Identified Need	Chronic Disease – Obesity, including Nutrition and Physical Activity Direct measurement from 2008-2010 BRFSS suggests 36.6% of adults in Harford County are at a healthy weight (not overweight or obese); 35.2% of adults have a BMI between 26.0 and 29.9 (considered overweight); and according to CHNA 2012 (CHAP 2010), 25.1% of adults have a BMI >30 (considered obese). Direct measurement from CHNA 2012 (CHAP 2010) suggests 31.7% of adults in Harford County report they eat two or more servings of high fat foods daily; 18.3% adults in Harford County report eating 3 or more daily servings of fruits; and 26.3% adults in Harford County report eating 3 or more daily servings of vegetables. Direct measurement from CHNA 2012 (CHAP 2010) suggests 67.4% of adults in Harford County report moderate aerobic activity thirty minutes a day three or more times per week.
2. Was this identified through the CHNA process?	Yes this was identified through the CHNA process.
b. Hospital Initiative	We addressed this need with more than one initiative: • Director of Community Health Improvement and Leadership Development holds key leadership position for the county wide Obesity Task Force, which is charged with generating policy change to reverse the obesity trend. • BMI and body composition analyses through monthly Wellness Centers and specific requests from community, business, and faith based groups. • Nutritional education, presentations, and workshops encompassing all ages; young children through seniors. • Harford County Schools Obesity Initiative through participation in the School Health Council and providing educational presentations and workshops as requested to individual schools/groups. • Promotion of exercise through education and physical activities at health fairs. The giveaways at the health fairs are specifically chosen for encouraging the participant to increase their daily activity level, i.e. exercise bands, jump ropes, pedometers, etc.
c. Total Number of People Within the Target Population	249,215 in Harford County 76.7% in Harford County = 191,127 adults, >18 years 30% of adults that report a BMI of 30 or more in Harford County = 57,338 adults 23% of adults aged 20 and over reporting no leisure-time physical activity = 43,959 adults (Source: County Health Rankings)
d. Total Number of People Reached by the Initiative	• 94 adults received a Body Fat Composition Analysis

Within the Target Population	• 344 adults attended Physician Information Sessions regarding weight loss surgery. • 335 adults attended Weight Loss Surgery Support Groups • 371 individuals participated in the How Sweet It Is Program • 159 individuals participated in the My Plate Program • 814 individuals participated in the Activity Wheel Program
e. Primary Objective of the Initiative	To increase number of adults at a healthy weight (not overweight or obese) to 38.4%. To decrease the number of adults that have a BMI between 26.0 and 29.9, considered overweight to 33.4%. To decrease the number of adults that have a BMI >30, considered obese to 23.8%. To decrease eating two or more servings of high fat foods daily to 30.1%. To increase eating 3 or more daily servings of fruits; 29.3% report eating 3 or more daily servings of vegetables to 19.2%. To increase reported moderate aerobic activity thirty minutes a day three or more times per week to 70.8%.
f. Single or Multi-Year Initiative –Time Period	Multi-Year
g. Key Collaborators in Delivery of the Initiative	HC=Harford County ARC Northern Region Bel Air Police Department Boys & Girls Club Charm City Run Greater Edgewood Education Foundation Harford Community College HC Council HC Dept. of Community Services HC Dept. of Parks & Recreation HC Dept. of Planning & Zoning HC Dept. of Public Works HC Government HC Health Dept. HC Public Library HC Public Schools HC Sheriff's Office Healthy Harford Office of the County Executive The Arena Club

	Town of Bel Air UM UCH UM UCH Community Outreach YMCA	
h. Impact/Outcome of Hospital Initiative?	150 adults had a Body Fat Composition completed at one of our community events; of which 59% had a reading of >25%. Of that 59%, 27 adults did not have a Primary Care Physician and were referred to the HealthLink Physician Referral Line or to Beacon Health Center. We believe that this showed success because we were able to get 27 people into preventative care by linking them with a Primary Care Physician.	
i. Evaluation of Outcomes:	BRFSS 2006-2012 shows a reduction in percentage of adults who have a BMI >=30 from 35.2% to 29.7%. CHAP 2015 showed reduction in the percentage of adults who eat 3 or more fruits and vegetables per day.	
j. Continuation of Initiative?	Yes, we will continue our initiatives. Obesity remains one of our top three health risks in Harford County. We will continue to focus on reducing the number of obese children and adults in Harford County, with an emphasis on meeting or achieving My Plate Nutritional Guidelines.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $11,161 of dollars	B. Direct Offsetting Revenue from Restricted Grants

a. 1. Identified Need	Chronic Disease – Tobacco, including Asthma/COPD Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least 1 serious tobacco-related illness. In addition, tobacco use costs the U.S. $193 billion annually in direct medical expenses and lost productivity. Direct measurement from CHNA 2012 (CHAP 2010) suggests 19.8% of adults in Harford County smoke; measurement from MYTS 2010 suggests 26.8% of high school students (grades 9-12) have used a tobacco product in the past 30 days; and

2. Was this identified through the CHNA process?	measurement from 2008 DHMH Youth tobacco survey suggests 15.7% of Harford County youth smoke. Direct measurement from HSCRC 2010 suggests 67.8 ED visits in Harford County for asthma per 10,000 of population; measure from HCPS 2011 suggests 15% of school age children in Harford County have Asthma; measure from BRFSS 2008 suggests rate of second hand smoke exposure 5.2%. Yes this was identified through the CHNA process.
b. Hospital Initiative	We addressed this need with more than one initiative: • Director of Community Outreach holds key leadership position with the county wide Local Health Improvement Plan (LHIP) Tobacco Workgroup, charged with generating policy change to decrease community tobacco use. • Directors from the Heart and Vascular Institute and Respiratory Care sit on the LHIP Tobacco Workgroup. • Community Health Improvement will provide tobacco use and cessation education through targeted and age specific educational programs. • Address tobacco use in HealthLink Primary Care patient population through assessing patient's readiness to quit. • Cancer LifeNet (CLN) will offer two free eight-week smoking cessation programs per annum by a certified tobacco specialist. • Director of Respiratory Care is a Board Member of Baltimore County College Respiratory Care Program • Community Outreach, in partnership with the Harford County Health Department (HCHD) and Harford County Public Schools, provides education in the community for both adults and children regarding the health consequences of tobacco use.
c. Total Number of People Within the Target Population	249,215 in Harford County 76.7% in Harford County = 191,127 adults, >18 years 18% of adults smoke in Harford County = 34,403 adults 71 adults in Harford County die annually from chronic lower respiratory disease (BRFSS 2011-2013)
d. Total Number of People Reached by the Initiative Within the Target Population	• 472 children and adults participated in KATU – Kids Against Tobacco Use • 65 adults attended smoking cessation classes • 615 children and adults received education on Second Hand Smoking • 101 children participated in Smoking Out the Truth
e. Primary Objective of the Initiative	• Decrease percentage of adults who smoke to 18.6%. • Decrease the percentage of High School students (grades 9-12) who have used

	any tobacco product in the past 30 days to 24.3% • Decrease the percentage of Harford County youth who smoke to 14.9%. • Decrease the number of ED visits for asthma per 10,000 of population to 49.9. • Decrease the percentage of school age children in Harford County who have Asthma to 14.3% • Decrease the rate of second hand smoke exposure to 4.9%	
f. Single or Multi-Year Initiative – Time Period	Multi-Year	
g. Key Collaborators in Delivery of Initiative	UM UCH Community Outreach LHIC Tobacco Task Force Harford County Public School Cancer Life Net Harford County Health Department Harford County Community Services Healthy Harford Town of Aberdeen Town of Havre de Grace County Council	
h. Impact/Outcome of Hospital Initiative?	An E-cigarette Position Paper written and distributed to key County organizations and to the incorporated City Councils. Presentation to Aberdeen and Havre de Grace City Councils encouraging e-cigarettes to be included in their Public Tobacco Use Policy. E-cigarette use included in Town of Bel Air Tobacco Use Policy. UM UCH instituted a No Tobacco Use Policy for new hires.	
i. Evaluation of Outcomes:	BRFSS 2011-2013 shows a reduction in rate of deaths due to chronic lower respiratory disease from 40.7 per 100,000 (2007-2013) to 37.1 per 100,000. BRFSS 2013 showed a reduction in adult cigarette use from 18.6 (2011) to 16.9. YRBSS 2013 showed a reduction in adolescent tobacco use from 26.8 (2010) to 20.2	
j. Continuation of Initiative?	Yes, while the tobacco use rates have dropped in youth and adults, Harford County is still above the average. Harford County is unique in that its top 3 leading causes of death are Cancer, Heart Disease and COPD. All causes are related to tobacco use. We will continue to focus on tobacco initiatives.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct	A. Total Cost of Initiative $13,193 of dollars	B. Direct Offsetting Revenue from Restricted Grants

Offsetting Revenue		

a. 1. Identified Need	Cancer, including Cervical, Breast, Prostate, Skin, Colorectal, Oral Cavity and Pharynx Cancer is the second leading cause of mortality in Harford County. Direct measurement from 2009 Vital Statistics suggests 185.8 cancer deaths per 100,000 population in Harford County. Direct measurement from CHNA 2012 (CHAP 2010) suggests 88.9% of women have had a pap smear within the past 2 years. Direct measurement from CHNA 2012 (CHAP 2010) suggests 75.6% of women 50-69 years of age have had a mammogram within the past year. Direct measurement from CHNA 2012 (CHAP 2010) suggests 63.4% of men 50 years of age and older have had a digital rectal exam within the past year. Direct measurement from CHNA 2012 (CHAP 2010) suggests 41.4% of adults report they regularly wear sunscreen when outdoors; 65% of adults with children >20 report their children regularly wear sunscreen when outdoors. Direct measurement from CHNA 2012 (CHAP 2010) suggests 32.7% of >50 years of age have had a sigmoid/colonoscopy within the past year.
2. Was this identified through the CHNA process?	Yes this was identified through the CHNA process.
b. Hospital Initiative	We addressed this need with more than one initiative: • Cancer LifeNet (CLN) offers free comprehensive, professional supportive & educational services, & advocacy from Oncology Nurse Navigators and Clinical Oncology Social Workers to improve disease management, access to care, and access to critical resources to improve health outcomes through: individual & family counseling, educational programs and services, support groups, and integrative therapies (Yoga, Tai Chi, massage therapy, etc...) • Provide education related to individual cancers through targeted educational programs, risk assessments, and dissemination of health information. • Supported the American Cancer Society's (ACS) initiative to increase the number of low income women receiving mammography through participation in the ACS/NFL Breast Cancer Screening Grant.

	• CLN offered a monthly Breast Cancer Support group. UCH Breast Center offers specialized services of a Certified Breast Nurse Navigator to women who receive screening, diagnostic & treatment services through the UCH Breast Center. Certified Breast Nurse Navigator conducts community outreach through educational presentations at health fairs and to community groups throughout the year. • Provide county wide free colorectal cancer screenings on an annual basis. • Provide county wide free oral cancer screenings on an annual basis.
c. Total Number of People Within the Target Population	249,215 in Harford County 76.7% in Harford County = 191,127 adults, >18 years 51% in Harford County = 127,068 female 49% in Harford County = 122,116 male
d. Total Number of People Reached by the Initiative Within the Target Population	• 2,742 individuals received cancer education • 114 adults participated in Reiki Therapy Sessions • 218 adults participated in Yoga Classes • 9 adults participated in Fit & Active • 20 adults participated in Stress Management • 5 children participated in CLIMB – Children's Lives Include Moments of Bravery • 116 adults attended Blood Cancer Support Groups • 37 adults attended Fresh + Local = Health Support Group • 70 adults attended Healing Through Support Groups • 34 adults attended meditation classes • 149 women received breast cancer education • 55 women attended a Breast Cancer Support Group • 33 women attended a Look Good Feel Better Support Group • 167 men attended a Man to Man Support Group • 164 children and adults received skin cancer education and participated with the Skin Analyzer Machine • 26 adults had a skin cancer screening • 21 children and adults participated in the Sun Sense Program
e. Primary Objective of the Initiative	To decrease cancer deaths per 100,000 population to 177.3. To increase the percentage of women 50-69 years of age who have had a mammogram within the past year to 79.4% To decrease percentage of adult women who have had a pap smear within the past two years to >85%. To increase the percentage of men 50 years of age and older who have had a digital

	rectal exam within the past year to 68.3%. To increase the percentage of adults who report they regularly wear sunscreen when outdoors to 43.5%. To increase the percentage of adults with children <20 who report their children regularly wear sunscreen when outdoors to 68.3%. To increase the percentage of >50 years of age that have had a sigmoid/colonoscopy within the past year to 34.3%.	
f. Single or Multi-Year Initiative – Time Frame	Multi-Year	
g. Key Collaborators in Delivery of the Initiative	UM UCH UM UCH Community Outreach Kaufman Cancer Center Center LifeNet American Cancer Society	
h. Impact/Outcome of Hospital Initiative?	We continue to see an increase in the number of participants in all types of cancer support groups. We believe this increase is due to continued outreach efforts within the community to all cancer patients whether they have received their care at UM UCH or at another facility.	
i. Evaluation of Outcomes?	SHIP 2015 shows a decrease in the cancer death rate per 100,000 from 185.8 (2009 Vital Statistics) to 167.9. BRFSS 2006-2012 stated 85.2% of women age 50+ reported having had a mammogram in the past 2 years. BRFSS 2006-2012 show an increase in the percentage of adults >50 years of age having had a sigmoid/colonoscopy within the past year from 32.7% (CHAP 2010) to 64.2% CHAP 2015 shows 33.2% of adults reported having a routine colorectal screening.	
j. Continuation of Initiative?	Yes, although there has been a reduction in the cancer death rate per 100,000, Harford County still ranks worse than the State average.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $246,922 of dollars	B. Direct Offsetting Revenue from Restricted Grants

a. 1. Identified Need 2. Was this identified through the CHNA process?	Access to Care Direct measurement from BRFSS 2008-2010 suggests 10.4% of population cannot afford to see an M.D. Yes this was identified through the CHNA process.
b. Hospital Initiative	HealthLink Primary Care Clinic - provided primary care services to the uninsured and underserved residents of Harford County who were <300% of the Federal Poverty Level guidelines. The clinic operated 5 days a week, including one half day Saturday. It was comprised of a stationary clinic located in the city of Havre de Grace, and a mobile medical van that functioned as a mobile clinic at various locations throughout the community. The clinic operated from 2001 through November 2014, at which time it closed. This was a result of several years working to bring a Federally Qualified Health Center to Harford County. This became successful with the opening of Beacon Health Center in Havre de Grace. Beacon Health Center – Federally Qualified Health Center opened December 2, 2014. UM UCH will provide a grant to the Center for the first several years. Upon Beacon Health Center's opening and HealthLink Primary Care Clinic closing, 73% of the HealthLink patient population were successfully transferred to Beacon Health Center. The HealthLink interpreter, CMA, and one of the Physician Assistant transferred to Beacon Health Center, thus providing continuity of care for the HealthLink patients.
c. Total Number of People Within the Target Population	249,215 in Harford County 76.7% in Harford County = 191,127 adults, >18 years 9% of adults in Harford County could not see a doctor due to cost = 17,201 adults
d. Total Number of People Reached by the Initiative Within the Target Population	1,452 adults received medical care in the HealthLink Primary Care Clinic before it closed in November 2014 and transitioned to Beacon Health Center, a Federally Qualified Health Center located in Havre de Grace, Maryland. Transportation vouchers
e. Primary Objective of the Initiative	To decrease the percentage of population who cannot afford to see an M.D. to 9.8%.
f. Single or Multi-Year Initiative –Time Period	Multi-Year

g. Key Collaborators in Delivery of the Initiative	UM UCH HealthLink Primary Care Clinic Health Care for the Homeless Beacon Health Center Harford County Health Department	
h. Impact/Outcome of Hospital Initiative?	We believe this initiative was successful as a result of providing Primary Care and preventative care to 1,452 underserved patients who otherwise would not have been able to receive primary care services. Additionally, we feel it was successful because we had 73% of the patients immediately transfer their care to Beacon Health Center.	
i. Evaluation of Outcomes?	County Health Rankings shows a reduction in the percentage of population who cannot afford to see an M.D. from 10.4% (BRFSS 2008-2010) to 9%.	
j. Continuation of Initiative?	Yes, UM UCH will continue to provide support through a grant to Beacon Health Center for operations for the next several years. Additionally UM UCH will be making referrals to Beacon Health Center through our Case Managers and Comprehensive Care Center.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $949,620	B. Direct Offsetting Revenue from Restricted Grants $81,470 – Health Care for the Homeless

a. 1. Identified Need	Illness and Injury Prevention: Flu Vaccines Direct measurement from CHNA 2012 (CHAP 2010), 83% of adults 65 years of age and older have had a flu vaccine within the past year; BRFSS 2008-2010, 38.7% of adults have had a flu shot in the last year; BRFSS 2010, 63.3% of children had a seasonal flu vaccination in the last 12 months.
2. Was this identified through the CHNA process?	Yes this was identified through the CHNA process.
b. Hospital Initiative	To provide flu clinics throughout Harford County free of charge or at a minimal cost.
c. Total Number of People	249,215 in Harford County

Within the Target Population	76.7% in Harford County = 191,127 adults, >18 years 14.1% in Harford County = 35,031 adults age 65 and older	
d. Total Number of People Reached by the Initiative Within the Target Population	1,345 children and adults received a flu vaccination or flu mist.	
e. Primary Objective of the Initiative	Increase the percentage of adults 65 of age and older who have had a flu vaccine within the past year to 85%. Increase the percentage of adults who received a flu shot in the last year to 57.2%	
f. Single or Multi-Year Initiative –Time Period	Multi-Year	
g. Key Collaborators in Delivery of the Initiative	UM UCH Community Outreach	
h. Impact/Outcome of Hospital Initiative	We feel this is successful because Harford County has the 2nd best ranking for influenza immunizations in Maryland.	
i. Evaluation of Outcomes:	BRFSS 2006-2012 stated 72.1% of adults age 65+ reported having had a flu vaccine in the past 12 months.	
j. Continuation of Initiative?	Yes, while Harford County ranks number 2 for seasonal flu vaccinations, we will continue to increase the number of adults of 65+ to our goal of 85%.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $5,779 of dollars	B. Direct Offsetting Revenue from Restricted Grants

a. 1. Identified Need	Illness and Injury Prevention: Hand Washing According to the Center of Disease Controls, hand washing is one of the most effective ways to prevent the spread of many types of infection and illness. 326 preschool and elementary age children participated in the Glow Germ program designed to educate and instruct children regarding the proper hand washing techniques of regular and thorough hand washing.
2. Was this identified	

through the CHNA process?	No, however a direct request from Harford County Public Schools.	
b. Hospital Initiative	To establish proper hand hygiene practices at a young age, Community Outreach will conduct a hand hygiene Glow Germ program targeting pre-school and elementary age children throughout the community.	
c. Total Number of People Within the Target Population	249,215 in Harford County 76.7% in Harford County = 191,127 adults, >18 years	
d. Total Number of People Reached by the Initiative Within the Target Population	259 children participated in the Glo Germ Program	
e. Primary Objective of the Initiative	To increase the number of preschool and elementary age children educated and instructed on the proper hand washing techniques and the importance of regular and thorough hand washing to >500.	
f. Single or Multi-Year Initiative – Time Period	Multi- Year	
g. Key Collaborators in Delivery of Initiative	UM UCH Community Outreach Harford County Public Schools	
h. Impact/Outcome of Hospital Initiative?	We believe this was a success because we provided the Glo Germ Program to 14 schools throughout Harford County, of which 33% completed a feedback survey stating that the program had an immediate positive impact on their students' hand washing habits.	
i. Evaluation of Outcomes:	100% of the surveys received stated that the program had an immediate positive impact on their students' hand washing habits.	
j. Continuation of Initiatives?	Yes	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $1,237 of dollars	B. Direct Offsetting Revenue from Restricted Grants

a. 1. Identified Need 2. Was this identified through the CHNA process?	Illness and Injury Prevention: Helmets According to the Children's Safety Network, bicycle helmets prevent 52 to 60 percent of bike-related head injury deaths (for all ages), as well as an estimated 68 to 85 percent of nonfatal head and scalp injuries, and 65 percent of upper and middle face injuries, even when misuse is considered. A direct measurement from CHNA 2012 (CHAP 2010) suggest 56.4% of parents with children under 20 years of age report their children always or often wear a helmet while bicycling, rollerblading, skateboarding, 4 wheeling, motor scootering, or other similar outdoor activities. Yes this was identified through the CHNA process.
b. Hospital Initiative	As bicycle helmets significantly reduce the total medical costs for bike-related head injuries, HealthLink in partnership with Greg Krause Helmet Foundation and the Harford County Health Department, will provide free to low cost child helmets and helmet fittings in the community.
c. Total Number of People Within the Target Population	249,215 in Harford County 76.7% in Harford County = 191,127 adults, >18 years
d. Total Number of People Reached by the Initiative Within the Target Population	83 children under the age of 18 were fitted and received bike helmets at Healthy Harford Day through the Greg Krause Foundation.
e. Primary Objective of the Initiative	To increase the percentage of parents with children under 20 years of age reporting their children always or often wear a helmet while bicycling, rollerblading, skateboarding, 4 wheeling, motor scootering, or other similar outdoor activities to 59.2%
f. Single or Multi-Year Initiative –Time Period	Multi-Year
g. Key Collaborators in Delivery of the Initiative	UM UCH Community Outreach Health Harford Greg Krause Foundation
h. Impact/Outcome of Hospital Initiative? i.	The hospital did not provide this initiative in FY15.
j. Evaluation of Outcomes:	No evaluation since initiative was not done in FY15.

k. Continuation of Initiative?	Yes, we will continue this initiative when possible because according to the CDC, over 26,000 children and adolescents who sustain bicycle-related traumatic brain injuries are treated in Emergency Departments. Continued education on helmet safety is necessary.	
l. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $0.00 of dollars	B. Direct Offsetting Revenue from Restricted Grants

a. 1. Identified Need	Illness and Injury Prevention: Car Safety Seats According to the National Highway and Traffic Safety Administration, 75% of all car seats are installed incorrectly. A direct measurement from KISS Crash Data 2008-2010, children ages 0-4 are 5 times less likely to be injured in a crash if they are in a property installed child restraint.
2. Was this identified through the CHNA process?	Yes this was identified through the CHNA process.
b. Hospital Initiative	We will address this need by providing free KISS trained car seat installation inspectors to assist parents and caregivers in proper car seat installations on a monthly basis.
c. Total Number of People Within the Target Population	249,215 in Harford County 76.7% in Harford County = 191,127 adults, >18 years
d. Total Number of People Reached by the Initiative Within the Target Population	78 infant car seats were checked for proper installation and safety.
e. Primary Objective of the Initiative	We intend to offer monthly KISS certified car seat inspections at two (2) locations in the county, serving >60 families per year.
f. Single or Multi-Year Initiative –Time Period	Multi-Year
g. Key Collaborators in Delivery of the Initiative	UM UCH Community Outreach

	KISS – Kids in Safety Seats	
h. Impact/Outcome of Hospital Initiative?	100% of infant car seats were installed correctly by one of our two nationally certified car safety seat instructors.	
i. Evaluation of Outcomes:	According to Safe Kids Worldwide, correctly installed child safety seats reduce the risk of death by as much as 71%.	
j. Continuation of Initiative?	Yes, UM UCH is the only organization/agency in that offers car seat safety checks in Harford County.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $1,872 of dollars	B. Direct Offsetting Revenue from Restricted Grants

APPENDIX I

FINANCIAL ASSISTANCE POLICY DESCRIPTION

Charity Care Policy Summary

Financial Assistance

- Made available to all of Upper Chesapeake Health's customers
- Applications are provided to every uninsured patient and upon request
- Notices of availability are at all patient access point, billing office and cashier's station
- Notice of availability provided to patients on patient bills and before discharge
- Free care is available to patients in households between 0% and 200% of FPL
- Reduced cost care is available to uninsured patients between 200% and 300% of FPL
- Interest-free payment plans are available to uninsured patients with income between 200% and 500% of FPL
- Financial Assistance determination appeal process in place
- Medical Hardship / Catastrophic Care policy in place

Purpose

- Commitment to provide financial assistance to persons who have health care needs and are: uninsured, underinsured, ineligible for government programs, or otherwise unable to pay for medically necessary care based on individual financial situation
- Based on indigence or high medical expenses resulting in hardship
- To ensure the ability to pay does not prevent patients from seeking or receiving healthcare

Criteria

- Assistance may be given after a review of the patient's financial circumstances, existing medical expenses, including accounts in bad debt
- UCH retains the right in its sole discretion to determine a patient's ability to pay
- All patients presenting in an emergency situation will be treated regardless of their ability to pay
- All patients are required to submit a financial assistance application unless they are eligible for presumptive care (eligible for presumptive: active MA coverage, QMB, PAC, Homelessness, EP, WIC, Food Stamps, deceased/no estate, other state/local assistance programs)
- Reasons for ineligibility: refusal to provide requested information, insurances that deny access to UCH, refusal to cooperate for eligibility in other assistance programs, elective procedures, non-U.S. citizens, liquid assets exceeding $20,000, failure to honor payment arrangements (past/present)

Process

- When possible: Patient Financial Advocate will consult via phone or meet with patients who request Financial Assistance to determine if they meet criteria for assistance as well as provide information on how to apply for Medical Assistance
- Each patient is required to submit a completed MD State Financial Assistance form, and may be required to submit: copy of most recent Federal Income Tax Return, copy of most recent paystub (or source of income i.e. disability, unemployment, etc.), proof of citizenship or green

card, reasonable proof of expenses, spouses income, a notarized letter of support if no source of income

- Patients have 30 days to submit required documentation, if the timeline is not followed the patient may re-apply to the program
- Applications initiated by the patient will be tracked, worked and eligibility determined
- A letter of final determination will be sent to each patient that has requested Financial Assistance
- Patients may be covered for a specific date of service up to six months succeeding the date of service, patients must then reapply
- Changes in financial status should be communicated by the patient to UCH
- UCH does not place judgments or report to credit bureau in attempt to collect debts

APPENDIX II

FINANCIAL ASSISTANCE POLICY CHANGES SINCE ACA DESCRIPTION

Our Financial Assistance Policy is based on a sliding scale model and complied with all regulatory requirements prior to the Medicaid expansion.

APPENDIX III

Upper Chesapeake Health

Subject: Financial Assistance Policy

Effective Date: 01/2013

Approved by: _____

Joseph E. Hoffman, Sr. VP CFO

_____

Board of Directors

To provide financial relief to patients unable to meet their financial obligation to Upper Chesapeake Health.

1. **Policy**
    a. This policy applies to Upper Chesapeake Health (UCH). UCH is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.
    b. It is the policy of UCH to provide Financial Assistance (FA) based on indigence or high medical expenses (Medical Financial Hardship program) for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for FA should be made, the criteria for eligibility, and the steps for processing applications.
    c. UCH will post notices of availability at appropriate intake locations as well as the Patient Accounting Office. Notice of availability will also be sent to patients on patient bills. Signs will be posted in key patient access areas. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request. A written estimate of total charges, excluding the emergency department, will be available to all patients upon request.
    d. FA may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include a review of the patient's existing medical expenses and obligations, including any accounts having gone to bad debt.

e. Patients applying for FA up to 2 years after the service date who have made account payment(s) greater than $25 are eligible for refund consideration
    i. Collector notes, and any other relevant information, are deliberated as part of the final refund decision; in general refunds are issued based on when the patient was determined unable to pay compared to when the payments were made
    ii. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for a refund
f. UCH retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services or diagnosed-cancer care will be treated regardless of their ability to pay, except as noted under 2. d. iv. below.

2. Program Eligibility

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UCH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the UCH commitment to our mission to provide healthcare to the surrounding community, UCH reserves the right to grant financial assistance without formal application being made by our patients.
b. Specific exclusions to coverage under the FA program include the following:
    i. Physician charges are excluded from UCH's FA policy. Patients who wish to pursue FA for physician related bills must contact the physician directly
    ii. Generally, the FA program is not available to cover services that are 100% denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications
    iii. Unpaid balances resulting from cosmetic or other non-medically necessary services
c. Patients may become ineligible for FA for the following reasons:
    i. Refusal to provide requested documentation or provide incomplete information
    ii. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, Motor Vehicle or other insurance

programs that deny access to UCH due to insurance plan restrictions/limits

iii. Refusal to be screened for other assistance programs prior to submitting an application to the FA program

d. Determination for Financial Assistance eligibility will be based on assets, income, and family size. Please note the following:
    i. Liquid assets greater than $15,000 for individuals, and $25,000 for families will disqualify the patient for 100% assistance.
    ii. Equity of $150,000 in a primary residence will be excluded from the calculation for determination of financial assistance; and
    iii. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans will not be used for determination of financial assistance.
    iv. Non-citizens/non-residents of the United States may only qualify for Financial Assistance under these circumstances: 1. an initial visit for emergency care or 2. if qualified for presumptive Medical Assistance upon inpatient admission or prior to outpatient treatments for cancer care, and only after a determination by the Financial Counselor/Director of Patient Accounting and/or V.P. of Finance. See the Upper Chesapeake Health Self Pay Billing policy for criteria for beginning outpatient cancer care for these patients.
e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a FA application unless they meet Presumptive FA (see section 3 below) eligibility criteria. If a patient qualifies for COBRA coverage, the patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
f. Free medically necessary care will be awarded to patients with family income at or below 200 percent of the Federal Poverty Level (FPL).
g. Reduced-cost, medically necessary care will be awarded to low-income patients with family income between 200 and 300 percent of the FPL
h. If a patient requests the application be reconsidered after a denial determination made by the Financial Counselor, the Director of Patient Accounting will review the application for final determination.

i. Payment plans can be offered for all self-pay balances by our Self Pay Vendor. Payment plans are available to uninsured patients with family income between 200 to 500 FPL.

3. Presumptive Financial Assistance

a. Patients may also be considered for Presumptive Financial Assistance eligibility with proof of enrollment in one of the programs listed below. There are instances when a patient may appear eligible for FA, but there is no FA form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patent with FA. In the event there is no evidence to support a patient's eligibility for FA, UCH reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100-percent write-off of the account balance. Presumptive FA eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
    i. Active Medical Assistance pharmacy coverage
    ii. Special Low Income Medicare Beneficiary (SLMB) coverage (covers Medicare Part B premiums)
    iii. Primary Adult Care coverage (PAC)
    iv. Homelessness
    v. Medical Assistance and Medicaid Managed Care patients for services provided in the ED beyond coverage of these programs
    vi. Maryland Public Health System Emergency Petition (EP) patients (balance after insurance)
    vii. Participation in Women, Infants and Children Program (WIC)
    viii. Supplemental Nutritional Assistance Program (SNAP)
    ix. Eligibility for other state or local assistance programs
    x. Deceased with no known estate
    xi. Determined to meet eligibility criteria established under former State Only Medical Assistance Program
    xii. Households with children in the free or reduced lunch program
    xiii. Low-income household Energy Assistance Program
    xiv. Self-Administered Drugs (in the outpatient environment only)
    xv. Medical Assistance Spenddown amounts
b. Specific services or criteria that are ineligible for Presumptive FA include:

i. Purely elective procedures (e.g. cosmetic procedures) are not covered under the program
ii. Uninsured patients seen in the ED under EP will not be considered under the presumptive FA program until the Maryland Medicaid Psych program has been billed

4. Procedures

a. The Financial Counselor will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage
b. The Financial Counselor will consult via phone or meet with patients who request FA to determine if they meet preliminary criteria for assistance.
    i. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility
    ii. All applications will be tracked and after eligibility is determined, a letter of final determination will be submitted to the patient
    iii. Patients will have fifteen days to submit required documentation to be considered for eligibility. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to
c. There will be one application process for UCH. The patient is required to provide a completed FA application. In addition, the following may be required:
    i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return)
    ii. Proof of disability income (if applicable)
    iii. A copy of their three most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income
    iv. A Medical Assistance Notice of Determination (if applicable)
    v. Proof of U.S. citizenship or lawful permanent residence status (green card)
    vi. Reasonable proof of other declared expenses may be taken in to consideration
    vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
    viii. A Verification of No Income Letter (if there is no evidence of income)
    ix. Three most recent bank statements

d. A patient can qualify for FA either through lack of sufficient income, insurance or catastrophic medical expenses. Within two (2) business days following a patient's request for Financial Assistance, application for Medical Assistance, or both, the hospital will make a determination of probable eligibility. Completed applications will be forwarded to the Director of Patient Accounting who will determine approval for adjustments up to $10,000. Adjustments of $10,000 or greater will be forwarded to the V.P. of Finance for an additional approval.
e. Once a patient is approved for FA, eligibility will be extended to the following accounts:
    i. All accounts in an FB (Final Billed) status
    ii. All accounts in a BD (Bad Debt) status that were transferred within one year of the service date of the oldest FB account being adjusted using the current application
    iii. All future visits within 6 months of the application date
f. Social Security beneficiaries with lifelong disabilities may become eligible for FA indefinitely and may not need to reapply
g. UCH does not report debts owed to credit reporting agencies.
h. Based on the following criteria, UCH reserves the right to place a lien on a patients income, residence, and/or automobile;
    i. Account is greater than $10,000
    ii. Account/s is/are in Bad Debt
    iii. Account/s greater than 120 days old (from date of final bill)
    iv. Based on information submitted, patient has ability to pay debt

5. Financial Hardship

a. Financial Hardship is a separate, supplemental determination of Financial Assistance and may be available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy
b. Financial Hardship Assistance is defined as facility charges incurred at UCH owned hospitals or physician practices for medically necessary treatment by a family household that exceeds 25% of the family's annual income. Family annual income must be less than 500% of the Federal Poverty Limit
c. Once a patient is approved for Financial Hardship Assistance, coverage may be effective starting with the first qualifying date of service and the following twelve (12) months
d. Financial Hardship Assistance may cover the patient and the immediate family members living in the same household. Each family member may

be approved for the reduced cost and eligibility period for medically necessary treatment.

e. Coverage will not apply to elective or cosmetic procedures.
f. In order to continue in the program after the expiration of an eligibility period, each patient (family member) must reapply to be considered.
g. Patients who have been approved for the program should inform UCH of any changes in income, assets, expenses or family (household) status within 30 days of such changes
h. All other eligibility, ineligibility and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance, unless otherwise stated

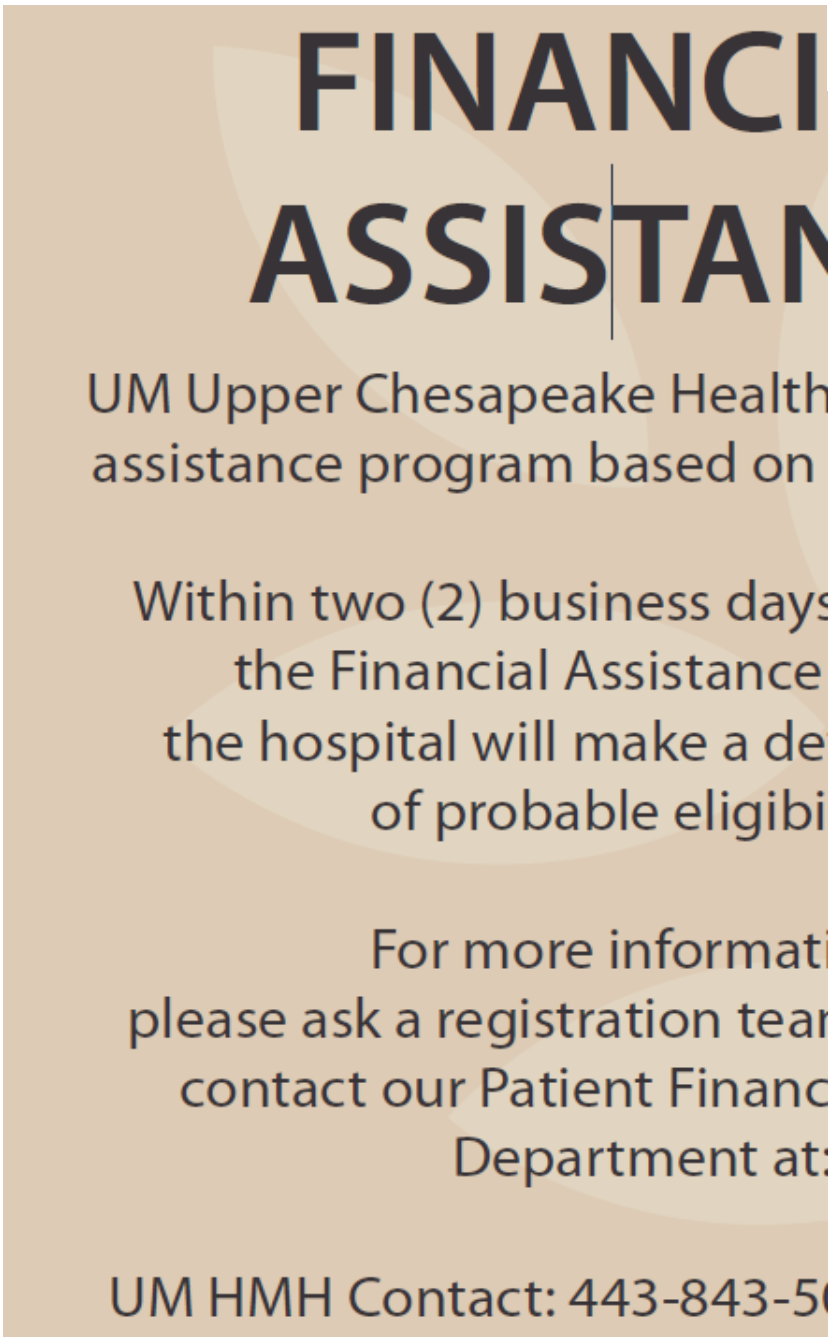
DEVELOPER:

Patient Financial Counselor, UCH

Reviewed / Revised: 09/2013

ORIGIN DATE: 10/2010

NEXT REVIEW DATE: 12/2014


FINANCI
ASSISTAN
UM Upper Chesapeake Health
assistance program based on
Within two (2) business days
the Financial Assistance
the hospital will make a de
of probable eligibi
For more informati
please ask a registration tear
contact our Patient Financ
Department at:
UM HMH Contact: 443-843-5

FINANCIAL ASSISTANCE

UM Upper Chesapeake Health has a financial assistance program based on financial need.

Within two (2) business days of receipt of the Financial Assistance Request, the hospital will make a determination of probable eligibility.

For more information, please ask a registration team member or contact our Patient Financial Services Department at:

UM UCMC Contact: 443-643-1000 Option 54

AYUDA FINANCIERA

UM Upper Chesapeake health tiene un programa de asistencia financiera basado en necesidad económica.

Dentro de dos (2) días de recibir la solicitud de asistencia financiera, el hospital hará una determinación de elegibilidad.

Para obtener más información, por favor pídale a un miembro del equipo de registro o póngase en contacto con nuestro Departamento de servicios financieros de paciente al:

UM HMH Contact: 443-843-5000 Option 34

APPENDIX V

UPPER CHESAPEAKE HEALTH MISSION, VISION, VALUE

Vision: The Vision of Upper Chesapeake Health is to become the preferred, integrated health care system creating the healthiest community in Maryland.

Mission: Upper Chesapeake Health is dedicated to maintaining and improving the health of the people in its communities through an integrated health delivery system that provides high quality care to all. UCH is committed to service excellence as it offers a broad range of health services, technology and facilities. It will work collaboratively with its communities and other health organizations to serve as a resource for health promotion and education.

Value: Upper Chesapeake Health is dedicated to excellence, compassion, integrity, respect, responsibility and trust. We create a healing and compassionate environment by providing the finest in care, courtesy and service to all people with whom we interact.

Excellence: We constantly pursue excellence and quality through teamwork, continuous improvement, customer satisfaction, innovation, education and prudent resource management.

Compassion: People are the source of our strength and the focus of our mission. We will serve all people with compassion and dignity.

Integrity: We will conduct our work with integrity, honesty, and fairness. We will meet the highest ethical and professional standards.

Respect: We will respect the work, quality, diversity, and importance of each person who works with or is served by Upper Chesapeake Health.

Responsibility: We take responsibility for our actions and hold ourselves accountable for the results and outcomes.

Trust: We will strive to be good citizens of the communities we serve and build trust and confidence in our ability to anticipate and respond to community and patient needs.