UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Community Benefit Narrative Report

Fiscal Year 2016

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 regulatory 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 meeting aggressive quality targets, the Model requires the State to 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 in this new environment, 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 operations, activities, and investments 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 (LHICs) 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) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(3) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(4) Local Health Departments;
(5) County Health Rankings (http://www.countyhealthrankings.org);
(6) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(7) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(8) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(9) CDC Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);

(10) CDC Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)
(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 such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/)
(16) CRISP Reporting Services

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.

HSCRC Community Benefit 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).
    a. Bed Designation – The number of licensed Beds;
    b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
    c. Primary Service Area Zip Codes;
    d. List all other Maryland hospitals sharing your primary service area;
    e. The percentage of the hospital's uninsured patients by county. (please provide the source for this data, i.e. review of hospital discharge data);
    f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data, i.e. review of hospital discharge data, etc.).
    g. The percentage of the Hospital's patients who are Medicare Beneficiaries. (Please provide the source for this data, i.e. review of hospital discharge data, etc.)

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area Zip Codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of Hospital's Uninsured Patients,:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
Primary Service Area (Top 60% of discharges) Harford Memorial Hospital (HMH) (Provider #21-0006): Licensed beds: 85 Upper Chesapeake Medical Center (UCMC) (Provider #21-0049): Licensed beds: 170	HMH: 4,384 UCMC: 11,480	HMH: 21001 21078 21903 21904 21040 UCMC: 21014 21040 21015 21009 21001 21050 21085	St. Joseph Health Center Greater Baltimore Medical Center Franklin Square Union of Cecil	Harford County 1.8%	Harford County 14.2%	HMH & UCMC 39.4%

Note: Data source is patient discharge data files.

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

a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):

(i) A list of the zip codes included in the organization's CBSA, and

(ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations reside.

(iii) Describe how the organization identified its CBSA, (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 community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/). 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)
Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)

Table II

Demographic Characteristic	Description	Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	UM Upper Chesapeake Health functions as one organizations with 2 hospitals located in and serving all of Harford County. Each of the two facilities offers certain services solely at that institution. Harford County residents, no matter their zip code, requiring that specialty service must receive that care at the facility that offers that service, e.g. cancer services at the Kaufman Cancer Center at Upper Chesapeake Medical Center in Bel Air or behavioral health services at Harford Memorial Hospital in Havre de Grace. As a result of how services are provided between the two facilities, the CHNA was completed as a joint document for the two facilities. UM UCH is the sole health care system in Harford County. The Harford County CHNA includes all 21 Harford County zip codes. This included the zip codes where our most vulnerable populations reside (21009, 21040, 21001 and 21078). In keeping with University of Maryland Upper Chesapeake Health mission of maintaining and improving the health of the people in its communities and providing high quality care to all, the CBSA was identified as all of Harford County. While the above four zip codes are identified as containing concentrated areas of poverty, there are pockets of poverty throughout many of the Harford County zip codes particularly in the northern zip codes where it is very rural. Identifying all of Harford County as the CBSA gives the organization a better opportunity to meet the needs of the vulnerable residents of Harford County. The demographic profile of the respondents who completed the online survey is as follows: approximately 56% of all respondents reside in	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

	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.	

	The top 3 zip codes that our Medicaid population comes from are 21001, 21040 and 21078. The top 3 zip codes where our readmission high utilizers are coming from are 21014, 21001 and 21078. These 3 zip codes contain high concentrations of the Medicare population. While our primary service area contains two Cecil County zip codes, our CBSA does not. Due to limited resources, these zip codes were not included in the CBSA. However, currently there is a collaboration of planning between Cecil and Harford County's hospitals, health departments and FQHC's to look more closely at addressing the needs of identified high utilizers within Cecil County.	
Median Household Income within the CBSA	$81,016	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
Percentage of households with incomes below the federal poverty guidelines within the CBSA	7.7% (Individuals) 6.0% (All Families) 9.5% (Families w/ related children under 18 years) 8.8% (Families w/related children under 5 years only) 21.2% (Families with female householder, no husband present) 28.6% (with related children under 18) 44.9% (w/related children under 5 years only)	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html;h http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	6.3% Civilian Non-institutionalized Population 3.2% Civilian Non-institutionalized Population (under 18)	U.S. Census Bureau, 2009 American Community Survey http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml

Percentage of Medicaid recipients by County within the CBSA.	25.3%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
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: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Black: 77.7 White: 79.6	SHIP 2012-2014, Maryland DHMH Vital Statistics Administration http://dhmh.maryland.gov/ship/Pages/home.aspx
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Represented per 100,000 population Age-Adjusted Mortality Rate from Cancer – 170.9 Non-Hispanic White: 174.2 Non-Hispanic Black: 184.3 Age-Adjusted Mortality Rate from Heart Disease – 169.6 Non-Hispanic White:172.2 Non-Hispanic Black:170.9 Stroke – 38.2 (2007-2013) Chronic Lower Respiratory Disease – 36.9 Unintentional Injury – 31.9 Diabetes – 15.7	SHIP 2012-2014, Maryland DHMH Vital Statistics Administration http://dhmh.maryland.gov/ship/Pages/home.aspx
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:	• 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).	

http://dhmh.maryland.gov/ship/SitePages/measures.aspx	• Harford is primarily rural and suburban with a strong car culture. Traffic speed and limited safe bike and pedestrian infrastructure has a severe negative 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, i.e. along the route 40 corridor in the southern portion of the county, public transportation (i.e. busing) is limited in both routes and scheduling. The limited routes and restricted scheduling makes it challenging for residents to rely solely on public transportation to access full time employment. All Harford County transit buses are 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 rates of tobacco use, substance abuse, behavioral health issues that result in suicide, and high minority obesity rates, (DHMH SHIP - LHIC) • Homeownership in Harford County is at 79.1% with a median value of $279,300 for owner occupied housing units. There is an average of 2.7 people per household (US Census ACS 2010-2014). 8% of the population is in poverty (2014 SAIPE), and 47.8% of Harford County households earn less than $75,000. The inventory for affordable housing is limited, and the high average housing price pushes many low and moderate income people out of the housing market. 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 immediately surrounding APG includes are some of the most impoverished census tracts in our community.	
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	• Primary Language Spoken ○ English: 89.84% ○ Other than English: 10.16% (41% of which is Spanish)	ACS 2010-2014 http://www.usa.com/harford-county-md-population-and-races.htm
Adult Obesity (Percentage of adults that report BMI >30)	Harford County: 28% MD: 28%	County Health Rankings 2016 http://www.countyhealthrankings.org/app/maryland/2016/rankings/harford/county/outcomes/overall/snapshot
Diabetes (percentage of adults aged 20 and above with diagnosed diabetes)	Harford County: 9% MD: 10%	County Health Rankings 2016 http://www.countyhealthrankings.org/app/maryland/2016/measure/outcomes/60/data
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)	Non-Hispanic White: Harford County 47.6; MD 51.5 Non-Hispanic Black: Harford County: 43.9; MD 45.4 Hispanic: Harford County: 4.6; MD 30.0 Asian: Harford County: 100; MD 51.1	SHIP 2013, Maryland DHMH Behavioral Risk Factor Surveillance System (BRFSS) http://dhmh.maryland.gov/ship/Pages/home.aspx

Percentage of Adults who currently smoke	Non-Hispanic White: Harford County 23.0, MD: 15.5 Non-Hispanic Black: Harford County 3.1, MD: 16.8	SHIP 2014, Maryland DHMH Behavioral Risk Factor Surveillance System (BRFSS) http://dhmh.maryland.gov/ship/Pages/home.aspx
Adolescents Who Use Tobacco Products (percentage of adolescents who used any tobacco in the last 30 days)	Non-Hispanic White: Harford County 20.3; MD 19.0 Non-Hispanic Black: Harford County: 19.0; MD 14.1 Hispanic: Harford County 26.8; MD 18.0	SHIP 2013, Maryland Youth Risk Behavior Survey (YRBS) http://dhmh.maryland.gov/ship/Pages/home.aspx
Cancer Mortality (per 100,000 population)	White: Harford County 177.9, MD 169.9 Black: Harford County 207.3, MD 194.8	Centers for Disease Control and Prevention, National Center for Health Statistics 2005-2011 http://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/MD/Harford/486
Annual Average unemployment rate (COUNTY HEALTH RANKINGS 2015)	Harford County: 5.8%; MD: 5.8%	County Health Rankings 2016 http://www.countyhealthrankings.org/app/maryland/2016/rankings/harford/county/outcomes/overall/snapshot
Rate of Suicides per 100,000 population	Harford County: 11.6; MD: 9.2	SHIP 2014, Maryland DHMH Vital Statistics Administration http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
Rate of drug induced death per 100,000 population	Harford County: 19.2; MD: 15.2	SHIP 2012-2014 http://dhmh.maryland.gov/ship/Pages/home.aspx

Health Disparities Infant Mortality Rate (per 1,000 live births) Percentage of births that are low birth weight (per 1,000 live births) Rate of hospital encounters for newborns with maternal drug/alcohol exposure (rate exposed per 1,000 newborns)	 Harford County 4.8; MD 6.5 Harford County 7.5; MD 8.6 Non-Hispanic White: Harford County 6.8; MD 6.6 Non-Hispanic Black: Harford County 10.4; 12.1 Hispanic: Harford County 6.6; MD 7.3 Asian: Harford County 10.0; MD 8.1 Harford County 29.4; MD 20.1	SHIP 2014, Maryland DHMH Vital Statistics Administration http://dhmh.maryland.gov/ship/Pages/home.aspx HSCRC Hospital Data, 2000-2015, Maryland resident births only.
Emergency Department Visits related to domestic violence per 100,000 population Diabetes Hypertension Mental Health Asthma Addictions related conditions	 Non-Hispanic White – Harford County 126.1; MD 107.9 Non-Hispanic Black – Harford County 361.6; MD 309.4 Non-Hispanic White – Harford County 125.1; MD 113.2 Non-Hispanic Black – Harford County 536.3; MD 415.1 Non-Hispanic White – Harford County 2661.6; MD 3373.2 Non-Hispanic Black – Harford County 2908.6; MD 2913.7 Non-Hispanic White – Harford County 28.3; MD 26.7 Non-Hispanic Black – Harford County 117.8; MD 108.5 Non-Hispanic White – Harford County 1629.6; MD 1284.5 Non-Hispanic Black – Harford County 1862.8; MD 1734.2	SHIP 2014, Maryland Health Services Cost Review Commission (HSCRC) http://dhmh.maryland.gov/ship/Pages/home.aspx

Education Percentage of population graduating high school Bachelor's Degree or higher	 92.9% (percentage of persons age 25+) 33.4% (percentage of persons age 25+)	United States Census QuickFacts 2010-2014 http://www.census.gov/quickfacts/table/PST045215/24025,00
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 1-2 within the past three fiscal years?

   _X_ Yes
   ____No

   Provide date here. 06/30/15 (mm/dd/yy)

   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 3?

   _XYes 06/30/15 (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. Are Community Benefits planning and investments part of your hospital's internal 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, Healthy Harford, Harford County Office on Aging, and Beacon Health (Harford County FQHC).

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
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. __X_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.
- Responsible for development and implementation of the organization's Strategic Plan.
- 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)
  - Involved in the development of the annual Operating Plan which addresses the population health initiatives.
- Director of Community Outreach and Health Improvement (Nurse)
  - 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. Population Health Leadership and Staff

1. __X__ Population Health VP or equivalent (please list)
   a. Colin Ward, Vice President, Population Health – Serves as the lead strategist on the identification and implementation of initiatives related to population health.
2. __X__ Other population health staff (please list staff)
   a. Philip Nivatpumin, Medical Director of Population Health – collaborates in the development of Population Health initiatives and provides clinical expertise for the identified initiatives.
   b. Sharon Lipford, Executive Director of Healthy Harford – collaborates in the development of Population Health initiatives and provides clinical expertise in behavioral health and addiction initiatives.
   c. Dina Willard, Executive Assistant - provides administrative support to the Vice President of Population Health and Clinical Integration.

Describe the role of population health leaders and staff in the community benefit process.

iv. Community Benefit Operations

1. __X__Individual (2 FTE)

    a. Vickie Bands, Director of Community Outreach and Health Improvement – 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 and Health Improvement
        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. Curt Ohler – Finance
    f. Brian Trantules - 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 and Health Improvement - direct oversite for community outreach and

community benefit to include both the annual Community Benefit Report and the CHNA.
   b. Bari Klein, Grants Administrator
   c. Kimberly Theis, Community Benefits/CHI Business Manager
   d. Julie Siejack, HealthLink Clinical Nurse Manager
   e. Judy Lauer, Events Coordinator

4. ___Task Force (please list members)

5. _X__Other (please describe)
   a. 1.1 FTE: 33 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 and Health Improvement and the VP of Population Health and Clinical Integration. 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 November.

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___ FQHC
__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
Harford County Government	Amber Shrodes	Director of Community Services, Local Government Official	Member of the Strategic Planning Session
Healthy Harford	Sharon Lipford	Executive Director	Member of the Strategic Planning Session, and Key

			Leadership Focus Group
Healthy Harford and Harford County Health Department	Bari Klein	Public Health Program Manager	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	Barb Cysyk	Primary Stroke Center Manager	Member of Community Benefit Advisory Board
UM UCH	Curt Ohler	Manager of Cost Reporting & Regulatory Compliance	Member of Community

			Benefit Advisory Board
UM UCH	Debbie Ostrowski	Diabetes RN Education	Member of Community Benefit Advisory Board
UM UCH	Karen Hensley	Director of Women's & Children's Service	Member of Community Benefit Advisory Board
UM UCH	Kimberly Theis	Community Health Improvement/Community Business Manager	Member of Community Benefit Advisory Board
UM UCH	Brian Trantules	Marketing Coordinator	Member of Community Benefit Advisory Board
UM UCH	Mark Lewis	Director, Heart and Vascular Institute	Member of Community Benefit Advisory Board
UM UCH	Nate Albright	Director, Ortho/Neuro/ Spine Service Line	Member of Community Benefit Advisory Board
UM UCH	Patsy Astarita	Manager, Oncology Support Care Services	Member of Community Benefit Advisory Board
UM UCH	Vickie Bands	Director of Community Outreach and Health Improvement	Member of Community Benefit Advisory Board

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 and Health Improvement - Tobacco Workgroup for LHIC
- Bari Klein, Public Health Program Manager of Healthy Harford – Community Engagement Workgroup for LHIC

- Sharon Lipford, Executive Director of Healthy Harford – Behavioral Health 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, Post Discharge Readmission Project Coordinator
Pat Thompson, Director of Behavioral Health
Mark Lewis, Director, Heart and Vascular Institute
Karen Goodison, Director, Respiratory
Richard Lewis, Physician - Behavioral Health
Robin Stokes-Smith, ED Diversion Assistant Patient Navigator
Vickie Ensor Bands, Director of Community Outreach and Health Improvement
Bari Klein, Public Health Program Manager

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

- 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 links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/)
(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? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)

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?

- 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.

- 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 up to 90 days post discharge through the establishment of community based teams.

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
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.

   Access to certain outpatient specialty care is insufficient in the UM UCH service area (i.e. rheumatology, some pediatric subspecialties). In these situations, patients are required to travel outside of the service area for their care. UM UCH addresses this problem by assisting independent community providers with recruitment and succession planning and partnering with its academic partner to identify satellite practice settings for certain faculty-based subspecialists.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to 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.

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	$2,293,943.00 (Includes adult and pediatric hospitalists, anesthesiologists, intensivists, palliative care, and behavioral health IP practices)
Non-Resident House Staff and Hospitalists	(Hospitalists reported above)
Coverage of Emergency Department Call	$2,389,121.00
Physician Provision of Financial Assistance	The total amount of Physician Provision of Financial Assistance is $52,409. This is for payment related to providing coverage for patients in the ED who need consultation, procedures, and follow up when referred by the ED physician while this Physician is on call. This is for self-pay patients who don't pay or for patients with insurance companies that these physicians do not participate with.

Physician Recruitment to Meet Community Need	$80,695 - includes signing bonuses, relocation assistance, advertising, meals, travel, etc. for
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

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
    - besides English, in what language(s) is the Patient Information sheet available;
    - 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) SELECT POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy
- Reduce infant mortality
- 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
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- 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 hospital ED visits from asthma
- Reduce hospital ED visits related to mental health conditions
- Reduce hospital ED visits related to addictions
- Reduce Fall-related death rate

The FY15 CHNA for Harford County identified the following as their health priorities and identified needs in priority order:

- Chronic Disease
- Tobacco Used
- Mental Health/Addictions
- Access to Care
- Maternal and Child Health
- Injury and Illness Prevention

TABLE III

Identified Need	Chronic Disease – Heart Disease, including hypertension Hypertension is a known risk factor for heart failure, heart attack, stroke and chronic kidney disease. According to the US Preventative Task Force, high blood pressure affects almost 30% of the US population and was the primary or contribution cause of death for more than 362,000 Americans. The US Preventative Task Force reaffirms the benefit of screening for high blood in adults 18 and older. Evidence continues to show accurate screening and appropriate treatment can help prevent strokes, heart attacks and other health conditions. According to the 2015 CHNA, Harford County's incidence of adults with hypertension (29.7%) is in alignment with the national statistic of 30%. Harford County Data: • 250,105 in Harford County (County Health Ranking) • 77% in Harford County = 192,581 adults, >18 years (County Health Rankings) • 2012-2014 – 169.6 heart disease deaths in Harford County per 100,000 population (2012-2014 Vital Statistics) Direct measurement from 2015 CHNA suggests: • 7.4% adult residents in Harford County diagnosed with heart disease • 29.7% adult residents in Harford County report having or have had high blood pressure. • 47.4% adult residents in Harford County report watching their sodium or salt intake.
Hospital Initiative	The Community Blood Pressure Program The initiative aims to identify and educate people with high blood pressure to prevent or delay the development of hypertension and lower their risk of heart attack, heart disease, stroke and other chronic conditions.
Primary Objectives	1) Identify adults over the age of 18 with elevated (>139/89) blood pressure.

	a. Blood pressure screening forms are returned and reviewed for participants with elevated blood pressures. b. Screening forms of the participants with elevated blood pressure are submitted to a nurse for telephonic follow-up. 2) Provide education and coaching on controlling blood pressure through life style modifications including diet/salt reduction, increase physical activity, healthy weight, stress management, tobacco cessation, and medication compliance. 3) Provide telephonic follow-up to participants whose blood pressures is >140/90. Follow-up is focused on identifying barriers to care. a. The following information will be tracked on each follow-up call: i. Name ii. Place iii. Date iv. Phone Number v. Age vi. Blood Pressure reading vii. Blood Pressure meds taken viii. PCP ix. PCP issues x. Call Date b. Other potential problems c. Outcome of call
Single or Multi-Year Initiative – Time Period	Multi-Year
Key Partners in Development and/or Implementation	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
Outcomes (Include process and impact measures)	• 3,069 adults had their blood pressure taken at a community event. o 828, or 27% were found to have a blood pressure reading >139/89. ▪ Of these 828 adults, 190 were referred to the HealthLink Referral Line or to the Beacon Health Center due to not having a Primary Care Physician. ▪ Of these 828 adults, 396 received follow-up phone calls by a HealthLink nurse as part of our Blood Pressure Program.

	• The 396 adults had a combined total of 503 blood pressure encounters. • 59 of the 396 adults had their blood pressure taken more than once. • Of these 59 adults, 49% showed a decrease in blood pressure. ▪ The blood pressure follow up program is in alignment with the Maryland SHIP measures. • 16 adults educated with Heart Risk display. • 238 adults received Halt the Salt education.	
Continuation of Initiative?	Multi-year and on-going screening and education program.	
A. Total Cost of Initiative for Current Fiscal Year B. What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $23,782 of dollars	B. Direct Offsetting Revenue from Restricted Grants

Identified Need	Chronic Disease According to the National Council on Aging, about 80% of older adults have one chronic disease and 68.4% of Medicare beneficiaries have two or more chronic diseases and 36.4% have four or more. More than 2/3 of all health care costs are for treating chronic diseases. 95% of health care costs for older Americans can be attributed to chronic disease. NCOA and Stanford University collaborated to disseminate a proven program that empowers individuals with chronic disease to manage their own care and improve their quality of life. The most highly regarded self-management program for people with chronic disease is Stanford Chronic Disease Self-Management Program (CDSP). Harford County Data: • 250,105 in Harford County (County Health Ranking) • 77% in Harford County = 192,581 adults, >18 years (County Health Rankings) • 2012-2014 – 169.6 heart disease deaths in Harford County per 100,000 population (2012-2014 Vital Statistics) • 2011-2013 – 34.5 stroke deaths in Harford County per 100,000 population (source: 2011-2013 Vital Statistics) • 165.5 ED visits due to diabetes per 100,000 population (source: 2014 Maryland DHMH)

	• 170.9 cancer deaths in Harford County per 100,000 population (Source: 2012-2014 Vital Statistics) Direct measurement from 2015 CHNA suggests: • 1.7% of adult residents in Harford County diagnosed with stroke. • 7.4% adult residents in Harford County diagnosed with heart disease • 7.7% adults in Harford County report having been told by a practitioner that they have or had diabetes; 9.9% male, 7.3% female. This need was identified through the 2015 CHNA process.
Hospital Initiative	Living Well (Chronic Disease Self-Management Program) This initiative educates participants on self-management strategies to improve their health and quality of life living with chronic diseases. Better management of their chronic disease in turn will potentially have a positive impact on health care expenditures.
Primary Objectives	1) Work with the community PCPs to identify patients with chronic disease that would benefit from the self-management program. a. In person visits to local PCP offices for program information and participant criteria. b. Medical Staff Office distributes a blast fax of program times and locations to PCP's and specialty physician offices. c. Class information disseminated through social media, faith based community, Office on Aging, Maryland Health Matters and current events calendar. 2) Provide five classes per year with a 60% completion rate. Program to be offered multi dates, locations and times to maximum accessibility. a. To collaborate with Office on Aging and county library for class locations. 3) Facilitate program to help participants gain self confidence in their ability to control their symptoms and learn how their health problems affect their lives. a. Program includes: i. Ways to maintain strength flexibility and endurance ii. Managing medications iii. Dealing with frustration, fatigue, pain and isolation iv. Improving effective communication with family friends and health professionals. v. Healthy eating and stress reduction
Single or Multi-Year Initiative – Time Period	Multi-Year
Key Partners in Development and/or Implementation	UM UCH Community Outreach Harford County Office on Aging Harford County Libraries Harford County Parks and Recreation

	DHMH	
Outcomes (Include process and impact measures)	Data from this program must be submitted to Maintaining Active Citizens (MAC) who holds UM Upper Chesapeake Health's license to provide program. Data analysis includes: Number of workshops held: 5 Average participants per workshop: 12.8 Number of participants: 51 Number of participants completing program: 38 of 51 (75%) Female: 86% Male: 14% Chronic conditions: Hypertension: 45% Arthritis: 45% Chronic Pain: 33% Diabetes: 31% Depression or Mental Illness: 27% Lung Disease: 22% Heart Disease: 22% Cancer: 18% Stroke: 16% Osteoporosis: 12% 84% of participants had multiple chronic conditions. In the future we are looking for opportunities to directly correlate program participants and medical expenditures.	
Continuation of Initiative?	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $**8,779** of dollars	B. Direct Offsetting Revenue from Restricted Grants

Identified Need	Chronic Disease – Diabetes Diabetes is the sixth leading cause of death in Harford County. Harford County Data: • 249,215 in Harford County • 76.7% in Harford County = 191,127 adults, >18 years • 165.5 ED visits due to diabetes per 100,000 population (source: 2014 Maryland DHMH)

	• 10% of adults age 20 and above in Harford County have been diagnosed with diabetes = 17,145 (Source: County Health Rankings) • 44 adults in Harford County die annually from diabetes (2014 Vital Statistics) Direct measurement from 2015 CHNA suggests: • 7.7% adults in Harford County report having been told by a practitioner that they have or had diabetes; 9.9% male, 7.3% female. This need was identified through the 2015 CHNA process.	
Hospital Initiative	Diabetes Health Fair This initiative is aimed to educate individuals on the many ways diabetes affect their health and provides information on new technology, supplies, medications and educational programs.	
Primary Objectives	1) To increase awareness of new technology, medications and services to diabetics in the community providing them with increased opportunity to manage their disease more effectively. 2) To provide flu vaccines to the diabetic participants. According the CDC, if you have diabetes, you are three times more likely to be hospitalized from the flu and its complications than other people. 3) To familiarize the participants with the risks, causes, symptoms and treatments for the disease.	
Single or Multi-Year Initiative – Time Period	Multi-Year	
Key Partners in Development and/or Implementation	UM UCH Community Outreach UM UCH Diabetes & Endocrine Center Harford County Office on Aging	

Outcomes (Include process and impact measures)	• 116 adults attended a Diabetes Health Fair
	  • 10 blood pressures
	  • 8 Body Fat Analyses
	  • 9 A1C screenings
	  • 1 Flu Shot
	• A program evaluation was given to all participations.
	  • 18 evaluations were completed and returned.
	  • 100% responded that they plan to use the information received at the Health Fair to make improvements in their health.	

Continuation of Initiative?	Yes, UM UCH has a Center of Excellence for Diabetes, The center will continue to provide education to diabetics in the community through a Diabetes Health Fair.	
A. Total Cost of Initiative for Current Fiscal Year	A. Total Cost of Initiative $7,124 of dollars	B. Direct Offsetting Revenue from Restricted Grants

B. What Amount is from Restricted Grants/Direct Offsetting Revenue		

Identified Need	Chronic Disease – Obesity, including Nutrition According to the American Heart Association, about 1 in 3 American kids and teens are overweight or obese. The prevalence in obesity in children has more than tripled from 1971 to 2011. 17.5% males and 14.7% females; African American, 22.6% males and 24.8 females. Harford County Data: • 250,105 in Harford County (County Health Ranking) • 77% in Harford County = 192,581 adults, >18 years (County Health Rankings) • 40.6% of adults in Harford County are at a healthy weight (not overweight or obese) (Source: 2014 BRFSS) • 30% of adults that report a BMI of 30 or more in Harford County = 57,338 adults (Source: County Health Rankings) • 9.1% of children and adolescents are obese in Harford County. (Source: 2013 Maryland Youth Risk Behavior Survey) Direct measurement from 2015 CHNA suggests: • 10.3% adults in Harford County report eating 3 or more daily servings of fruits in the past 30 days. • 9.4% adults in Harford County report eating 3 or more daily servings of vegetables in the past 30 days. • 32.3% adults in Harford County reporting eating fast food in the past 30 days more than once a week sometimes, most of the time or always. • 13.6% adults in Harford County report drinking regular soda or pop that contains sugar in the past 30 days at least once per day. • 13.8% adults in Harford County report drinking sugar-sweetened fruit drinks (such as Kool-aid) in the past 30 days at least once per day. This need was identified through the 2015 CHNA process.
Hospital Initiative	Days of Taste This initiative aims to educate at-risk elementary school children to appreciate the taste and benefits of fresh food by introducing them to the basic elements of taste and teaching them about food's journey from farm to table. To bring together chefs, farmers and volunteers in the community with kids for hands-on activities both in the classroom and at local farms. This 3 day program includes: • Day 1: Taste and Nutrition Basics with a Chef - students will engage in fun activities to evaluate diverse foods and experience the four traditional elements of taste – salty, sour, bitter and sweet. The concept of balance in foods, for good nutrition and good taste, will be introduced.

	• Day 2: Trip to the farm – students will visit a local working farm and will be guided by the farmer to see first-hand how vegetables are grown and/or how animals are raised, and how the food is prepared for delivery to the market. • Day 3: Preparing Salad and Dressing with the Chef: Back in the classroom, students will revisit the concepts of sour, salty, bitter and sweet ingredients as they make their own farm-fresh salad and vinaigrette dressing with the Chef using many of the vegetables they saw on the farm.	
Primary Objectives	1) To introduce at risk children in Harford County to healthy eating and nutrition. 2) To reduce childhood obesity.	
Single or Multi-Year Initiative – Time Period	Multi-Year	
Key Partners in Development and/or Implementation	Healthy Harford Harford County Public Schools Chef Sherifa Clark of Laurrapin Grill	

Outcomes (Include process and impact measures)	• Five title one schools in Harford County participated is a 3 day curriculum which introduced at-risk children to concepts of nutrition, growing seasons, and healthy eating.
	  • These 5 title one schools contain the zip codes of the most vulnerable areas in Harford County.
	  • Havre de Grace Elementary School (21078)
	  • Abindgon Elementary School (21009)
	  • Joppatowne Elementary School (21085)
	  • Edgewood Elementary School (21040)
	  • Roy Williams Elementary School (21078)
	• 250 fifth grade children participated in the program.	

Continuation of Initiative?	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative 3,702 of dollars	B. Direct Offsetting Revenue from Restricted Grants

Identified Need	Tobacco Use 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. Harford County Data: • 250,105 in Harford County (County Health Ranking) • 77% in Harford County = 192,581 adults, >18 years (County Health Rankings) • 15% of adults smoke (source: 2016 County Health Rankings) • 20.2% of adolescents who used any tobacco produce in the last 30 days (source: 2013 Maryland Youth Risk Behavior Survey) • Rate of second hand smoke exposure is 5.2% (Source: 2008 BRFSS) • 102 adults in Harford County die annually from chronic lower respiratory disease (2014 Vital Statistics) • 56 ED visits for asthma per 10,000 of population (source: 2009 Maryland Family Health Administration DHMH) • 20.2% of children in Middle School that have ever been diagnosed with asthma. (2010 Maryland Governor's Office for Children) • 22.3% of children in High School that have ever been diagnosed with asthma. (2010 Maryland Governor's Office for Children) Direct Measurement from 2015 CHNA suggests: • 10% adults smoke • 3.75% adults use electronic cigarettes sometimes, most of the time or always. • 16.4% adults exposed to second hand smoke or vaping mist at home or work sometimes, most of the time or always. • 1.7% adults have been told by a doctor, nurse or other health profession that they have COPD. • 15.8% adults have been told by a doctor, nurse or other health profession that they have asthma. This need was identified through the 2015 CHNA process.
Hospital Initiative	Smoking Cessation Classes
Primary Objectives	1) To reduce tobacco use among community members through offering free evidence-based interventions and nicotine replacement therapies via group model with specially trained smoking cessation counseling. This will lead to ultimate goal of lower risks of diseases associated with tobacco use. 2) To reduce tobacco use for patients undergoing cancer treatment to improve symptoms, quality of life, and treatment outcomes.
Single or Multi-Year Initiative – Time Period	Multi-Year

<table>
<tr><td>Key Partners in Development and/or Implementation</td><td colspan="2">Kaufman Cancer Center
Harford County Health Department</td></tr>
<tr><td>Outcomes (Include process and impact measures)</td><td colspan="2">

63 individuals registered for the program
39 individuals attended at least 3 sessions
22 individuals received patches
3 individuals received gum
6 individuals received patches and gum
9 individuals received patches and lozenges

<table>
<tr><th></th><th>Quit at end of class</th><th>Quit at 3 months</th><th>Quit at 6 months</th></tr>
<tr><td>Session 1</td><td>57%</td><td>57%</td><td>50%</td></tr>
<tr><td>Session 2</td><td>67%</td><td>20%</td><td>20%</td></tr>
<tr><td>Session 3</td><td>42%</td><td>20%</td><td></td></tr>
</table>
</td></tr>
<tr><td>Continuation of Initiative?</td><td colspan="2">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.</td></tr>
<tr><td>A. Total Cost of Initiative for Current Fiscal Year
B. What Amount is from Restricted Grants/Direct Offsetting Revenue</td><td>A. Total Cost of Initiative
$9,108 of dollars</td><td>B. Direct Offsetting Revenue from Restricted Grants</td></tr>
</table>

Identified Need	Mental Health/Addictions According to the National Council for Behavioral Health, one in four Americans experience a mental health or addition disorder each year. Harford County suicide mortality rates are significantly worse than the State average. Harford County Data: • 250,105 in Harford County (County Health Ranking) • 77% in Harford County = 192,581 adults, >18 years (County Health Rankings) • 1,673.6 ED visits in Harford County per 100,000 population for addictions-related conditions (Source: 2014 Maryland HSCRC) • 11.7 age-adjusted death rate per 100,000 population due to suicide. (2009 Maryland Assessment Tool for Community Health)

	This need was identified through the 2015 CHNA process.
Hospital Initiative	Mental Health First Aid Program This initiative aims to provide a Mental Health First Aid course to 130 participants that teaches individuals how to identify, understand and respond to signs of mental illnesses and substance use disorders. The course is 8 hours.
Primary Objectives	1) To educate participants about the signs and symptoms of specific illnesses like anxiety, depression, schizophrenia, bipolar disorder, eating disorders, and addictions. 2) To offer concrete tools and answers key questions like "What can I do?" and "Where can someone find mental health help?" 3) To introduce participants to local mental health professionals and resources, national organizations, support groups, and online tools for mental health and addictions treatment and support. Topics include: • What is Mental Health First Aid (MHFA)? • Mental Health Problems in the United States • Mental Health First Aid Action Plan • Understanding Depression and Anxiety • Mental Health First Aid Action Plan for Depression and Anxiety o *Suicidal Thoughts and Behavior* o *Symptoms of Depression* o *Non-suicidal Self-Injury* • Mental Health First Aid Action Plan for Depression and Anxiety o *Panic Attacks* o *Traumatic Events* o *Symptoms of Anxiety* • Understanding Psychosis • Mental Health First Aid Action Plan o *Psychosis* o *Disruptive or Aggressive Behavior* • Understanding Substance Use Disorders • Mental Health First Aid Action Plan o *Overdose* o *Withdrawal* o *Substance Use Disorders* • Using your Mental Health First Aid Training
Single or Multi-Year Initiative – Time Period	Multi-Year
Key Collaborators in Delivery of the Initiative	Healthy Harford

Outcomes (Include process and impact measures)	• Conducted 11 Mental Health First Aid training classes.
	  • 156 individuals participated in a Mental Health First Aid Training Class.
	  • 100% completion rate
	  • 100% received certification	

Continuation of Initiative?	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $**11,680** of dollars	B. Direct Offsetting Revenue from Restricted Grants

Identified Need	Access to Care Harford County Data: • 250,105 in Harford County (County Health Ranking) • 77% in Harford County = 192,581 adults, >18 years (County Health Rankings) • 9% of adults in Harford County could not see a doctor due to cost = 17,201 adults • 10.4% of population cannot afford to see an M.D. (source: BRFSS 2008-2010) This need was identified through the 2015 CHNA process.
Hospital Initiative	Comprehensive Care Center (CCC) This initiative is a transitional program that delivers individualized care to patients frequently utilizing the Emergency Department, have repeat readmissions, or have not had a primary care visit in the last 12 months. The program focuses on addressing the barriers to care for these identified patients. Support will include follow-up phone calls and or home visits, medication reconciliation, care coordination and education regarding disease management.
Primary Objectives	1) To decrease emergency department visits and/or in-patient admissions for patients who frequently utilize the ED and have repeat readmissions. 2) To assist individuals who frequently utilize the ED and have repeat readmissions by coordinating communication between them and their health care team including primary care providers, specialists and appropriate social services.

<table>
<tr><td></td><td>3) To assist patients with connecting to services and or programs that will assist them in better managing their health and well-being.</td></tr>
<tr><td>Single or Multi-Year Initiative – Time Period</td><td>Multi-Year

Ongoing</td></tr>
<tr><td>Key Partners in Development and/or Implementation</td><td>UM UCH
Beacon Health Center
West Cecil Health Center
Harford County Health Department
Office on Aging
Ashley Treatment Center
Shop Rite Pharmacy
Harford County Community Services
Meals on Wheels
Harford County Transit
Department of Social Services
Welcome One Homeless Shelter
Upper Bay Counseling
Key Point Health Services
Alliance
Community PCP’s
Mental Health Providers
Harford County Food Banks</td></tr>
<tr><td>Outcomes (Include process and impact measures)</td><td>1,811 individual patients were seen in the Comprehensive Care Center with 8,000 patient visits (encounters).

Data available is for first 10 months (July through April) of FY16:

<table>
<tr><td></td><td colspan="2">Patients</td><td></td><td></td></tr>
<tr><td></td><td>*Pre (90d)</td><td>**Post (90d)</td><td>Visits Saved</td><td>Total Saved</td></tr>
<tr><td>Inp/Obs Visits</td><td>1,293</td><td>356</td><td>937</td><td>$ 1,344,403</td></tr>
<tr><td>ED Visits</td><td>1,117</td><td>471</td><td>646</td><td>$ 82,688</td></tr>
<tr><td>Total</td><td>2,410</td><td>827</td><td>1,583</td><td>$ 1,427,091</td></tr>
</table>
*90 days prior to Comprehensive Care Center referral
**90 days post Comprehensive Care Center services</td></tr>
<tr><td>Continuation of Initiative?</td><td>Yes</td></tr>
<tr><td>A. Total Cost of Initiative for Current Fiscal Year
B. What Amount is from Restricted Grants/Direct Offsetting Revenue</td><td>A. Total Cost of Initiative
$275,462</td><td>B. Direct Offsetting Revenue from Restricted Grants</td></tr>
</table>

Identified Need	Maternal and Child Health Harford County Data: • 250,105 in Harford County (County Health Ranking) • 77% in Harford County = 192,581 adults, >18 years (County Health Rankings) • 4.4 infant mortality rate per 1,000 live births. (Source: 2014 Maryland DHMH Vital Statistics Administration) • 10.7 infant mortality rate per 1,000 African American births • 67% of Harford County pregnant women receive prenatal care beginning in the first trimester. (source: 2014 Maryland DHMH Vital Statistics Administration) • 149% increase in newborn exposure to drugs/alcohol over the past 15 years for Harford County resident. (Source: 2000-15 HSCRC Hospital Data) • 29.4 rate of newborns per 1,000 born with maternal drug/alcohol exposure in Harford County. (Source: 2000-2015 HSCRC Hospital Data) This need was identified through the 2015 CHNA process.
Hospital Initiative	Healthy Mom/Healthy Baby The initiative aims to get substance using pregnant woman into prenatal care and/or substance abuse treatment during their pregnancy.
Primary Objectives	1) To develop a formal referral process for OB/GYN doctors and substance use treatment programs to refer pregnancy woman for proper care during their pregnancy. 2) To increase and assure that the substance exposed infant is properly observed and treated after birth. 3) To deliver healthier substance exposed infants.
Single or Multi-Year Initiative – Time Period	Multi-Year Ongoing
Key Partners in Development and/or Implementation	Family Birth Place Harford County OB Practices Ashley Addiction Treatment Addition Recovery Services (ARS) MedMark Treatment Center (MAT) Harford County Health Department Office of Drug Control Policy

Outcomes (Include process and impact measures)	Referral process in effect as of August 2016. No data at this time.	
Continuation of Initiative?	Yes	
C. Total Cost of Initiative for Current Fiscal Year D. What Amount is from Restricted Grants/Direct Offsetting Revenue	C. Total Cost of Initiative $2,096	D. Direct Offsetting Revenue from Restricted Grants

Identified Need	Illness and Injury Prevention Harford County Data: • 249,215 in Harford County • 76.7% in Harford County = 191,127 adults, >18 years • 14.1% in Harford County = 35,031 adults age 65 and older • 58.5% of adults 65+ report having influenza vaccine in past 12 months (2006-2012 BRFSS) • 63.3% of children had a seasonal flu vaccination in the last 12 months (Source: 2010 BRFSS) Direct measurement from 2015 CHNA suggests: • 65.5% have had a flu vaccine within the past year This need was identified through the 2015 CHNA process.
Hospital Initiative	Community Flu Clinics This initiative aims to improve access to flu vaccinations for children and adults, with an emphasis on the Senior population throughout Harford County free of charge or at a minimal cost.
Primary Objectives	1) To increase the number of community residents that receive an annual flu vaccination. 2) To increase the communities awareness of the need for an annual flu vaccination.
Single or Multi-Year Initiative – Time Period	Multi-Year
Key Partners in Development and/or Implementation	UM UCH Community Outreach
Outcomes (Include process and impact measures)	Flu vaccinations were made available at 40 locations throughout the County, including all six Senior Centers.

	1,459 children and adults received a flu vaccination or flu mist.	
Continuation of Initiative?	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. 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

Identified Need	Illness and Injury Prevention: 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. Harford County Data: • 250,105 in Harford County (County Health Ranking) • 77% in Harford County = 192,581 adults, >18 years (County Health Rankings) This need was a direct request from Harford County Public Schools.
Hospital Initiative	Hand Washing This initiative aims to educate 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.
Primary Objectives	1) 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.
Single or Multi-Year Initiative – Time Period	Multi- Year
Key Partners in Development and/or Implementation	UM UCH Community Outreach Harford County Public Schools

Outcomes (Include process and impact measures)	The Glo Germ Program was presented at 7 schools throughout Harford County. A program evaluation was sent to each school. 33% completed a feedback survey. 100% stated the program had an immediate positive impact on their students' hand washing habits. 238 children participated in the Glo Germ Program.	
Continuation of Initiatives?	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $1,200 of dollars	B. Direct Offsetting Revenue from Restricted Grants

Identified Need	Illness and Injury Prevention According to the National Highway and Traffic Safety Administration, 75% of all car seats are installed incorrectly. Harford County Data: • 250,105 in Harford County (County Health Ranking) • 77% in Harford County = 192,581 adults, >18 years (County Health Rankings) • Children ages 0-4 are 5 times less likely to be injured in a crash if they are in a property installed child restraint. (Source: 2008-2010 KISS Crash Data) This need was identified through the 2015 CHNA process.
Hospital Initiative	Child Safety Seat Program This initiative aims to provide free child safety seat inspection events up to 12 per year. At these events, participants will be educated on how to properly install the

	child safety seat as well as how to property restrain the child in the safety seat or with a seat belt.	
Primary Objectives	1) To offer monthly child safety seat inspection events serving >60 families per year. According to Safe Kids Worldwide, correctly installed child safety seats reduce the risk of death by as much as 71%.	
Single or Multi-Year Initiative – Time Period	Multi-Year	
Key Collaborators in Delivery of the Initiative	UM UCH Community Outreach Maryland Kids in Safety Seats (KISS) Heart to Hart Harford County Sheriff's Department	
Outcomes (Include process and impact measures)	95 child safety seats/restraints were checked for proper installation and safety. 100% of the participants were provided education on proper installment of child safety seats/restrains and able to demonstrate proper installation and use.	
Continuation of Initiative?	Yes	
C. Total Cost of Initiative for Current Fiscal Year D. What Amount is from Restricted Grants/Direct Offsetting Revenue	C. Total Cost of Initiative $**2,710** of dollars	D. 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

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APPENDIX II

New Financial Assistance Policy Changes Pursuant to the ACA

ACA Health Care Coverage Expansion Description

Since implementation of the Affordable Care Act's (ACA) Health Care Coverage Expansion Option became effective on January 1, 2014, there has been a decrease in the number of patients presenting to the hospital in either uninsured and/or self-pay status. Additionally, the ACA's Expansion Option included a discontinuation of the primary adult care (PAC) which has also reduced uncompensated care. While there has been a decrease in the uncompensated care for straight self-pay patients since January 1, 2014, the ACA's Expansion Option has not completely eradicated charity care as eligible patients may still qualify for such case after insurance.

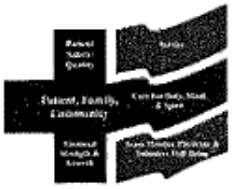
The following additional changes were also made to the hospital's financial assistance policy pursuant to the most recent 501(r) regulatory requirements:

1. **LANGUAGE TRANSLATIONS**
    a. Requirement: The new 501(r) regulations lowered the language translation threshold for limited English proficient (LEP) populations to the lower of 5% of LEP individuals in the community served/1000-LEP individuals. University of Maryland Upper Chesapeake Health (UM UCH) translated its financial assistance policy into the following languages: English; Spanish.

2. **PLAIN LANGUAGE SUMMARY**
    a. Requirement: The new 501(r) regulations require a plain language summary of the FAP that is clear, concise, and easy for a patient to understand. UM UCH created a new plain language summary of its financial assistance policy in addition to its already-existing patient information sheet.

3. **PROVIDER LISTS**
    a. Requirement: The new 501(r) regulations require each hospital to create and maintain a list of all health care providers (either attached to the FAP or maintained as a separate

appendix) and identify which providers on that list are covered under the hospital's FAP and which providers are not. UM UCH maintains that list which is available for review.



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. Payments made for care received during the financial assistance eligibility window that exceed the patients determined responsibility will be refunded if that amount exceeds $5.00
    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. The financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.
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

Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted.

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 Manager 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. In rare cases, accounts may warrant Extraordinary Collection Actions (ECAs). Once an account has met the following criteria, the account is closed by the collection agency as "uncollectible" and forwarded back to Patient Accounting for review to establish grounds for legal action. UCH reserves the right to place a lien on a patient's income, residence and/or automobile. This only occurs after all efforts to resolve the debt have been exhausted.

    Criteria:
    i. The debt is valid
    ii. The account is equal to or greater than 120 days old
    iii. Patient refuses to acknowledge the debt
    iv. Upon review and investigation, we have determined liquid assets are available (checking, savings, stocks, bonds or money market accounts)

v. The VP of Finance must authorize legal action

Action will be preceded by notice 30 days prior to commencement. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

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: 04/2016

ORIGIN DATE: 10/2010

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 HMH Contact: 443-843-5000 Option 34

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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

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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.sss