COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

FY2017 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

Union Hospital of Cecil County
106 Bow Street
Elkton, MD 21921

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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.

As provided by federal regulation (26 CFR §1.501(r)—3(b)(6)) and for purposes of this report, a **COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)** report is a written document that has been adopted for the hospital facility by the organization's governing body (or an authorized body of the governing body), and includes:

(A) A definition of the community served by the hospital facility and a description of how the community was determined;

(B) A description of the process and methods used to conduct the CHNA;

(C) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in

identifying certain health needs as significant; and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and

(F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

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 & Roadmaps (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;
(15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/); and
(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 address health needs identified by the CHNA.

Required by federal regulations, the **IMPLEMENTATION STRATEGY** is a written plan that is adopted by the hospital organization's governing body or by an authorized body thereof, and:

With respect to each significant health need identified through the CHNA, either—
(i) Describes how the hospital facility plans to address the health need; or
(ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address it.

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 total number of licensed beds

   b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;

   c. Primary Service Area (PSA) zip codes;

   d. Listing of all other Maryland hospitals sharing your PSA;

   e. The percentage of the hospital's uninsured patients by county. (Please provide the source for this data, e.g., "review of hospital discharge data");

   f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data (e.g., "review of hospital discharge data.")

   g. The percentage of the hospital's patients who are Medicare beneficiaries. (Please provide the source for this data (e.g., "review of hospital discharge data.")

Table I

Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area zip codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. % Hospital's Patients who are Uninsured:	f. % Hospital's Patients who are Medicaid Recipients:	g. % Hospital's Patients who are Medicare Beneficiaries
118 beds; 84 licensed	Total Inpatients: 5,445 Cecil County Inpatients: 4,785	21921 21901 21916 21920 21915 21914 21911	None	All Uninsured visits: 1.7% Cecil County Uninsured visits: 1.1%	All Medicaid visits: 27.2% Cecil County Medicaid visits: 24.3%	All Medicare visits: 51.4% Cecil County Medicare visits: 46%

Note: Percentages were calculated out of the Total Inpatients figure.

Source: Hospital patient data

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 (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.

(iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., 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).

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/Pages/home.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 Chart Book 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 (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.	21901, 21902, 21903, 21904, 21911, 21912, 21913, 21914, 21915, 21916, 21917, 21918, 21918, 21920, 21921, 21930 The majority of patients come from Elkton (21921) and North East (21901). People that reside in the zip codes below the C&D Canal (21912-Warwick, 21915-Chesapeake City, 21913-Cecilton, 21919-Earleville, and 21930-Georgetown) as well as south of Rising Sun and west of North East (21902-Perry Point, 21903-Perryville, 21904-Port Deposit, 21914-Charlestown, 21917-Colora, and 21918-Conowingo) often have the most difficulty accessing services because of distance to the nearest service provider and/or lack of reliable transportation. Geography plays a significant role in vulnerability for poverty in Cecil County. There is poverty in the more rural areas, like Conowingo, Earleville, and Cecilton, but also in Elkton which is more urban-rural.	*Claritas, Inc. 2017. A Nielsen product, part of the Healthy Communities Institute portal for Cecil County.* *https://www.uhcc.com/about-us/community-benefit/cecil-county-health-data/*
Median Household Income within the CBSA	$66,396	*US Census Bureau, 2011-2015 American Community Survey 5-year Estimates, Selected Economic Characteristics*
Percentage of households in the CBSA with household income below the federal poverty guidelines	6.8%	*US Census Bureau, 2011-2015 American Community Survey 5-year Estimates, Selected Economic Characteristics*
Percentage of Uninsured in CBSA	7.9%	*US Census Bureau, 2011-2015 American Community Survey 5-year Estimates, Selected Economic Characteristics*

Percentage of Medicaid recipients by County within the CBSA.	30.4%	*US Census Bureau, 2011-2015 American Community Survey 5-year Estimates, Selected Economic Characteristics*
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	In 2015, life expectancy at birth in Cecil County was: • All races: 77.1 years (Maryland: 79.5 years) • Whites: 77.2 years (Maryland: 80.2 years) • Black/African Americans: 73.9 years (Maryland: 77 years)	*Maryland DHMH Vital Statistics Administration, Maryland Vital Statistics: Annual Reports, 2015. Pg. 67 and 68, Tables 6 and 7.* *http://dhmh.maryland.gov/vsa/Pages/reports.aspx*
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx	Mortality – Infants In Cecil County the infant mortality rate was 6.8 deaths per 1,000 live births: • Non-Hispanic White: 7.1 deaths per 1,000 live births • All other race and ethnic breakouts were less than 5 deaths per 1,000 live births (statistically unreliable) Mortality – Deaths In Cecil County there were 952 deaths: • Non-Hispanic White: 870 deaths • Non-Hispanic Black: 69 deaths • Non-Hispanic American Indian: 2 death • Non-Hispanic Asian or Pacific Islander: 4 deaths • Hispanic: 7 deaths Mortality – Cause of Death In Cecil County the leading causes of death were: • Diseases of the Heart: 233 deaths White: 214 deaths Black: 17 deaths Asian/Pacific Islander: 2 deaths Hispanic: 1 death • Malignant Neoplasms: 216	*Maryland DHMH Vital Statistics Administration, Maryland Vital Statistics: Annual Reports, 2015. Pg. 1271, Table 33.* *http://dhmh.maryland.gov/vsa/Pages/reports.aspx* *Maryland DHMH Vital Statistics Administration, Maryland Vital Statistics: Annual Reports, 2015. Pg. 146, Table 39.* *http://dhmh.maryland.gov/vsa/Pages/reports.aspx* *Maryland DHMH Vital Statistics Administration Jurisdiction Data: Cecil County Deaths, 2015. Pg. 4-7, Table 15.* *http://dhmh.maryland.gov/vsa/Pages/reports.aspx*

	deaths White: 202 deaths Black: 13 deaths Asian/Pacific Islander: 1 death Hispanic: 1 death • Chronic Lower Respiratory Disease: 69 deaths White: 66 deaths Black: 3 deaths Asian/Pacific Islander: 0 deaths Hispanic: 0 deaths • Cerebrovascular Diseases: 53 deaths White: 47 deaths Black: 6 deaths Asian/Pacific Islander: 0 deaths Hispanic: 0 deaths	
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://ship.md.networkofcare.org/ph/county-indicators.aspx	Access to Care BRFSS data from 2011-2012 indicates that 11.24% of adults aged 18+ years did not have a regular source of primary care in Cecil County. Data from the Area Health Resource File (American Hospital Association) for 2013 indicates that there were 44 total primary care providers (PCPs) in Cecil County. During that time, the ratio of the Cecil County population to PCPs was 2,316:1. Access to Healthy Foods – Grocery Stores vs. Fast Food Restaurants Data from 2015 shows that there were 16.81 grocery stores per 100,000 population (convenience stores and superstores excluded) and 59.34 fast food restaurants per 100,000 population in Cecil County.	*BRFSS, 2011-2012 (data is from the CHNA profile for Cecil County on the Community Commons portal). Indicator: Lack of a Consistent Source of Primary Care. www.CommunityCommons.org)* *County Health Rankings: Cecil County, Primary Care Physicians, 2013. http://www.countyhealthrankings.org/app/maryland/2016/measure/factors/4/data* *US Census Bureau, Business Register, County Business Patterns, 2015 (data is from the CHNA profile for Cecil County on the Community Commons portal). Indicators: Food Access - Grocery Stores; Food Access - Fast Food Restaurants.*

		www.communitycommons.org)
	Access to Healthy Foods – Food Deserts and Food Insecurity In 2015 in Cecil County, 42.11% of the census tracts contained food deserts: • Central Elkton (Tracts 305.03 and 305.05) • Central North East, all of Charlestown, and eastern Perryville (Tract 309.06) • Earleville, Cecilton, and Warwick (Tract 301)	*USDA, Food Access Research Atlas (FARA), 2015 (data is from the CHNA profile for Cecil County on the Community Commons portal). Indicator: Food Access – Food Desert Census Tracts. www.communitycommons.org)*
	In 2015 in Cecil County: • 9,620 people were food insecure (9.4% food insecurity rate) • 33% of food insecure people were above the SNAP threshold of 200% of poverty level • 68% of food insecure people were below the SNAP threshold	*Feeding America, Map the Meal Gap, 2017. http://map.feedingamerica.org/*
	Physical Activity Maryland BRFSS data from 2013 shows that that 39.1% of adults engaged in moderate to vigorous physical activity per week.	*Maryland BRFSS, 2013 (data is from the Healthy Communities Institute portal for Cecil County). Indicator: Adults Engaging in Regular Physical Activity https://www.uhcc.com/about-us/community-benefit/cecil-county-health-data/*
	Obesity Maryland BRFSS data from 2015 shows that 16.9% of adults aged 18 years or older were obese in Cecil County (reported a BMI of 30 or greater). There was an 18% reduction in adult obesity from 2014-2015.	*Maryland BRFSS, 2015 (data is from the Healthy Communities Institute portal for Cecil County). Indicator: Adults who are Obese. https://www.uhcc.com/about-us/community-benefit/cecil-county-health-data/*
	Youth Risk Behavior Survey data from 2014 shows that 14.1% of adolescents (aged 12-19 years) were obese.	*Youth Risk Behavior*

		Survey, 2014 (data is from the Healthy Communities Institute portal for Cecil County). Indicator: Adolescents who are Obese. *https://www.uhcc.com/about-us/community-benefit/cecil-county-health-data/*
	<u>Poor Nutrition</u> Maryland BRFSS data from 2010 shows that only 16.4% of adults aged 18 years and older consumed 5 or more servings of fruits and vegetables each day.	*Maryland BRFSS, 2010 (data is from the Healthy Communities Institute portal for Cecil County). Indicator: Adult Fruit and Vegetable Consumption.* *https://www.uhcc.com/about-us/community-benefit/cecil-county-health-data/*
	<u>Tobacco Use</u> Maryland BRFSS data from 2015 shows that 17.5% of adults aged 18 years or older smoked in Cecil County (a 5% increase from 2014).	*Maryland BRFSS, 2015 (data is from the Healthy Communities Institute portal for Cecil County). Indicator: Adults who Smoke.* *https://www.uhcc.com/about-us/community-benefit/cecil-county-health-data/*
	Data from the 2014 Maryland Youth Tobacco Survey shows that 16.7% of Cecil County high school teens smoked.	*Maryland Youth Tobacco Survey, 2014 (data is from the Healthy Communities Institute portal for Cecil County). Indicator: Teens who Smoke: High School Students.* *https://www.uhcc.com/about-us/community-benefit/cecil-county-health-data/*
	Data from the 2014 YRBS showed that 25.2% of Cecil County adolescents used tobacco products.	*YRBS, 2014 (data is from the Healthy Communities Institute portal for Cecil County). Indicator: Adolescents who Use Tobacco.* *https://www.uhcc.com/ab*

	Education Data from the 2016 Maryland Report Card shows that 90.65% of Cecil County's 2016 high school cohort graduated high school in four years. The 2016 drop-out rate was 7.48% (a nearly 2% rate reduction from 2015). Data from 2011-2015 shows that 12.11% of Cecil County adults aged 25 years and older had no high school diploma or equivalency: • 26.74% resided in a neighborhood in central Elkton • 25.68% resided in an area comprised of northern North East, southeast Rising Sun, and the eastern tip of Port Deposit Transportation Data from 2011-2015 shows that 5.4% of Cecil County households did not have a vehicle. Violent Crime In 2015, Cecil County's violent crime rate was 357.5 crimes committed per 100,000 population.	*out-us/community-benefit/cecil-county-health-data/* *Maryland Report Card, 2016. Indicators: Graduation Rate: 4-Year Adjusted Cohort and Drop-Out Rate: 4-Year Adjusted Cohort (Class of 2016, Cecil County). http://reportcard.msde.maryland.gov/Graduation.aspx?K=07AAAA#DROPOUTgrade5all* *US Census Bureau, American Community Survey, 2011-2015 (data is from the CHNA profile for Cecil County on the Community Commons portal). Indicator: Population with No High School Diploma (Age 25+), Percent by Tract. www.communitycommons.org)* *US Census Bureau, American Community Survey, 2011-2015 (data is from the Healthy Communities Institute portal for Cecil County). Indicator: Households without a Vehicle. https://www.uhcc.com/about-us/community-benefit/cecil-county-health-data/* *Maryland Governor's Office of Crime Control and Prevention, Uniform Crime Report, 2015 (data is from the Healthy Communities Institute portal for Cecil County) https://www.uhcc.com/about-us/community-benefit/cecil-county-*

	Environmental Hazards Annual ozone air quality for Cecil County was measured at a level of 5 from 2013-2015. State of the Air 2017 assigned Cecil County's ozone with a grade of F (on a grading scale of A-F) with red ozone days or "unhealthy" air quality days. Particle Air Pollution during a 24-hour period was assigned a grade of B with purple ozone days or "very unhealthy" air quality days. Particle Pollution annually has a grade of "Pass." On September 27, 2017 at 3:45 pm the air quality index for Metro Baltimore was 49 (green = good). Particle pollutants (PM2.5) were scored at 28 (green = good).	*health-data/* *American Lung Association, 2013-2015 (data is from Healthy Communities Institute portal for Cecil County). Indicator: Annual Ozone Air Quality. https://www.uhcc.com/about-us/community-benefit/cecil-county-health-data/* *State of the Air, American Lung Association, 2017 http://www.lung.org/our-initiatives/healthy-air/sota/city-rankings/states/maryland/cecil.html?referrer=http://www.lung.org/our-initiatives/healthy-air/sota/city-rankings/states/maryland/cecil.html* *AIRNow, Maryland Department of the Environment, 2017. https://airnow.gov/index.cfm?action=airnow.local_city&zipcode=21921&submit=Go*
Available detail on race, ethnicity, and language within CBSA.	Population: 101,960 people Gender Male: 50,644 (49.7%) Female: 51,316 (50.3%) Age Under 5 years: 5,928 (5.8%) 5-9: 6,817 (6.7%) 10-14: 7,110 (7%) 15-19: 7,123 (7%) 20-24: 6,549 (6.4%) 25-34: 11,606 (11.4%) 35-44: 13,227 (13%) 45-54: 16,243 (15.9%) 55-59: 7,911 (7.8%) 60-64: 5,981 (5.9%) 65-74: 8,224 (8.1%)	*US Census Bureau, 2011-2015 American Community Survey 5-year Estimates, ACS Demographic and Housing Estimates and Selected Social Characteristics in the United States*

	75-84: 3,807 (3.7%) 85 +: 1,434 (1.4%) <u>Median Age</u>: 40.1 years <u>Race</u> White: 90,625 (88.9%) Black/African American: 6,891 (6.8%) American Indian & Alaska Native: 234 (0.2%) Asian: 1,313 (1.3%) Native Hawaiian and other Pacific Islander: 22 (0%) Some other race: 951 (0.9%) 2+ races: 1,924 (1.9%) <u>Ethnicity:</u> Hispanic/Latino: 3,984 (3.9%) Non-Hispanic/Latino: 97,976 (96.1%) <u>Language Spoken at Home</u> Population 5 years and over: • Only English: 95% • Spanish: 2.1% • Other Indo-European: 2% • Asian/Pacific Islander: 0.7% • Other languages: 0.2%	

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Within the past three fiscal years, has your hospital conducted a Community Health Needs Assessment that conforms to the IRS requirements detailed on pages 1-2 of these Instructions?

__X__Yes	Provide date approved by the hospital's governing body or an authorized body thereof here: 02/01/2015
____No	Planning the CHNA occurred from February 2015 – June 2015. Primary data collection occurred from July 2015 – September 2015 via focus groups and administration of an online community survey. Analysis of primary and secondary data collected occurred from November 2015 through mid-January 2016. Data was presented to the Community Health Advisory Committee (CHAC) member organizations on January 21, 2016 for priority selection and again on March 16, 2016 to start building the Community Health Improvement Plan (CHIP) to address the health priorities chosen in January. The CHNA report was prepared and finalized from January 2016 – June 2016.

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).

2. Has your hospital adopted an implementation strategy that conforms to the IRS requirements detailed on pages 3-4?

_X__Yes	Enter date approved by governing body/authorized body thereof here: 02/01/2015
___No	The Union Hospital Board approved to conduct the CHNA/CHIP process in February 2015 – this was when the CHNA planning team started planning for the CHNA/CHIP. In addition to the hospital board's approval, the CHNA planning team (Union Hospital and the Cecil County Health Department) received approval from CHAC member organizations in July 2016.

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

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.

a. Are Community Benefits planning and investments part of your hospital's internal strategic plan?

___Yes
_X__No

If yes, please provide a specific description of how CB planning fits into the hospital's strategic plan. If this is a publicly available document, please provide a link here and indicate which sections apply to CB planning.

While Community Benefit can be applied to and/or work in conjunction with the Service Access and Care Management components of the strategic plan, it is not formally referenced or integrated into the plan. It should be noted that the hospital's strategic plan language changed between Fiscal Year 2015 and Fiscal Year 2016 and that the next rewrite will not occur until Fiscal Year 2019.

b. What stakeholders within 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. ____ CFO
3. _X__Other (CMO, CIO, CNO)

Describe the role of Senior Leadership.

The **CEO**, Chief Executive Officer, meets with leadership of community partner organizations to keep up collaborative momentum and connect the vision and strategies of Union Hospital's population health efforts with those efforts of the local community, as well as those efforts of partnering hospitals in other Maryland jurisdictions. The CEO updates the Community Benefit office on these collaborative efforts and together they work on how to draw out applications for Community Benefit, as well as how to strengthen and sustain current and future community partnerships.

The **CMO**, Chief Medical Officer, and the Community Benefit Coordinator meet regularly to discuss how to apply Community Benefit to the population health goals of the hospital through care management/coordination, service access, and community partnership building.

The **CIO**, Chief Innovations Officer, works with Community Benefit on data applications used for creating service access through community care coordination efforts involving telehealth and other data-driven health care innovations. The CIO also works with Community Benefit on connecting the dots between Community Benefit initiatives and hospital population health efforts.

CNO, Chief Nursing Officer, keeps a pulse on Community Benefit and how Nursing can be more fully integrated into Community Benefit initiatives, programs, and activities.

ii. Clinical Leadership

1. _X__Physician
2. _X__Nurse
3. _X__Social Worker
4. _X__Other (please specify)

Describe the role of Clinical Leadership

Physician. Community Benefit works with physicians and extenders to provide community health education opportunities, primarily through speaking engagements, health fairs, and free screenings. In addition to assisting with the coordination of these efforts, Community Benefit also utilizes the expertise from the Provider Services and Medical Staff Office, the Cancer Program Director, and the Registered Dietitians with the hospital's outpatient Medical Nutritional Services and Diabetes Center to provide access to community health education opportunities and free screenings.

Nurse. Community Benefit works with every Nurse Manager and Director to continue to identify and develop Community Benefit activities for staff to participate in and take ownership of. Community Benefit also meets with new supervisory hires to establish connections to community health resources and develop the conversation around what counts for Community Benefit, the "how-to" of developing activities, and identifying what strengths nursing staff can bring to the table for addressing the CHIP objectives.

Other. Community Benefit works with the Case Management via weekly Long-Stay Patient meetings where patient cases are discussed and community support plans are crafted. Staff attending these meetings includes the: Manager of Case Management, Nurse Case Managers, Emergency Department Case Managers, Readmissions Case Manager, Licensed Clinical **Social Worker**, Ambulatory Case Manager, and Ambulatory Nurse Practitioner. Community Benefit attends to brainstorm community support plan strategies for long-stay patients to overcome social barriers, how to access social services and resources, how to obtain and keep caregiver support, and how to sustain self-management of disease when linked to community support programs.

iii. Population Health Leadership and Staff

1. ____ Population health VP or equivalent (please list)
2. __X__ Other population health staff (please list staff)

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

Union Hospital does not have a designated Population Health office, but the following staff work on Population Health strategies managed by different committees, projects, and partner affiliations: the CEO, CMO, CIO, CNO, VP of Physician Enterprise, Regional Director of Behavioral Health, Case Management, all employed practices, the Comprehensive Care Center, and other staff that are called on to promote and implement initiatives for Population Health.

Community Benefit works with senior leadership and supporting staff on a number of initiatives including, but not limited to: a) effective access to care strategies (i.e., establishing a plan for a crisis stabilization service built on community partnerships); b) building health literacy in underserved communities; and c) promoting telehealth capabilities in the management and monitoring of chronic conditions in a community/home setting.

The Community Benefit Coordinator also serves on committees for readmissions, patient education, WATCH program (HSCRC Transformational Grant program), and health literacy.

iv. Community Benefit Operations

1. _X__Title of Individual(s) (please specify FTE) Community Benefit Coordinator (1 FTE)
2. ___Committee (please list members)
3. _X__Department (Community Benefit Coordinator)
4. ___Task Force
5. _X__Other (please describe) Director of Marketing (0.05 FTE)

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

The **Community Benefit Coordinator**, located in the **Community Service department** (1 staff) performs the following functions:

- Tracks, reports, and evaluates Community Benefit activities in accordance with national standards and public reporting requirements
- Manages CBISA
- Analyzes and interprets a variety of health, economic, and social data
- Directs and supports work teams in planning Community Benefit activities
- Leads hospital in assessing the community's health needs, developing and managing community outreach initiatives, and measuring and reporting program accomplishments and results
- Develops and oversees implementation of initiatives and policies to further Union Hospital's Community Benefit priorities and strategic objectives
- Participates in efforts to identify, prioritize, measure, and track mission integration goals and strategies
- Promotes and facilitates community outreach partnership development and collaborative planning
- Prepares the HSCRC Report and the IRS Schedule H
- Writes grants to support population health initiatives
- Serves on several community health task forces and coalitions; current co-chair for CHAC, the Cecil County Local Health Improvement Coalition

The **Director of Marketing** serves in a supervisory role (0.05 FTE) to the Community Benefit Coordinator. She is available to answer questions and brainstorm ideas. The Community Benefit Coordinator has a robust connection to internal and external hospital communications. The Community Benefit Coordinator works closely with

the Director of Marketing to communicate pertinent Community Benefit information to hospital staff, collaborative service line partners, affiliated organizations, and community partners engaged in improving population health.

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

Spreadsheet	_____yes	__X___no
Narrative	_____yes	__X___no

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

Note: While there is not an internal audit, Union Hospital does undergo an external audit of hospital financials, which includes a review of the Community Benefit HSCRC Report, the Community Health Needs Assessment, and the IRS Schedule H. The external audit is completed by Baker Tilley. Community Benefit works with Deron Brown, Director of Accounting, to compile and submit the information for Baker Tilley. The external audit is signed off on by James Raab, interim Chief Financial Officer (CFO).

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

If no, please explain why.

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

___X___Yes _____No

If yes, please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

Community Benefit is referenced in Appendix A: Executive Summary of the FY 2016 Hospital Strategic Transformation Plan as part of the Population Health. Four strategies are listed for population health:

1) Develop or acquire the infrastructure needed to identify, prioritize, and monitor targeted populations;
2) Develop an ambulatory care management system in collaboration with other providers;
3) Develop/adopt a risk stratification tool to help measure effectiveness of interventions for targeted populations; and

4) Develop community wellness and health literacy programs.

Community Benefit is indirectly referenced in Section 5, where collaboration with other partners is given to provide the context for how each strategy will be implemented. For all population health strategies, the Cecil County Health Department is described as an "integral partner in the conduction of the Community Health Needs Assessment and Community Health Improvement Plan, especially in its role as main support for the Cecil County Local Health Improvement Coalition." Community Benefit partners with the health department every three years to conduct the Community Health Needs Assessment and create the resulting Community Health Improvement Plan. The Community Benefit Coordinator also co-chairs the Local Health Improvement Coalition with the health department.

Additional description in Section 5 directly references Community Benefit through the following:

> "For Strategy 4, Union Hospital will utilize support from: … the Community Benefits program, which facilitates external community health programs in partnership with a variety of community partners, through program development and shared programming support. Shared programming support refers to Union Hospital making referrals to community health programs or working together with community organizations to facilitate access to care, care coordination efforts, health education, and other assistance, especially among the most vulnerable and underserved in the community."

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

__X___Other hospital organizations

__X___Local Health Department

__X___Local health improvement coalitions (LHICs)

__X___ Schools

__X___Behavioral health organizations

__X___Faith based community organizations

__X___Social service organizations

___X__Post-acute care facilities

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct a CHNA. Provide a brief description of collaborative activities indicating the roles and responsibilities of each partner and indicating the approximate time period during which collaborative activities occurred (please add as many rows to the table as necessary to be complete).

Organization	**Name of Key Collaborator**	**Title**	**Collaboration Description**
Cecil County Health Department	Dan Coulter	Health Policy Analyst & Accreditation Specialist	Together, Dan and Jean-Marie Kelly (Community Benefit Coordinator) worked to: collect, analyze, and interpret the CHNA's primary and secondary health data; conduct the focus groups; facilitate both CHAC meetings and applicable breakout sessions which yielded the selection of health priorities and the strategies to address them; gather public feedback ; and write and finalize the CHNA and CHIP reports. They both will continue to monitor progress on the CHIP. In addition, Dan serves as the partner Co-chair of CHAC alongside Jean-Marie.
Cecil County Health Department	Stephanie Garrity	Health Officer	Stephanie provided oversight to the CHNA/CHIP processes and provided support for the CHNA planning team. Stephanie secured resources to conduct the focus groups for the CHNA. She made sure the Health Department leadership was cooperative with process deliverables. She also made sure that CHNA information was received by CHAC member organizations.
Cecil County Health Department	Robin Waddell	Deputy Health Officer	Robin provided insight for the CHNA/CHIP processes and supported the CHNA planning team. Robin also assisted with the facilitation of both CHAC meetings.
Cecil County Health	Gregg Bortz	Public Information	Gregg provided the link to communications for the community via

Department		Officer	press releases and posting information on the Health Department's website to support the CHNA/CHIP processes.
Cecil County Community Health Advisory Committee (CHAC)	See the list below of member organizations	Member organizations	The member organizations participated in two CHAC meetings and several breakout sessions to select priority health issues and create strategies to address them. CHAC serves as the county's Local Health Improvement Coalition (LHIC).

CHAC Member Organizations

Affiliated Santé Group (Mobile Crisis)
American Cancer Society
Cecil County Dept of Emergency Services
Cecil County Dept of Juvenile Services
Cecil County Dept of Social Services
Cecil County Director of Administration
Cecil County Executive Office
Cecil County Health Dept
Cecil County Liquor Board
Cecil County Public Schools
Cecil County Sheriff's Office
County Council Members
DHMH - Office of Population Health Improvement
Cecil College
Cecil County Dept of Community Services
Cecil County Dept of Corrections
Cecil County Housing
Deep Roots
Elkton Community Kitchen
Elkton Housing Authority
Maryland State Delegates
Maryland State Senators
Meadow Wood Behavioral Health System
Private Citizens
Private Education Organizations
Private Health Care Professionals
Seventh Day Adventist Church
Union Hospital of Cecil County
Upper Bay Counseling & Support Services
West Cecil Health Center
Youth Empowerment Source
Immaculate Conception
Meeting Ground
On Our Own of Cecil County
Paris Foundation
Serenity Health
Stone Run Family Medicine
WIN Family Services

Elkton Police Department YMCA

Elkton Presbyterian Church

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

__X___yes _____no

If the response to the question above is yes, please list the counties for which a member of the hospital organization co-chairs the LHIC.

Cecil County, MD

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

__X___yes _____no

If the response to the question above is yes, please list the counties in which a member of the hospital organization attends meetings or is a member of the LHIC.

Cecil County, MD

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Please use Table III to provide a clear and concise description of the primary need identified for inclusion in this report, 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.

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

a. 1. Identified need: This may have been identified through a CHNA, a documented request from a public health agency or community group, or other generally accepted practice for developing community benefit programs. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include a description of the collaborative process used to identify common priority areas and alignment with other public and private organizations.

2. Please indicate how the community's need for the initiative was identified.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based community health improvement initiatives may be found on the CDC's website using the following links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/), or from the County Health Rankings and Roadmaps website, here: http://tinyurl.com/mmea7nw. (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 or other negative health factor 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,

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. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.

h. Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.

Describe here the measure(s)/health indicator(s) that the hospital will use to evaluate the initiative's impact. The hospital shall evaluate the initiative's impact by reporting (in item "i. Evaluation of Outcome"):

(i) Statistical evidence of measurable improvement in health status of the target population. If the hospital is unable to provide statistical evidence of measurable improvement in health status of the target population, then it may substitute:

(ii) Statistical evidence of measureable improvement in the health status of individuals served by the initiative. If the hospital is unable to provide statistical evidence of measureable improvement in the health status of individuals served by the initiative, then it may substitute:

(iii) The number of people served by the initiative.

Please include short-term, mid-term, and long-term population health targets for each measure/health indicator. These should be monitored and tracked by the hospital organization, preferably in collaboration with appropriate community partners.

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? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the

short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)

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? If not, why? 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, and grants associated with the fiscal year being reported.
B. Of the total costs associated with the initiative, what amount, if any, was provided through a restricted grant or donation?

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples: the fact that another nearby hospital is focusing on that identified community need, or that the hospital does not have adequate resources to address it.) This information may be copied directly from the section of the CHNA that refers to community health needs identified but unmet.

Health Needs Identified but Not Prioritized	**Rationale**
Access to care (incl. addressing special populations, like children and the disabled, the lack of Primary Care Providers, the lack of quality care in the emergency department, and the lack of providers outside of Elkton, Maryland)	Access to care may be addressed in all health priority areas. Historically, access to care for children has been the specific responsibility of specialized children's hospitals, like Nemours, or through youth specific programs facilitated through the Cecil County Health Department or through Medicaid-based programs. This is also the case for disabled persons. Their access issues are addressed through the Department of Community Services. The lack of primary care providers can stem from a recruitment and retention problem, one that Cecil County currently suffers from. Service providers, like Cecil County Health Department and Union Hospital, look to state agencies, like the State Office of Rural Health for support in financing and finding primary care providers to bring into the county. However, this is an ongoing and very difficult issue to solve. There are many factors at play in the recruitment and retention of primary care providers for Cecil County. This also applies to the lack of providers outside of Elkton. The lack of quality care in the emergency department (ED) was brought up during the

	homeless focus group and was based on sentiments that staff are not accepting of homeless persons or the fact that compliance is difficult to maintain due to their social circumstances. This issue is currently being addressed as the hospital works to enhance standard of care with cultural competencies.
Dental health	Dental health is a major problem in Cecil County with dwindling resources to support existing programs that serve vulnerable populations. A large factor in providing dental care, especially in the low-income and Medicaid populations, is financial backing. Processes are currently in place to strengthen dental care supports in this community. As this is a larger systematic issue, it was not included in the list of health priorities for the county. However, the risk factors that lead to poor dental health may be included in strategies to support the chronic conditions.
Problem gambling	Problem gambling is not as widely a recognized health issue in Cecil County as it is in areas with many casinos or avenues to encourage excessive gambling. Still, resources do exist to intervene at the personal level with problem gambling, including counseling services.
Cancer	Lung cancer is actually being addressed as part of the Respiratory/Lung disease health priority. The Union Hospital Cancer Program will also be creating a radiation suite where Maryland Medicaid patients (a large portion of the Union Hospital cancer patient population) can receive covered radiation services. This was a barrier that was identified during the last cancer needs assessment and is currently being addressed in the Cancer Program's strategic plan. There are also other cancer supports available in this community, which include: breast, colon, and cervical cancer supports through the Cecil County Health Department; county-wide fundraisers promoted by the Union Hospital Cancer Program and Breast Center that help support patients without access to basic needs during treatments; and many free and reduced-cost cancer screenings offered by Union Hospital in partnership with area physicians and oncologists, like skin cancer, prostate cancer, head and neck cancer, and low-dose lung CT screenings.
High blood pressure	High blood pressure may be addressed as part of the Chronic Disease health priority for heart disease/stroke.

Obesity	Obesity may be addressed as part of the Chronic Disease health priority for heart disease/stroke, diabetes, and/or respiratory/lung disease.
Tobacco use	Tobacco use may be addressed as part of the Chronic Disease health priority for heart disease/stroke and/or respiratory/lung disease.
Infectious diseases (incl. Hepatitis)	Infectious diseases (communicable diseases) were not chosen by CHAC because there are already programs in place through the Cecil County Health Department to address them. Also the disease burden is not large in Cecil County.
Vaccination	There are already programs in place, facilitated by the schools, the Cecil County Health Department, Union Hospital, and physician practices, that offer either free vaccinations or support to obtain them, as well as emphasize the importance of getting vaccinated.
Outdoor health impediments (incl. Lyme disease, deer tick bites, allergies, skin rashes, and muscle/body aches)	These were health issues that were brought up during the focus group with the migrant workers. Because of their outdoor, manual labor they are more prone to these outdoor health impediments. Through a quick assessment of free resources available through the Cecil County Health Department, the CHNA planning team was able to provide education materials on how to prevent these health impediments moving forward.
Environmental health	Environmental health was not a feasible priority to take on due to lack of available resources.
Injuries – Falls	Falls prevention is currently being worked on between several service providers: the Cecil County Health Department, Union Hospital, and the Department of Community Services.
Injuries – Fire-arm, Motor vehicle/pedestrian	Prevention of fire-arm injuries falls to law enforcement, and the prevention of motor vehicle/pedestrian injuries falls to the Department of Transportation.
Maternal/infant health	Maternal and infant health could be addressed through the Chronic Disease and/or the Behavioral Health priorities if applicable to the CHIP strategic planning process.
Sexually Transmitted Infections (STIs)	Local non-profit organization programs, like the Boys and Girls Club's SMART Moves program, work with youth to remain abstinent so as to avoid contraction of STIs. In addition, the Cecil County Health Department is currently focusing on the rise of Chlamydia and Gonorrhea in Cecil County. Union Hospital and the health department are also working local physicians on having youth under 26 years old vaccinated with Gardasil to prevent the

	spread of HPV and to prevent the onset of cervical and head and neck cancers.
Teenage pregnancy	Teenage pregnancy is addressed by the Cecil County Health Department, the health curriculum in public and private schools, and the Cecil County Pregnancy Center. Churches and other non-profit programs also play a large role in reducing teenage pregnancy in the county.
Child abuse and neglect	There is currently a Cecil County task force for Child Maltreatment Prevention. This task force focuses on strengthening family supports, promoting positive parenting, and spreading awareness of child abuse prevention in the county by working with various family service partners and health and social service supports.
Domestic violence	Domestic violence is a large issue in Cecil County. Current resources addressing this issue include the domestic violence shelter, a part of the Department of Social Services, and local law enforcement.
Homicide	Homicide is addressed by local and state law enforcement in Cecil County. Agencies and health care services do partner with law enforcement to support these efforts as premature death impacts all health outcomes.
Rape/sexual assault	Rape/sexual assault are addressed by the Department of Social Services, the Department of Emergency Services, Union Hospital, and local law enforcement.
Suicide prevention	Suicide is most frequently addressed through inpatient and outpatient programs in the community, mediation services like Eastern Shore Mobile Crisis, Upper Bay Counseling Services, and hot- and warm-lines providing real-time interventions to those at-risk for suicide. While it may stand alone statistically, suicide prevention could be incorporated into access to behavioral health services or addressing the mental health landscape of Cecil County (part of the Behavioral Health priority).
Barriers to Care Identified but Not Prioritized	**Rationale**
Income	Income issues may be addressed as part of the Determinants of Health priority for poverty and homelessness.
Employment	Employment issues may be addressed as part of the Determinants of Health priority for poverty and homelessness.

Health insurance availability and cost	There are currently programs in place through the Maryland Health Connection and Seedco which help Marylanders obtain health insurance through Medicaid and with subsidies for qualified health plans based on need.
Transportation	Transportation will continue to be an issue in Cecil County. CHAC is aware of this issue and will work to incorporate this to help overcome barriers within the health priorities selected.
Health care costs (incl. high cost of medications and co-pays)	There are several programs in the county that can assist with the high costs of health care, including medication costs and co-pays. Some examples include: the Union Hospital Community Assisted Medication Program (CAMP), the Union Hospital Cancer Program community outreach support, many outreach programs at the Cecil County Health Department, local pharmacy assistance programs, and the Department of Community Services assistance programs through MAPP, options counseling, and Community First Choice.
Home Health eligibility	Home Health eligibility can be processed by programs that assist persons with the application process (ex. the county Department of Community Services).
Politics	Cecil County politicians are active in facilitating connections in the health care field. While politics may not be a focused barrier to address through the CHNA, politicians are included as thought leaders and advocates for the health priorities that have been selected.
Lack of knowledge (incl. low health literacy, lack of access to health information)	Health literacy may be addressed in all three priority areas.
Public assistance qualifications	Public assistance qualifications, like Home Health eligibility and health insurance costs, can be addressed through support agencies like the Cecil County Health Department, the Department of Community Services, the Department of Social Services, and the certified health insurance navigators through Seedco and the Maryland Health Connection.
Need for more medical and social supports	There will always be a need for more medical and social supports, but as discussed in previous rationales, there is quite a strong infrastructure for providing these supports. Clients have to seek out these supports or ask agencies how to access help.
Affordable housing	Affordable housing is a large barrier in Cecil County, especially among the poor and low-income. Some aspects of affordable housing may be addressed through the Determinants of Health priority for poverty/homelessness.

Language barriers	Language barriers can be addressed through the use of interpreters. Most programs in the county have access to medical and social interpreters or contracted interpreter services. If access is a problem then there is opportunity to partner with organizations that have these resources. For patients or clients having trouble with language barriers there is opportunity for organizations to provide materials in other languages and/or hire or borrow professionals that can speak other languages.
Time limitations	Time limitations were specifically referenced during the migrant worker focus group. Due to long working hours on the farms and the limited amount of health care services in the areas below the canal in Cecil County (Chesapeake City, Earleville, Cecilton, and Warwick), the migrant workers voiced that there were not enough doctors' offices open into the evening hours. This makes it more difficult for them to access needed services, especially for pediatric care. While this was not specifically selected as a determinant of health, it is something that Union Hospital and other health and social services continuously work to improve upon. However, this is not the responsibility of any one service provider. In some cases, and in some underserved areas of the county, there must be a collaborative effort to provide health care services to those whose access is limited on a perpetual basis.

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

   Community Benefit is heavily involved in the work being done in population health with the Maryland SHIP process. The Community Benefit Coordinator is the co-chair of Cecil County's Local Health Improvement Coalition (LHIC) which: a) oversees progress made on the core SHIP measures for Cecil County established by the Maryland Department of Health; and b) fosters collaboration between member community leaders and partnering organizations in order to build and implement strategies that can improve population health for Cecil County.

   The Community Benefit Coordinator is a public health professional who understands the importance of population health improvement alignment between Union Hospital, the Cecil County Health Department, and other service agencies caring for patients and community alike. Alignment is primarily reflected in how the Community Health Needs Assessment (CHNA) process is conducted and how the Community Health Improvement Plan (CHIP) is implemented – the Community Benefit Coordinator and health department leadership support process alignment between Union Hospital state and IRS Community Benefit reporting requirements and the health department's Public Health Accreditation Board requirements. The CHNA is conducted and CHIP implemented during the same 3-year cycle using collaborative/shared monetary and in-kind resources. This alignment helps the hospital-health

department collaboration create and sustain unity in the county for improving population health. In addition, alignment helps Community Benefit rally hospital leadership to support population health efforts in the community and connect applicable community partners to hospital population health efforts.

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

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.

   The analysis is provided in Table IV under "Physician Recruitment to Meet Community Need" and "Subsidized Health Services."

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	N/A
Non-Resident House Staff and Hospitalists	N/A
Coverage of Emergency Department Call	N/A
Physician Provision of Financial Assistance	N/A
Physician Recruitment to Meet Community Need	Outpatient specialties that provide the greatest recruitment challenges for Union Hospital are Dermatology (0 owned providers, 2 private practice providers), Neurology (1 owned provider, 1 private practice provider), and Psychiatry (1.5 owned providers, 1 private practice organization). While there are no dermatologists in Cecil County, there are two private practice plastic surgeons, Dr. Thornton and Dr. Scheiner who can provide some dermatological care. Beth Money, Director of the Union Hospital Cancer Program, also asks Dr. Thornton to provide free skin cancer screenings for the community at Union Hospital. Neurologists treat a multitude of conditions related to the nervous system. In Cecil County, Union Hospital serves large patient populations seeking care for chronic pain, dementia, Alzheimer's, and stroke. Therefore, having access to neurologists is a much needed resource. Union Hospital has not been successful

	in recruiting additional neurologists with the departure of Dr. Singhania in Fiscal Year 2014 and Dr. Moghal in Fiscal Year 2015. Dr. Mahmood is currently the only Union Hospital outpatient neurologist. Dr. Melnick is the only private practice outpatient neurologist in Cecil County. Each covers for the other when one is out of town. While Union Hospital continues to build-up its behavioral health service lines, outpatient psychiatry by far presents the largest recruiting challenge for Union Hospital. In Fiscal Year 2016, Dr. Galvis began working solely with outpatients and has even taken on patients from Dr. Yu's practice (Dr. Yu left during Fiscal Year 2016). Union Hospital also recruited Dr. Ahmed who sees outpatients in a part-time capacity.
Subsidized Health Services (hospital outpatient practices operating at a loss)	Union Hospital continues to subsidize permanent outpatient services despite financial losses that are incurred. These services include: Gastroenterology, Primary Care, Vascular, Urology, Rheumatology, Neurology, and Outpatient Psychiatry. Losses and financial assistance write-offs for these services are recorded under category C3-Hospital Outpatient Services. With increasing rates for prostate and colon cancers it is necessary to have enough providers to meet the needs of this community. In addition, Cecil County lacks a sufficient number of primary care providers which serve as the first point of contact for new patients seeking to manage their care appropriately, as well as serving as the go-to contacts to manage care alerts, advocate for connection to community health resources, and serve as the patient's advocate and support structure to prevent potentially avoidable utilization (PAU) of hospital services and readmissions. Cecil County is seeing an increase in PAU and readmissions especially for chronic conditions. Therefore, it is vitally important to have primary care providers available and at the ready to provide care for the Cecil County population, especially as it is becoming more aged, poor, and is developing many more chronic conditions.

VI. 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;
- 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).

APPENDIX I

Description of Financial Assistance Policy

Union Hospital of Cecil County utilizes a Financial Assistance Policy to ensure that the Hospital's staff follows a consistent and equitable process in granting financial assistance to appropriate patients, while respecting the individual's dignity. The policy is in agreement with the established Maryland State Financial Assistance Guidelines.

The policy describes the application process for the Financial Assistance Program, the information required to verify income and assets, the timeline for application review and tiered adjustments based on Federal Poverty Guidelines.

The application for Financial Assistance is available to all underinsured and uninsured patients of Union Hospital. Applications and signage are located throughout the Hospital, emergency room, and outpatient areas. The Financial Assistance application and brochure (in English and Spanish) are available on the hospital's website: https://www.uhcc.com/patient-financial-services/financial-assistance/. In addition, the hospital places an advertisement once a year in the local newspapers outlining its financial assistance policy.

All Financial Assistance applications received are processed for eligibility. Patients who are not eligible for financial assistance are referred to the Cecil County Health Department to determine if other assistance is available. Any individual who presents to Union Hospital in person to discuss his/her bill is provided with a Financial Assistance application. All inpatient self-pay patients are visited by financial assistance navigators and are screened for the Financial Assistance Program, as well as for Medicaid and other state and county programs. Following discharge from the hospital, each patient receives a summary of charges which includes notice of the Financial Assistance Program and a designated contact telephone number and email.

APPENDIX II

Description of Changes to Financial Assistance Policy

In Fiscal Year 2015, Union Hospital's Finance department divisions of Managed Care, Revenue Cycle, and Billing began working on changes to the Financial Assistance Policy (FAP) to reflect the ACA's Health Care Coverage Expansion Option effective January 1, 2014. The resulting new FAP is much more comprehensive in that it includes more descriptions, patient expectations, and content that is easy to follow and digest. The previous FAP was narrative based, but also very short in length and in description of component parts.

The new FAP has additional sections that give the policy more depth, but also provide clear-cut instructions and examples for the reader. Additional sections include:

- Definitions
- Scope
- Presumptive Eligibility
- Eligibility Period
- Reconsideration of Denial of Free or Reduced-Cost Care
- Medical Debt Determination (Limit on Charges)
- Action in the Event of Non-Payment
- Ensuring Compliance
- Plain Language Summary
- References

There are also sections in the new FAP which are more comprehensive in detail when compared to the previous FAP. These sections include:

- **General Procedure.** This section clearly defines patient expectations and offers a step-by-step process for patient application, document review, and request for more information. This section includes information on how the patient can be connected to other state programs, the Maryland Health Connection, and Medicaid. This section includes an additional adjustment not included in the previous FAP based on a patient's financial hardship if household income is up to 500% of the Federal Poverty Guidelines. Finally, this section includes approval levels granted once the application is completed.
- **Measures to Publicize this Policy.** This section includes the same language that is on Union Hospital's Financial Assistance website and gives many more ways to effectively access information related to the new FAP.

APPENDIX III

UNION HOSPITAL	The policies set forth do not establish a standard of care to be followed in every case. It is recognized that each case is different and those individuals involved in providing health care are expected to use their clinical judgment in determining what is in the best interests of the patient, based on the circumstances existing at the time. It is impossible to anticipate all possible situations that may exist and to prepare policies for each. Accordingly, these policies should be considered to be guidelines to be consulted for guidance with the understanding that departures from them may be required at times.

POLICY TITLE: Financial Assistance Policy and Procedure	
POLICY #: F-415	
Review Responsibility: Director, Patient Financial Services	
Approved By: Board of Directors	Signature/Date: May 27, 2016 Approval Reflected in Board Minutes
Effective: 03/2004	
Reviewed: 06/2004, 03/2006, 12/2008, 02/2009, 03/2009, 04/2010, 03/2013, 09/2014, 06/2015	
Revised: 03/2004 (replaces Charity Care Policy and Procedure), 06/2004, 09/2004, 03/2006, 12/2008, 02/2009, 04/2010, 08/2012, 09/2014, 06/2015	
Scope: Patient Financial Services	

I. Purpose

A. Union Hospital of Cecil County is a not-for-profit entity established to provide safe, high quality health and wellness services to the residents of Cecil County and neighboring communities. Accordingly, the hospital is committed to providing emergency and medically necessary services to patients, without discrimination, regardless of the patient's financial assistance eligibility.

B. This policy is to ensure that a consistent and equitable process is followed in granting financial assistance to appropriate patients while respecting the individual's dignity.

C. This policy is designed in accordance with the federal Patient Protection and Affordable Care Act (PPACA), Section 501(r)(4) of the Internal Revenue Service Code and Code of Maryland Regulations (COMAR) 10.37.10.26.A

II. Policy

A. Union Hospital of Cecil County is committed to providing programs that facilitate access to care for vulnerable populations including the provision of financial assistance (charity care) to the uninsured, underinsured, those ineligible for governmental insurance programs, or where the ability to pay is a barrier to accessing emergency or medically necessary care.

III. Definitions: The following terms are meant to be interpreted as follows within this policy:

1. **Emergency Care** – Emergency care is immediate care which is necessary to prevent serious jeopardy to a patient's health, serious impairment to bodily functions, and/or serious dysfunction of any bodily organ or part of the body as could reasonably be expected by the prudent layperson. See also 42 US Code § 1395dd.

2. **Financial Counselor** – A financial counselor is an employee of Union Hospital who provides assistance to patients seeking information regarding patient billing, financing, health coverage options including financial assistance.
3. **Financial Hardship** – A financial hardship as defined in COMAR 10.31.26.A is medical debt, incurred by a family over a 12-month period that exceeds 25 percent of the family income.
4. **Free Care** – Free care or a 100% medical debt adjustment is available to patients with household income between 0% and 200% of the Federal Poverty Level (FPL) and who otherwise meet the requirements to receive financial assistance under this policy.
5. **Gross Charge** – Gross charge is the full amount of the bills for a medical service.
6. **Homelessness** – Homelessness is an "individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing" (42 U.S.C. § 254b).
7. **Household Income** – As provided in the cost assistance guidelines under PPACA, the amount equal to the Modified Adjusted Gross Income (MAGI) of the head of household and spouse plus the Adjusted Gross Income (AGI), of anyone claimed as a dependent based on most recent tax return with additional updates as appropriate.
8. **Household Size** – Household size is defined per Internal Revenue Service guidelines and generally includes the tax filer, spouse and tax dependents.
9. **Medical Debt -** A medical debt is the amount a patient is responsible for paying after all discounts, deductions, and reimbursements are applied to the gross charges for services provided.
10. **Medically Necessary Services** – A medically necessary service is care rendered to a patient in order to diagnose, alleviate, correct, cure, or prevent the onset of a worsening of conditions that could endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate handicap, or result in overall illness or infirmity and based on generally accepted standards of medicine in the community.
11. **Presumptive Eligibility for Financial Assistance** – Presumptive eligibility for financial assistance is provided for a patient who is the beneficiary/recipient of means-tested social programs as defined in COMAR 10.37.10.26 and as listed in this policy.
12. **Reduced-Cost Care -** Reduced-cost care is a pro-rated medical debt adjustment available to patients with household income between 200% and 400% of the Federal Poverty Level (FPL) and who otherwise meet the requirements to receive financial assistance under this policy.
13. **Underinsured Patient** – An underinsured patient is one who has limited healthcare coverage or third-party assistance that leaves the patient with an out-of-pocket liability, and therefore may still require assistance to resolve their medical debt.
14. **Uninsured Patient** – An uninsured patient is one with no insurance or third-party assistance to help resolve their medical debt.

IV. Scope

A. This policy applies to medical debt incurred for emergency or medically necessary services, inpatient or outpatient, rendered at the hospital or its affiliates by the following owned entities:
- Union Hospital of Cecil County;
- Union Multi-Specialty Practices;
- Union Urgent Care;
- Union Diagnostic Centers;
- Open MRI of Elkton; and
- Union Radiation Oncology Center.

B. This policy applies to medical debt incurred for emergency or medically necessary services, inpatient or outpatient, rendered at the hospital by the following contracted physician entities:
- Maryland Emergency Physicians (MEP);
- Physician Inpatient Care Specialist (MDICS);
- Nemours Pediatric Hospitalists.

C. This policy does not apply to any other provider of care rendering services at Union Hospital or its affiliates, to include but not limited to, independent physicians who provide primary or consultation services that operate as their own business entity.
- These services are generally billed separately from hospital services and are excluded.

V. General Procedure

A. Patient shall make application for financial assistance using the Maryland State Uniform Financial Assistance Application form through a financial counselor.
1. If appropriate, the financial counselor may take the application orally.
2. A financial counselor may request verification of income to include:
   - Pay stubs, unemployment benefits, Social Security checks, cash assistance checks, alimony or child support checks;
   - Federal and State Income Tax Returns;
   - Two recent bank statements or financial records;
   - Proof of U.S. citizenship or permanent residency;
   - Proof of address;
   - Proof of screening for either Maryland Medicaid or a Qualified Health Plan with a patient navigator (if uninsured);
   - Proof that employer does not offer a health plan.
3. The patient is expected to cooperate with the timely completion and submission of all requested information.
   - If the patient does not provide complete verification of income within 30 days of the application, the request for financial assistance may be denied.

B. Patients receive financial counseling, referrals and assistance to identify potential public or private healthcare programs to assist with long term needs.
1. If uninsured, the patient will be provided assistance to determine Maryland Medicaid or Qualified Health Plan eligibility through the appropriate Maryland Health Connection connector entity or other qualified health insurance marketplace.

C. Union Hospital will use a household income-based eligibility determination and the current Federal Poverty Guidelines to determine if the patient is eligible to receive financial assistance.

1. The Federal Poverty Guidelines (FPL) are updated annually by the U.S. Department of Health and Human Services.
2. If the patient's household income is at/or below the amount listed below, financial assistance will be granted in the form of free care (a 100% adjustment) or reduced-cost care (25%-75% adjustment to their medical debt.
    - Household income up to 200% of FPL 100% Adjustment
    - Household income between 201% & 250% of FPL 75% Adjustment
    - Household income between 251% & 300% of FPL 50% Adjustment
    - Household income between 301% & 400% of FPL 25% Adjustment
3. Patients with household income up to 500% of FPL and with a financial hardship will receive a 25% adjustment.
4. A payment plan is available for all individuals eligible for financial assistance under this policy and for those with household income up to 500% of FPL, if requested.

D. Once the financial assistance application is complete, decisions regarding eligibility will be made within 15 business days with the following approvals:

1. < $ 5000.00 – approved by financial counselor;
2. $ 5000.00 to $ 9999.99 – approved by Director, Patient Financial Services;
3. > $10,000 – approved by Chief Financial Officer.

VI. Presumptive Eligibility

A. Presumptive Eligibility for Financial Assistance:
Patients who are beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free care upon completion of a financial assistance application, and proof of enrollment within 30 days (30 additional days permitted if requested):

1. Households with children in the free or reduced lunch program;
2. Supplemental Nutritional Assistance Program (SNAP);
3. Low-income-household energy assistance program;
4. Women, Infants and Children (WIC);
5. Other means-tested social services programs deemed eligible for free care policies by the Department of Health and Mental Hygiene (DHMH) and the Health Services Cost Review Commission (HSCRC), consistent with HSCRC regulation COMAR 10.37.10.26.

B. Presumptive eligibility for financial assistance will be granted under the following circumstances without the completion of a financial assistance application but with proof or verification of the situation described:

1. A patient that is deceased with no estate on file;
2. A patient that is deemed homeless;
3. A patient that presents a sliding fee scale or financial assistance approval from a Federally Qualified Health Center or Cecil County Health Department;

- Financial assistance will be awarded as outlined in the approval letter provided from that agency.

4. Non-billable services resulting from guardianship determinations for observation hours or inpatient days;
5. A patient that has been approved for Specified Low-Income Medicare Beneficiary (SLMB) programs after verification is made through the State system.

VII. Eligibility Period

A. Once eligibility for financial assistance has been established, the patient shall remain eligible for free or reduced-cost, emergency and medically necessary care during the 12-month period beginning on the date on which the initial episode of care occurred. If a patient returns to UHCC for treatment during their eligibility period, he/she may be asked to provide additional information to ensure that all eligibility criteria have been met.

B. At the conclusion of the eligibility period, the patient must re-apply for financial assistance.

C. If a patient enrolled in a health plan drops coverage without a qualified life change event taking place, the patient will not be able to apply for financial assistance.

1. If a qualified life event takes place, the patient will be able to apply for financial assistance if they are denied Medicaid and have been rescreened per Section V of this policy.

D. If within a two-year period after the date of service, the patient is found to have been eligible for free care on that date of service (using the eligibility standards applicable to that date of service) the patient shall be refunded amounts received from the patient/guarantor exceeding $5.00.

1. If documentation demonstrates lack of cooperation by the patient providing information to determine eligibility for financial assistance, the two-year period may be reduced to 30 days from the date of initial request for information.

E. If a patient has received reduced-cost, medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household shall remain eligible for reduced-cost, medically necessary care during the 12-month period beginning on the date on which the initial episode of care occurred.

VIII. Reconsideration of Denial of Free or Reduced-Cost Care

A. A patient who is denied financial assistance under this policy has the right to request reconsideration of that denial.

B. Upon request from the patient, the Chief Financial Officer, or designee, will review all components of the application and make the final determination of eligibility.

IX. Medical Debt Determination (Limit on Charges)

A. Financial assistance eligible individuals receiving emergency or medically necessary care will be charged less than gross charges for services. Gross charges will be reduced by one of the following percentages:

1. The 501(r)(4) Amount Generally Billed ("AGB") method for all services provided by affiliates other than the hospital.
    - In August of each year, the Amount Generally Billed percentage will be calculated utilizing the look-back method with Medicare fee-for-service claims from the previous fiscal year.
2. The COMAR 10.37.10.26.A method for all services provided by the hospital.
    - The hospital mark-up percentage as provided annually in the HSCRC rate order.

B. Each August, the applicable percentage described in IX.A of this policy will be updated on the Maryland Uniform Financial Assistance Application cover sheet and applied as a deduction to gross charges.

1. A financial assistance adjustment will be applied prior to the final determination of the patient's medical debt.

X. Balances Eligible for and Excluded from Financial Assistance

A. All self-pay balances, including self-pay balances after insurance payments, including copays, co-insurance and deductibles, may be eligible for consideration for Financial Assistance with the following exceptions:

1. Balances covered by health insurance.
2. Balances covered by a government or private program other than health insurance.
3. Balances for patients that would qualify for Medical Assistance, individual or family health coverage through the Maryland Health Connection or equivalent insurance marketplace, or through an employment-based health plan, but do not apply.
    - Applications received during a non-enrollment period, either through the Maryland Health Connection or through employment- based health care, that were not otherwise screened on a previous account, and that are deemed ineligible for Maryland Medicaid, may be allowed to apply on a case-by-case basis.
    - If the patient chooses not to elect health benefits offered by employer, or as an eligible dependent, or through the Maryland Health Connection, the patient will be deemed ineligible for financial assistance, but may be evaluated on a case-by-case basis for hardship or circumstances justifying lack of employer or Maryland Health Connection coverage.
4. Balances for patients who are not U.S. residents may be allowed after an administrative review and on a case-by-case basis as approved by the Chief Financial Officer or designee.
5. Balances on cosmetic surgery and other procedures that are considered elective and without which the patient's general health would not be adversely affected.
6. Balances for patients who falsify information on, or related to, the application.
7. Union Hospital of Cecil County reserves the right to evaluate applications with special or extenuating circumstances on a case-by-case basis as approved by the Chief Financial Officer or designee.

XI. Action in the Event of Non-Payment

A. Union Hospital may contract with outside collection services to pursue collection of delinquent accounts. All unpaid accounts without exception or payment arrangements are placed in outside collection after a minimum of 90 days from the initial billing statement and delivery of all scheduled patient account statements to the patient/guarantor.

B. Union Hospital does not conduct, or permit collection agencies to conduct on their behalf, extraordinary collections efforts against individuals.

XII. Measures to publicize this policy

A. Information regarding the UHCC Financial Assistance Program and the availability of financial counseling is communicated broadly.

B. Financial assistance communications include, but are not limited to, the following:
   1. Statement of availability on financial consent form;
   2. Upon discharge from inpatient, observation or surgical services;
   3. On billing statements/invoices.
   4. On electronic or paper signs located at registration locations.

C. A patient can access this policy and a plain language summary through the following methods:
   1. Electronic copies are can be accessed on the Union Hospital of Cecil County Website at:
      - www.uhcc.com/About/Patients-Visitors/Admission/Financial-Assistance
   2. Paper copies are available:
      - By mail: Union Hospital of Cecil County
Patient Financial Services Department
106 Bow St.
Elkton, MD 21921
      - By Phone: 443-406-1337 or 410-392-7033
      - By E-mail: unionhospitalbilling@uhcc.com
      - Upon Request at the following locations:
        a. Outpatient Registration Department
        b. Emergency Department Registration
        c. Patient Financial Services Department
        d. Customer Service Department
   3. Union Hospital informs local public and community organizations that address the health needs of the community's vulnerable and low-income populations of this policy.

XIII. Ensuring Compliance

A. Each August, the Director of Patient Financial Services or designee, will perform an audit to include:
   1. A recalculation of the percentage discount from gross charges as described in IX.A of this policy;
   2. A random sampling of 25 billing statements from the prior fiscal year to ensure all required information is present;

3. A visit to each registration point within the hospital to ensure each location has updated financial assistance policies, applications and supporting materials;
4. An audit of the website to ensure that application and policy are easily accessible;
5. A review of current census data for the primary service area to ensure materials are available in additional languages spoken by greater than 5% of the population served.

XIV. Plain Language Summary

Consistent with its mission to provide safe, high quality health and wellness services to the residents of Cecil County and neighboring communities, Union Hospital of Cecil County and its affiliates are committed to providing free or discounted care to individuals who are in need of emergency or medically necessary treatment and have household income below 400% of the Federal Poverty Level (FPL) Guidelines. Individuals who are eligible for financial assistance will not be charged more than the average amounts generally billed to insured patients, for emergency or medically necessary care.

Financial counselors are available Monday through Friday, from 8:00am until 4:30pm to discuss the application process either in person at Union Hospital or via phone at 443-406-1337 or 410-392-7033.

Union Hospital will not pursue extraordinary collection actions against any individual.

For a free copy of the entire Financial Assistance Policy and/or an Application for Financial Assistance in English or Spanish, patients can:

- Visit the website at: www.uhcc.com/About/Patients-Visitors/Admission/Financial-Assistance
- Send a request by mail to: Union Hospital of Cecil County
Patient Financial Services Department
106 Bow St.
Elkton, MD 21921
- Request by calling 443-406-1337 or 410-392-7033
- Send a request by E-mail to unionhospitalbilling@uhcc.com
- Request in person at the following locations:
  - Outpatient Registration Department o Emergency Department Registration
  - Patient Financial Services Department
  - Customer Service Department

XV. References

A. Code of Maryland Regulations (COMAR) 10.37.10.26
B. Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010))
C. Department of Treasury, Internal Revenue Service Code 501(r)(4)
D. US Department of Health and Human Services: Federal Register and the Annual Federal Poverty Guidelines

E. US Code Title 42 Chapter 6A Subchapter II Part D Subpart I § 254b – Health Centers
F. US Code Title 42 Chapter 7 Subchapter XVIII Part E § 1395dd – Examination and treatment for emergency medical conditions and women in labor

XVI. Related Documents/Policies:

- Maryland State Uniform Financial Assistance Application

APPENDIX IV

Patient Information Sheet

The Patient Information Sheet requirements are included in the Union Hospital Patient Handbook which is provided to all patients at admission and discharge. The handbook is attached separately as Appendix IV-A – Patient Handbook. The handbook covers patient rights and responsibilities (PDF pgs. 13-14), privacy and information (PDF pg. 16), preparing for discharge (PDF pg. 17), and resources (PDF pgs. 18-19).

The following information is included in the *Financial Assistance Brochure* which can be found on the Union Hospital Financial Assistance website (https://www.uhcc.com/patient-financial-services/financial-assistance/). The brochure is also available in Spanish.

Community Assistance Program

The Community Assistance Program, as sponsored by Union Hospital of Cecil County, offers hospital services, as well as physician services at multi-specialty practices, at a reduced cost based on a patient's inability to pay. The Community Assistance Program is a patient centered program to help eliminate your fear and anxiety regarding your medical bills. The application process is simple and straightforward.

The Community Assistance Program is a consistent and equitable process designed to grant financial assistance to appropriate patients while respecting the individual's dignity. If approved, your balance will be adjusted between 25% - 100% based on Federal Poverty Guidelines. Eligibility shall include medical care for three months prior to, and continue for up a maximum of six months forward. To see if you qualify, just follow the steps below:

Guidelines for Eligibility

- If you are a US Citizen.
- If uninsured, under the Affordable Care Act, you must enroll in either Medicaid or enroll through your State's Health Connection to obtain insurance prior to applying for financial assistance through Union Hospital.
- If employed and uninsured you must enroll in an employment based health plan if available. If insurance is not available, you will need to enroll through your State's Health Connection.
- Meet income guidelines. Based upon Federal Poverty Guidelines.

Guidelines for Applying

The first step is to complete a Community Assistance Application and provide the following supportive documentation:

- 2 most recent copies of all pay stubs, unemployment benefits, social security checks, cash assistance checks, alimony or child support checks.
- 2 most recent copies of bank statements and/or financial records.
- Copy of Federal AND State Income Tax return, as well as W2.
- If uninsured, proof of enrollment for health insurance through your State's Health Connection, through your State for Medicaid, or if you or your spouse is employed, proof that the employer does not offer health insurance.
- Copy of letters of any awarded benefits you are currently receiving including: Food Stamps, TCA, or Energy Assistance.
- A letter of support (preferably notarized) if no evidence of income.

When all information is gathered, a Financial Counselor will do a preliminary review and verify your eligibility, at which time additional documentation may be requested by correspondence. Failure to provide the requested documentation within a specified time frame may result in your application being denied. If you need help applying for any State of Maryland programs, a representative is on site at Union Hospital to assist you. If you have any questions, please feel free to contact one of our Financial Counselors at 410-392-7033.

APPENDIX V

Union Hospital's Mission and Values

Union Hospital's mission and values statements identify the importance of providing safe, high-quality, personalized services to patients. Services are conducted by professionally trained staff who demonstrate collaboration and prudent management of the Hospital's resources.

Mission Statement

To provide safe, high-quality health and wellness services to the residents of Cecil County and neighboring communities.

Values Statement

Union Hospital strives to create and sustain a quality, caring and respectful environment for all patients. Through employee and patient relations, as well as the Hospital's provision of care, the following values are embodied:

Caring and Compassion

- Treating everyone with dignity and respect in a non-judgmental way
- Anticipating the needs of others and responding with a personal touch
- Giving undivided attention and practicing presence in all interactions
- Listening with empathy and understanding

Integrity

- Telling the truth
- Taking responsibility for all actions and words
- Having the courage to do what is right
- Following through on commitments

Leadership

- Being role models for all organizational values
- Creating solutions
- Being proactive and taking initiative
- Being open-minded and embracing change

Shared Learning

- Actively listening and taking the initiative to learn and grow
- Sharing knowledge, skills and experiences across all departments and within the community
- Encouraging and supporting peer learning

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

A. 1. Identified Need: A. 2. How was the need identified:	**Behavioral Health:** a) Illicit Drug Use/Problem Alcohol Use; b) Mental Health; and c) Access to Behavioral Health Care These Behavioral Health needs were identified through the FY15-FY16 Community Health Needs Assessment (CHNA) and strategies were created to address these needs through the Community Health Improvement Plan (CHIP). Union Hospital's improvement efforts will aim to address the following CHIP objectives: • 1.1.1: By June 30, 2019, reduce the drug induced death rate by 5% • 1.1.2: By June 30, 2019 reduce the percentage of youth in grades 9-12 reporting the use of alcohol on one or more of the past 30 days to no more than 33.8% • 1.2.1: By June 30, 2019, reduce the percentage of youth in grades 9-12 who felt sad or hopeless almost every day for 2 weeks or more during the past 12 months to no more than 24.8% • 1.3.1: By June 30, 2019, decrease the rate of emergency department (ED) visits related to mental health conditions by 10% and emergency department visits related to substance use disorders by 5% **Cecil County Data** **Illicit Drug Use** • The drug-induced death rate increased from to 26.5 deaths (2011-2013) to 30.5 deaths (2013-2015) per 100,000 population *(Maryland Vital Statistics Administration)* • In 2014, there were 2,165.7 ED visits per 100,000 population for substance use disorders, one of the highest county rates in Maryland *(HSCRC, Research Level Statewide Outpatient Data Files)* • In 2014, 15.5% of high school students reported taking prescription drugs without a doctor's prescription one or more times in their life *(Maryland Youth Risk Behavior Survey, Cecil County)* • In 2014, 4.2% of high school students reported using heroin one or more times during their life *(Maryland Youth Risk Behavior Survey, Cecil County)* **Problem Alcohol Use** • In 2015, 16.7% of adults reported binge drinking *(Maryland Behavioral Risk Factor Surveillance Survey)* • In 2014, 21.6% of high school students reported drinking more than 5 drinks in a row within a couple of hours on at least 1 day in a 30-day period *(Maryland Youth Risk Behavior Survey, Cecil County)* **Mental Health** • In 2014, there were 5,501.6 ED visits per 100,000 population for mental health conditions *(HSCRC, Research Level Statewide Outpatient Data Files)* • From 20017-2013, there were 13.9 suicide deaths per 100,000 population *(Bridged-Race Population Estimates and National Vital Statistics System-Mortality)* • In 2014, 22.1% of middle school students reported feeling sad or hopeless almost every day for two or more weeks in a row *(Maryland Youth Risk Behavior Survey, Cecil County)*

	• In 2014, 29.4% of high school students reported feeling sad or hopeless almost every day for two or more weeks in a row *(Maryland Youth Risk Behavior Survey, Cecil County)* • In 2014, 18.5% of high school students reported seriously considering attempting suicide in the last year *(Maryland Youth Risk Behavior Survey, Cecil County)* ○ In 2014, 15.7% of high school students reported making a plan to commit suicide in the last year *(Maryland Youth Risk Behavior Survey, Cecil County)*
B: Name of hospital initiative	<u>To address CHIP objective 1.1.1</u>: • Community Health Education: Neonatal Abstinence Syndrome (NAS) • Working with the Local Overdose Fatality Review Team (LOFRT) <u>To address CHIP objective 1.1.2</u>: • Working with the Maryland Strategic Prevention Framework 2 (MSPF2) <u>To address CHIP objective 1.2.1</u>: • Working with the Mental Health Core Services Agency (MHCSA) Advisory Council <u>To address CHIP objective 1.3.1</u>: • Working with the MHCSA Advisory Council • Working with the Crisis Intervention Team (CIT) • Peer Recovery Advocates program • Crisis Center

C: Total number of people within target population	<u>2016 Cecil County Population Estimates</u>
	• Total Population: 102,175
	  ○ Adults (18+ years): 78,128 (76.5%)
	  ○ Adolescents (10-14 years): 6,923 (6.8%)
	  ○ Adolescents (15-19 years): 6,750 (6.6%)
	
	Source: 2012-2016 American Community Survey, 5-Year Estimates, US Census Bureau, Sex and Age

D: Total number of people reached by the initiative	<u>In FY17</u>: • A total of **<u>905</u>** clients were served through hospital programs to reduce the burden of behavioral health issues in Cecil County. • There were a total of **<u>405</u>** encounters from all of the Council and team meetings attended.
E: Primary objective of initiative:	**Community Health Education: NAS** • <u>Objective</u>: Teach drug-addicted mothers how to soothe their infants suffering from NAS and how to access assistance and resources when needed

	LOFRT Work • Objective: Support the team in reviewing drug overdose cases and effectively participate in discussing prevention strategies with behavioral health providers **MSPF2 Work** • Objective: Support the team's efforts to reduce underage drinking in Cecil County **MHCSA Advisory Council Work** • Objective: Support the Council's objectives to provide interventions and action steps to enhance mental health care and increase access to mental health services **CIT Work** • Objective: Support the team's efforts in supporting clients in crisis by enhancing community-based strategies to support law enforcement management of mental health in the field and address the gaps in data collection **Peer Recovery Advocates Program** • Objective: Provide peer counselors for patients struggling with addictions and facilitate access to addictions supports and community treatment programs **Crisis Center** • Objective: Create and sustain a short-term crisis stabilization program to offer a safe place for Cecil County residents to work through crisis situations and reduce overutilization of the emergency department for mental health conditions
F: Single or multi-year plan:	Multi-year
G: Key collaborators in delivery:	**Community Health Education: NAS** Union Hospital Elkton Treatment Center **LOFRT Work** Cecil County Health Department Union Hospital Community Behavioral Health Providers **MSPF2 Work** Cecil County Health Department Union Hospital Law Enforcement

	Department of Emergency Services Youth Empowerment Source Cecil County Public Schools Weaver Liquors Cecil County Liquor Control Board Department of Juvenile Services Private Citizens **MHCSA Advisory Council Work** Cecil County Health Department Union Hospital Community Behavioral Health Providers Cecil County Public Schools Department of Juvenile Services Law Enforcement Department of Emergency Services **CIT Work** Cecil County Health Department Union Hospital Community Behavioral Health Providers Cecil County Public Schools Department of Juvenile Services Law Enforcement Department of Emergency Services **Peer Recovery Advocates Program** Union Hospital Cecil County Health Department **Crisis Center** Union Hospital Union Behavioral Health Cecil County Health Department Upper Bay Counseling Services Eastern Shore Mobile Crisis Key Point Health Services
H: Impact of hospital initiative:	**Community Health Education: NAS** • This community program utilized Union Hospital Pediatric unit staff to visit treatment centers to provide infant soothing and parental support education to drug-addicted mothers. • However, in FY17 there were no education sessions scheduled because the program dissolved due to many factors beyond control. **LOFRT Work** • LOFRT reviews all overdose deaths in Cecil County through an interdisciplinary team meeting comprised of behavioral health service

providers throughout the county. Recommendations for prevention are also discussed and implemented.
- In FY17, dedicated hospital staff from the inpatient and outpatient behavioral services attended the LORFT meetings.

MSPF2 Work
- MSPF2 applies for a grant every 3-5 years to organize community support and law enforcement interventions to reduce and prevent underage drinking in Cecil County.
- In FY17, two hospital staff from Quality and Purchasing attended meetings. Both staff has interest in preventing underage drinking and volunteered to represent the hospital.

MHCSA Advisory Council Work
- The Council maintains the strategies for the CHIP objectives that address mental health (1.2.1 and 1.3.1). Subcommittees will be assigned in FY18 to create and implement short-term objectives.
- In FY17, dedicated hospital staff from Community Benefit as well as inpatient and outpatient behavioral health services attended monthly meetings.

CIT Work
- The CIT branched off of the MHCSA Advisory Council in FY13 to help identify strategies to increase access to behavioral health services. Today the CIT serves as a crisis support arm to bring together many stakeholders from law enforcement to mental health providers to address gaps in service access and train law enforcement on how to effectively manage mental health in the field. CIT is now coordinated through the Eastern Shore Mobile Crisis team and meets monthly with service providers and law enforcement to discuss strategies for crisis support, data analysis and management, and training.
- In FY17, dedicated hospital staff from Community Benefit as well as inpatient and outpatient behavioral health services attended quarterly meetings.

Peer Recovery Advocates Program
- The Cecil County Health Department provides the Peer Recovery Advocate counselors who work with Union Hospital crisis intervention staff in the Emergency Department and on the Psychiatric Unit. Peer counselors encourage patients to utilize clinical and community addictions supports via treatment programs and connections to: providers/counselors, support groups/meetings, and medication management counseling. The Cecil County Health Department provides the encounter data, and staff time is reported by Union Hospital.
- <u>FY17 outputs include</u>:
  - Counseling encounters: 905
    - Q1: 329 contacts

	▪ Q2: 239 contacts ▪ Q3: 176 contacts ▪ Q4: 161 contacts ○ UHCC Staff hours: 208 ▪ CIS Staff work with peer counselors 4 hours/week x 52 weeks **Crisis Center** • The Crisis Center will provide several short-term rehabilitation crisis beds, as well as detox services. • Center planning was completed in FY16 and construction was scheduled to begin in FY17. However, there has been some hold-up involving funding, which has pushed back construction to FY18 and the grand opening to FY19. • Reporting for the Crisis Center will therefore be reflected in FY18 and FY19 HSCRC reports.
I: Evaluation of outcomes:	CHIP objectives are evaluated by analyzing county-level data and drawing conclusions which are then provided to community stakeholders through report-outs at Local Health Improvement Coalition meetings held twice a year, as well as included in written annual updates to the CHNA during the 3-year measurement cycle. Union Hospital programs that address specific CHIP objectives are evaluated by comparing year-to-year outputs and notifying community partners of impact. Since FY17 is the first year of this 3-year CHNA cycle, an output comparison for hospital initiatives will be provided in this section of Table III in the FY18 and FY19 HSCRC Reports.
J: Continuation of initiative:	**Community Health Education: NAS** This program was discontinued due to a change in unit staffing and structure when Nemours took over the Pediatric unit in FY17. In addition, this program was coordinated by staff that no longer works at Union Hospital. An inpatient NAS program is currently being created to provide care and support for drug-addicted mothers and their NAS babies. **LOFRT Work** Staff from Union Hospital's inpatient psychiatric unit serves on LOFRT and will continue to support LOFRT as long as there are mental health needs in Cecil County. **MSPF2 Work** MSPF2 meets monthly to discuss progress made on its grant-funded activities. Union Hospital will continue to provide in-kind support through staff participation and support of strategic plan objectives and action steps.

<table>
<tr><td></td><td colspan="2">MHCSA Advisory Council Work
Staff from Union Hospital's Community Benefit program, outpatient Behavioral Health Services, and inpatient psychiatric unit serve on the Council and will continue to support the Council as long as there are mental health needs in Cecil County.

CIT Work
Staff from Union Hospital's Community Benefit program, outpatient Behavioral Health Services, and inpatient psychiatric unit serves on CIT and will continue to support CIT as long as there are mental health needs in Cecil County.

Peer Recovery Advocates Program
The Peer Recovery Advocates Program has demonstrated patient support success since FY14, so Union Hospital will continue to provide this program for those patients struggling with addictions. An update on the Crisis Center will be provided in the FY18 and FY19 HSCRC Report Table III.

Crisis Center
Once the construction begins on the Crisis Center, the planning team will resume more regular communication to keep up-to-date on progress. Based on the timeline for construction and the grand opening, a narrative describing the completed Center and services offered will be reported in the applicable HSCRC Report.</td></tr>
<tr><td>K: Expense:</td><td>a. Total Cost of Initiatives

<u>Community Health Education: NAS</u>
• N/A

<u>LOFRT Work</u>
• 4 meetings = 100 encounters
• Paid hours: 6 = <u>$258</u>

<u>MSPF2 Work</u>
• 6 meetings = 100 encounters
• Paid hours: 9.51 = <u>$340</u>

<u>MHCSA Advisory Council Work</u>
• 7 meetings = 137 encounters
• Paid hours: 5.5 (cost reported as part of Community Benefit FTE salary)
• Paid hours: 16.5 = <u>$989</u>

<u>CIT Work</u>
• 4 meetings = 68 encounters
• Paid hours: 3.5 (cost reported as part of Community Benefit FTE salary)
• Paid hours: 7.25 = <u>$411</u></td><td>b. Grants/Offsetting Revenue

N/A</td></tr>
</table>

	Peer Recovery Advocates Program • 905 clients served • Paid hours: 208 = $15,423 Crisis Center • N/A **Total Community Benefit: $17,421**	

A. 1. Identified Need:
A. 2. How was the need identified:
	<u>Chronic Disease</u>: a) Diabetes; b) Respiratory & Lung Diseases; and c) Heart Disease & Stroke
	
	These Chronic Disease needs were identified through the FY15-FY16 Community Health Needs Assessment (CHNA) and strategies were created to address these needs through the Community Health Improvement Plan (CHIP). Union Hospital's improvement efforts will aim to address the following CHIP objectives:
	
	Diabetes
	• **2.1.1:** By June 30, 2019, increase physician practice sites making referrals to chronic disease self-management programs by 2 sites
	• **2.1.3:** By June 30, 2019, promote 1 county-wide walking program
	
	Respiratory & Lung Diseases
	• **2.2.1:** By June 30, 2019, increase the number of individuals receiving low-dose lung CT screenings by 5%, in order to increase awareness for lung cancer prevention
	• **2.2.2:** By June 30, 2019, reduce the prevalence of tobacco use among adolescents by 5% and cigarette smoking among adults by 5%
	
	Heart Disease & Stroke
	• **2.3.1:** By June 30, 2019, reduce high blood pressure among adults by 5%, in order to reduce the incidence of stroke in Cecil County
	• **2.3.3:** By June 30, 2019, implement a wellness program for one local small business
	
	<u>Cecil County Data</u>
	
	Diabetes
	• In 2015, 8.7% of adults were diagnosed with diabetes *(Maryland Behavioral Risk Factor Surveillance System)*
	• In 2014, there were 250.2 ED visits due to Diabetes per 100,000 population *(HSCRC, Research Level Statewide Outpatient Data Files)*
	• From 2014-2016, there were 17.3 deaths (age-adjusted) due to diabetes per 100,000 population *(Table 50. Age-Adjusted Death Rates by Political Subdivision, 2016 Maryland Vital Statistics Annual Report)*
	
	Respiratory & Lung Diseases
	• From 2010-2014, there were 78.5 cases of lung cancer per 100,000 population *(National Cancer Institute, State Cancer Profiles, CDC)*
	• From 2010-2014, there were 59.1 deaths (age-adjusted) per 100,000 population due to lung cancer *(National Cancer Institute, State Cancer Profiles, CDC)*
	• FY17 lung cancer screenings by category *(Union Hospital Lung Health Program data)*:
	  ○ Category 1: 66
	  ○ Category 2: 57
	  ○ Category 3: 17

	○ Category 4A: 4 ○ Category 4B: 2 **Heart Disease & Stroke** • From 2014-2016, there were 200 deaths (age-adjusted) per 100,000 population due to heart disease *(Table 50. Age-Adjusted Death Rates by Political Subdivision, 2016 Maryland Vital Statistics Annual Report)* • From 2014-2016, there were 54 deaths (age-adjusted) per 100,000 population due to stroke *(Table 50. Age-Adjusted Death Rates by Political Subdivision, 2016 Maryland Vital Statistics Annual Report)* **Risk Factors** • In 2013, 39.1% of adults engaged in regular physical activity *(Maryland Behavioral Risk Factor Surveillance System)* • In 2013, 27.7% of adults were not physically active *(Centers for Disease Control and Prevention)* • In 2015, 15.5% of adults smoked *(Maryland Behavioral Risk Factor Surveillance System)* • In 2014, 16.7% of teenagers smoked *(Maryland Youth Tobacco Survey)* • In 2015, 34.8% of adults had high blood pressure *(Maryland Behavioral Risk Factor Surveillance System)*
B: Name of hospital initiatives	<u>To address CHIP objective 2.1.1, 2.1.3, 2.3.2, and 2.3.3</u>: • Working with the Cecil County Healthy Lifestyles Task Force (HLTF) • Union Hospital Health Fair <u>To address CHIP objectives 2.2.1 and 2.2.2</u>: • Working with the Cecil County Cancer Task Force <u>To address CHIP objective 2.3.1 (not a part of the HLTF short-term objectives)</u>: • Community Health Education: Stroke
C: Total number of people within target population	<u>2016 Cecil County Population Estimates</u> • Total Population: 102,175 ○ Adults (18+ years): 78,128 (76.5%) ○ Adolescents (10-14 years): 6,923 (6.8%) ○ Adolescents (15-19 years): 6,750 (6.6%) *Source: 2012-2016 American Community Survey, 5-Year Estimates, US Census Bureau, Sex and Age*
D: Total number of people reached by the initiatives	<u>In FY17</u>: • A total of **<u>150</u>** people were served by the Union Hospital Health Fair. No Stroke Education was provided in the community, so no encounter data was available to report. • There were a total of **<u>145</u>** encounters from all the task force meetings attended.

E: Primary objectives of initiatives:	**HLTF Work** The HLTF has developed a work plan including short-term objectives (STOs) per CHIP objective: • 2.1.1 – STO 1: By June 30, 2017, upload updated Health Promotion Program Referral Form into the EHR at 2 health care sites • 2.1.1 – STO 3: By July 31, 2017 meet with Dr. Sirin Pandey, Jennifer Noll, and Ashley Farrell at Union Medical Nutritional Services and Diabetes Center (UMNSDC) about referral form location in the EHR and using the EHR to send referrals • 2.1.3 – STO 7: By June 30, 2017, engage three Healthiest Maryland Businesses (HMB) to promote the Walk Maryland activity • 2.1.3 – STO 8: By September 30, 2017, three HMB will promote walking via social media or their websites • 2.3.3 – STO 1: By June 30, 2017, Union Hospital and Triangle Health Alliance (THA) will use the CDC Worksite Health Scorecard at as a part of the "Roadmap to Wellness" employee wellness program **Union Hospital Health Fair** • Objective: Provide health education to the community to increase engagement in personal health care **Cancer Task Force Work** The Cecil County Cancer Task Force has developed a work plan according to 3 subcommittees which include short-term objectives (STOs) for CHIP objective 2.2.1: Health Fair Subcommittee • STO 1: By June 30, 2018, 2 presentations will be completed to advertise and promote the low-dose CT screening program in the community EMR Flagging & Referrals • STO 1: By October 30, 2017, 1 health care provider will identify active clients in their caseload who meet eligibility for lung cancer screenings • STO 3: By June 30, 2018, 1 health care provider will establish a procedure to identify active clients in their caseload who meet eligibility for lung cancer screenings Social Media Subcommittee • STO 1: By June 30, 2018, plan and implement 2 Cecil County Lung Cancer awareness activities to advertise and promote the low-dose CT screening program **Community Health Education: Stroke** • Objective: The Stroke Program Coordinator provides stroke education in the community via seminars and presentations. These educational opportunities are crafted and reported in addition to education provided at community health fairs.

F: Single or multi-year plan:	Multi-year
G: Key collaborators in delivery:	**HLTF Work** Cecil County Health Department Union Hospital Union Primary Care of Elkton Union Primary Care of Perryville UMNSDC Triangle Health Alliance (THA) **Union Hospital Health Fair** Union Hospital Community Partners Union Multi-Specialty Practices Triangle Health Alliance UMNSDC **Cancer Task Force Work** Cecil County Health Department Union Hospital Union Primary Care of Elkton American Cancer Society – Newark, DE Office **Community Health Education: Stroke** Union Hospital Community Organizations
H: Impact of hospital initiatives:	**HLTF Work** 2.1.1 – STO 1 • In FY17 the Cecil County Health Department made contact with Union Primary Care offices in Elkton and Perryville to introduce the chronic disease support programs referral form. • The form was updated based on provider feedback, shared with the practices, and uploaded into the practice EMR. The test referral was confirmed and the practices began making referrals to the Cecil County Health Department in FY17. 2.1.1 – STO 3 • In FY17, the Cecil County Health Department met with staff from the UMNSDC. • A training was scheduled to provide guidance on how-to access the chronic disease support program referral form and the referral process. • The test referral was confirmed and the UMNSDC began making referrals to the Cecil County Health Department in FY17. 2.1.3 – STO 7 • In FY17, the Cecil County Health Department contacted Healthiest Maryland Businesses (HMB) to get a list of all qualifying HMBs in Cecil County.

- Union Hospital and THA were then contacted by the Cecil County Health Department to begin planning FY18 Maryland Walk Day activities at each location.

2.1.3 – STO 8

- The Cecil County Health Department developed a walking info-graphic and other walking resources and shared them with the Cecil County HMB sites.
- As part of the FY18 Walk Maryland Day, Union Hospital and Triangle Health Alliance plan to promote these resources as part of each of their Maryland Walk Day activities.

2.3.3 – STO 1

- In FY17, Union Hospital worked with its Employee Wellness program to incorporate the CDC's Worksite Health Scorecard into the "Roadmap to Wellness" program at the request of the Healthy Lifestyles Task Force.

Union Hospital Health Fair

- Union Hospital started its annual health fair in 2016 (6/11/16), where there were 17 hospital department/practice booths, 1 THA booth, and 10 community partner booths who provided information on health topics and health services. In 2016 there were approximately 120 people engaged and 78 respondents to the satisfaction survey.
- <u>FY17 outputs</u>:
  - Date: 4/29/17
  - 16 hospital department/practice booths
  - 6 THA booths
  - 17 community partner booths
  - 150 people engaged
  - 72 respondents to the satisfaction survey

Cancer Task Force Work

<u>Health Fair – STO 1</u>

- Work was done in FY17 to prepare for a breakout session at the 55+ Healthy Lifestyles Expo in September 2017 (FY18) to educate attendees about the eligibility and benefits of Union Hospital's Lung Cancer Screening program. Hospital staff will lead the presentation with subcommittee members available to answer questions. Outcomes will be reported in FY18.
- Prep work was also completed in FY17, in conjunction with the Social Media Subcommittee and a University of Delaware student who will provide full media support, to prepare content for a short lung cancer video to be used to promote the ease of getting a lung cancer screening and promote awareness of the screening's importance. The video will be available in FY18 for a showing at the 55+ Healthy Lifestyles Expo and to be promoted by community partners. Analytics on video reach will be reported in FY18.

<u>EMR Flagging & Referrals – STO 1</u>

- Union Primary Care of Elkton was identified as the provider site for assessing patient eligibility for lung cancer screenings. The Patient Care Coordinator pulled the appropriate data, filtered it based on the eligibility criteria for lung

	cancer screenings, and established a list of active patients eligible for the screenings. • Letters will be sent patients on the active list in July 2017 (FY18) encouraging them to contact Union Primary Care to get a referral for the lung cancer screening. • The Patient Care Coordinator will track and report the number of patients who are referred for a lung cancer screening. Outcomes will be reported in FY18. <u>EMR Flagging & Referrals – STO 3</u> • Union Primary Care will establish a procedure for its providers to order a lung cancer screening test in its Electronic Medical Record (EMR). Test patient accounts were tested in FY17. The procedure will be finalized in FY18 and applicable outcomes will be reported in FY18. <u>Social Media – STO 1</u> • In FY17, this subcommittee crafted messaging for Facebook posts to increase awareness of lung cancer in the community. • This subcommittee also supported the Health Fair subcommittee in drafting content for the short video to be used in the community in FY18. Video reach analytics will be reported in FY18. • In addition, this subcommittee began planning ideas for the FY18 Social Media Campaign to promote the lung cancer screening and awareness around the impact of lung cancer in Cecil County. Campaign outcomes will be reported in FY18. **Community Health Education: Stroke** • In FY17, there were no stroke education events in the community due to lack of staff availability. • Community Benefit will connect with the Stroke Program Coordinator in FY18 to plan for opportunities to educate in the community.
I: Evaluation of outcomes:	CHIP objectives are evaluated by analyzing county-level data and drawing conclusions which are then provided to community stakeholders through report-outs at Local Health Improvement Coalition meetings held twice a year, as well as included in written annual updates to the CHNA during the 3-year measurement cycle. Union Hospital programs that address specific CHIP objectives are evaluated by comparing year-to-year outputs and notifying community partners of impact. Since FY17 is the first year of this 3-year CHNA cycle, an output comparison for hospital initiatives will be provided in this section of Table III in the FY18 and FY19 HSCRC Reports.
J: Continuation of initiatives:	**HLTF Work** Staff from Union Hospital, UMNSDC, and THA attends the HLTF meetings and subcommittee meetings regularly. Attending the task force meetings is a great way to learn about programs in the community and to provide updates to local partners

<table>
<tr><td></td><td colspan="2">about hospital collaborative projects associated with diabetes prevention and chronic disease management. In addition, attending the subcommittee meetings provides hospital and THA staff the opportunity to actively impact the CHIP objectives for chronic disease. Therefore, Union Hospital, et al., will continue to attend task force meetings and support the work of the task force subcommittees year-to-year.

Union Hospital Health Fair
Union Hospital has adopted this health fair as an annual event. The first Union Hospital Health Fair ran in the late spring of 2016. Lessons learned from the FY16 fair helped the planning team improve attendance and booth offerings for the FY17 fair held in early spring 2017. The hospital also used enhanced community advertising via a local radio station and included a larger spread of community partners that provided information that addressed both health issues and impacting the social determinants of health. Union Hospital will continue to provide this health fair as long as there is hospital and community support for the event.

Cancer Task Force Work
Staff from Union Hospital and Union Primary Care attends the Cancer Task Force meetings and subcommittee meetings regularly. Attending the task force meetings is a great way to engage with community providers on strategic planning for short-term objectives associated with the Respiratory and Lung Disease CHIP objectives. Furthermore, participation on the subcommittees provides hospital and outpatient practice staff the opportunity to actively impact these CHIP objectives through manageable action steps pertinent to patient care inside and outside of the hospital. Union Hospital, et al., will continue to attend task force meetings and support the work of the task force subcommittees year-to-year.

Community Health Education: Stroke
The Stoke Program Coordinator has great rapport with the local community plans educational presentations with women's civic leagues, clubs, and special populations throughout the year. As a department of one, there was some issue with available time in FY17 and no presentations were scheduled. However, the Stroke Program Coordinator will work to incorporate education in the community in FY18 and beyond.</td></tr>
<tr><td>K: Expenses:</td><td>a. Total Cost of Initiative

<u>HLTF Work</u>
• Work group 1
○ 4 meetings = 26 encounters
○ 4 paid hours (cost reported as part of Community Benefit FTE salary)
○ 2 THA hours (not counted)
• Work group 2
○ 4 meetings = 25 encounters
○ 4 paid hours (cost reported as part</td><td>b. Grants/Offsetting Revenue

N/A</td></tr>
</table>

	of Community Benefit FTE salary) ○ 2 THA hours (not counted) <u>Union Hospital Health Fair</u> • Implementation ○ 150 people served ○ 217.47 unpaid hours ○ 4 paid hours = <u>$66</u> <u>Cancer Task Force Work</u> • Task Force Restructure/Subcommittee Creation ○ 2 meetings = 4 encounters ○ 2 paid hours = <u>$85</u> • Task Force ○ 4 meetings = 65 encounters ○ 1 THA hour (not counted) ○ 23 paid hours = <u>$922</u> • EMR Flagging & Referrals Subcommittee ○ 1 meeting = 9 encounters ○ 1 THA hour (not counted) ○ 2 paid hours = <u>$40</u> • Social Media Subcommittee ○ 3 meetings = 16 encounters ○ 10 paid hours = <u>$197</u> <u>Community Health Education: Stroke</u> • N/A **Total Community Benefit: $1,310**	

A. 1. Identified Need:
A. 2. How was the need identified:
	Determinants of Health: a) Homelessness
	
	This Determinants of Health need was identified through the FY15-FY16 Community Health Needs Assessment (CHNA) and strategies were created to address these needs through the Community Health Improvement Plan (CHIP). Union Hospital's improvement efforts will aim to address the following CHIP objectives:
	
	• 3.2.1: By June 2018, expand services and interventions for homeless individuals/families to decrease prevalence of homelessness in Ceil County by 10%.
	  ○ Services/interventions will be based on three tiers: 1) emergency/immediate assistance; 2) intermediate/short-term assistance; and 3) longer-term assistance geared toward those experiencing chronic homelessness.
	
	Union Hospital provides assistance to the homeless community through activities and initiatives that are not specifically included in the CHIP, but provide significant support to this population. These activities would be considered immediate assistance under Tier 1.
	
	Cecil County Data
	
	Poverty
	• Percentage of Families and People whose Income in the Past 12 Months was below the Poverty Level *(2012-2016 American Community Survey 5-Year Estimates, US Census Bureau)*:
	  ○ Individuals: 10.6%
	  ○ Families: 7.3%
	  ○ Families with children under 5 years: 11.9%
	• Free and Reduced Meals Data by Student Group *(2017 Maryland Report Card)*
	  ○ Elementary: 52% (3,909 students)
	  ○ Middle: 44.8% (1,545 students)
	  ○ High: 35.6% (1,630 students)
	
	Homelessness
	• 2017 Point In Time Survey data
	  ○ Total Homeless Count: 193 ppl
	  ○ Sheltered: 58% (112 ppl)
	  ○ Unsheltered: 42% (81 ppl)
	  ○ Children (under 18): 17% (32 ppl)
	  ○ Chronically Homeless: 19% (37 ppl)
	  ○ Have a mental health problem: 28% (54 ppl)
	  ○ Veterans: 30% (39 ppl)
	  ○ Victim of domestic violence: 14% (27 ppl)
	• In early 2016, there were 774 homeless students in the Cecil County public school system *(Cecil County Public Schools)*
	• In FY17, there were 452 ED visits from homeless patients at Union Hospital *(aggregate Union Hospital visit data)*

B: Name of hospital initiatives	Activities/initiatives provided to support the homeless community (not a part of the CHIP): • Backpacks for the Homeless • Food Services food donations • Donations to Homeless Support Organizations • Working with the Cecil County Inter-Agency Council on Homelessness (CCIACH) • Point in Time Homeless Survey Volunteer Support

C: Total number of people within target population	2016 Cecil County Population Estimates
	• Total Population: 102,175
	  ○ Adults (18+ years): 78,128 (76.5%)
	  ○ Adolescents (10-14 years): 6,923 (6.8%)
	  ○ Adolescents (15-19 years): 6,750 (6.6%)
	Source: 2012-2016 American Community Survey, 5-Year Estimates, US Census Bureau, Sex and Age

D: Total number of people reached by the initiative	In FY17: • **23** homeless individuals received backpacks from the Union Hospital MSU department's Backpacks for the Homeless program • The Union Hospital Food Services department donated enough food to serve **3,951** homeless individuals. • Union Hospital staff provided donations to homeless support organizations which supported **810** homeless individuals. **Total Homeless Served by FY17 Initiatives**: **4,784** • There were a total of **90** encounters from all of the Council and planning meetings attended.
E: Primary objective of initiative:	**Backpacks for the Homeless** • Objective: MSU department supports homeless patients at discharge by providing backpacks filled with necessities that they can take with them into the community **Food Donations – Food Services Dept** • Objective: Food Services department provides monthly food donations to local homeless support programs to feed homeless people in the community **Donations to Homeless Support Organizations** • Objective: Hospital staff provide donations of food, clothing, and service time to local homeless support organizations to serve the homeless in the community

	CCIACH Work • Objective: Support the Council's missions to serve as the collaborative governing body for Cecil County's Continuum of Care for homelessness and to promote community-wide planning for the strategic use of resources toward ending homelessness and helping individuals and families achieve long-term stability **Point in Time Homeless Survey Volunteer Support** • Objective: Support the Point in Time Homeless Survey by providing volunteers to help conduct the survey in the homeless camps
F: Single or multi-year plan:	Multi –year
G: Key collaborators in delivery:	**Backpacks for the Homeless** Union Hospital Union Comprehensive Care Center Rotating Shelter – Meeting Ground **Food Donations – Food Services Dept** Union Hospital Local Homeless Support Organizations **Donations to Homeless Support Organizations** Union Hospital Paris Foundation Rotating Shelter – Meeting Ground Community Kitchen – Elkton Presbyterian Church **CCIACH Work** Union Hospital Cecil County Health Department Local Homeless Support Organizations **Point in Time Homeless Volunteer Support** Union Hospital Cecil County Health Department Local Homeless Support Organizations
H: Impact of hospital initiatives:	**Backpacks for the Homeless** • MSU provides the backpacks at discharge to homeless patients (homeless status is determined via patient notes captured during the stay or verbal confirmation from the patient). Backpacks are filled with toiletries, gently used clothing, and seasonal items. • In FY17, the MSU department provided 10 backpacks to homeless patients at discharge, 1 backpack for a homeless patient identified by the Union Comprehensive Care Center (outpatient care management and home visit

	program), and 12 backpacks for the Cecil County Rotating Shelter, an emergency homeless shelter open in the winter, hosted by local churches, and operated by Meeting Ground, a homeless services provider. **Food Donations – Food Services Dept** • In FY17, the Union Hospital Food Services department provided food donations to local homeless support organizations every week of each month in the fiscal year. In total these food donations served nearly 4,000 people. • The Food Services department is dedicated to providing access to nutritious food for everyone from patients, to staff, to the community. This dedication is evident in their sustainable provision of food to the homeless community. **Donations to Homeless Support Organizations** • In FY17, hospital staff provided donations of food, clothing, and their time in service of the homeless in Cecil County. Working with local homeless support organizations, like the Paris Foundation (provides evening meals and fellowship), the Meeting Ground programs (provide day services, meals, the winter Rotating Shelter, and fellowship), and local churches (provide meal services to homeless), hospital staff provided immediate assistance to the homeless community. **CCIACH Work** • In FY17, Union Hospital staff served in an in-kind capacity on the Council to support its strategic plan to stabilize those in homelessness. **Point in Time Homeless Survey Volunteer Support** • As of the 2017 Point in Time Survey there were 193 homeless people counted in Cecil County. • In FY17, hospital staff was represented on the planning workgroup. • In FY17, Union Hospital did not participate as a Point in Time Survey Site and did not provide volunteers to help conduct the survey in the homeless camps due to staffing issues. • In FY18, the hospital will work the Point in Time planning team to ramp up volunteer participation in Survey conduction in the community.
I: Evaluation of outcomes:	CHIP objectives are evaluated by analyzing county-level data and drawing conclusions which are then provided to community stakeholders through report-outs at Local Health Improvement Coalition meetings held twice a year, as well as included in written annual updates to the CHNA during the 3-year measurement cycle. Union Hospital programs that address specific CHIP objectives are evaluated by comparing year-to-year outputs and notifying community partners of impact. Since FY17 is the first year of this 3-year CHNA cycle, an output comparison for hospital initiatives will be provided in this section of Table III in the FY18 and FY19 HSCRC Reports.

<table>
<tr><td>J: Continuation of initiatives:</td><td colspan="2">Backpacks for the Homeless
This program was started in FY15 when nursing staff noticed many patients being discharged back into homelessness, and the staff wanted to provide what support they could. Knowing that homelessness is a large problem in Cecil County, Union Hospital will continue to support this program as long as there is a need.

Food Donations – Food Services Dept
The Food Services department has been donating food to homeless support organizations for years. Knowing that homelessness is a large problem in Cecil County, Union Hospital will continue to support this program as long as there is a need.

Donations to Homeless Support Organizations
Union Hospital staff realizes the importance of giving back, and they work closely with the hospital's community homeless support partners to maintain an effective level of in-kind support through donations of food, clothing, and service. As long as there is a need hospital staff will rally to support it.

CCIACH Work
The Council appointed the Community Benefit Coordinator to serve on the Council in FY14. Since then the Community Benefit Coordinator has been the liaison between the Council's strategic objectives and both hospital leadership and staff support. The Community Benefit Coordinator will renew her membership on the Council in FY18.

Point in Time Homeless Survey Volunteer Support
While this Survey captures only a snapshot of homelessness in Cecil County, it provides much needed data for comparison year-to-year of the impact of homelessness. The hospital will continue to offer volunteer support for Survey operations to be able to collect as much data as possible.</td></tr>
<tr><td>K: Expenses:</td><td>a. Total Cost of Initiative

<u>Backpacks for the Homeless</u>
• 23 homeless ppl served
• 20 unpaid hours
• 8 paid hours = <u>$430</u>

<u>Food Donations – Food Services Dept</u>
• 3,951 ppl served
• 92 paid hours = <u>$2,855</u>
• Food Expenses = <u>$8,812.75</u>

<u>Donations to Homeless Support Organizations</u>
• Community Kitchen Serves
○ 5 Serves = 260 ppl served
○ 30.5 paid hours = <u>$1,244</u></td><td>b. Grants/Offsetting Revenue

N/A</td></tr>
</table>

	• Rotating Shelter Serves
	  ○ 3 Serves = 50 ppl served
	  ○ 34.25 unpaid hours
	• Paris Foundation Donations
	  ○ 350 ppl served
	  ○ 19.85 unpaid hours
	• Annual Coat Drive
	  ○ 100 coats collected = 100 ppl served
	  ○ 12 unpaid hours
	  ○ 5 paid hours = $206
	• Homeless Camp Outreach
	  ○ 50 ppl served
	  ○ 10 unpaid hours
	
	CCIACH Work
	• 5 meetings = 80 encounters
	• 4 paid hours (cost reported as part of the Community Benefit FTE salary)
	• 2.75 paid hours = $130
	
	Point in Time Homeless Survey Volunteer Support
	• 1 planning meeting = 10 encounters
	• 1 paid hour (cost reported as part of the Community Benefit FTE salary)
	
	Total Community Benefit: $13,677.75	