Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for the fiscal year.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Frederick Health Hospital	◉	○	
Your hospital's ID is: 210005	◉	○	
Your hospital is part of the hospital system called None	◉	○	
The primary Narrative contact at your hospital is Malcolm Furgol	○	◉	Heather Kirby
The primary Narrative contact email address at your hospital is mfurgol@frederick.health	○	◉	hkirby@frederick.health
The primary Financial contact at your hospital is Hannah Jacobs	◉	○	
The primary Financial email at your hospital is hjacobs@frederick.health	◉	○	

Q4. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. Please select the community health statistics that your hospital uses in its community benefit efforts.

- [x] Median household income
- [x] Percentage below federal poverty line (FPL)
- [x] Percent uninsured
- [x] Percent with public health insurance
- [x] Percent with Medicaid
- [ ] Mean travel time to work
- [x] Percent speaking language other than English at home
- [x] Race: percent white
- [x] Race: percent black
- [x] Ethnicity: percent Hispanic or Latino
- [ ] Life expectancy
- [ ] Crude death rate
- [ ] Other

Q6. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

The Community Foundation of Frederick County 2018 Human Needs Assessment; Alice Report (United Way); The Liveable Frederick Master Plan; 2018 Frederick County Uneven Opportunities; How Conditions for Wellness Vary Across the Metropolitan Washington Region.

Q7. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q8. Section I - General Info Part 2 - Community Benefit Service Area

Q9. Please select the county or counties located in your hospital's CBSA.

☐ Allegany County	☐ Charles County	☐ Prince George's County
☐ Anne Arundel County	☐ Dorchester County	☐ Queen Anne's County
☐ Baltimore City	☑ Frederick County	☐ Somerset County
☐ Baltimore County	☐ Garrett County	☐ St. Mary's County
☐ Calvert County	☐ Harford County	☐ Talbot County
☐ Caroline County	☐ Howard County	☐ Washington County
☐ Carroll County	☐ Kent County	☐ Wicomico County
☐ Cecil County	☐ Montgomery County	☐ Worcester County

Q10. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Frederick County ZIP codes located in your hospital's CBSA.

☐ 20842	☐ 21719	☑ 21775
☐ 20871	☑ 21727	☐ 21776
☑ 21701	☑ 21754	☑ 21777

- [x] 21702
- [x] 21703
- [x] 21704
- [x] 21705
- [x] 21710
- [ ] 21713
- [x] 21714
- [x] 21716
- [x] 21717
- [x] 21718
- [x] 21755
- [x] 21757
- [x] 21758
- [ ] 21759
- [x] 21762
- [x] 21769
- [x] 21770
- [x] 21771
- [x] 21773
- [x] 21774
- [x] 21778
- [x] 21780
- [ ] 21783
- [ ] 21787
- [x] 21788
- [x] 21790
- [ ] 21791
- [x] 21793
- [x] 21798

Q21. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q32. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

- [ ]

Based on ZIP codes in your Financial Assistance Policy. Please describe.

☑ Based on ZIP codes in your global budget revenue agreement. Please describe.

Appendix E of the Global Budget Revenue agreement signed on 2/21/14 defines the hospital's service areas. The hospital monitors our market share on an ongoing basis by analyzing and identifying changes in levels of the patient volumes that are derived from its primary and secondary service areas. There have been no significant changes in patient volumes from outside the primary or secondary service area.

☐ Based on patterns of utilization. Please describe.

☐ Other. Please describe.

Q35. Provide a link to your hospital's mission statement.

https://www.frederickhealth.org/about/mission-vision-values/

Q36. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Q37. Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

Q38.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

◉ Yes

○ No

Q39. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q40. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

05/01/2019

Q41. Please provide a link to your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

https://www.frederickhealth.org/documents/content/2019-Frederick-County-CHNA-FINAL-5.1.19.pdf

Q42. Please upload your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

2019-Frederick-County-CHNA-FINAL-5.1.19.pdf
4MB
application/pdf

Q43. Section II - CHNAs and Stakeholder Involvement Part 2 - Internal CHNA Partners

Q44. Please use the table below to tell us about the internal partners involved in your most recent CHNA development.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Approved CHNA at 3/26/19 meeting and subsequently appr implementation strategy on 9/24/19
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☑	☑	☐	☐	☑	☑	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Physician(s)	☐	☐	☐	☑	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Nurse(s)	☐	☐	☐	☑	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Social Workers	☐	☐	☐	☑	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Other (specify)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

Q46. Please use the table below to tell us about the internal partners involved in your community benefit activities during the fiscal year.

	Activities									
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	The Quality Committee of the Board is briefed on the implementation plan and evaluation of community initiatives during monthly meetings
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	
Nurse(s)	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	
Social Workers	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐	
Other (specify)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

Q47. Section II - CHNAs and Stakeholder Involvement Part 4 - Meaningful Engagement

Q48. Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. Please use the table below to tell us about the external partners involved in your most recent CHNA. In the first column, select and describe the external participants. In the second column, select the level of community engagement for each participant. In the third column, select the recommended practices that each stakeholder was engaged in. The Maryland Hospital Association worked with the HSCRC to develop this list of eight recommended practices for engaging patients and communities in the CHNA process.

Refer to the FY 2022 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2022.

	Level of Community Engagement	Recommended Practices

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here: Not applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Department -- Please list the Local Health Departments here: Frederick County Health Department	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☐	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here: Frederick County Health Care Coalition	☑	☑	☑	☑	☑	☑	☑	☐	☐	☑	☐	☐	☐	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other State Agencies -- Please list the agencies here: Not Applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Govt. Organizations -- Please list the organizations here: City of Frederick Housing and Human Services/FQHC	☑	☑	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Faith-Based Organizations	☑	☑	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here: Frederick County Public Schools	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here: Hood College	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here: Frederick County Mental Health Association; Behavioral Health Partners	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here: Not Applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here: Not Applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here: Asian American Center; Centro Hispano	[x]	[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[x]	[ ]
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Consumer/Public Advocacy Organizations -- Please list the organizations here: Not applicable	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other -- If any other people or organizations were involved, please list them here: Not applicable	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress

Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

Q50. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q51. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

9/24/19

Q52. Please provide a link to your hospital's CHNA implementation strategy.

https://www.frederickhealth.org/documents/content/FMH-CHNA-Implementation-Strategy-Signed-9-24-19.pdf

Q53. Please upload your hospital's CHNA implementation strategy.

FMH-CHNA-Implementation-Strategy-Signed-9-24-19.pdf
4MB
application/pdf

Q54. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q55. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

The 2019 CHNA analyzed Frederick County health data and input from residents for the purpose of identifying issues that impact the health of community residents. Public discussion about the findings occurred at the Frederick County Health Improvement Priority Setting Summit on January 15th, 2019. The event concluded with the identification of three health improvement priorities, two* of which were continued from the prior CHNA cycle. • Adverse Childhood Experiences* & Infant Health • Behavioral Health* • Chronic Conditions (primary focus on colorectal cancer and obesity) Data for this report was gathered from four areas with a focus on inclusion of disparity populations and health equity: • Health Perception Survey - An online Community Health Needs Survey was conducted with Frederick County residents between July and August 2018. Partners throughout the county were recruited to promote geographical and ethnic diversity among respondents. The survey was available in English and Spanish in paper and online, and available in Vietnamese in paper. A total of 1,692 surveys were received. • Advocates for Health Equity - Input was gathered from key informants and advocates in our community with the goal of giving more sections of our community a voice. These Advocates for Health Equity submitted their insights between September and October 2018. A total of 8 advocates responded and represented ALICE (asset limited, income constrained, employed), disabled, Hispanic, homeless, LGBT, seniors, and youth. • Focus Groups - Four sessions of Focus Groups were conducted in focus sessions with different community groups including African American, Hispanic, homeless, and the Emmitsburg/Thurmont area of the county. These groups and locations were selected because of data showing existing health disparities. The goal of the focus group was to delve deeper into these populations to gain better insight in order to more effectively tailor services and interventions and reduce disparities. A total of 52 community members participated in the focus groups. • Secondary Data - All data was gathered prior to October 1, 2018. The analysis of community health status described in this report is derived from publicly reported state and federal data. By implementing the data collection methods that are outlined above in the CHNA planning process, a representative sample based on geographic location of residence, income, ethnicity and race was obtained. Inclusion of disparity populations and health equity advocates in the planning process built on processes implemented in the previous CHNA cycle.

Q56. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q57. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- ○ Yes
- ◉ No

Q58.

Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

- ☐ Health Conditions - Addiction
- ☐ Health Conditions - Arthritis
- ☐ Health Conditions - Blood Disorders
- ☐ Health Conditions - Cancer
- ☐ Health Conditions - Chronic Kidney Disease
- ☐ Health Conditions - Chronic Pain
- ☐ Health Conditions - Dementias
- ☐ Health Conditions - Diabetes
- ☐ Health Conditions - Foodborne Illness
- ☐ Health Conditions - Health Care-Associated Infections
- ☐ Health Conditions - Heart Disease and Stroke
- ☑ Health Conditions - Infectious Disease
- ☐ Health Conditions - Mental Health and Mental Disorders
- ☐ Health Conditions - Oral Conditions
- ☐ Health Conditions - Osteoporosis
- ☐ Health Conditions - Overweight and Obesity
- ☐ Health Conditions - Pregnancy and Childbirth
- ☐ Health Conditions - Respiratory Disease
- ☐ Health Conditions - Sensory or Communication Disorders
- ☑ Health Conditions - Sexually Transmitted Infections
- ☐ Health Behaviors - Child and Adolescent Development
- ☐ Health Behaviors - Drug and Alcohol Use
- ☐ Health Behaviors - Emergency Preparedness
- ☐ Health Behaviors - Family Planning
- ☐ Health Behaviors - Health Communication
- ☐ Health Behaviors - Injury Prevention
- ☐ Health Behaviors - Nutrition and Healthy Eating
- ☐ Health Behaviors - Physical Activity
- ☐ Health Behaviors - Preventive Care
- ☐ Health Behaviors - Safe Food Handling
- ☐ Health Behaviors - Sleep
- ☐ Health Behaviors - Tobacco Use
- ☐ Health Behaviors - Vaccination
- ☐ Health Behaviors - Violence Prevention
- ☐ Populations - Adolescents
- ☐ Populations - Children
- ☐ Populations - Infants
- ☐ Populations – LGBT
- ☐ Populations - Men
- ☐ Populations - Older Adults
- ☐ Populations - Parents or Caregivers
- ☐ Populations - People with Disabilities
- ☐ Populations - Women
- ☐ Populations - Workforce
- ☐ Other Social Determinants of Health
- ☐ Settings and Systems - Community
- ☐ Settings and Systems - Environmental Health
- ☐ Settings and Systems - Global Health
- ☐ Settings and Systems - Health Care
- ☐ Settings and Systems - Health Insurance
- ☐ Settings and Systems - Health IT
- ☐ Settings and Systems - Health Policy
- ☐ Settings and Systems - Hospital and Emergency Services
- ☐ Settings and Systems - Housing and Homes
- ☐ Settings and Systems - Public Health Infrastructure
- ☐ Settings and Systems - Schools
- ☐ Settings and Systems - Transportation
- ☐ Settings and Systems - Workplace
- ☐ Social Determinants of Health - Economic Stability
- ☐ Social Determinants of Health - Education Access and Quality
- ☐ Social Determinants of Health - Health Care Access and Quality
- ☐ Social Determinants of Health - Neighborhood and Built Environment
- ☐ Social Determinants of Health - Social and Community Context
- ☐ Other (specify)

Q59. Why were these needs unaddressed?

The mission of Frederick Health Hospital is to positively impact the well-being of every individual in our community. HIV and Sexually Transmitted Infections have not been a focus of the hospital as they were also not identified as top priorities during the Local Health Improvement Planning Process/Summit, which is the community-wide action planning process associated with the CHNA. Frederick Health Hospital does provide diagnosis and treatment for these conditions. As a charter member of the Frederick County Health Care Coalition Frederick Health will continue working with community partners to ensure the needs of our community are met in the best and most appropriate manner possible.

Q60. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

Frederick Health Hospital tracks health disparity data through a number of avenues, including the CRISP Public Health and QBR dashboards, health equity of care data provided through our clinical quality partnership with Premier, Inc., Press Ganey Health Equity Partnership, as well as publicly reported data including the annual Maryland Vital Statistics Report, BRFSS, and available Cancer and Drug Related Death Data are all used to identify and track health disparities. The Community Health Needs Assessment also provides valuable data that can be used to identify populations or communities within our service area where health disparities exist. Efforts to reduce health disparities include cohosting a community health fair with with Asian American Center of Frederick. During this fair individuals receive education, screening and navigation to services to address medical/health related concerns as well as address social determinants of health. The Bridges Lay Health Educator Program provides education and training for individuals from diverse backgrounds, faith-based communities and other community organizations serving diverse and often marginalized or underserved communities. These Lay Health Educators break down barriers to difficult to reach communities, providing a pathway for Frederick Health to engage and meet the communities needs. During and post pandemic Frederick Health has actively partnered with the Frederick County Health Department, the City of Frederick Housing and Human Services Department, The Asian American Center of Frederick, The Love for Lochlin Foundation, Spanish Speaking Communities of Maryland, Inc. to provide COVID-19 vaccines across the county, reaching members of the community where vaccine acceptance is low, or residents may experience issues with transportation or other barriers to accessing care. As much as possible during these outreach efforts in addition to providing COVID-19 vaccines we optimized every interaction with community to also educate on the importance of colorectal cancer screening, understanding pre-diabetes/diabetes risk, and the importance of healthy behaviors, including healthy diets, activity, elimination of sugar added beverages and reduced screen time.

Q61. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [ ] None
- [x] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [x] The COVID-19 Long-Term Care Partnership Grant
- [x] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q62. If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q63. Section III - CB Administration

Q64. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [ ] Yes, by the hospital's staff
- [ ] Yes, by the hospital system's staff
- [x] Yes, by a third-party auditor
- [ ] No

Q65. Please describe the third party audit process used.

The data introduced on the financial spreadsheet is used in the development of the IRS-990 form which is completed and filed annually. The audit is completed by Ernst & Young, a third party accounting firm, in collaboration with Frederick Health Hospital staff.

Q66. Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

Q67. Please describe the community benefit narrative audit process.

The narrative is reviewed by the Vice President of Integrated Care & Chief Population Health Officer as well as the Community Benefits Committee

Q68. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- ○ Yes
- ● No

Q69. Please explain:

The data included in the financial spreadsheet is used in the development of the IRS 990 forms which is completed and filed annually. The audit is completed by Ernst & Young, a third party accounting firm, in collaboration with Frederick Health Hospital Staff.

Q70. Does the hospital's board review and approve the annual community benefit narrative report?

- ○ Yes
- ● No

Q71. Please explain:

The entire narrative report is not presented to the hospital board, but is made available to members upon request. Initiatives and data included in the narrative are presented at regular intervals to the Quality Committee of the board. This committee reports quarterly to the hospital board. Included in this report are presentations presented at the committee level and copies of all committee minutes

Q72. Does your hospital include community benefit planning and investments in its internal strategic plan?

- ● Yes
- ○ No

Q73. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

The Frederick Health Hospital strategic plan includes goals pertaining to population health, which are derived from the community benefit, population health, SIHIS, and local health improvement plan priorities. The strategic planning process is a significant input into the annual budget and capital allocation. The entire Frederick Health Hospital leadership team engages in the strategic planning process annually through recurring Strategy Council meetings, and the final plan is presented to the hospital board at an annual spring retreat (April/May)

Q74. If available, please provide a link to your hospital's strategic plan.

Q75. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents

Diabetes was added as a priority to the scope of our Chronic Disease workgroup; Frederick Health was awarded a Regional Partnership Grant, thus the work largely focused on leveraging community stakeholder buy-in and support to achieve grant goals. (not included in our original implementation plan, however added at the request of the LHIC/Local Health Department when MDH priorities were published

- [ ]

Opioid Use Disorder - Improve overdose mortality

[x] Maternal and Child Health - Reduce severe maternal morbidity rate

Implementation of the Family Connects Universal Home Visiting Program - FY 22 was largely planning and implementation readiness

[ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

[ ] None of the Above

Q76. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q77. Section IV - Physician Gaps & Subsidies

Q78. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

( ) No
(x) Yes

Q79. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	( )	(x)	
Anesthesiology	(x)	( )	Coverage of emergency department call
Cardiology	(x)	( )	Coverage of emergency department call
Dermatology	( )	(x)	
Emergency Medicine	(x)	( )	Non-resident house staff and hospitalists
Endocrinology, Diabetes & Metabolism	( )	(x)	
Family Practice/General Practice	(x)	( )	Non-resident house staff and hospitalists
Geriatrics	( )	(x)	
Internal Medicine	(x)	( )	Non-resident house staff and hospitalists
Medical Genetics	( )	(x)	
Neurological Surgery	(x)	( )	Coverage of emergency department call
Neurology	(x)	( )	Coverage of emergency department call
Obstetrics & Gynecology	(x)	( )	Coverage of emergency department call
Oncology-Cancer	(x)	( )	Coverage of emergency department call
Ophthalmology	(x)	( )	Coverage of emergency department call
Orthopedics	(x)	( )	Coverage of emergency department call
Otolaryngology	(x)	( )	Coverage of emergency department call
Pathology	( )	(x)	
Pediatrics	(x)	( )	Non-resident house staff and hospitalists
Physical Medicine & Rehabilitation	( )	(x)	
Plastic Surgery	(x)	( )	Coverage of emergency department call

Preventive Medicine	○	●	
Psychiatry	●	○	Coverage of emergency department call
Radiology	●	○	Coverage of emergency department call
Surgery	●	○	Coverage of emergency department call
Urology	●	○	Coverage of emergency department call
Other, (Describe) Gastroenterology, Nephrology, Oral Maxillary, Facial Surgery, Pulmonary Medicine, Vascular Surgery, Interventional Cardiology	●	○	Coverage of emergency department call

Q80. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

Frederick Health Hospital subsidizes Hospitalists to meet the needs of our patients. There are not sufficient primary care providers in Frederick County to accommodate all of the inpatient needs. The majority of primary care physicians int eh community do not maintain hospital privileges and therefore, not credentialed to provider care for their patients while in the hospital. Frederick Health Hospital contracts with the following specialties to provide coverage on a 24/7 basis - anesthesiology, bariatric surgery, cardiology, Gastroenterology, General Surgery, Hematology/Oncology, Interventional Cardiology, Nephrology, Opthalmology, Oral/Maxillo/Facial, Orthopedics, Pediatrics, Plastic Surgery, Pulmonary Medicine, Urology, Vascular Surgery, Neurosurgery, Without subsidies from the organization to compensate providers for this coverage, medical practices would not be able to recruit a sufficient number of personnel to provide around the clock coverage for the Emergency Department

Q81. Please attach any files containing further information and data justifying physician subsidies at your hospital.

Q82. Section VI - Financial Assistance Policy (FAP)

Q83. Upload a copy of your hospital's financial assistance policy.

Viewing Financial Assistance Policy, FN 100.html
132.3KB
text/html

Q84. Provide the link to your hospital's financial assistance policy.

https://www.frederickhealth.org/documents/page%20links/billing%20&%20finance/Financial-Assistance-Policy-FN-100.pdf

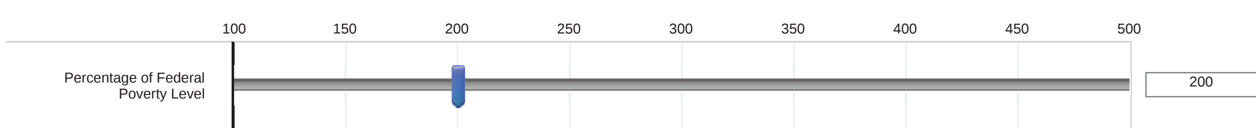
Q85. Has your FAP changed within the last year? If so, please describe the change.

○ No, the FAP has not changed.

● Yes, the FAP has changed. Please describe: updated to comply with HSCRC policy

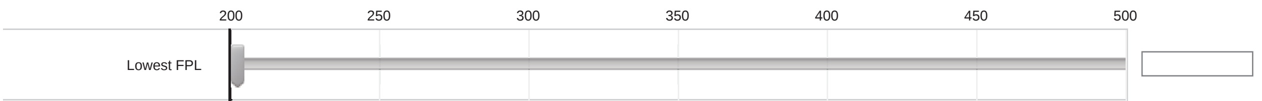
Q86. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

Please select the percentage of FPL below which your hospital's FAP offers free care.



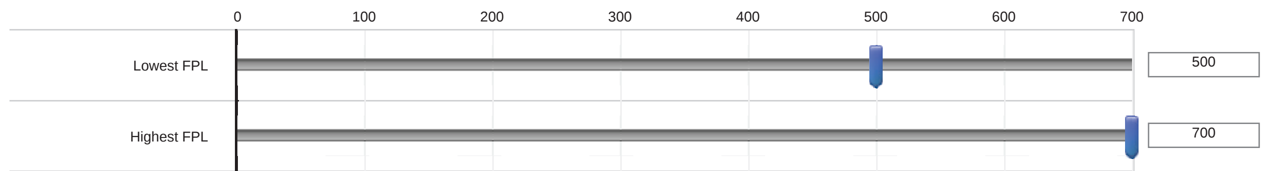
Q87. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.

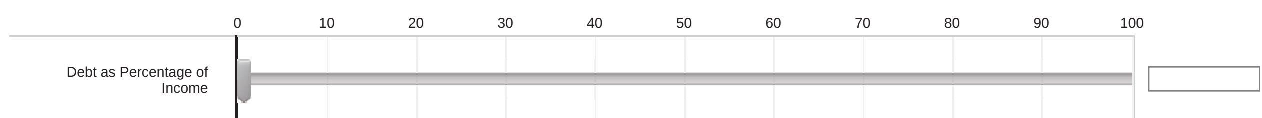


Q88. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.



Q89. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q90. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [x] Local property tax (real and personal)
- [ ] Other (Describe)

Q91. Summary & Report Submission

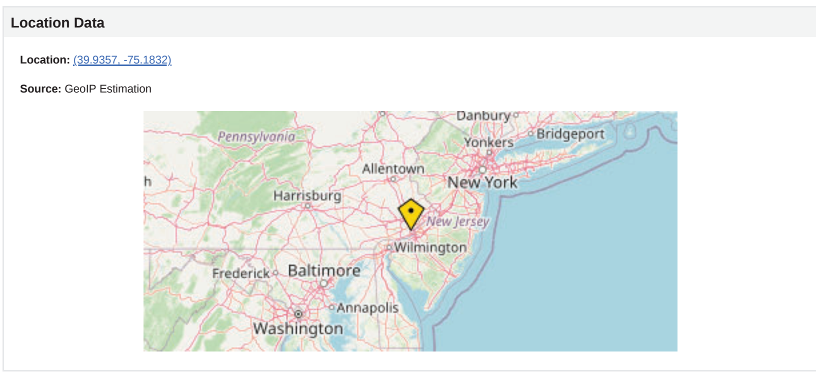
Q92.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.



FREDERICK COUNTY
COMMUNITY
HEALTH
NEEDS
ASSESSMENT
2019
FREDERICK COUNTY
HEALTHCARE COALITION

Contents

Executive Summary ... 4
Introduction ... 5
Frederick County Community Profile ... 7
Methodology ... 9
Community Perceptions and Themes ... 12
  Other Community Assessments ... 14
Prioritization of Health Issues ... 17
  2019 Health Improvement Priorities ... 29
Community Resources ... 31
Conclusions ... 32
Appendix 1. Primary Data ... 33
  Community Survey Data ... 33
  Community Focus Groups ... 39
  Advocates for Health Equity ... 43
Appendix 2. Secondary Data ... 49
  Demographics ... 49
  Health Outcome: Length of Life ... 54
    Leading Causes of Death ... 54
    Cancer Deaths ... 55
    Drug and Alcohol Overdose Deaths ... 57
    Infant Mortality ... 58
  Health Outcomes: Quality of Life ... 59
    Cancer Incidence ... 59
    Maternal and Child Health ... 60
    Chronic Conditions ... 65
    HIV ... 68
    Mental Health ... 68

Health Factors: Socio-Economic 69
Education 69
Income 69
Health Factors: Physical Environment 70
Lead Levels 70
Rabies 70
Health Factors: Health Behaviors 71
Alcohol 71
Tobacco Use 72
Diet & Exercise 73
Sexual Health 75
Health Factors: Clinical Care 76
Oral Health 76
Appendix 3. Frederick County Health Indicators: Prioritization Matrix 77
Appendix 4. Maryland State Health Improvement Plan (SHIP) Goals 81
Appendix 5. Healthy People 2020 Goals Included in this Assessment 82
Appendix 6. Disparities 83
Appendix 7. Online Survey 84
Appendix 8. Planning Process Participants 92

Executive Summary

The 2019 Community Health Needs Assessment (CHNA) was conducted by the Frederick County Health Care Coalition (Coalition) to identify health issues in Frederick County and to provide critical information to those in a position to take positive steps that will impact the health of area residents.

The Coalition is a nonprofit organization formed in 2006 in response to a need to coordinate efforts to address barriers to health care access. The Coalition's mission is to promote quality health care in Frederick County through collective impact efforts that engage local organizations and citizenry. A core responsibility of the Coalition is the completion of a periodic assessment that informs and engages the community in health improvement initiatives. The assessment process is repeated every three years to reflect changing local conditions.

A CHNA examines disease and death statistics for the community and compares local outcomes to the state and other benchmarks. The CHNA also identifies available resources to address health issues and resident perceptions about health and social concerns. Finally, a CHNA calls out major health problems and, with input from the public, narrows those health issues into a manageable set of priorities.

The 2019 CHNA analyzed Frederick County health data and input from residents, advocates and community organizations. The Coalition shared the results of the analysis and facilitated public discussion about the findings at the Frederick County Health Improvement Priority Setting Summit on January 15th, 2019. The event concluded with the identification of three health improvement priorities, two* of which were continued from the prior CHNA cycle.

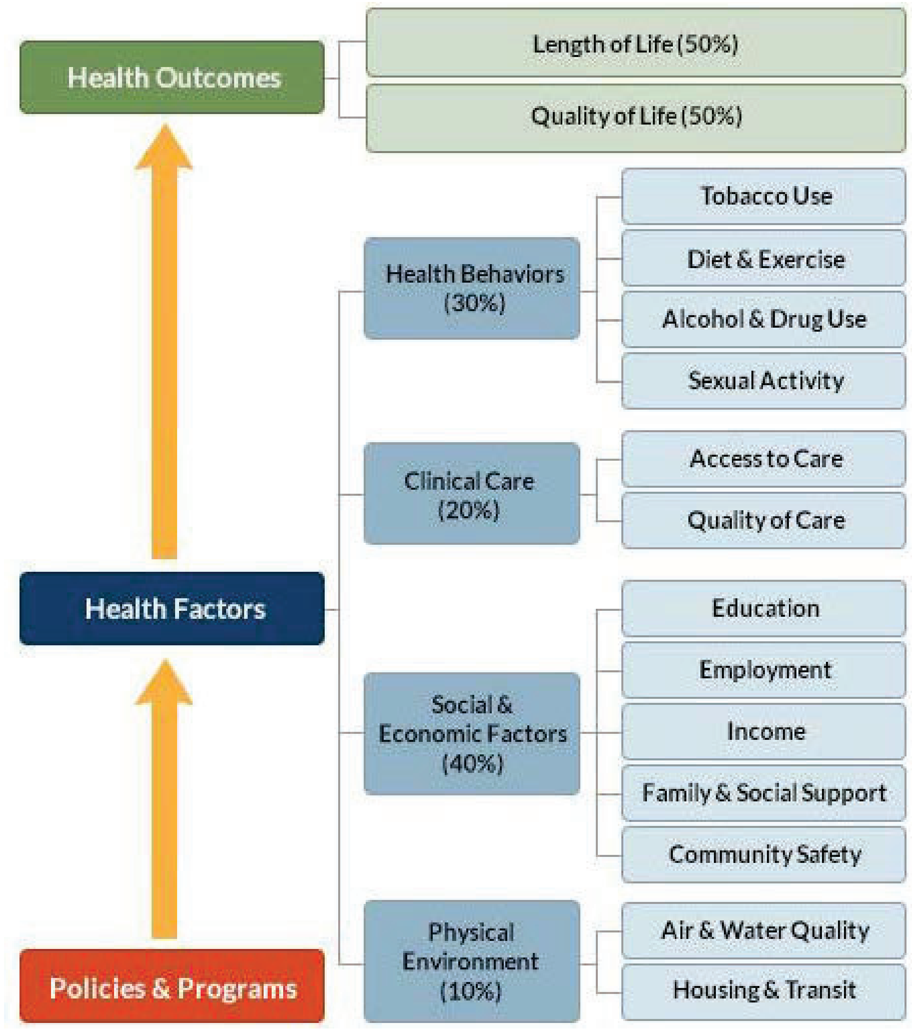
- **Adverse Childhood Experiences* & Infant Health**
- **Behavioral Health***
- **Chronic Conditions**

The Coalition has facilitated the formation of three community participant work-groups charged with developing action steps to address each priority. Work plans will include measurable goals, strategies, and responsible parties, and will be compiled into a Local Health Improvement Plan that will be available to the public by Fall 2019. Over the next three years, the Coalition will evaluate the progress of the work groups and will report back to the community on a periodic basis.

Introduction

Good health is more than not being sick or getting routine medical care. The health of an individual, or of a community, is influenced by our personal behaviors, the clinical care we receive, social and economic factors, and where we live. Other factors also impact our health, such as education, safety of the neighborhood, air quality, housing conditions, poverty and employment. These factors are called **social determinants of health**. All these factors together form a complex web in our community and influence our health.

This report includes many health issues that are influenced by social determinants of health. The picture to the right depicts a framework of how influencing factors and health outcomes fit together. The County Health Rankings are based on a concept of community health that includes both Health Outcomes (length and quality of life) and Health Factors (determinants of health).



The health issues included in this report (see Appendix 2) have been organized by this model. This framework is useful in identifying key drivers and where to focus interventions. The model is also helpful for future program design.

The 2019 CHNA was conducted by the Frederick County Health Care Coalition (Coalition), a non-profit organization dedicated to improving the health of Frederick County residents. Coalition board members represent a broad range of health and social service organizations, as well as community volunteers, committed to implementing health improvement solutions.

The CHNA was sponsored by the Frederick County Health Department (FCHD) and Frederick Regional Health System (FRHS). Participation in the CHNA process by FCHD and FRHS fulfills regulatory and accreditation requirements for conducting a periodic community health assessment with public input and participation.

The 2019 CHNA included collation of data from primary (qualitative) and secondary (quantitative) sources. Data analysis identified significant health problems experienced by various geographic sub-areas and resident populations within Frederick County. The CHNA answers the following questions:

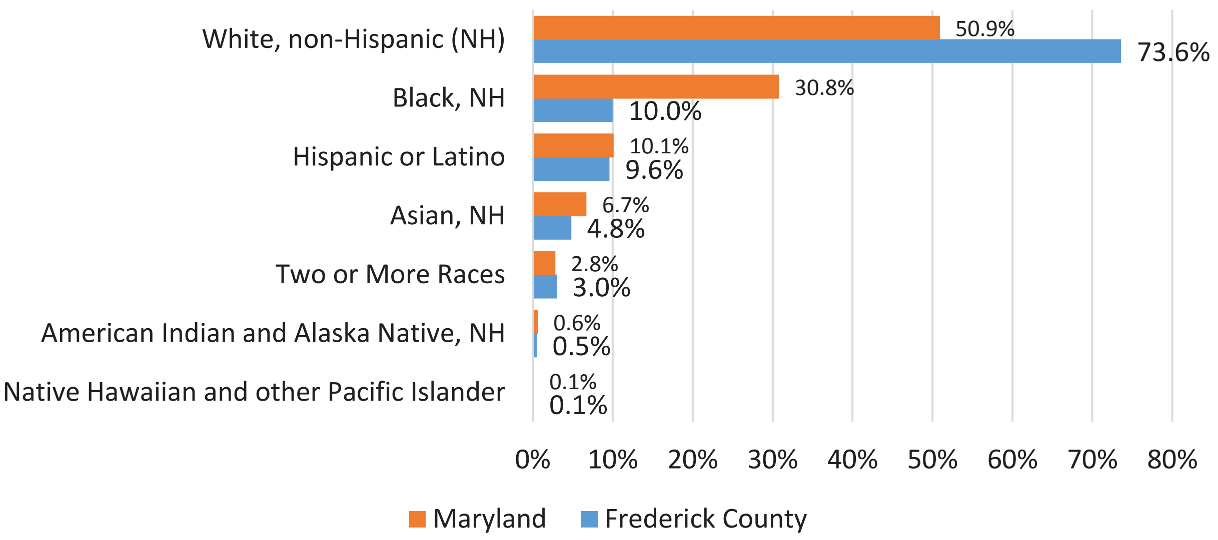
- What are the major causes of illness, injury and death in the community?
- What health issues and behaviors are most concerning to local citizens and community organizations serving Frederick County?
- What barriers and resources exist for residents to achieve better health?

The following report presents the findings of the CHNA and the 2019-2021 health improvement priorities in Frederick County.

Frederick County Community Profile

The service area for this report is Frederick County, MD[1]. The county jurisdiction was selected because it constitutes the service area for the health and human service providers who are charged with implementing actions to address priority needs.

Frederick County is located in northern Maryland. In 2018, the County's population was 252,022. Compared to Maryland, Frederick County has a larger population of residents who are White, non-Hispanic than other demographic groups. It should be noted that the County's racial and ethnic composition has continued to change. Minority populations are increasing, creating a need for increased availability of translation and interpretation services and culturally appropriate service providers to meet the health needs of the changing population.



Other Facts about Frederick County Residents:

92.6% are high school graduate or higher (25+ years)

40.5% have bachelor's degree+

14.1% are 65 years or older

7.5% have a disability (<65 years)

13.1% speak a language other than English at home

10.2% are foreign-born

5.5% don't have health insurance (under age of 65)

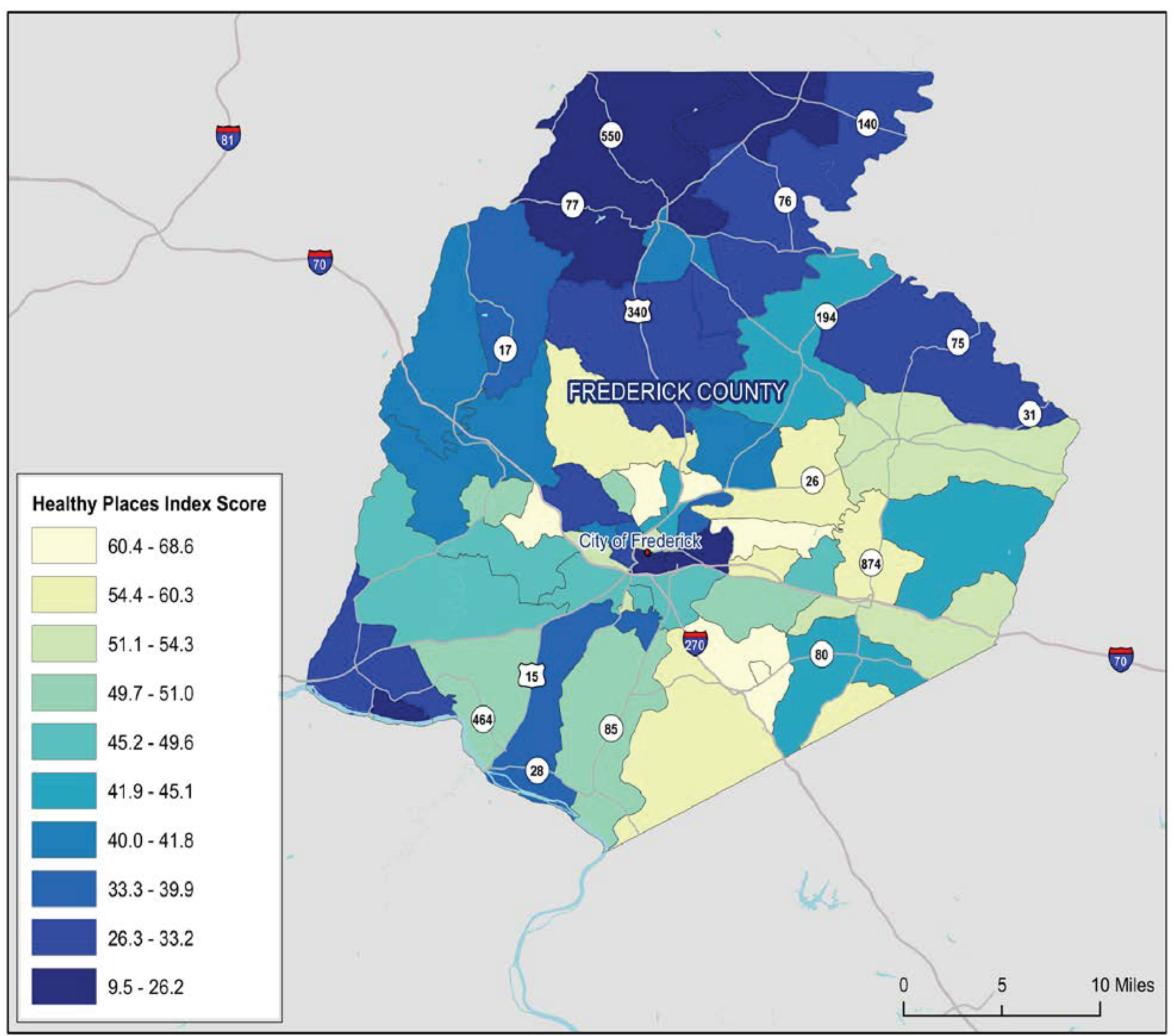
6.9% are in poverty

Source: U.S. Census Bureau, QuickFacts: Frederick County, Maryland, population estimates July 1, 2018.
Bolded facts indicate that Frederick County is higher than Maryland; Non-bolded shows Frederick County is lower than Maryland.

[1] Frederick County constitutes the service area for Frederick Memorial Hospital, a sole community hospital and subsidiary of Frederick Regional Health System. The service area represents 86% of all patients discharged for acute care services. The CHNA service area definition meets the regulatory requirement for hospitals participating in a collaborative CHNA.

Our health is impacted by many factors, from personal decisions to eat well and exercise, access to healthy foods, literacy and educational level, household resources, housing, and transportation. Because of these factors, some communities in Frederick County are healthier than others.

The map below shows the Healthy Places Index by census tract in Frederick County. This tool captures a variety of the factors that impact our health. Lighter shaded areas are healthier than darker shaded areas. This map highlights the fact not all communities within Frederick County have the same opportunity to be healthy.



Source: Uneven Opportunities: How conditions for wellness vary across the metropolitan Washington Region, October 2018. https://www.mwcog.org/documents/2018/10/26/uneven-opportunities-how-conditions-for-wellness-vary-across-the-metropolitan-washington-region-health-health-data/

Methodology

The Health Care Coalition formed an ad hoc CHNA Planning Committee comprised of Coalition board members and community partners. This group had oversight responsibility for the CHNA process and reviewed the components as they were accomplished. Additionally, a CHNA Data Sub-Committee was formed to conduct the detailed data analysis, which as then reported to the CHNA Planning Committee. See Appendix 8 for a member listing.

The 2019 CHNA included collation of data from primary (qualitative) and secondary (quantitative) sources. Four inputs were identified for inclusion in the data analysis. Three of the inputs provided insights about the perspective and priority of health issues and social determinants by the Frederick County population. The fourth input was health outcome indicators gathered from reliable public resources, and where possible, included data on health disparities.

The CHNA process began with the distribution of a community survey available to any adult (over 18 years of age) Frederick County resident. The survey was designed to assess respondents' personal health status, health risk behaviors, and preventive health practices. An online and paper version of the survey was distributed between July and August 2018 in English, Spanish, and Vietnamese. Community partners were asked to distribute, communicate and if requested, facilitate completion of the survey. A total of 1,692 surveys were received.

The next step in the CHNA process focused on input from vulnerable and known health disparity populations. Data from the 2016 CHNA indicated that residents of Northern Frederick County (defined as Emmitsburg and Thurmont zip codes) had poorer health outcomes. Disparity data revealed African American and Hispanic residents also had poorer health outcomes. Homeless/low income residents were also identified as a vulnerable population with respect to access to resources. Observation Baltimore, a qualitative research firm, led a moderated discussion with each group in September 2018. A total of 52 community members participated in the focus groups. Participants were recruited by partner organizations that provide services or support to the target populations. The goal of the focus group was to delve deeper into these affected populations in order to learn how to more effectively tailor services and interventions that will result in a reduction in health disparities.

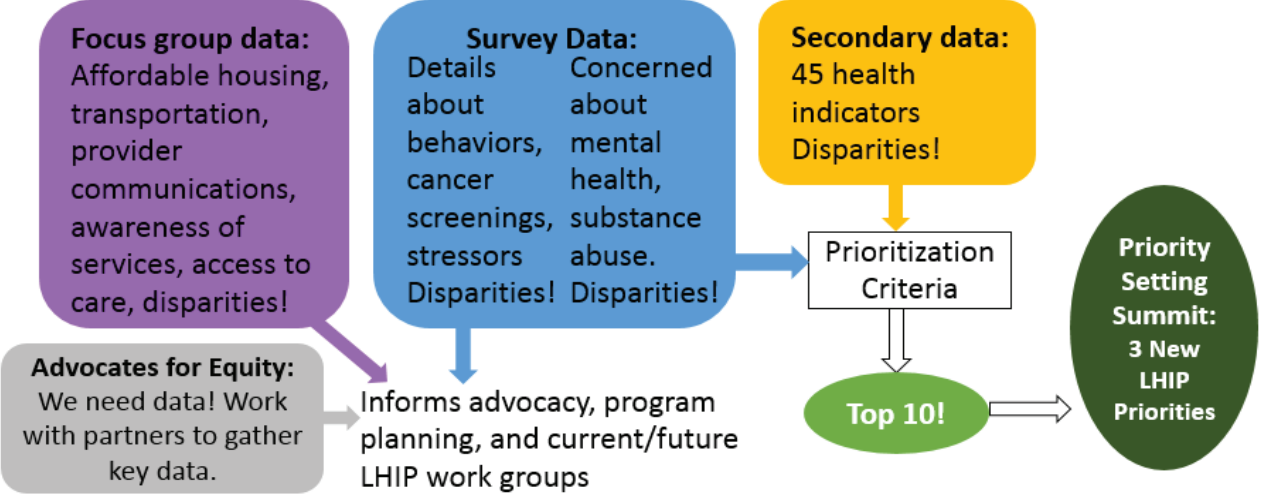
Members of the CHNA Planning Committee expressed a concern that four focus groups may not adequately cover all the vulnerable or target populations within Frederick County. However, data were not available to document health disparities or specific access issues in other populations. This situation provided an opportunity to capture more information for further study going forward. A health equity survey was subsequently developed and distributed, and a total of eight respondents submitted their insights between September and October 2018. The advocates represented ALICE (asset limited, income constrained, employed), disabled, Hispanic, homeless, LGBTQ, seniors, and youth populations.

Secondary data was gathered on 45 health indicators prior to October, 2018. The analysis of community health status described in this report is derived from the following sources:

- Drug and Alcohol Intoxication Deaths in Maryland https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Pages/Data-and-Reports.aspx
- Healthy People 2020 https://www.healthypeople.gov/
- Maryland Behavioral Risk Factor Surveillance System (BRFSS) www.marylandbrfss.org
- Maryland Cancer Reports https://phpa.health.maryland.gov/cancer/Pages/surv_data-reports.aspx
- Maryland Department of Health Vital Statistics Annual Reports https://health.maryland.gov/vsa/pages/reports.aspx
- Maryland Youth Risk Behavior Survey (YRBS) https://phpa.health.maryland.gov/ccdpc/Reports/Pages/yrbs.aspx
- U.S. Census Bureau: State and County Quick Facts http://www.census.gov/quickfacts/table/PST045215/24021
- Maryland State Health Improvement Process (SHIP) http://ship.md.networkofcare.org/ph/
- Maryland Department of Labor, Licensing & Regulations http://www.dllr.state.md.us/lmi/laus/
- Metropolitan Washington Council of Government Report. October 2018. Uneven Opportunities: How Conditions for Wellness Vary Across the Metropolitan Washington Region. https://www.mwcog.org/documents/2018/10/26/uneven-opportunities-how-conditions-for-wellness-vary-across-the-metropolitan-washington-region-health-health-data/

Fitting it all Together

The information collected from the four focus groups, Advocates for Equity survey, and the community survey will inform local advocacy efforts and can be used for program planning. Community survey and secondary data were compiled for the prioritization component of the CHNA process. A modified prioritization matrix method was used for prioritization of the data across several criteria in order to narrow down the information into the top ten health concerns.



Progress from 2016 CHNA Cycle

An important aspect of any planning cycle is evaluating the impact of actions completed during the prior planning cycle. This review can offer insight for future cycles, as well as practical takeaways on how to improve the planning process. A summary of key achievements of the 2016 cycle work groups are below[2]:

- Adverse Childhood Experiences (ACEs)
  - Increased community awareness of ACEs by providing education through avenues such as book clubs, monthly magazine column, movie screenings, and Parent Cafes.
  - 2018 Summit of Intersections conference for licensed behavioral health providers focused on the intersection of Behavioral Health, Intimate Partner Violence, and Substance Use Disorder with ACEs.
  - Effected local private and public funding policy resulting in a minimum of $440,000 in private sector grants incorporating ACEs as a criteria in the funding decisions over a 3-year cycle and a new funding priority for ACES in County funded community grants.
  - Developed screening tool recommendations and a trauma-focused provider survey which will be implemented during the next cycle.
- Behavioral Health
  - Trained community-based lay educators about available crisis services.
  - Developed and delivered more than 30 presentations on an anti-stigma campaign to increase awareness of how stigma adversely impact efforts to address the issues in the community. Distributed over 35,000 bookmarks and postcards as part of the campaign.
  - Served as a catalyst for the County funding the establishment of a 24-hour detox facility.
- Senior Support
  - Conducted survey of transportation needs and identified existing resources.
  - Through participation with the Frederick County Commission on Aging and the National Aging in Place Council identified resources needed to "age in place" and made recommendations to existing governmental agencies to establish a clearing house.
  - Formed a Transportation and Mobile Care Task Force, which expanded the focus beyond seniors to other groups facing transportation challenges.

Two key findings were identified when evaluating the progress made since the 2016 CHNA. The first is that sustaining community engagement requires consistent support. All work group participants are voluntary and the duration of commitment is three years. In order to sustain involvement, work groups members need consistent support and technical expertise throughout action plan development and implementation. The second finding is that work groups had difficulty measuring the impact of their actions. This does not mean the actions were not impactful, but rather most of the action plans measured process outcomes.

Going forward, work groups will have facilitators to assist with action plan development and ongoing technical support. In addition, work groups will be required to use a logic model in the development of the action plan. The logic model incorporates goals, measurable outcomes, and identification of resource requirements and steps necessary to achieve the goals. United Way of Frederick County will provide logic model training to benefit organizations implementing health improvement solutions.

[2] See http://health.frederickcountymd.gov/LHIP for work group progress reports for the 2016 CHNA.

Community Perceptions and Themes

Community Survey

See Appendix 7 for the survey and Appendix 1 for the detailed results.

Advocates for Health Equity

A major theme from the survey was lack of data, which highlights the need to work together to identify health disparities in order to address them. Frequently mentioned needs based on client service requests included:

- Access
- Transportation
- Mental Health
- Affordable housing
- Affordable health care
- Dental services
- Job
- Substance use treatment

See Appendix 1 for detailed responses.

Focus Groups

Similar themes emerged in the current focus groups as in the 2016 cycle. Newly identified community issues are shown in red.

2016	Current
✓Transportation ✓Health insurance cost ✓Awareness of services at Health Department	✓Affordable housing ✓Provider communications: relatability, language ✓Transportation ✓Awareness of community services and resources ✓Getting a provider appointment when needed

Housing was an overwhelming top concern – which is consistent with the United Way ALICE Index that shows Frederick County scores poorly on affordable housing. This is even more apparent in the focus group populations, where all but 4% of participants would be considered an ALICE household. Transportation was cited in terms of lack of public options and affordability among North County and Hispanic focus groups. Provider issues emerged prominently in African American and Hispanic focus groups.

The four focus groups identified the following health service needs and obstacles:

Low Inc/Homeless	African American	North County	Hispanic
1. Mental health 2. Dental care 3. Pain Management *Obstacles:* ▪ Complex eligibility processes for services ▪ Literacy ▪ Insurance acceptance and local network inadequacy	1. Dental care 2. Relatable mental health providers 3. Health education and training in self-advocacy *Obstacles:* ▪ Cultural values – delayed care, avoidance of care ▪ Service awareness and insurance coverage	1. Adequate providers 2. Affordable activity and nutrition options 3. Access to medical supplies *Obstacles:* • No gym, sidewalks or safe walking paths • No fresh produce at local markets	1. Vision 2. Dental care 3. Care for elderly 4. Translation services *Obstacles:* • Language • Cost • Affordable transportation • Insurance acceptance

See Appendix 1 for detailed responses.

Other Community Assessments

Other recent community assessments were reviewed for consideration in the CHNA. Findings and issues emphasized in these assessments are similar to concerns expressed by the public in the CHNA process. These assessments may be useful for the health priority work groups as they identify target populations and design implementation strategies. In addition, the CHNA and these assessments strongly suggest community collaboration on social determinants of health and allocation of resources to fund initiatives to address improvement opportunities.

ALICE: A Study of Financial Hardship in Maryland, 2018 Report

In October 2018, United Way of Frederick County released The ALICE Index, an assessment of the well-being of working families. ALICE collates cost of living indicators such as housing, transportation, food and health care to estimate the annual income necessary for a family to address basic needs in a given community. The purpose of the index is to identify the number of individuals and families in Frederick County who are above the federal poverty line and employed, but unable to afford the basic necessities.

The study identified 32% of households in Frederick County at economic risk. Within the County, the communities of Emmitsburg, Thurmont and Frederick City had the highest percentage of ALICE households. A demographic analysis reveals that all races are at risk of being an ALICE Household, but 69% of single women live in an ALICE household. The survival budget necessary to reside in Frederick County varies from $31,000 for a single person to $75,000 for a family with two children. These budget requirements equate to a minimum wage of $15/hour, which is higher than the state minimum wage requirement of $10.10.

The two largest cost indicators that lead to an ALICE household are housing costs and transportation – both of which were identified as community concerns by all four focus groups in the CHNA. Potential impacts of living in an ALICE household include stress, food insecurity, absenteeism related to lack of child care and transportation, and increased health care utilization due to delay in care to avoid costs.
https://www.unitedforalice.org/maryland

The Community Foundation of Frederick County, 2018 Human Needs Assessment

The Community Foundation of Frederick County is a philanthropic organization that connects people who care with causes that matter to enrich the quality of life in Frederick County. Their funding provides scholarships to students and grants to area nonprofit organizations.

The Foundation completed a Human Needs Assessment in 2018 to guide funding allocations over the next ten years. The assessment included a review of qualitative data and quantitative input from key informants and the public, and identified three priorities:

- Supporting families with children of all socioeconomic backgrounds
- Preparing for a growing elderly population
- Responding to substance use disorder including opioids and alcohol.

Foundation leadership participated in the CHNA Planning Committee and local health improvement health priorities were considered prior to finalizing the human needs priorities. Two of the Foundation priorities - substance use and supporting families with children – directly align with health priorities in the 2019 CHNA. This intersection will facilitate funding for strategies in response to addressing both human and health needs.
https://www.frederickcountygives.org/Impact-Initiatives/Human-Needs-Assessment-Report

The Liveable Frederick Master Plan: 2018 Frederick County

Liveable Frederick is a comprehensive plan that aligns what citizens' value about Frederick County within a framework for planned growth. The plan links transportation, public health and jobs to land use decisions, and includes tenants that sustain protection of the environment, historical and cultural assets and an agricultural economy.

Of note, the plan recognizes and sets goals related to improving housing stock and diversity and transportation methods to address the risks identified in the ALICE Index discussed above. The plan also includes a vision for community health with goals for active places and environmental spaces that increase physical activity, healthy food choices and food access, safe built environments, and community support for access to resources, behavioral health, social bonding, child growth and aging.

The plan utilized the same data sources and many of the same public inputs that were involved in the CHNA process. Liveable Frederick goals align and support the identified community health priorities. This alignment will help with community consensus building and potential resource allocation for implementation strategies.
https://www.livablefrederick.org/master-plan

Uneven Opportunities: How conditions for wellness vary across the metropolitan Washington Region, October 2018

The Virginia Commonwealth University Center on Society and Health produced a report for the Health Officials Committee of the Metropolitan Washington Council of Governments (MWCOG). The report was requested by MWCOG because health status is not uniform across the region. In fact, the statistics of individual neighborhoods vary dramatically. This study examined mortality rates across the region's 1,223 census tracts and found that life expectancy at birth—how long a newborn baby can expect to live—varied by 27 years in the District of Columbia and by 13 years in Frederick County, Maryland. The geographic disparities in health that exist across neighborhoods are shaped largely by the social determinants of health.

Census tract-level data for each area were collected on 48 indicators covering six broad policy action areas, as well as 16 additional indicators to assess the influence of race-ethnicity and immigrant status. The Metropolitan Washington Healthy Places Index (HPI) provides a snapshot measure of the conditions in a census tract that are associated with increased (or decreased) life expectancy. The HPI is useful to anyone interested in learning how local neighborhood conditions influence the health of communities, and it shows that life expectancy in the metropolitan Washington region is shaped less by health care than by the social determinants of health.

Health care is a necessary but insufficient solution to addressing these health inequities. Health is about more than health care. Tools such as the Healthy Places Index can help identify "hot spots" for community and economic development. Long term solutions require targeted interventions and investments in marginalized neighborhoods to improve access to affordable, healthy housing as well as affordable transportation, child care, and health care (e.g., primary care, dental care, behavioral health services).

https://www.mwcog.org/documents/2018/10/26/uneven-opportunities-how-conditions-for-wellness-vary-across-the-metropolitan-washington-region-health-health-data/

Prioritization of Health Issues

Frederick County data for 45 health indicators were used to determine the health issues with the greatest adverse impact on Frederick County residents. A modified prioritization matrix was used to evaluate and rank the data. The following criteria were applied:

		Scoring		
Item	**Definition**	**Low (1)**	**Medium (2)**	**High (3)**
1. Size	Percent of population with health problem	0.01-10% of population	10-25% of population	>25% of population
2. Severity	Seriousness of health problem based on morbidity rates, mortality rates, economic loss, and the degree to which there is an urgency for intervention	Less severe, causes discomfort or acute illness, intervention not urgent	Moderately severe, causes disability or chronic illness, intervention strongly recommended	Very severe, causes death or significant disability, intervention urgent
3. Trend	Has the problem improved, worsened or not changed in recent years?	Trend is improving	Trend is staying the same	Trend is getting worse
4. Impact on others	Does this issue impact the health outcomes and/or is a driver for other conditions?	Little impact on health outcomes or other conditions	Some impact on health outcomes or other conditions	Great impact on health outcomes or other conditions
5. Variance vs benchmarks *different scale	How do local rates compare to MD SHIP if available, or HP2020? See Appendix 4 & 5	-1: Local rates are better than the benchmark	0: Local rates are the same as the benchmark or no benchmark available	1: Local rates are worse than the benchmark
6. Community Perception	Has this issue been identified by more than 50% of survey respondents (question 3)		+2 for issues identified by community	
7. Disparity	Are some populations disproportionately burdened? See Appendix 6			+3 if disparity is known

See Appendix 3 for the health indictor scoring using the Prioritization Matrix.

After applying the criteria, the CHNA Planning Committee reviewed the results of the prioritization matrix and narrowed the list of health issues to outcome indicators ranking above 10 points. Related health indicators were combined to produce a final ranking. The following pages show Fact Sheets for each of the top ten health indicators.

Indicators ranked over 10

	Health Indicator	Rank
1	Alcohol Use (adolescents)	14
2	Breast Cancer (incidence)	13
3	Syphilis	13
4	Obesity (adolescents)	13
5	Hypertension	12
6	Gonorrhea	12
7	Cancer, all (incidence)	11
8	Overdose deaths	11
9	Melanoma Cancer (incidence)	11
10	Infant mortality	11
11	HIV	11
12	Tobacco Use (adolescents)	11
13	Chlamydia	10
14	Obesity (adults)	10
15	Intentional Self- Harm/ Suicide	10
16	Colorectal Cancer (incidence)	10
17	Low birth weight	10
18	Alcohol Use (adults binge)	10
19	Oral Cancer (incidence)	10
20	Mental Health	10
21	Adverse Childhood Experiences	10

Combinations:

- Top ranking cancers
- STIs (gonorrhea, chlamydia & syphilis)
- Infant health (infant mortality and low birth weight)
- Substance Use (alcohol, tobacco, overdose deaths)
- Adult/teen indicators

Top 10 (with combinations)

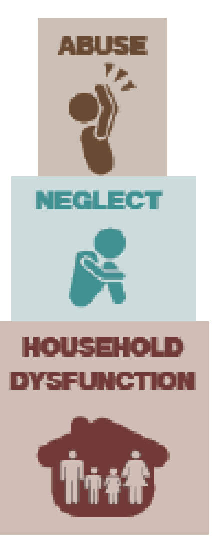
Health Indicator	Rank
Cancer (breast 13, all 11, melanoma 11, colorectal 10, oral 10)	55
Substance Use (alcohol-teen 14, overdose deaths 11, tobacco 11, alcohol-adult 10)	46
STI (syphilis 13, gonorrhea 12, chlamydia 10)	35
Obesity (teen 13, adult 10)	23
Infant Health (mortality 11, low birth weight 10)	21
Hypertension	12
HIV	11
Intentional Self- Harm/ Suicide	10
Mental Health (8-30 days not good/month)	10
Adverse Childhood Experiences (ACEs) (3+)	10

2019 Frederick County, MD

Adverse Childhood Experiences (ACES)

Quick Facts:

- Adverse Childhood Experiences (ACEs) are traumatic incidents in a child's life that cause toxic stress--especially abuse, neglect, and exposure to violence.
- Toxic stress can build up and overwhelm a child's ability to cope when exposure to adversity happens without healthy support from adults. Toxic stress undermines brain architecture and function, increasing the risk of negative physical and mental health outcomes.
- Having multiple ACEs increases risk for negative behavioral and mental outcomes, chronic disease, and possibly early death.

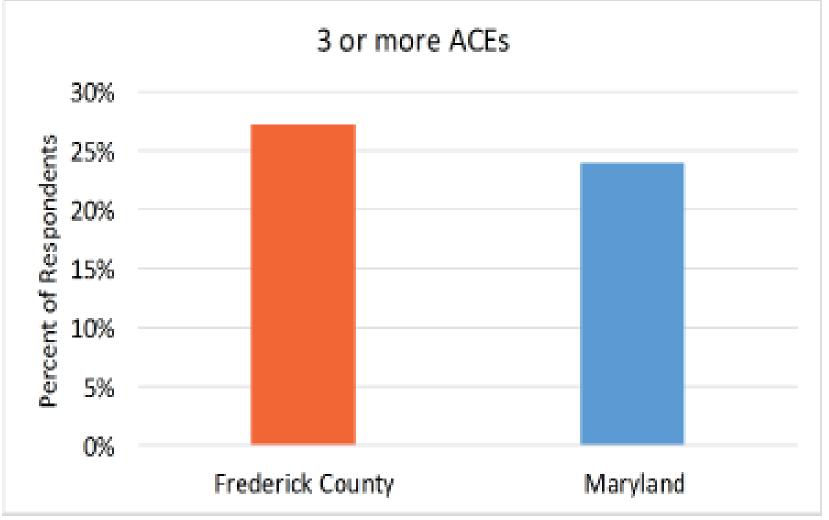


How many people does this affect?

52,578 Frederick County adults with 3+ ACEs or 27.2% in 2016.

Severity: Moderately severe. Early life impact can cause chronic, generational issues, intervention strongly rec.

Disparity:
No Frederick County data available.



Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS)

No **Trend** data available

Cancer (breast, melanoma, colorectal, oral)

Quick Facts:

- Complex and interrelated factors contribute to the risk of developing cancers.
- Many cancers are preventable by reducing risk factors and by early screening.
- Cancer continues to be the second leading cause of death in Frederick County.

How many people does this affect in Frederick County?

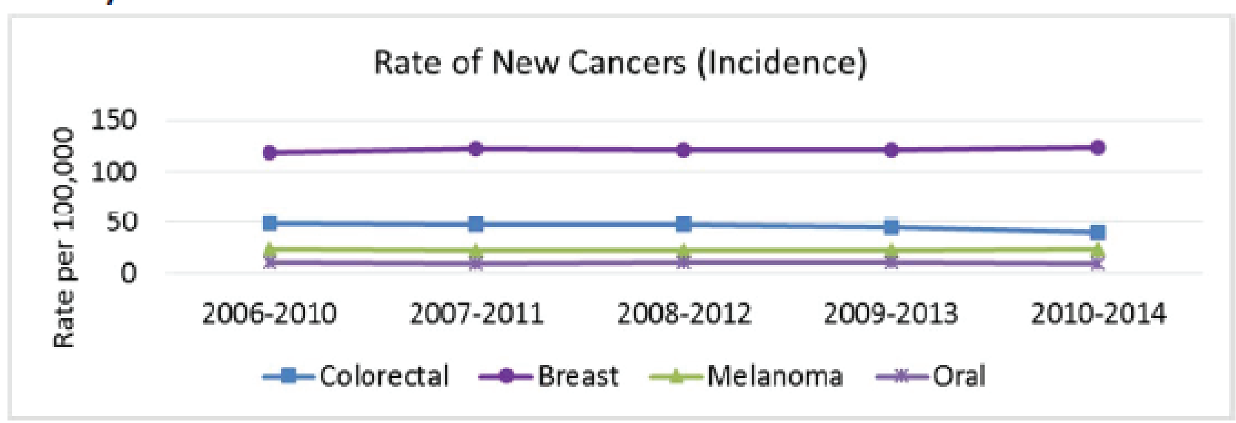
	# diagnosed in 2014	Rate Dx per 100,000	Mortality Rate per 100,000	HP 2020 Goals for Mortality Rate per 100,000
Oral	24	9.5		N/A
Melanoma	58	23.1	2.4	2.4 **MET**
Colorectal	100	39.5	15.5	14.5 **NOT MET**
Breast	313	124.2	21.3	20.7 **NOT MET**

Severity: *Very severe*, causes death or significant disability, intervention is urgent

Disparity:

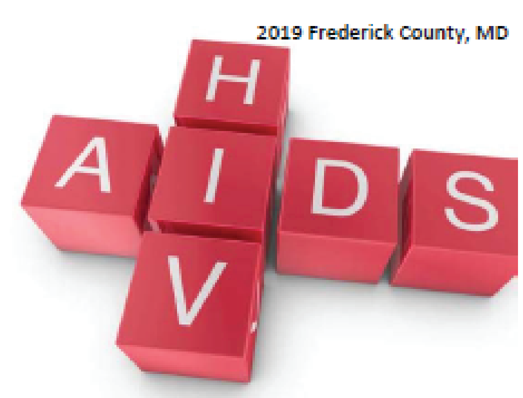
- Oral: higher in men
- Melanoma: higher in men
- Colorectal: higher in Blacks and men
- Breast: higher in Black women

Trend is: **worsening for breast and melanoma, improving for colorectal, steady for oral**



Source: Maryland Cancer Report. Rates are per 100,000 and are age-adjusted to 2000 US standard population.

HIV



Quick Facts:

- The human immunodeficiency virus (HIV) is a virus spread through certain body fluids that attacks the body's immune system. If untreated, HIV progresses to acquired immunodeficiency syndrome or AIDS.
- Public perception in the United States about the seriousness of HIV has declined in recent years, but HIV is preventable through testing and treatment.
- An estimated 16% of people with HIV in Maryland are undiagnosed. We have the knowledge and tools needed to slow the spread of HIV infection and improve the health of people living with HIV.

How many people does this affect?

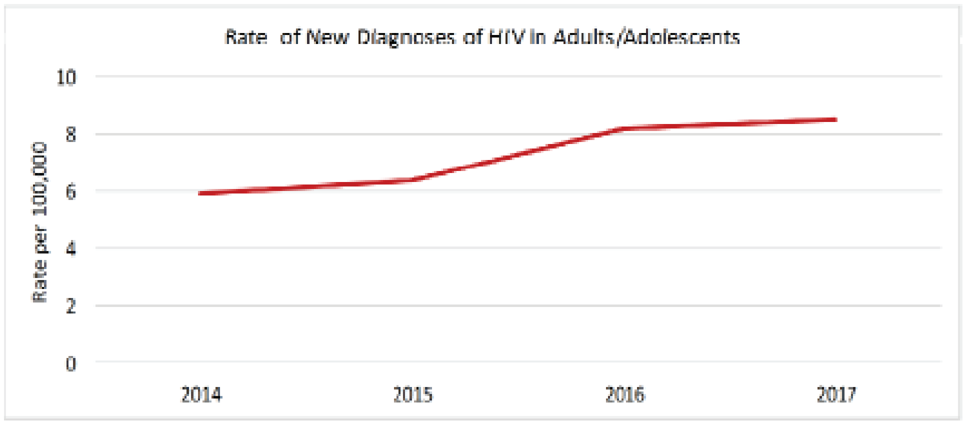
18 adults/adolescents diagnosed with HIV in 2017 or 8.5 per 100,000

MD SHIP Goal:
26.7 per 100,000
MET

Severity: *Very severe*, causes death or significant disability, intervention urgent

Disparity:

- Higher among White men



Source: Maryland Annual HIV Epidemiological Profile

Trend is:
getting worse

2019 Frederick County, MD

Hypertension

Quick Facts:

- High blood pressure is a common and dangerous condition. Having high blood pressure means the pressure of the blood in your blood vessels is higher than it should be.
- Hypertension increases the risk of heart disease, stroke, dementia, and kidney problems

How many people does this affect?

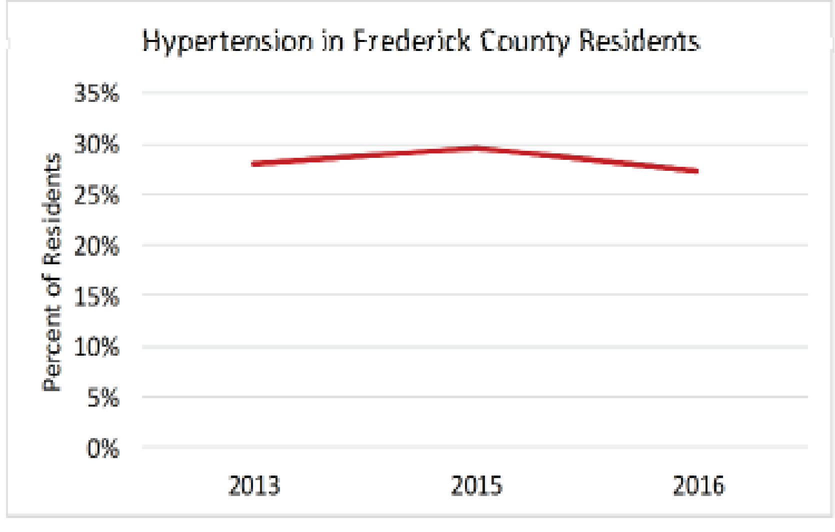
52,578 adults have hypertension or 27.2% in 2016.

HP 2020 Goal:

26.9%
NOT MET

Severity: *Moderately severe*, causes disability or chronic illness, intervention strongly recommended

Disparity:
No Frederick County data available.



Trend is:
getting better

Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS)

Infant Health (Infant Mortality, Low Birth Weight)

Quick Facts:

- Healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.
- Frederick County has better infant health outcomes than Maryland, but experiences significant racial disparities.
- Low birth weight can lead to increased risk of obesity, hypertension, diabetes, and heart disease.
- Low birth weight is defined as weighing less than 2500 grams or ~5.5lbs.

How many people does this affect in Frederick County?

17 infant deaths or 6.3 deaths per 1,000 in 2017

MD SHIP Goal: 6.3 per 1,000 MET

187 infants at low birth weight or 6.9% in 2017

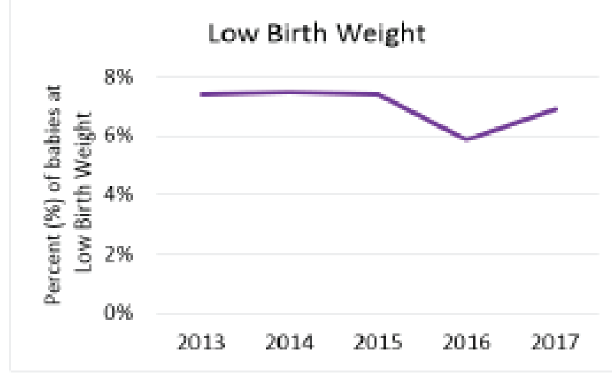
MD SHIP Goal: 8% - MET

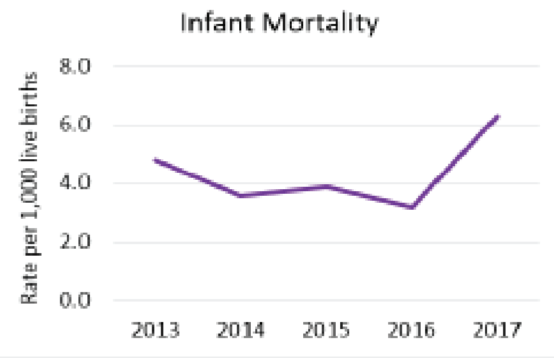
Severity:
Infant mortality: *Very severe*, causes death or significant disability, intervention is urgent
Low birth weight: Moderately severe

Disparity:

- Both higher in Blacks than in Whites

Trend is: getting worse





Note: different scales on graphs

Source: Maryland Vital Statistics Reports

2019 Frederick County, MD

Mental Health

Quick Facts:

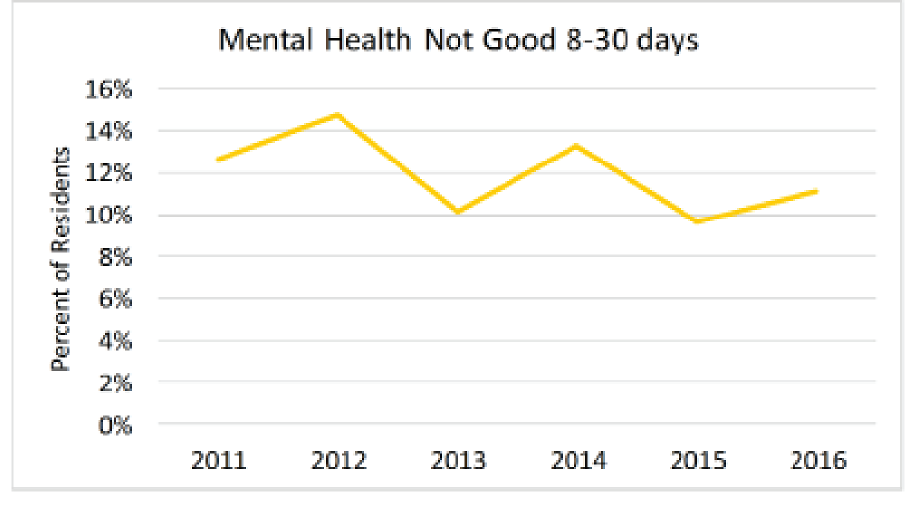
- Mental health is an important part of overall health and well-being and includes our emotional, psychological, and social well-being.
- It helps determine how we handle stress, relate to others, and make healthy choices and is important at every stage of life, from childhood and adolescence through adulthood.
- Poor mental health is linked to higher unemployment, poverty, disability

How many people does this affect?

21,456 adults reported 8-30 days their mental health wasn't good in the last 30 days, or **11.1%** of adults.

Severity: *Moderately severe*, causes disability or chronic illness, intervention strongly recommended

Disparity:
No Frederick County data available.



Trend is:
Overall decreasing, but increased in last year

Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS)

2019 Frederick County, MD

Obesity (Adults and Adolescents)

Quick Facts:

- Diet and body weight are related to health status. Good nutrition is important to the growth and development.
- Individuals who are not at a healthy weight are more likely to:
    - Develop chronic disease risk factors, such as high blood pressure.
    - Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
    - Experience complications during pregnancy.
    - Die at an earlier age

How many people does this affect in Frederick County?

1,232 high school students or 9.6% in 2016

51,611 adults or 26.7 in 2016

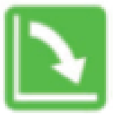
HP 2020 Goal:
30.5% - MET

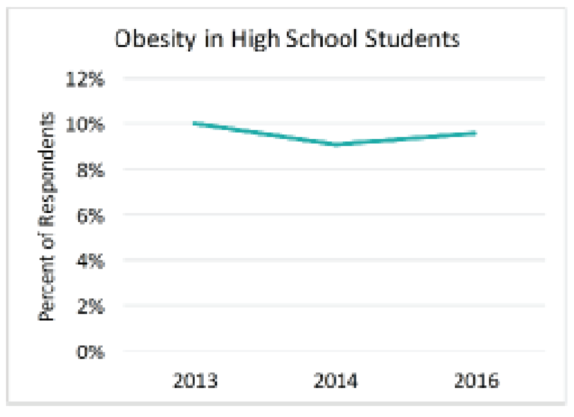
Severity:
Moderately severe, causes disability or chronic illness, intervention strongly recommended

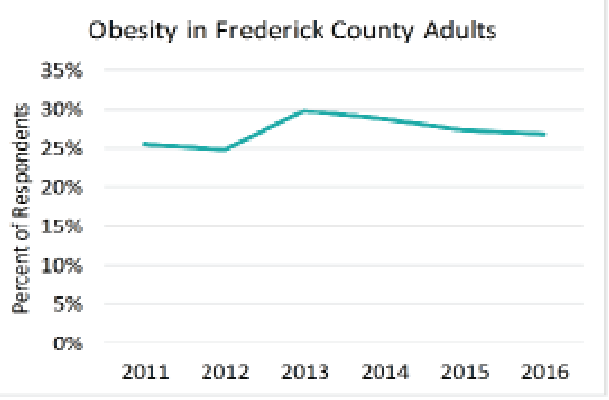
Disparity:

- Higher in high school boys than girls

Trend is:
getting better







Note: different scales on graphs

Source: Maryland Behavioral Risk Factor Surveillance System and Youth Risk Behavior Survey

2019 Frederick County, MD

Sexually Transmitted Infections

(Syphilis, Gonorrhea, and Chlamydia)

Quick Facts:

- STIs are acquired during unprotected sex with an infected partner.
- Untreated STIs can lead to serious long-term health consequences, especially for adolescent girls and young women.
- Frederick County has lower rates than Maryland for syphilis, gonorrhea, and chlamydia.
- Syphilis may lead to dementia, blindness, and deaths.
- Gonorrhea and chlamydia may lead to infertility, pregnancy complications

How many people does this affect in Frederick County?

26 syphilis cases or 1.6 cases per 100,000 in 2017

138 gonorrhea cases or 54.8 cases per 100,000 in 2017

862 chlamydia cases or 342.0 cases per 100,000 in 2017

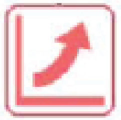
MD SHIP Goal: 431 chlamydia cases per 100,000 MET

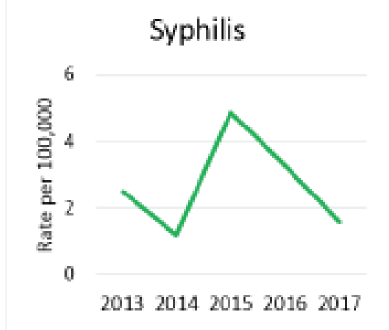
Severity:
Syphilis: *Very severe*, causes death or significant disability, intervention is urgent
Gonorrhea: Moderately severe
Chlamydia: Less severe

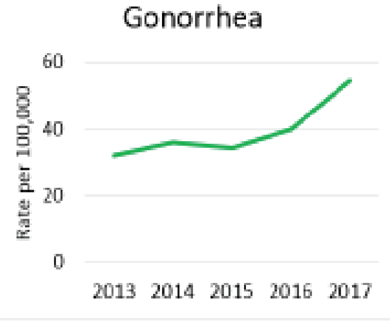
Disparity:

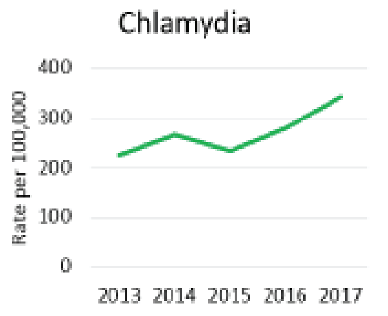
- Syphilis: higher in Whites and males
- Gonorrhea: higher in Black and males
- Chlamydia: higher in females

Trend is: getting worse









Note: different scales on graphs

Source: Maryland Department of Health Reports

2019 Frederick County, MD

Substance Use (Alcohol, Tobacco, Overdose)

Quick Facts:

- Large percentages of the Frederick County population are experiencing substance use.
- Adolescent (teen) use of substances such as alcohol and tobacco can have a significant impact on their lifelong health and wellbeing.
- Drug and alcohol related deaths include any death that was the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, fentanyl, alcohol, cocaine, prescription opioids, etc.

How many people does this affect in Frederick County?

78 people died of drugs/alcohol or 30.9 per 100,000 in 2017 → 12.6 per 100,000 NOT MET*

3,016 high school students use tobacco or 23.5% in 2016 → 15.2% NOT MET*

4,094 high school students use alcohol or 31.9% in 2016

37,500 adults binge drink alcohol or 19.4% in 2016 → 24.2% MET**

GOALS

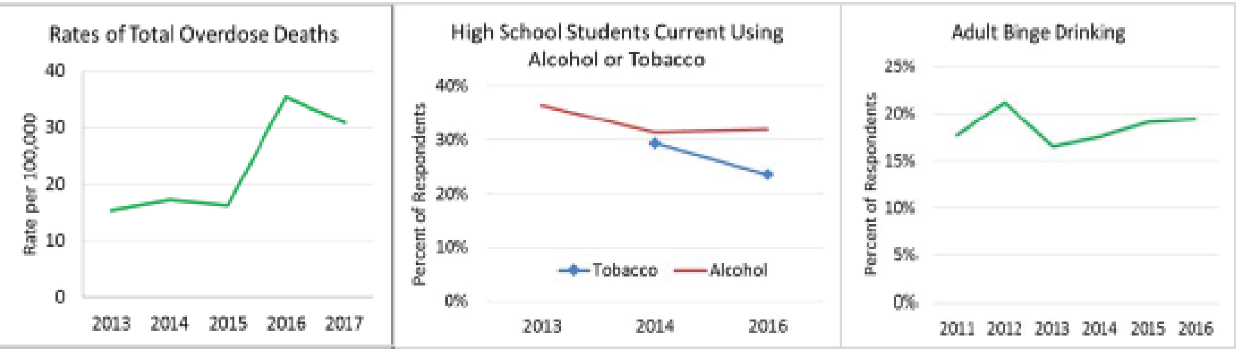
*MD SHIP **HP2020

Severity:
Overdose: *Very severe*, causes death or significant disability, intervention is urgent
Tobacco use: Less severe
Alcohol use in teens: Moderately severe
Adult binge drinking: Less severe

Disparity:

- Alcohol and tobacco use in adolescents: higher in males, Black, and Hispanic

Trend is: overall worsening, some recent improvement



Note: different scales on graphs

Source: Maryland Behavioral Risk Factor Surveillance System and Youth Risk Behavior Survey

Suicide

Quick Facts:

- Suicide/intentional self-harm is the 10th *leading cause of death in Frederick County* and U.S, and is 12th in Maryland.
- The suicide rate in Frederick County is *higher* than Maryland.

2019 Frederick County, MD

How many people does this affect?

28 suicide deaths in 2017 or 10.3 deaths per 100,000 in Frederick County in 2015-2017

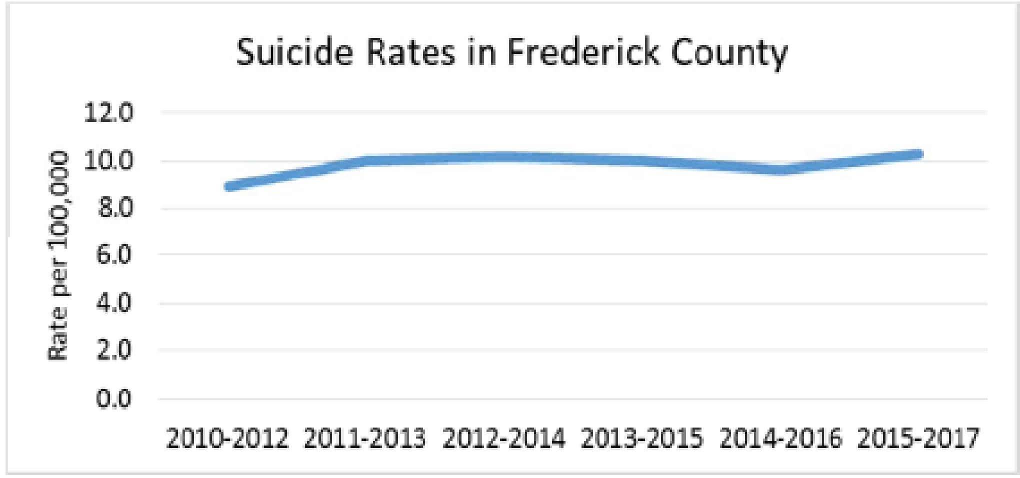
HP 2020 Goal:

10.2 deaths per 100,000
NOT MET

Severity: *Very severe*, causes death or significant disability, intervention urgent

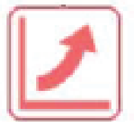
Disparity:

- Suicide rate are higher for *Whites* than Blacks
- Suicide rate are higher for *men* than women



Source: Maryland Vital Statistics Reports

Trend is:
getting worse



2019 Health Improvement Priorities

A Frederick County Health Improvement Priority Planning Summit was held on January 15, 2019 to establish the priorities for local health improvement. Over 130 participants, including elected officials, non-profits, county agencies, healthcare, and community members came together to hear presentations by local subject matter experts on the top ten health issues. Summit participants then completed a readiness assessment to determine the top three health improvement priorities for the next three years using the following questions:

1. Can we see measurable results/change within 3 years?
2. Do we have tangible resources/assets in our community available to address this problem?
3. Is there community support?
4. Could working on this problem support other identified problems?

Participants scored all ten health issues by assigning a point value to the four questions:

1=No/I don't think so 2=Some/Maybe 3=Yes/A Lot

Participants were also asked which topic they were willing to work on. Results were tabulated and reviewed by the group.

Health Topic	Total Score	# Willing to Work on
Substance Abuse	1257	68
ACEs	1249	78
Mental Health	1216	78
Infant Health	1189	45
Hypertension	1147	51
Suicide	1141	56
Cancer	1134	39
Obesity	1101	54
HIV	1011	23
STIs	997	20

Summit participants discussed the assessment findings and opted to combine related health indicators to narrow down the focus to three priorities:

- Adverse Childhood Experiences (ACEs) and Infant Health
- Behavioral Health (including substance use, mental health, suicide)
- Chronic Disease (including hypertension, obesity, cancer, STI's/HIV)

Two of the priorities are continuations from the prior cycle: Behavioral Health and ACEs. These priorities have new focal areas for the current cycle. Infant health has been added to the ACEs priority, and suicide has been added to Behavioral Health priority. Remaining health issues were reassigned a broader category of chronic health conditions, as they are preventable or may be influenced by changes in health behaviors.

Following the priority selection process, participants were offered the opportunity to engage in a work group kick-off process. Participants who expressed an interest in the priority topic were asked to join together to identify work group leaders and to set a timeframe for the first planning meeting. All three workgroups have subsequently begun the implementation planning process.

Community Resources

The following table inventories community resources that may be employed to address the top ten health issues and the 2019 CHNA health improvement priorities.

Priority Area	Community Resources
Adverse Childhood Experiences (ACEs)	• Interagency Early Childhood Committee • ACEs work group • Multiple system collaborations • Service Providers
Cancer	• Frederick Memorial Hospital Cancer Committee • FRHS Cancer Services (diagnostic, treatment and enabling resources) • FCHD cancer screening program for low income residents
HIV	• Frederick HIV Coalition/The Frederick Center • Free HIV testing at locations around community • Home test kits
Hypertension	• Bridges Lay Health Educators • Community Health Workers • Faith-Based Communities • Local Non-Profits focused on heart disease
Infant Health	• Special Delivery Nurse Home Visiting • Health Families Frederick • Frederick County Infants & Toddlers Program • Frederick County Family Partnership • Community Health Workers • WIC Program • The Judy Center • Safe Kids Coalition • Head Start Advisory Board • Fetal Infant Mortality Review Committee • Substance Exposed Newborns Program
Mental Health	• Network of mental health providers, outpatient to residential across age groups • Partnerships between schools, courts, hospitals, healthcare providers and mental health systems
Obesity	• Girls on the Run • Livewell Frederick: 5-2-1-0 Program • Frederick County Public Schools nutrition and physical activity policies
Sexually Transmitted Infections (STIs)	• Providers trained in case identification and reporting to FCHD
Substance Use	• Community drug take-back events • Public school curriculum • Merchant education and enforcement of age restrictions • Overdose response trainings • Syringe services and other harm reduction strategies • Underage Party Hotline
Suicide	• 24/7 call center • Suicide awareness, alertness, and intervention trainers providing evidence based trainings • Mental Health Association walk-in program and mobile crisis teams • AFSP Suicide Awareness Walk • Survivor of Suicide Loss group • Frederick Memorial Hospital acute care services (emergency, behavioral health unit, partial hospitalization program) • Training for law enforcement • Existing crisis services collaborations

Conclusions

The picture of Frederick County's health shown in this report is consistent with previous reports, as well as with other health assessments. Overall health in Frederick County is often, but not always, better than in Maryland. Improvements are seen in many health indicators, but chronic diseases like heart disease and cancer remain the leading causes of death. Some populations within Frederick County continue to see poorer health outcomes. Social and environmental issues, specifically affordable housing and transportation, remain top concerns of Frederick County residents.

Working within The County Health Rankings framework of community health illustrates the connections between health factors and health outcomes. Achieving positive change in the health status of Frederick County is only possible through the collaboration of all community sectors and alignment of effort and resources to focus on common concerns.

Local Health Improvement Plan work groups for each of the three priorities will establish their short and long term goals and objectives in action. These plans will be presented to the community when completed in Fall 2019. Progress reports will be posted for public review at: http://health.frederickcountymd.gov/LHIP. Community forums will be scheduled to discuss progress on the health priorities and ways for the community to remain involved.

CHNA data relevant to the work groups and other newly available health data will updated in 2020 and posted online at https://md-frederickcountyhealth.civicplus.com/455/Community-Health-Assessment.

Appendix 1. Primary Data

Community Survey Data

Race/ Ethnicity	% of survey	% FC 2017
Asian	7%	5%
Black	4%	10%
Hispanic	12%	10%
Native American	1%	0.1%
Other	2%	
White	79%	74%

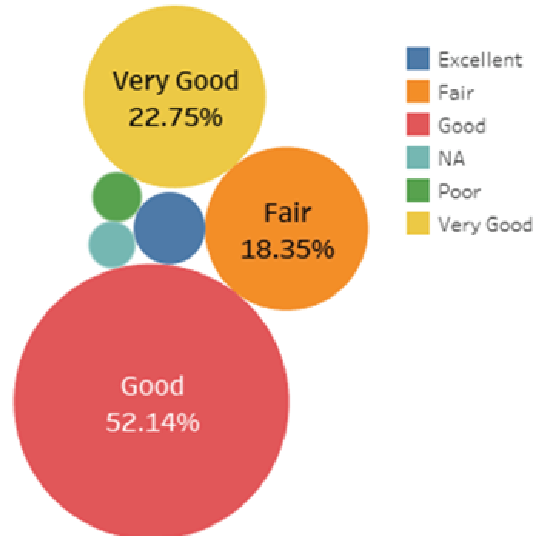
Age	%
18-30y	8%
31-40y	22%
41-50y	32%
51-64y	28%
65-80y	10%
81+y	0.00%

0% 10% 20% 30% 40%

19% 81%

Men Women

How do you rate the health of people who live in your community?



Nearly 80% of all respondents rate their community's health as good or better....but gender, age, race and ethnicity are significant influencers on ratings.

How do you rate your health?

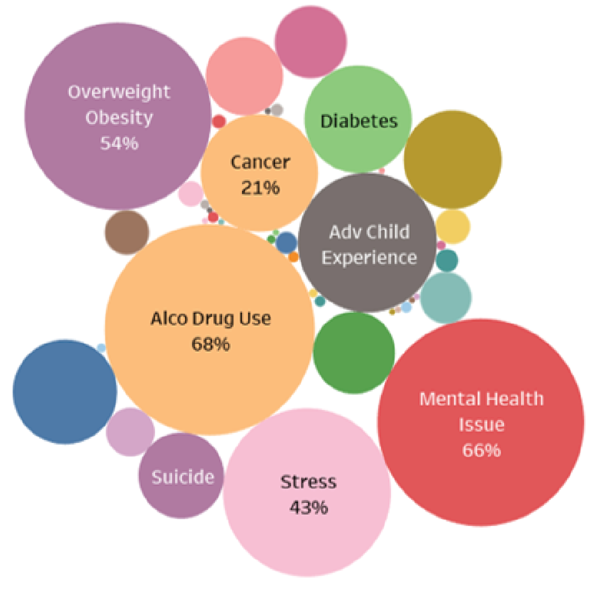
84% of residents said their health was good or better.

Focus groups rated their own health much lower.

Income is a large contributor to health.

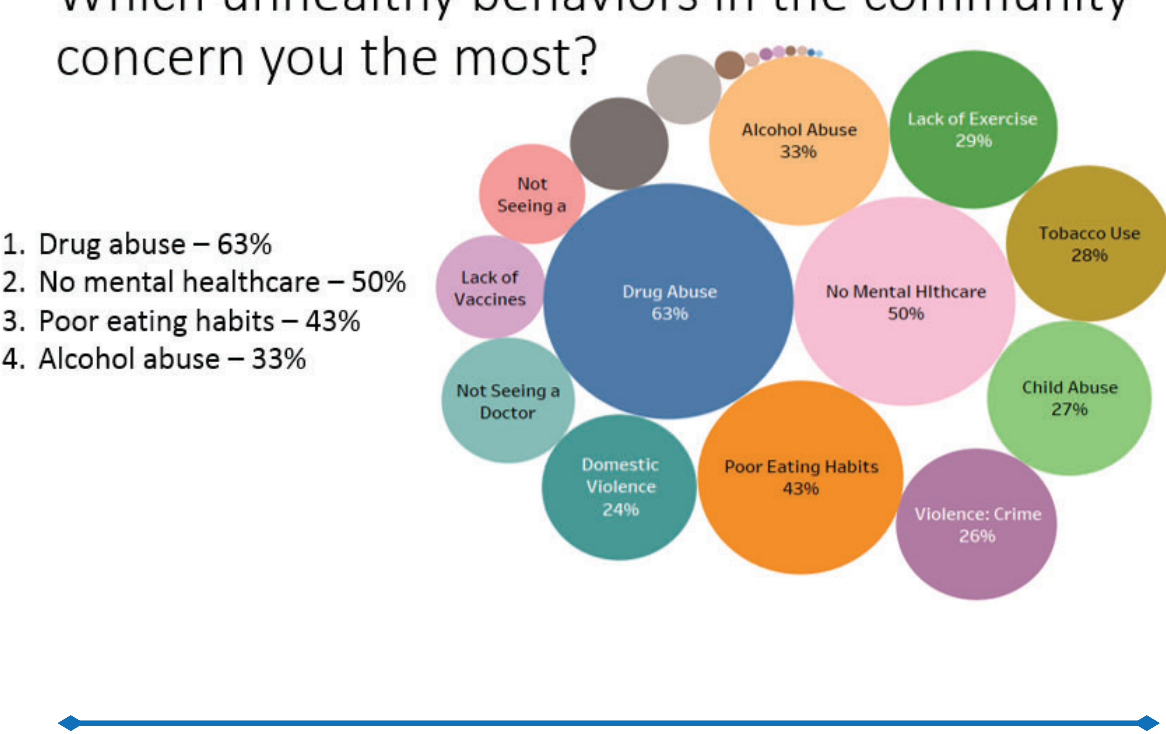
- Top 3 populations reporting good or better: White (87%), >$75K (92%), 41-64yrs (86%).
- Poorest health reported by Hispanics (34%) and households <$25K (38%).

Most important health issues in your community?



- Across the board, substance abuse and mental health are most important concerns
- Lower income groups were more concerned about dental health.

- Substance abuse and mental health are most important concerns.
- Lower income groups were more concerned about dental health.

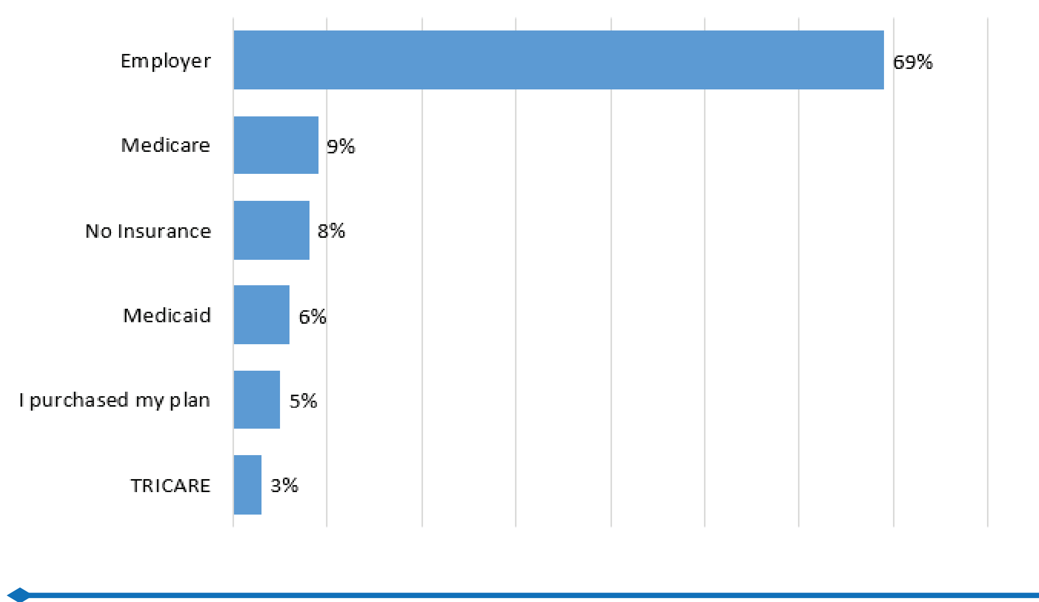


Which healthcare services are difficult to get in your community?

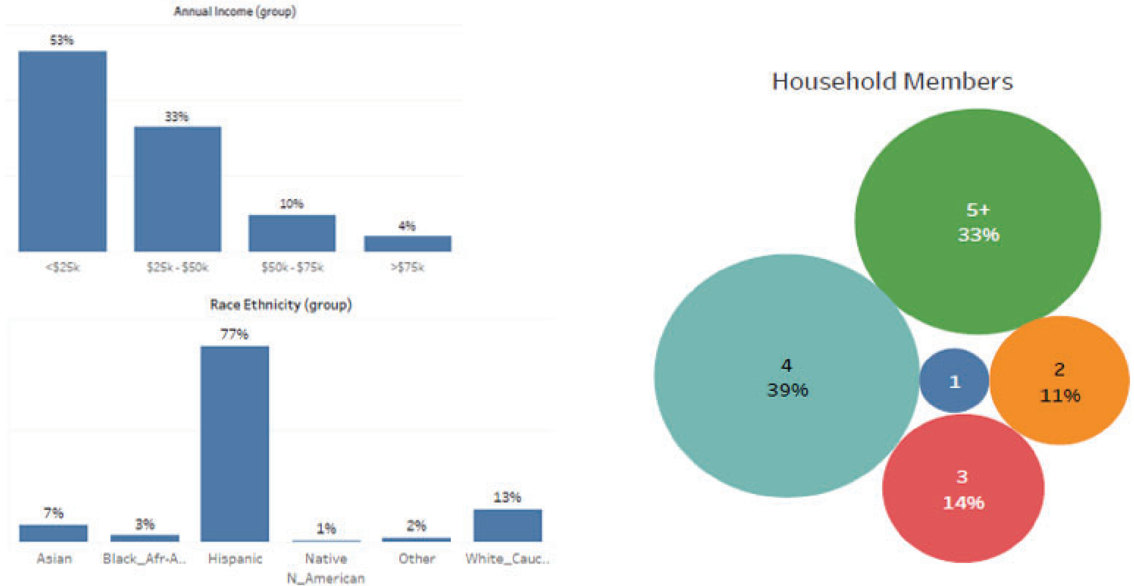
Mental Hlth Srvcs 53%
Elderly Services 29%
Spec Medicine 24%
Alt Therapies 21%
Alc_Drug Trtmt 41%
Dental Care 21%
Vision Care 12%
Family Doctor 14%
Help Nav Hlthcare 40%
Emergency Med 13%

	Annual Income (group)			
Q5 DiffSrvcs (group)	<$25k	$25k - $50k	$50k - $75k	>$75k
Afford Hlthcare	1%	5%	3%	1%
Alc_Drug Trtmt	35%	39%	43%	43%
Alt Therapies	15%	24%	26%	22%
Closer Hlthcare	1%	1%	1%	0%
Dental Care	48%	35%	17%	11%
Elderly Services	28%	26%	34%	29%
Emergency Med	18%	18%	16%	10%
Family Doctor	29%	21%	14%	9%
Family Planning	14%	14%	9%	10%
Hearing Aids	12%	13%	11%	6%
Help Nav Hlthcare	27%	34%	43%	45%
High Qual Hlthcare		1%	2%	1%
Hlthcare for My Ins			1%	0%
LGBTQ Hlthcare		1%	1%	0%
Mental Hlth Srvcs	42%	51%	57%	60%
Office Hours				0%
Other	1%	2%		1%
Prescriptions	25%	18%	15%	8%
PT_Rehab	18%	17%	8%	6%
Spec Medicine	23%	34%	27%	23%
Vision Care	25%	19%	9%	7%

Where do respondents get health insurance?



Who reported no insurance?



- 77% of uninsured respondents were Hispanic, 13% white and 7% Asian.
- The average household size of uninsured respondents is 4-5 members: there is high likelihood that entire family is also uninsured.
- 86% of uninsured respondents had HH incomes less than $50K – therefore affordability is a factor.
- 61% are working full-time, part-time and self-employed – they either cannot afford coverage or are not provided coverage through their employment.

Where do you go for care?

	Overall	White	Black	Asian	Hispanic
Family MD	87%	94%	87%	88%	46%
Urgent Care	41%	47%	40%	22%	20%
Hospital ED	24%	22%	30%	31%	40%
Free Clinic	4%	0%		5%	30%
Go Without	5%	3%	8%	6%	17%
VA/Military	2%	2%	5%	2%	2%
Low Cost	3%	1%	2%	3%	3%

Household Income	Asian	Hispanic
<$25K	29%	46%
$25-50K	30%	30%
Under$50K	***59%***	***76%***

Emergency Department usage is highest among minority populations – Hispanic, Asian and African American. Although both Asians and Hispanics have the highest percentage of lower household income, utilization of personal physicians varies greatly.

- Less than half of Hispanics identify they have a family physician
- 88% of Asians identify they have a family physician.

Cost is clearly an issue for Hispanic respondents and directly correlates to emergency department use–33% rely upon a free/low cost clinic and 17% go without care. Additionally, 76% of Hispanic respondents reported a household income of $50K and an average household size of 4-5 members.

African Americans access the VA/military health system at two times the rate of population as whole.

White and African Americans use urgent care at greater frequency – but employment and household income are likely co-factors.

Healthy Preventive Habits

Recommended Behavior	% Yes	% No	Why not? (barriers)	Who's worse?
Exercise	37%	63%	Too busy (59%), no motivation (53%, don't enjoy (29%)	Hispanic (77%), <$25K (74%)
Fruits & Veggies	18%	82%	Forget to (48%), cost (31%), dislike taste (12%)	Age 18-30 (10%), Hispanic (9%), <$25K (9%)
Cervical Cancer Screening	88%	12%	Too busy (48%), nervous/scared/don't care (26%), and there's no need (22%)	Asian (71%), <$25K (78%)
Breast Cancer Screening	84%	16%	Too busy (38%), nervous/scared/don't care (25%), and there's no need (20%)	$25K-50K (70%), <$25,000 (72%), Asian (75%), Hispanic (75%)
Colon Cancer Screening	76%	24%	Nervous/scared/don't care (35%), too busy (29%), and there's no need (18%)	Asian (33%), Hispanic (43%), and <$25K (38%)

Exercise:

- No motivation is the top answer for African Americans (46%) and people 65-80 years (63%).
- Cost is a bigger barrier for the Asian respondents (25%) and for respondents 18-30 yrs (16%) and 31-40 years (15%).
- Physical limitation is a bigger barrier for respondents 65-80 years (38%) and African Americans (29%).
- Lack of exercise companion was the biggest barrier for respondents' age 65-80 yrs (25%.)

Fruits/veggies:

- Cost was the biggest barrier for Hispanics (54%), and people making less than $50,000 (50%)

Cervical cancer screening:

- One third of the two lowest incomes (<$25K, 31% and $2K-$50K, 33%) reported cost as a barrier to getting a pap smear test.

Breast cancer screening:

- A third of Hispanic respondents (31%) and low income (<$25K, 33%) said cost was a barrier to getting a mammogram.
- Half (50%) of Asian respondents said they were nervous/scared/don't care.

Colorectal cancer screening:

- 71% of Asian respondents and 60% of African American respondents said that their doctor has not recommended colon cancer screening.
- Cost was a barrier for one out of four Hispanic respondents (25%) and more than one third (36%) of respondents with household incomes of $25K-50K.

Community Focus Groups

The four (4) focus groups were segmented to supplement findings resulting from the 2018 Frederick Community Health Survey. Community partners recruited participants within the specific concentrations, participant qualification is distinct by segment.

Composition n=52

- Homeless/Low Income: <$60k annually screening criteria, n=15 (*14 homeless)
  - Conducted at the Frederick Community Action Agency
- African American: African American or mixed ethnicity, n=12
  - Conducted at the Quinn Christian Center
- North County – Reside in zip codes 21727 & 21788, n=13
  - Conducted at the Seton Center
- Hispanic: Speak Spanish at home, n=12
  - Conducted at Centro Hispano de Frederick

Participants were recruited by community partners of the Frederick County Healthcare Coalition. The 2018 Frederick Community Health Survey was completed anonymously by participants prior to focus group participation.

Key Insights from focus groups:

- Sources of healthcare information:
  - Community outreach
  - Doctor / location where healthcare is administered
  - News sources
  - Internet, social media
  - Church
- Health knowledge
  - Gaps in health knowledge exist for many Low Income participants
  - Hispanic participants understand healthy habits, but neglected to mention 'water'
  - North County and African American participants have sufficient knowledge about preventive health practices
- Barriers to care
  - Insurance (acceptance, premiums, and/or co-pay costs)
  - Communication (availability of services, ethnic barriers, clinician communication)
  - Transportation
  - Mental health services
- Needs – Overall
  - Affordable housing
  - Doctor communicates so I understand
  - Transportation

Not included, but emerges as important:

  - Dental services (with the exception of North County)

Needs Identified by Focus Groups

All groups identified the following needs:

- Affordable Housing
- Communication:
  - Doctor communicates so I understand
  - Availability of relatable (race, ethnic) doctors
  - Communication about available services
- Transportation
  - (Access) Easy to get an appointment with a doctor when I need it

Homeless/Low Income: Priority is Community Infrastructure

- Safety
- Healthy Food
- Transportation
- Added attributes: Full-service Dental services, Communication about services

Additional insights:

- *Safety, meals, mental health and hygiene more pressing than health care, particularly preventive services (likely due to homelessness)*
- *Access*
  - *Mental health*
  - *Complex eligibility processes to access services*
- *Obstacles*
  - *Comprehension and literacy*
  - *Acceptance of Medicaid or other insurances*
- *Additional need: pain management*

African American Group: Priority is Community Infrastructure

- Affordable Housing
- Communication: Doctor communicates so I understand , Ethnic doctors' availability
- Reasonable wait times to see a doctor
- Added attribute: Dental services

Additional Insights:

- Provider quality
- Services available in Frederick, but lack of awareness and uncertainty if insurance covers service
- Heightened sense of racism
- Obstacles
  - *Patterns of delay: self-diagnosis, denial and cost considerations*
  - *Cultural values: avoid doctor until urgent, male avoidance behavior*
- Additional needs
  - *Relatable and adequate mental health services*
  - *Health education*
  - *Training in self-advocacy*

North County Group: Priority is Community Infrastructure

- Affordable housing
- Transportation
- Safe places to be active

Additional Insights:

- Lack of local services –specialists, urgent care. Limited primary care.
- Only 1 bus route daily (pilot for 2nd), takes all day to travel to Frederick for health services. *Community group collaborating on transportation
- Healthy choices limited
  - *No gym, sidewalks or safe walking path*
  - *Cost of fruits and vegetables*
  - *Lack of fresh produce at market*
- Additional needs
  - *Structured programs*
  - *Access to medical supplies*

Hispanic Group: Priority is Doctor

- Reasonable wait times to see a doctor
- Doctor communicates so I understand
- (Access) Easy to get an appointment with a doctor when I need it

Additional Insights:

- Obstacles to care:
  - Few providers speak Spanish
  - Cost
  - Affordable transportation
  - Insurance acceptance (Medicaid, or Dual Eligible)
- Cultural factors – lack of responsibility when seeking care(missed appointments)
- Additional needs
  - *Vision*
  - *Dental*
  - *Translation services for non-Spanish speaking providers*
  - *Care for elderly*

The groups engaged in an exercise that asked them to identify needs as it relates to four domains: providers, self-care and community infrastructure. This allowed more discovery on the adequacy and dynamics of the health provider system, personal preventive and self-management behaviors and community influencers of their health (i.e., social determinants).

When asked about specific health service needs and obstacles to receiving health services, there were distinct concerns. Dental care and mental health were mentioned, but additional services like pain management and vision were identified. Supportive services, such as translation, care for elderly family, and access to medical supplies were mentioned. Provider adequacy was identified by African American and North County participants – the need was expressed as providers who were relatable (meaning similar language, race, and ethnicity) and sufficient supply. The obstacles reflected demographic, geographic and social barriers that each group faced. Only the African American focus group spoke about cultural factors that impact health. Finally, insurance acceptance of Medicaid and dual Medicare/Medicaid coverage was a definite barrier – it is likely associated with the health plan that an individual participant may be assigned, as several Medicaid health plans lack provider network adequacy in Frederick County for specialty care.

The African American focus group participants were most articulate about issues related to navigation to services and their experiences. They were forthcoming about cultural values or norms that inhibit access to care. For example, the severity and duration of medical issues is directly related to the sense of urgency in seeking a health care provider. They engage in self-diagnosis, denial and an evaluation of cost implications before pursuing care. They also described pride as a factor in elderly persons and men.

North County residents identified transportation as a critical issue. There is only one daily bus route to Frederick, which results in a medical appointment taking all day. In Emmitsburg, there are limited safe places to be active and no structured programs for companionship and support. In addition, the North County area has more limited primary care, specialist, urgent care and mental health services situated in the community. Cost and a lack of fresh produce in the grocery store also make healthy eating difficult.

Advocates for Health Equity

Please briefly describe the population you serve or advocate for. (i.e. size, characteristics, location, etc.)	
Service Coordination, Inc.	SCI serves more than 12,500 individuals with intellectual and developmental disabilities, those with mental health challenges, the elderly, transitioning youth, court-involved individuals, and veterans throughout Maryland. Within Frederick County, we currently support approximately 776 individuals.
Frederick County Senior Services Division	A population of older adults, and adults with disabilities- a diverse group including all ages, ethnic backgrounds, physical, cognitive, education & economic levels
The Frederick Center	We serve the Lesbian, Gay, Bisexual, Transgender, and Queer communities of Frederick County. According to national statistics and local statistics this would encompass Between then 9,000 and 20,000 Frederick County residents (national 4.5% of the population, local YBRS data is 9.5%)
Family Partnership	We serve parents with children under the age of 12, youth aged 16-24 who are parenting or not parenting, children aged birth - 12 years old. Participants live within Frederick County, but majority live within Frederick City limits. We serve mostly low income families, however we also have some families who are just above the poverty level as well and don't qualify for certain benefits. About 50% of our population is Hispanic and about 30% African American. We have many participants who have been affected by trauma and are dealing with substance abuse and mental health challenges. We also serve a small % of participants who have been or currently involved with domestic violence. The majority of the parents we serve are females, however we do serve a % of dads in our dads parenting group. The majority of the youth aged 16-24 we serve are males.
Advocates for Homeless Families (2 individuals responded)	1. Homeless families and individuals as well as those at risk of homelessness in Frederick County. 2. Homeless families living in Frederick
United Way of Frederick County	ALICE. See unitedwayfrederick.org/ALICE for more details.
MFP – Julio Menocal, M.D.	Hispanics, underinsured, immigrants
Total Responses: 8	Three respondents were members of the group served; 5 were not.

Do you provide direct services or serve as advocate for this population?	
Service Coordination, Inc.	We provide quality information and helpful options that can guide people to resources of their choice, ultimately supporting their decisions to connect to available resources. We provide our case management services to individuals residing in the Southern, Central and Western Regions of Maryland. (Counted as Both)
Frederick County Senior Services Division	Both
The Frederick Center	Both
Family Partnership	Both
Advocates for Homeless Families	Both Both
United Way of Frederick County	Both
MFP – Julio Menocal, M.D.	Direct
Number of responses: 8	

Does the population you service or advocate for have specific health conditions? (i.e. higher rates of certain cancers, low birth weight, sexually transmitted diseases, dental problems, substance use disorders)	
Service Coordination, Inc.	The population SCI supports have a variety of health conditions including: intellectual & developmental disabilities (with associated health conditions), mental health issues, age-related ailments, and dental problems among others.
Frederick County Senior Services Division	Yes, including heart disease, diabetes, high blood pressure, Alzheimer's/dementia, osteoporosis, arthritis, respiratory, depression/mental health, falls, oral health, vision, hearing loss, limited mobility, pain management, obesity
The Frederick Center	For youth and young adults: 1. Higher rates of HIV 2. Higher rates of suicidal ideation and suicide attempts (rates are much higher within the LGBTQ population tor trans people). 3. Higher rates of harassment, victimization, violence, mental health issues, substance use, smoking, alcohol use, and homelessness. For adults and seniors: All of the disparities that youth and young adults face plus: 4. Suspicion of / estrangement from preventive medical visits because of medical professional ignorance and / or anticipated or actual hostility towards LGBTQ, and especially T people. 5. Higher rates of obesity for especially lesbian and bisexual women; coupled with tobacco and alcohol usage, this can contribute to higher rates of breast cancer. 6. Higher rates of cancer caused by HPV. 7. For bisexual women, high rates of physical violence, rape, and stalking. 8. Higher rates of depression. 9. Higher levels of social isolation.
Family Partnership	We see substance abuse disorders, dental problems, and mental health disorders.
Advocates for Homeless Families	1) higher rates of all conditions that are exacerbated by poverty and lack of access to treatment. 2) Yes- dental problems, substance use disorders, mental health
United Way of Frederick County	Yes, data indicates higher prevalence of ACES and other chronic health conditions. We are working on overlaying more ALICE data with public health data so we can learn more of the specifics
MFP – Julio Menocal, M.D.	low vaccination rates
Summary: Mental Health, Substance Use Disorders and Dental conditions are most frequently mentioned.	

Do you have data on health disparities in your local population? If yes, please describe. If no, what data would you need?	
Service Coordination, Inc.	No answer
Frederick County Senior Services Division	Health conditions are self-reported, not requested or required. Data needed is cooperative exchange of information between health care providers and service agencies.
The Frederick Center	We have YRBS data on Frederick youth for selected disparities (e.g., tobacco use, suicidal ideation, drug use, sexual activity and selected other categories) but do not have information on disparities for adults at the local level. We need to undertake a Frederick LGBTQ focused data collection effort on this.
Family Partnership	We do not have data on the health disparities. However many of our participants have no health insurance or State Medical assistance. Our population often lacks transportation to get to appointments, insurance, can't get off of work to go to dr., etc. I'm not exactly sure what we would need to capture this data.
Advocates for Homeless Families	I don't have the data but it would be helpful. Yes through Service Point.
United Way of Frederick County	Because ALICE includes over half of all African American and Hispanic households in the county yes there is some data available. Would like to cross reference more ALICE data with health outcomes info that is available for our communities.
MFP – Julio Menocal, M.D.	No
Conclusion: Data on health disparities is not available to the organizations that replied but all stated that it's a need.	

What issues does the population you serve or advocate for have with access to clinical care? (i.e. language, transportation, clinic hours, welcoming/affirming staff, providers that understand your culture, etc.)	
Service Coordination, Inc.	The population we support faces a variety of challenges in accessing clinical/medical care. Transportation is one of the most significant barriers to access. Others challenges include, but are not limited to issues related to eligibility, and access to the supports needed to understand and implement the recommendations offered.
Frederick County Senior Services Division	Limited number of Medicare providers, lack of Geriatricians, health care specialists with knowledge/experience working with older adults, accessibility to providers, affordable/accessible transportation
The Frederick Center	In Frederick: 1. Lack of LGBTQ affirming medical professionals. 2. Lack of knowledgeable medical professionals, especially for trans/gender nonconforming patients but also including treatments such as PrEP. 3. Hostile medical professionals (which is distinct from unaffirming).
Family Partnership	Not speaking English is a huge barrier to accessing services, as well as transportation. Sometimes hours can be a challenge depending on work hours and other responsibilities.
Advocates for Homeless Families (2 respondents)	1. inadequate or no insurance, transportation issues, inability to miss work for appointments 2. Few places take medical assistance and have waiting lists

United Way of Frederick County	Language, transportation, hours, costs.
MFP – Julio Menocal, M.D.	All of the above.
	Transportation issues (5) are the common barriers, followed by scheduling appointments, not accepting Medicaid, and language.

What types of social and economic factors create barrier to good health in the population you serve or advocate for population? (i.e. health as impacted by housing, language, education, getting and keeping a job, food access, access to health services, quality healthcare, stable income, housing, discrimination, social support)	
Service Coordination, Inc.	There are a variety of social and economic factors that create barriers to the good health of those we support. These barriers include, but are not limited to: affordable care, provider availability (especially related to mental health services and in relation to provider acceptance of MA), challenges to obtaining and maintaining MA, limited access to healthy and affordable food choices, and limited access to the supports needed to understand and implement medical recommendations.
Frederick County Senior Services Division	Affordable housing, accessing health services, prescription drug costs, language, education, food access, social supports
The Frederick Center	1. Getting and keeping a job because of homo/transphobia. 2. Access to local health services (see above answer) 3. Quality of healthcare provided (see prior answer) 4. Stress caused by homo/transphobia, including verbal and physical assault. 5. Isolation / lack of social support because of distant or broken ties to family and community caused by homo/transphobia.
Family Partnership	Barriers to good health for the population we serve: lack of affordable housing - many of our participants share housing with other family members/friends, so multiple families in one small home, we serve some youth and families who are homeless, nutritional food, clothing transportation, limited education/success in schools, keeping a job, affordable child care, lack of social support, past and current trauma which is impacting their current and future health, stigma about mental health services - many of our participants have not had success with mental health services or they don't "believe" they will be helpful.
Advocates for Homeless Families	1. all of the above 2. Most do not have employment with paid benefits such as sick leave. Few places accept medical assistance.
United Way of Frederick County	Housing, education, language, job stability, food stability, access to care.
MFP – Julio Menocal, M.D.	Community policing, transportation, scholastic achievement gap

What health behaviors and/or cultural beliefs impact the health of your population?	
Service Coordination, Inc.	No response
Frederick County Senior Services Division	Sensory deficits affect ability to comprehend & apply health care directives. Lack of social support systems.
The Frederick Center	1. For both economic (cannot afford it or do not have employer insurance) and cultural reason (anticipation of ignorant and / or hostile or unaffirming medical providers), a lack of getting proactive medical checkups, etc.
Family Partnership	Stigma again regarding mental health services; this is what my grandmother tells me to do - "old wives tales or the way things used to be dealt with (generational); generational trauma; don't trust the health systems;
Advocates for Homeless Families	1. Most health impacts are caused by poverty and lack of available services, not caused by particular "behaviors or beliefs." 2. Very little time for self-care
United Way of Frederick County	Difficulty in working on issues with a long view vs just getting through today.
MFP – Julio Menocal, M.D.	access to care

What actions, programs, or strategies would make the biggest difference for the population you serve or advocate for?	
Service Coordination, Inc.	Accessible/available transportation, affordable dental care better access to mental health services and supports.
Frederick County Senior Services Division	Availability of affordable housing, house calls by health care providers, wellness checks, reliable/affordable transportation, medication management, consistent access to healthy food, access to internet & devices to access health portals, socialization opportunities, Medicare coverage of vision, dental & hearing
The Frederick Center	1. Creating "centers of excellence" like Chase Brexton or Whitman Walker and / or documenting medical professionals who are both comfortable and competent in treating the physical and mental health needs of L, G, B, T, and Q patients. This is a critical need for the trans community in Frederick. 2. Assuring the intakes forms and EMR are able to document SOGI in an affirming manner. 3. Having major medical providers provide mandatory "LGBTQ 101" training to all staff on a regular basis. 4. Documenting the current state of medical provider LGBTQ services through a recognized instrument such as the HEI and then implementing process improvement efforts using the scoring as a guide. 5. Having major medical provider be more proactive in terms of reaching out to / communicating with the LGBTQ community.
Family Partnership	Accessible mental health services for everyone/everywhere - meaning at schools, jobs, hospitals, clinics, churches, homes - wherever people feel most comfortable and safe. Better public transportation or access to affordable transportation; easy to access health clinics where different languages are spoken and cultures are valued and all insurances are taken or people without insurance can be seen; affordable prescriptions
Advocates for Homeless Families	1. AFFORDABLE HOUSING A LIVING WAGE 2. Easier access to mental health services and therapy. Employment that included benefits such as paid sick leave.

United Way of Frederick County	Paths to better paying jobs, more quality affordable housing, better public transportation, accessible and affordable child care.
MFP – Julio Menocal, M.D.	increased policing; better and more effective transportation in my catchment area

If you had a blank check to use on improving the health of the population you serve or advocate for, what would be the one thing you would invest in for your population?	
Service Coordination, Inc.	Transportation
Frederick County Senior Services Division	CRNP on staff to provide in-home health assessment & treatment, housing w/service coordination, transportation, new/additional senior centers
The Frederick Center	Creating a Central Maryland Chase Brexton / Whitman Walker Clinic.
Family Partnership	I would have free health, dental, and mental health services provided at Family Partnership. I would love to increase our on-stop model to include more services under the same roof for the families and youth we serve so they don't have to go all around the County for the different services they need.
Advocates for Homeless Families	1. Affordable housing 2. All access medical assistance
United Way of Frederick County	Job training program for higher paying jobs connected with workforce housing and childcare supports.
MFP – Julio Menocal, M.D.	I already invested all my talent, treasure and time in my population The results are pretty good.
Number of responses: 6	

Appendix 2. Secondary Data

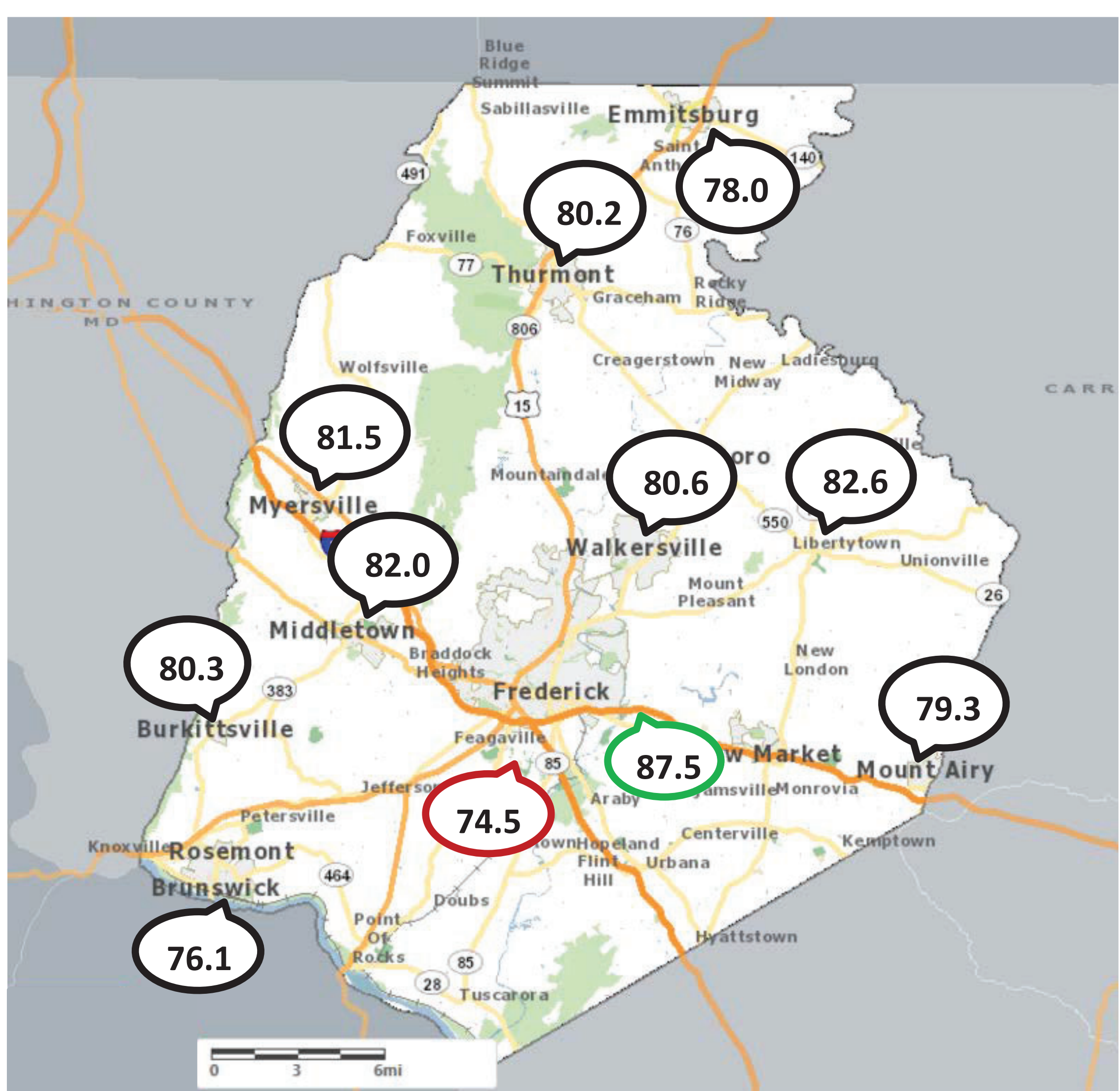
Demographics

Population estimates, July 1, 2018	Frederick County	Maryland	United States
Total Population	252,022	6,042,718	327,167,434
Gender			
Females	50.7%	51.5%	50.8%
Males	49.3%	48.5%	49.2%
Race			
White, non-Hispanic (NH)	73.6%	50.9%	60.7%
Black, NH	10.0%	30.8%	13.4%
Hispanic or Latino	9.6%	10.1%	18.1%
Asian, NH	4.8%	6.7%	5.8%
American Indian and Alaska Native, NH	0.5%	0.6%	1.3%
Native Hawaiian and other Pacific Islander	0.1%	0.1%	0.2%
Two or More Races	3.0%	2.8%	2.7%
Ages			
Under 5 Years Old	5.9%	6.1%	6.1%
Under 18 Years Old	23.3%	22.3%	22.6%
65 Years and Over	14.1%	14.9%	15.6%
Other Indicators			
High school graduate or higher (25+ years) (2013-2017)	92.6%	89.8%	87.3%
Bachelor's degree or higher (25+ years) (2013-2017	40.5%	39.0%	30.9%
Foreign born persons (2013-2017)	10.2%	14.9%	13.4%
Language other than English spoken at home, age 5+ years (2013-2017)	13.1%	18.0%	21.3%
Persons without health insurance (under age 65)	5.5%	7.0%	10.2%
Persons with a disability, under age 65 years (2013-2017)	7.5%	7.4%	8.7%
Persons in Poverty (2013-2017)	6.9%	9.3%	12.3%

Data Source: U.S. in 2017 Bureau: State and County Quick Facts; 2018 Population Estimates; American Community Survey 5-year Estimates; United States Department of Labor; Bureau of Labor Statistics (*not seasonally adjusted preliminary unemployment rates)

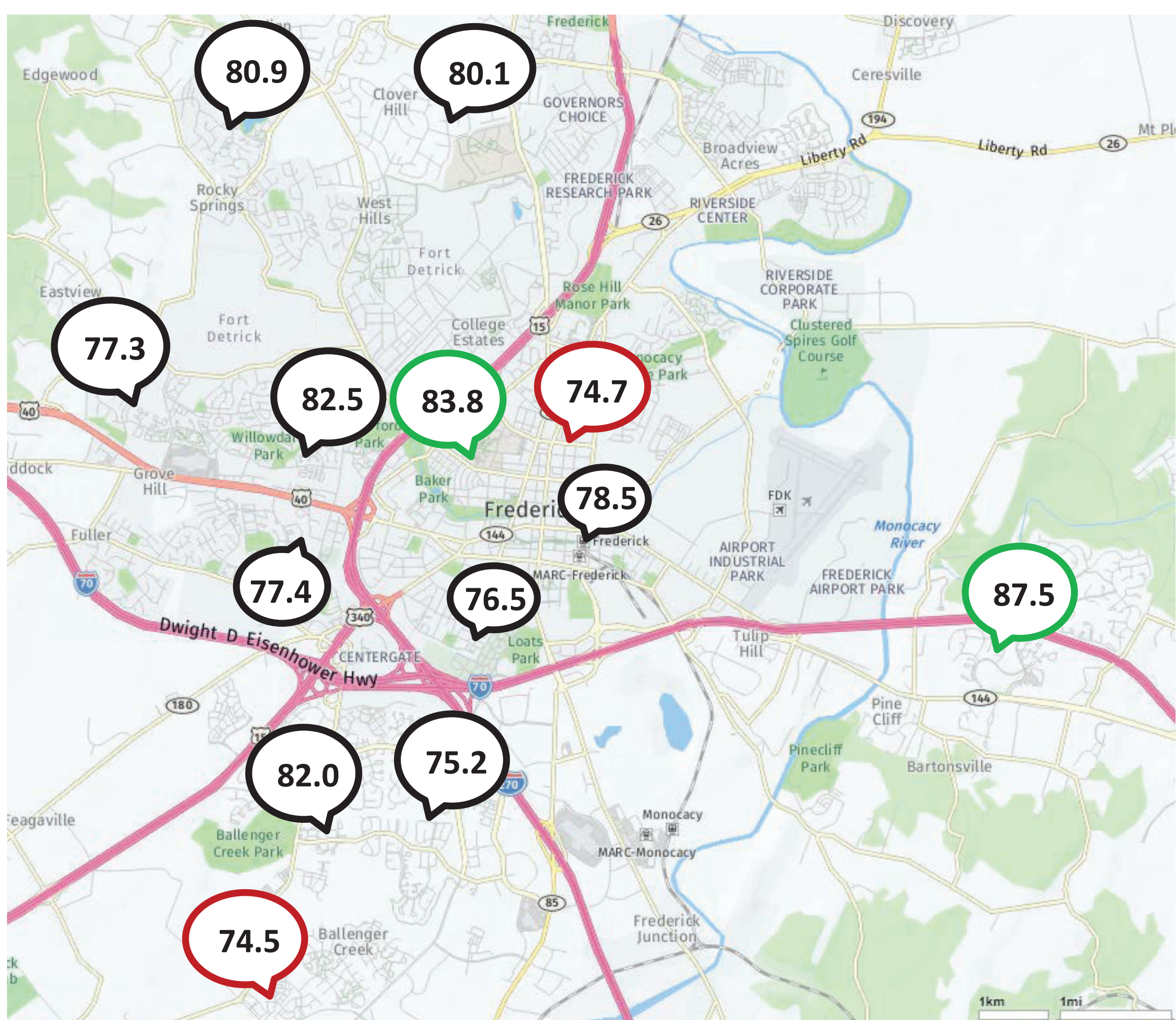
Life Expectancy, Map of Frederick County

The highest life expectancy in Frederick County is 87.5 years in the Spring Ridge community in the City of Frederick, shown in green in the map below. The lowest life expectancy in Frederick County is 74.5 years in the southern part of the Ballenger Creek community in the City of Frederick, shown in red in the map below. Other life expectancies are shown in black. A map of the City of Frederick is available on the next page, and a complete list of Frederick County towns is provided on the following page.



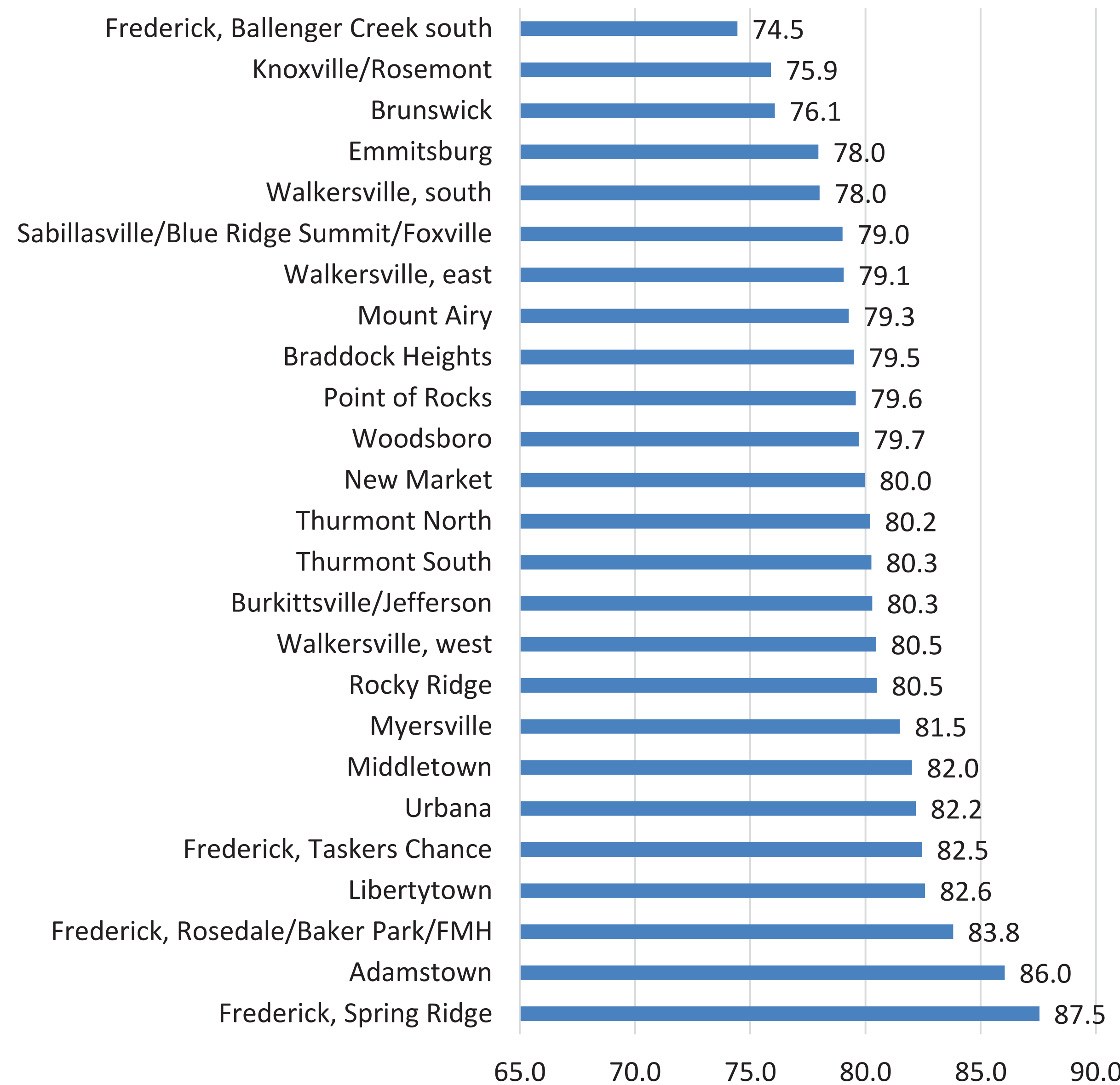
Average Life Expectancy (2005-2014), Maryland Vital Statistics Administration.

Life Expectancy, Map of City of Frederick



Average Life Expectancy (2005-2014), Maryland Vital Statistics Administration.

Life Expectancy, Map of Frederick County



Average Life Expectancy (2005-2014), Maryland Vital Statistics Administration.

Life Expectancy, Frederick County Census Tracts

Tract	Area	LE	Tract	Area	LE
7523.02	Adamstown	86.0	7507.02	Frederick, Villa Estates/Antietam Village	80.6
7526.03	Braddock Heights	79.5	7512.02	Frederick, Whittier	80.9
7754.00	Brunswick	76.1	7521.02	Green Valley	78.9
7525.01	Burkittsville/Jefferson	80.3	7753.02	Knoxville/Rosemont	75.9
7522.02	Centerville	78.4	7517.02	Libertytown	82.6
7668.00	Emmitsburg	78.0	7519.01	Linganore, east	79.4
7501.00	Frederick, 3rd to 7th street	74.7	7756.00	Linganore, west	78.1
7502.00	Frederick, All Saints to 3rd street	78.5	7526.01	Middletown	82.0
7507.01	Frederick, Amber Meadows/Govenors Choice	75.9	7519.03	Monrovia	79.7
7510.02	Frederick, Ballenger Creek Elementary School area	82.0	7520.01	Mount Airy	79.3
7510.01	Frederick, Ballenger Creek Middle School area	75.2	7517.01	Mount Pleasant	82.2
7523.01	Frederick, Ballenger Creek south	74.5	7528.02	Myersville	81.5
7512.01	Frederick, Clover Hill/Yellow Springs	80.1	7518.01	New Market	80.0
7722.00	Frederick, east, Sagner, fairgrounds	75.9	7523.03	Point of Rocks	79.6
7505.05	Frederick, Frederick Heights/Overlook/Prospect View, Linden Hills	77.4	7675.00	Rocky Ridge	80.5
7512.03	Frederick, Gambrill Park, west of Kemp lane, east of Gambrill Park Rd	83.5	7529.00	Sabillasville, Foxville, Blue Ridge Summit	79.0
7505.06	Frederick, Hillcrest Orchards/Monarch Ridge	80.9	7530.02	Thurmont North	80.2
7510.03	Frederick, New Design/Crestwood	82.2	7530.01	Thurmont South	80.3
7505.03	Frederick, north of 40, west of Key Parkway	77.3	7522.04	Urbana	82.2
7506.00	Frederick, Rosedale/Baker Park/FMH	83.8	7735.00	Walkersville, east	79.1
7508.01	Frederick, Selwyn Farms/Rose Hill	77.8	7508.02	Walkersville, north, Wormans Mill, Mill Island	80.6
7503.00	Frederick, South Benz, West South streets	78.1	7508.03	Walkersville, south, Dearbought, Monocacy Park, Monocacy Crossing	78.0
7651.00	Frederick, south of Patrick, west of 355	76.5	7402.00	Walkersville, west	80.5
7519.02	Frederick, Spring Ridge	87.5	7528.01	Wolfsville	80.8
7505.04	Frederick, Taskers Chance	82.5	7676.00	Woodsboro	79.7

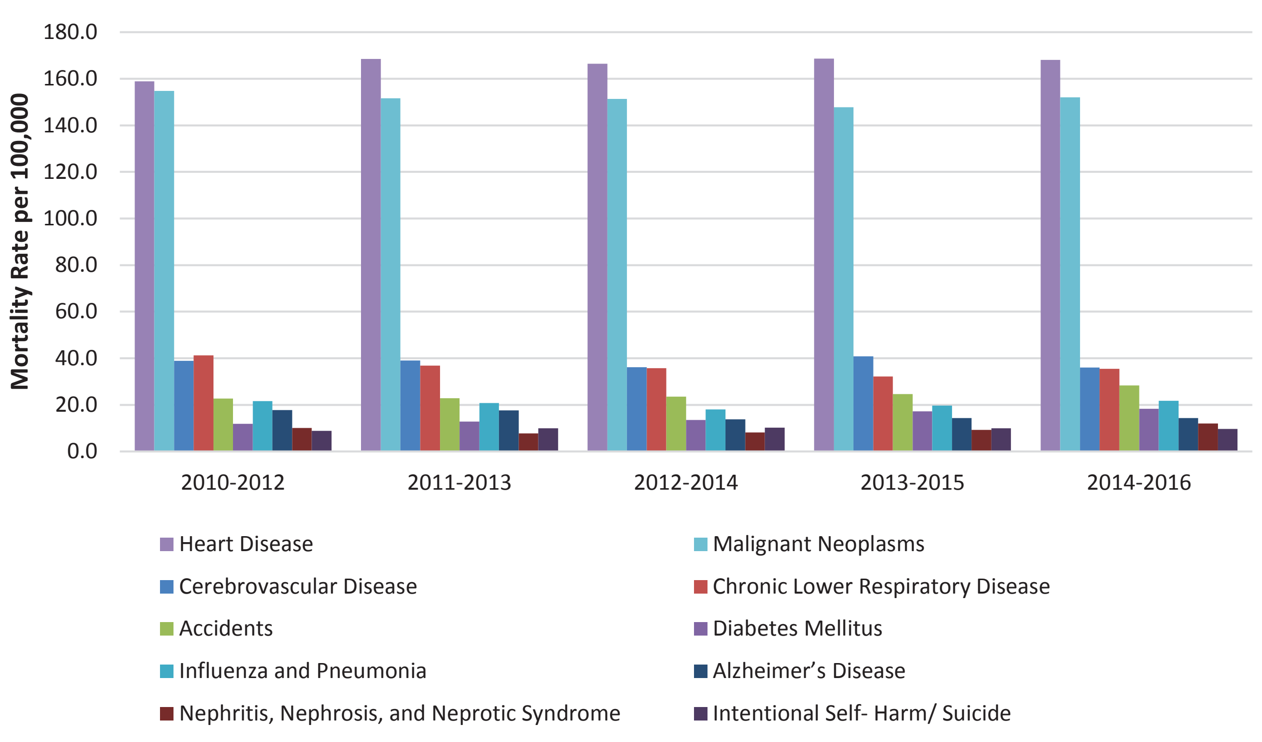
Average Life Expectancy (2005-2014), Maryland Vital Statistics Administration.

Health Outcome: Length of Life

Leading Causes of Death

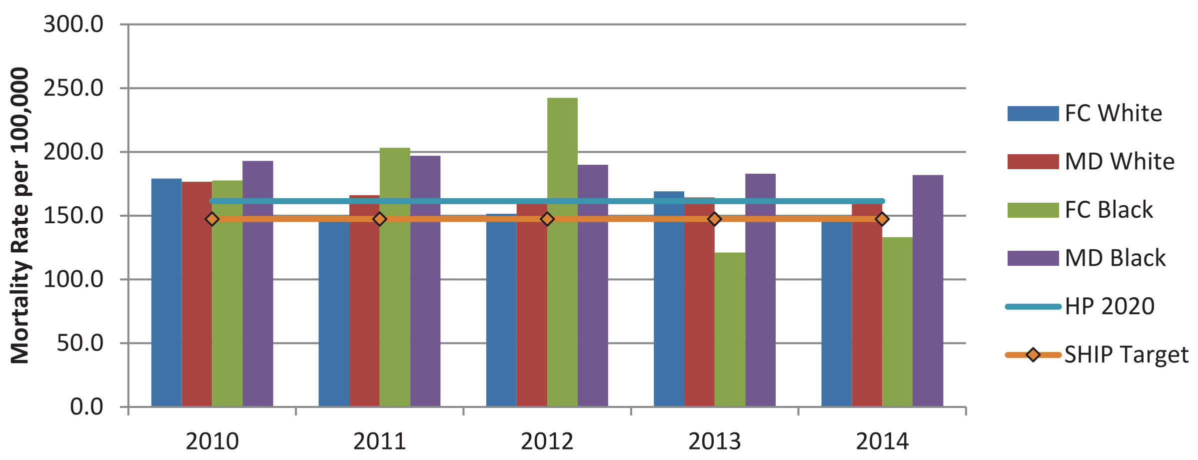
Leading Causes of Death in Frederick County, MD						Maryland
Mortality Rates per 100,000	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2014-2016
All Causes of Death (2014-2016)	662.8	669.6	665.9	664.7	691.2	706.7
Diseases of the Heart	158.9	168.5	166.5	168.7	168.1	166.9
Malignant Neoplasms	154.8	151.6	151.3	147.8	152.0	157.4
Cerebrovascular Disease	38.9	39.1	36.1	40.8	36.0	38.4
Chronic Lower Respiratory Disease	41.3	36.9	35.8	32.2	35.5	30.2
Accidents	22.7	22.9	23.6	24.7	28.4	30.5
Influenza and Pneumonia	21.6	20.8	18.1	19.7	21.8	16.1
Alzheimer's Disease	17.8	17.6	13.8	14.4	14.4	16.1
Diabetes Mellitus	11.9	12.8	13.5	17.2	18.3	19.2
Nephritis, Nephrosis, and Nephrotic Syndrome	10.1	7.7	8.1	9.3	12.0	12.0
Intentional Self- Harm/ Suicide	8.9	10	10.2	10.0	9.6	9.2

Source: Maryland Vital Statistics.



Cancer Deaths

Cancer Deaths in Frederick County, MD						Maryland
Cancer Mortality Rates (per 100,000)	2010	2011	2012	2013	2014	2014
All Cancers	148.1	154.9	162.8	141.8	156.0	161.8
Male	170.2	200.1	200.9	167.3	186.0	191.5
Female	128.3	123.0	138.2	124.5	133.2	141.7
White	148.8	151.4	169.1	145.9	152.2	238.7
Black	166.1	161.3	164.4	161.6	160.6	181.0



Overall, deaths from cancer have continued to decrease in Frederick County.

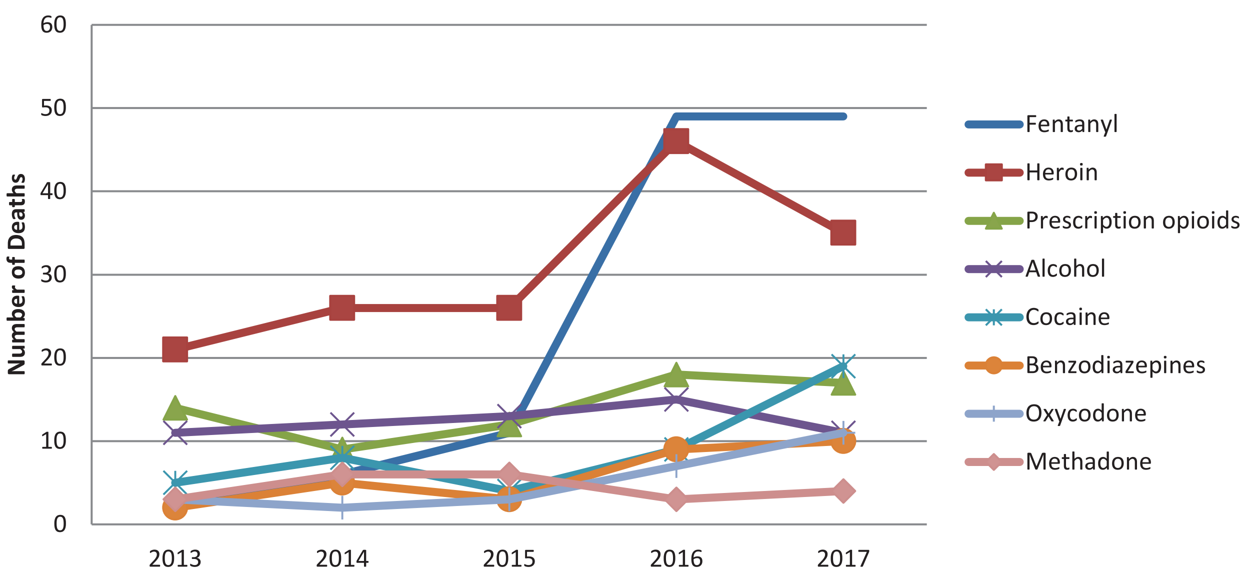
- Frederick County saw an 8% decrease in mortality rates for all cancers in last ten years (2005-2014), and a 10% increase since the last reporting year.
- Cancer mortality for men in Frederick County increased 9% from 2010 to 2014 and 11% from 2013 to 2014. Cancer mortality for women in Frederick County increased 4% from 2010 to 2014 and 7% from 2013 to 2014.
- Cancer mortality for Whites in Frederick County increased 2% from 2010 to 2014, and 4% from 2013 to 2014.
- Cancer mortality for Blacks in Frederick County increased 17% from 2010 to 2014, but increased 79% from 2013 to 2014.

Cancer Deaths in Frederick County, MD						Maryland
By Cancer Type	**2006-2010**	**2007-2011**	**2008-2012**	**2009-2013**	**2010-2014**	**2010-2014**
Lung and Bronchus Cancer Mortality	49.2	46.9	42.2	40.4	37.9	43.1
Male	61.9	60.1	51.0	47.4	45.0	52.0
Female	39.5	36.9	35.5	35.2	32.6	36.5
White	49.5	47.1	41.9	40.1	38.1	44.3
Black	56.3	52.8	57.4	55.8	49.3	44.2
Colorectal Cancer Mortality	17.1	17.0	16.8	16.0	15.5	14.5
Male	20.5	21.2	22.5	21.1	20.7	17.6
Female	14.2	13.5	12.6	12.1	11.4	12.2
Breast Cancer Mortality (Female only)	23.4	22.9	22.5	20.7	21.3	22.9
Prostate Cancer Mortality	21.4	22.7	21.9	21.7	21.3	20.3
Melanoma Cancer Mortality	3.8	3.5	3.2	2.9	2.4	2.5

Source: Maryland Cancer Report. Rates are per 100,000 and are age-adjusted to 2000 US standard population.
*Rates based on case counts of 1-19 are suppressed per DHMH/MCR Data Use Policy and Procedures.

Drug and Alcohol Overdose Deaths

Drug and Alcohol Overdose Deaths in Frederick County, MD						Maryland
Total Overdose Deaths	**2013**	**2014**	**2015**	**2016**	**2017**	**2017**
Fentanyl Deaths	2	6	11	49	49	1594
Heroin Deaths	21	26	26	46	35	1078
Cocaine Deaths	5	8	4	9	19	691
Prescrip. Opioid Deaths	14	9	12	18	17	413
Alcohol Deaths	11	12	13	15	11	517
Benzodiazepine Deaths	2	5	3	9	10	146
Oxycodone Deaths	3	2	3	7	11	122
Methadone Deaths	3	6	6	3	4	246
Overdose Death Rates by Substance per 100,000						
Fentanyl Death Rate	0.8	2.5	4.5	19.8	19.4	26.3
Heroin Death Rate	8.7	10.7	10.6	18.6	13.9	17.8
Cocaine Death Rate	2.1	3.3	1.6	3.6	7.5	11.4
Prescrip. Opioid Death Rate	5.8	3.7	4.9	7.3	6.7	6.8
Alcohol Death Rate	4.6	4.9	5.3	6.1	4.4	8.5
Benzodiazepine Death Rate	0.8	2.1	1.2	3.6	4.0	2.4
Oxycodone Death Rate	1.2	0.8	1.2	2.8	4.4	2.0
Methadone Death Rate	1.2	2.5	2.4	1.2	1.6	4.1



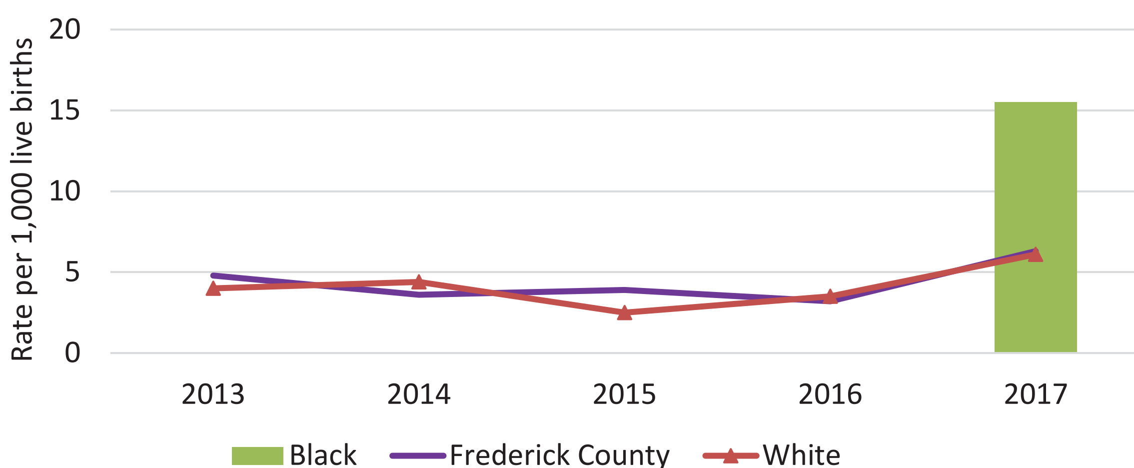
Source: Drug and Alcohol Intoxication Deaths in Maryland, https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Pages/Data-and-Reports.aspx

Infant Mortality

Infant Mortality in Frederick County, MD						Maryland
Rate per 1,000	**2013**	**2014**	**2015**	**2016**	**2017**	**2017**
Infant Mortality Rate	4.8	3.6	3.9	3.2	6.3	6.5
White	4.0	4.4	2.5	3.5	6.1	4.0
Black	*	*	*	*	15.5	11.2

Source: Maryland Vital Statistics Reports.

*Rates based on fewer than five events in the numerator are not presented since such rates are likely to be unstable.



Health Outcomes: Quality of Life

Cancer Incidence

Cancer Incidence in Frederick County, MD						Maryland
Cancer Incidence Rates (per 100,000)	**2010**	**2011**	**2012**	**2013**	**2014**	**2014**
All Cancers	437.6	422.6	434.0	440.6	431.8	443.4
Male	505.3	458.7	456.3	463.5	467.2	488.1
Female	386.4	392.5	427.3	430.6	409.9	413.2
White	433.2	417.9	439.1	445.2	429.8	449.3
Black	487.8	495.7	383.0	454.8	485.3	441.0
By Cancer Type	**2006-2010**	**2007-2011**	**2008-2012**	**2009-2013**	**2010-2014**	**2010-2014**
Lung and Bronchus Cancer Incidence	61.6	57.4	54.0	50.7	48.1	56.6
Male	74.4	68.8	67.9	55.5	55.0	64.6
Female	52.2	49.2	52.0	47.6	43.2	50.7
White	62.3	58.2	55.1	52.0	49.0	58.6
Black	71.3	66.7	58.0	46.4	46.8	56.1
Colorectal Cancer Incidence	47.9	47.0	47.1	43.8	39.5	36.7
Male	56.4	57.5	57.9	53.4	49.0	41.8
Female	41.3	38.4	38.6	36.2	31.7	32.7
White	48.5	47.1	47.0	43.6	38.6	35.3
Black	45.4	47.9	49.6	47.9	48.3	41.1
Breast Cancer Incidence (Female only)	119.3	122.2	121.1	121.3	124.2	129.2
White	120.5	122.4	121.9	122.5	122.7	130.1
Black	86.3	102.7	102.3	110.6	136.5	128.8
Prostate Cancer Incidence	128.6	128.2	122.0	111.5	103.0	125.4
White	124.6	121.0	113.8	103.1	95.5	107.6
Black	168.4	206.8	226.6	231.2	217.4	183.0
Cervical Cancer Incidence	6.6	5.7	5.6	5.4	5.0	6.4
Oral Cancer Incidence	9.9	9.5	9.8	10.0	9.5	10.5
Male	14.7	14.6	15.1	15.2	14.0	16.0
Female	5.8	5.0	5.3	5.6	5.6	6.0
Melanoma Cancer Incidence	22.5	22.2	21.9	22.0	23.1	21.4
Male	28.6	29.2	29.2	27.9	29.6	28.5
Female	18.3	17.0	16.1	17.1	18.1	16.4

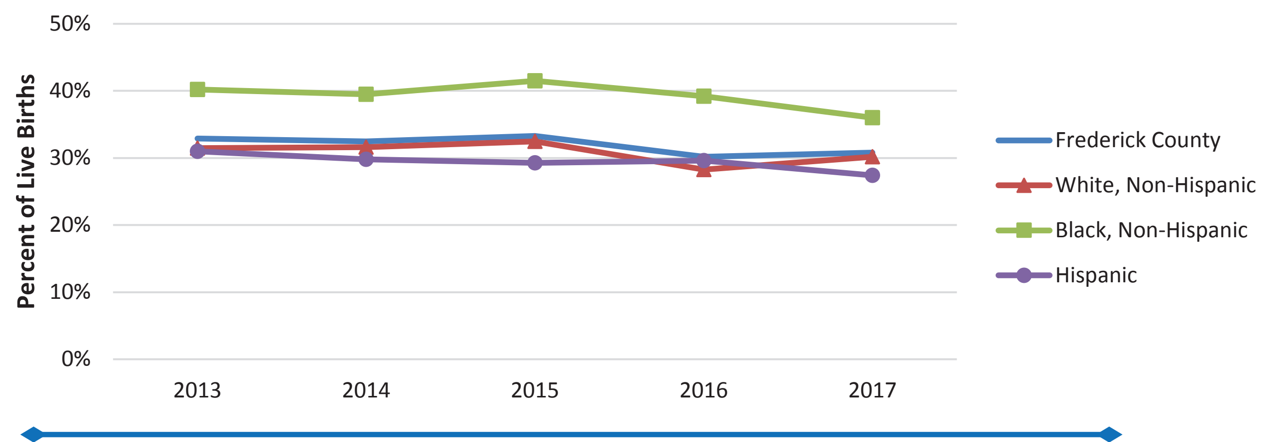
Source: Maryland Cancer Report. Rates are per 100,000 and are age-adjusted to 2000 US standard population.
*Rates based on case counts of 1-19 are suppressed per MDH/MCR Data Use Policy and Procedures

Maternal and Child Health

Cesarean Section

Cesarean Section Rates in Frederick County, MD						Maryland
	2013	2014	2015	2016	2017	2017
Frederick County	32.9%	32.5%	33.3%	30.2%	30.8%	33.8%
White	31.5%	31.6%	32.5%	28.3%	30.2%	31.5%
Black	40.2%	39.5%	41.5%	39.2%	36.0%	39.5%
Hispanic	31.0%	29.8%	29.3%	29.6%	27.4%	29.0%

Source: Maryland Vital Statistics Reports.



Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences in Frederick County, MD		Maryland
	2015	2015
Household mental illness	18.5	15.0
Household substance abuse	30.2	24.9
Incarcerated household member	*	7.6
Parental separation or divorce	30.5	27.5
Intimate partner violence	*	17.4
Emotional abuse	40.9	31.2
Physical abuse	*	16.9
Sexual abuse	*	11.1
0 ACEs	40.8	40.2
1 to 2 ACEs	32.0	35.7
3 or more ACEs	27.2	24.1

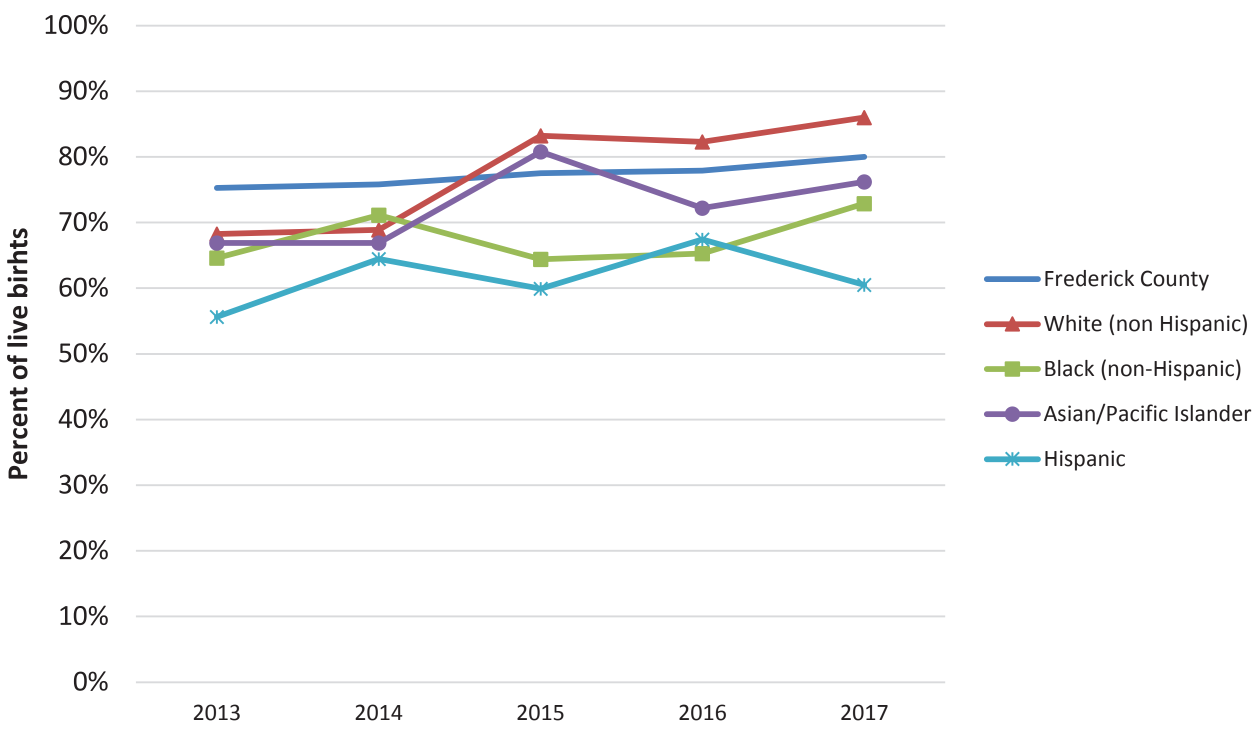
Source: Behavioral Risk Factor Surveillance Survey. * Suppressed due to denominator < 50 or relative standard error >= 30.0%.

Early Prenatal Care

Early entry into prenatal care is defined as prenatal care beginning in the 1st trimester of pregnancy.

Early Prenatal Care in Frederick County, MD						Maryland
	2013	2014	2015	2016	2017	2017
Frederick County	75.3%	75.8%	77.5%	77.9%	80.0%	69.6%
White	68.3%	68.9%	83.2%	82.3%	86.0%	79.4%
Black	64.6%	71.1%	64.4%	65.3%	72.9%	64.1%
Asian/Pacific Islander	66.9%	66.9%	80.8%	72.2%	76.2%	68.1%
Hispanic	55.6%	64.4%	59.9%	67.4%	60.5%	54.5%

Source: Maryland Vital Statistics Reports.

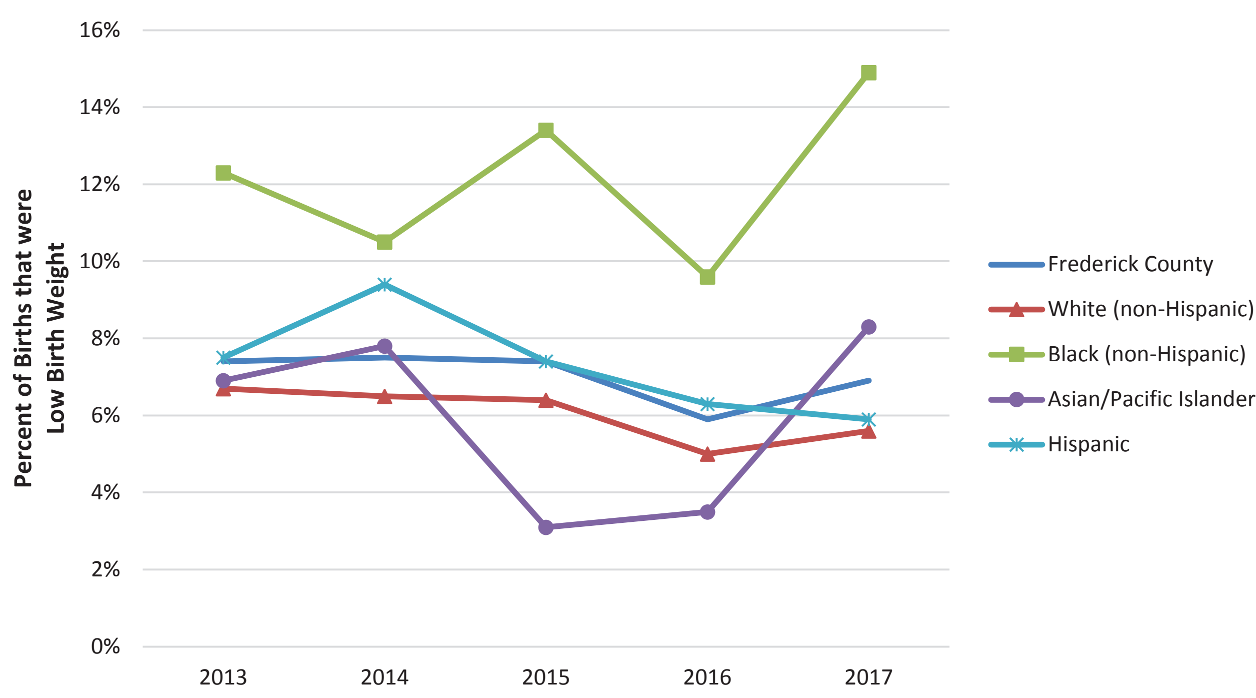


Low Birth Weight

Low birth weight is defined as a weight of less than 2500 grams at birth.

Low Birth Weight in Frederick County, MD						Maryland
	2013	2014	2015	2016	2017	2017
Frederick County	7.4%	7.5%	7.4%	5.9%	6.9%	8.9%
White	6.7%	6.5%	6.4%	5.0%	5.6%	6.6%
Black	12.3%	10.5%	13.4%	9.6%	14.9%	13.0%
Asian/Pacific Islander	6.9%	7.8%	3.1%	3.5%	8.3%	8.7%
Hispanic	7.5%	9.4%	7.4%	6.3%	5.9%	7.2%

Source: Maryland Vital Statistics Reports.

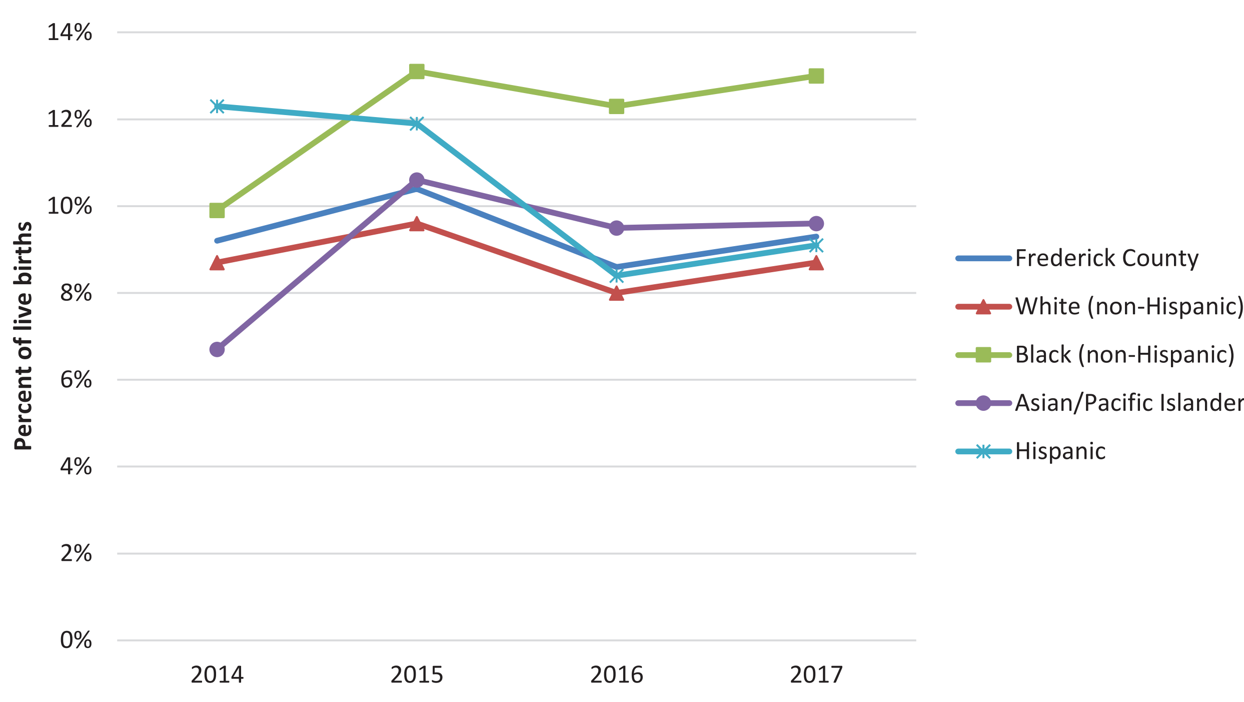


Preterm Birth

Preterm birth is less than 37 completed weeks of gestation.

Preterm Birth in Frederick County, MD						Maryland
	2013	2014	2015	2016	2017	2017
Frederick County	9.7%	9.2%	10.4%	8.6%	9.3%	10.5%
White		8.7%	9.6%	8.0%	8.7%	9.0%
Black		9.9%	13.1%	12.3%	13.0%	13.3%
Asian/Pacific Islander		6.7%	10.6%	9.5%	9.6%	9.0%
Hispanic		12.3%	11.9%	8.4%	9.1%	9.4%

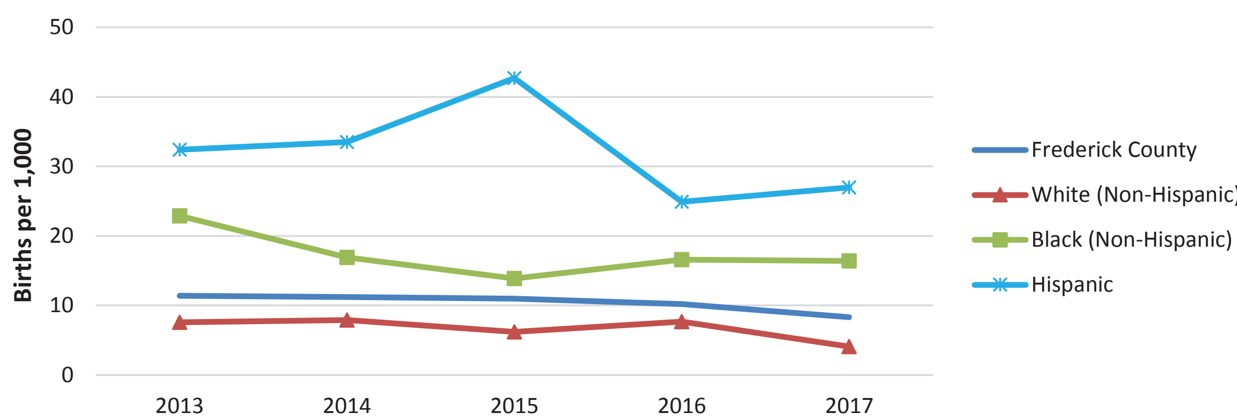
Source: Maryland Vital Statistics Reports.



Teen Birth Rate

Teen Birth Rate in Frederick County, MD						Maryland
Rate per 1,000	**2013**	**2014**	**2015**	**2016**	**2017**	**2017**
Frederick County	11.4	11.2	11.0	10.2	8.3	14.2
White (Non-Hispanic)	7.6	7.9	6.2	7.7	4.1	7.3
Black (Non-Hispanic)	22.3	16.9	13.9	16.6	16.4	18.0
Hispanic	32.4	33.5	42.7	24.9	27.0	37.8

Source: Maryland Vital Statistics Reports.

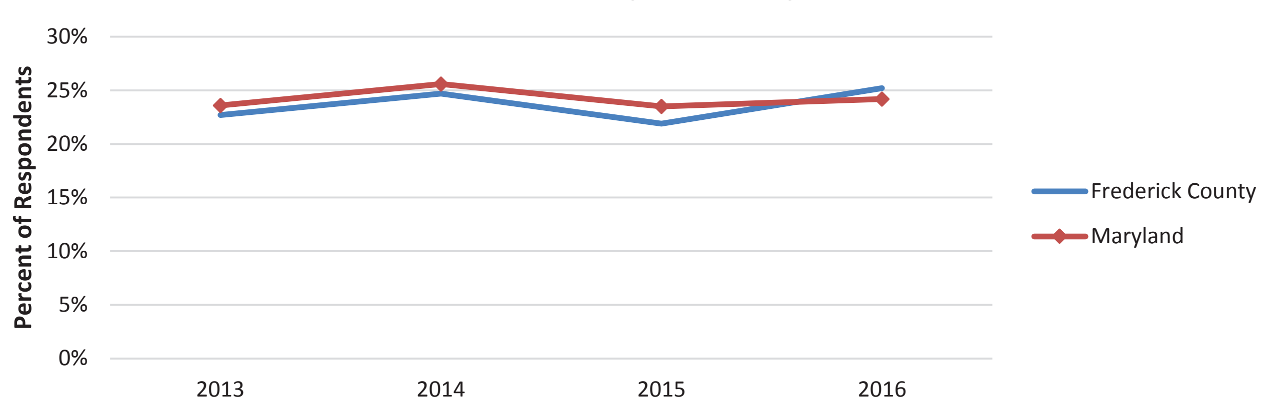


Chronic Conditions

Arthritis

Arthritis in Frederick County, MD						Maryland
	2012	2013	2014	2015	2016	2016
Arthritis (ever diagnosed)		22.7%	24.7%	21.9%	25.2%	24.2%

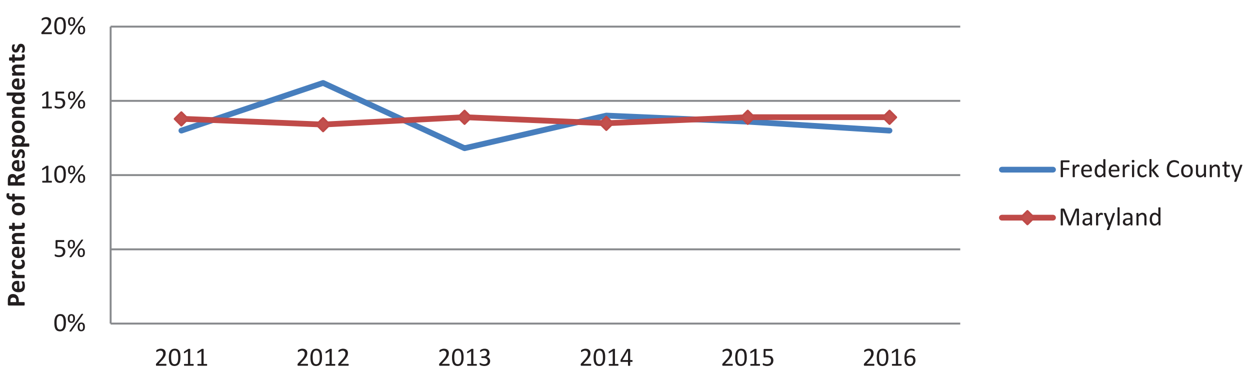
Source: Behavioral Risk Factor Surveillance Survey. Question: EVER BEEN TOLD BY A DOCTOR OR OTHER HEALTH PROFESSIONAL THAT YOU HAD ARTHRITIS?



Asthma

Adult Asthma in Frederick County, MD						Maryland
	2012	2013	2014	2015	2016	2016
Adult Asthma (ever diagnosed)	16.2%	11.8%	14.0%	13.6%	13.0%	13.9%

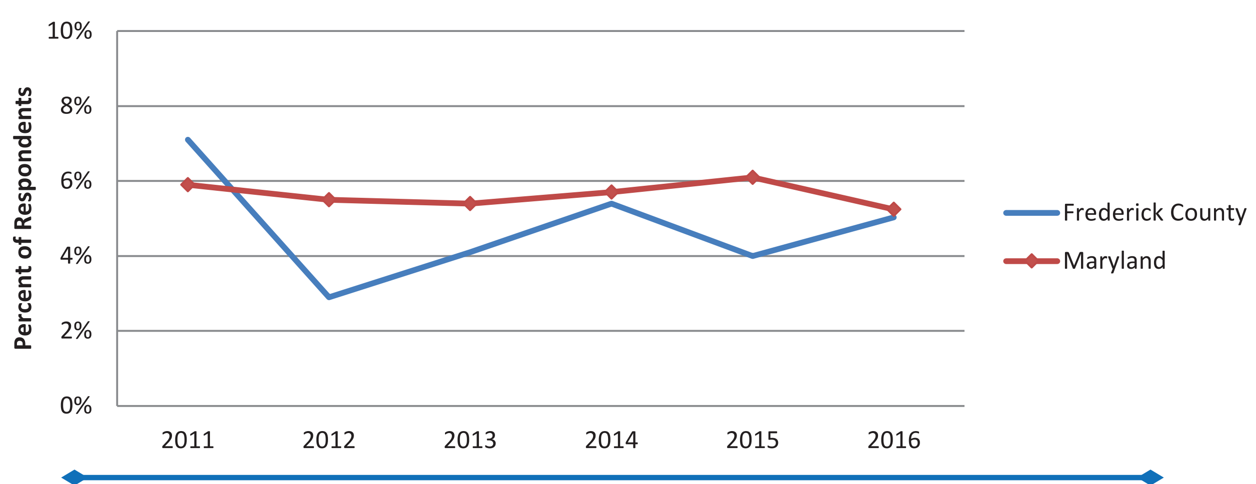
Source: Behavioral Risk Factor Surveillance Survey. Question: EVER BEEN TOLD BY A DOCTOR OR OTHER HEALTH PROFESSIONAL THAT YOU HAD ASTHMA?



COPD

Chronic Obstructive Pulmonary Disease in Frederick County, MD						Maryland
	2012	2013	2014	2015	2016	2016
COPD	2.9%	4.1%	5.4%	4.0%	5.0%	5.2%

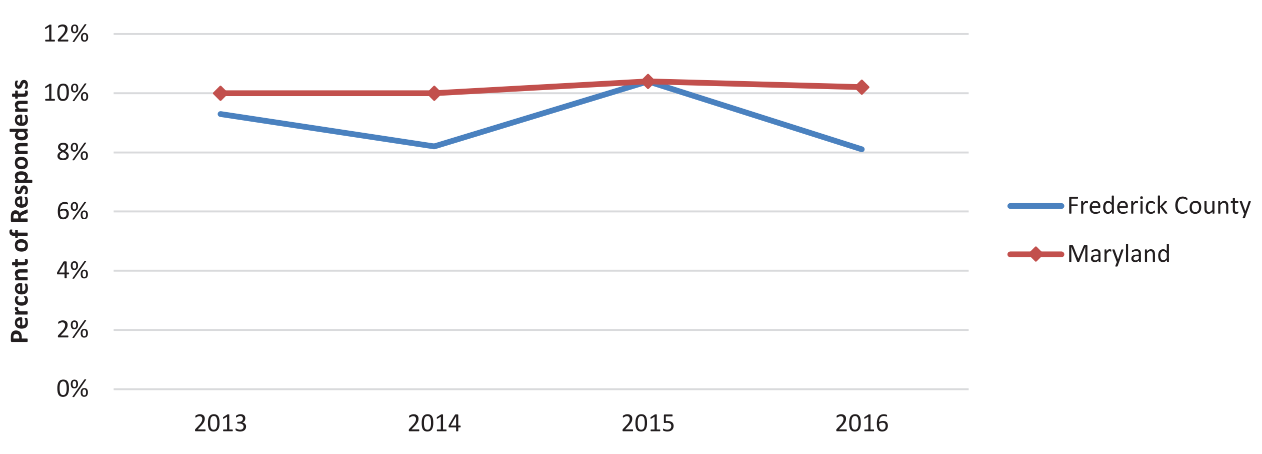
Source: Behavioral Risk Factor Surveillance Survey. Question: EVER BEEN TOLD YOU HAVE CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD), EMPHYSEMA, OR CHRONIC BRONCHITIS?



Diabetes

Diabetes in Frederick County, MD						Maryland
	2012	2013	2014	2015	2016	2016
Diabetes		9.3%	8.2%	10.4%	8.1%	10.2%

Source: Behavioral Risk Factor Surveillance Survey. Question: EVER TOLD BY A DOCTOR THAT YOU HAVE DIABETES? EXCLUDE: DIABETES AT PREGNANCY

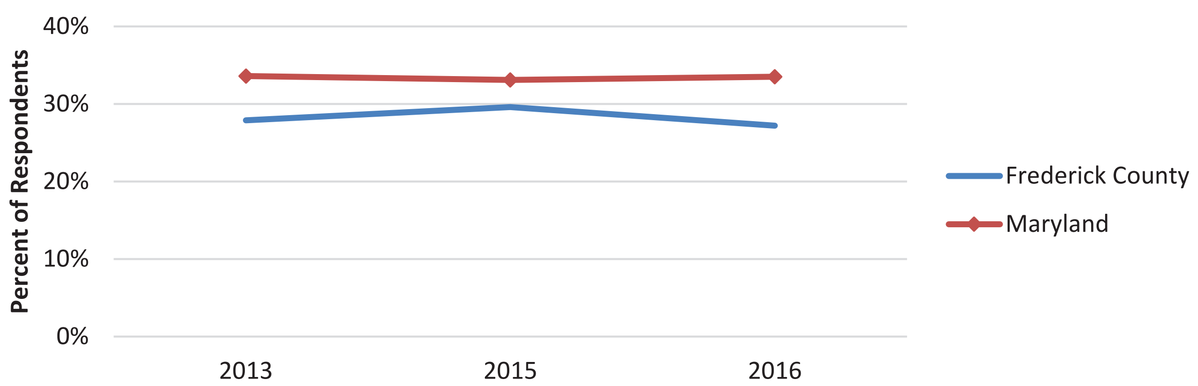


Hypertension

Hypertension in Frederick County, MD				Maryland
	2013	2015	2016	2016
Hypertension	27.9%	29.6%	27.2%	33.5%

Source: Behavioral Risk Factor Surveillance Survey. Question: EVER TOLD BY A DOCTOR THAT YOU HAVE HIGH BLOOD PRESSURE? EXCLUDE: WOMEN TOLD DURING PREGNANCY AND BORDERLINE HYPERTENSION.

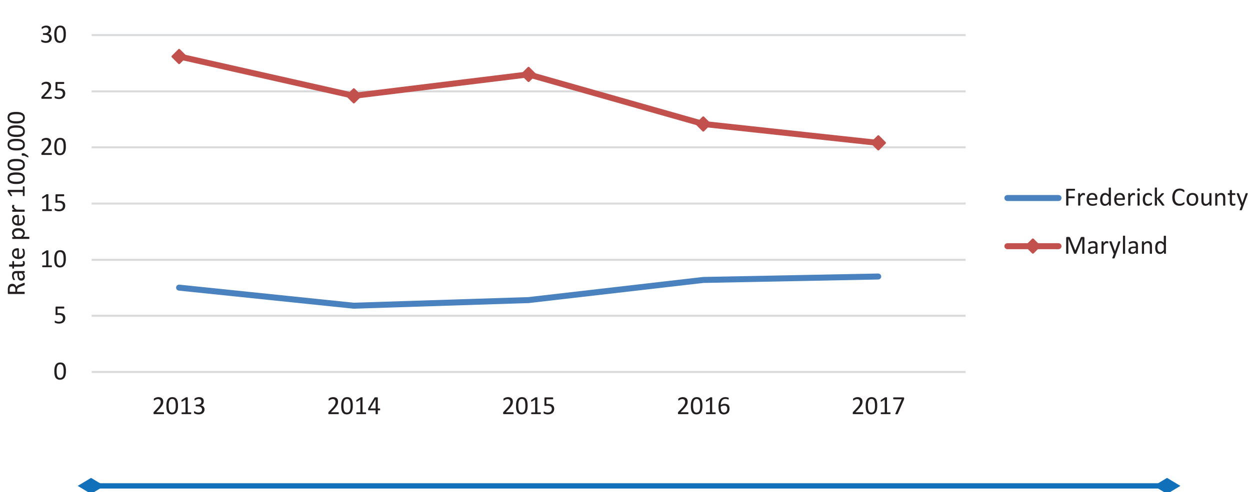
Hypertension in Frederick County and Maryland, 2013-2016



HIV

HIV Incidence Rate in Frederick County, MD						Maryland
Rate per 100,000	**2013**	**2014**	**2015**	**2016**	**2017**	**2017**
HIV Incidence Rate	7.5	5.9	6.4	8.2	8.5	20.4

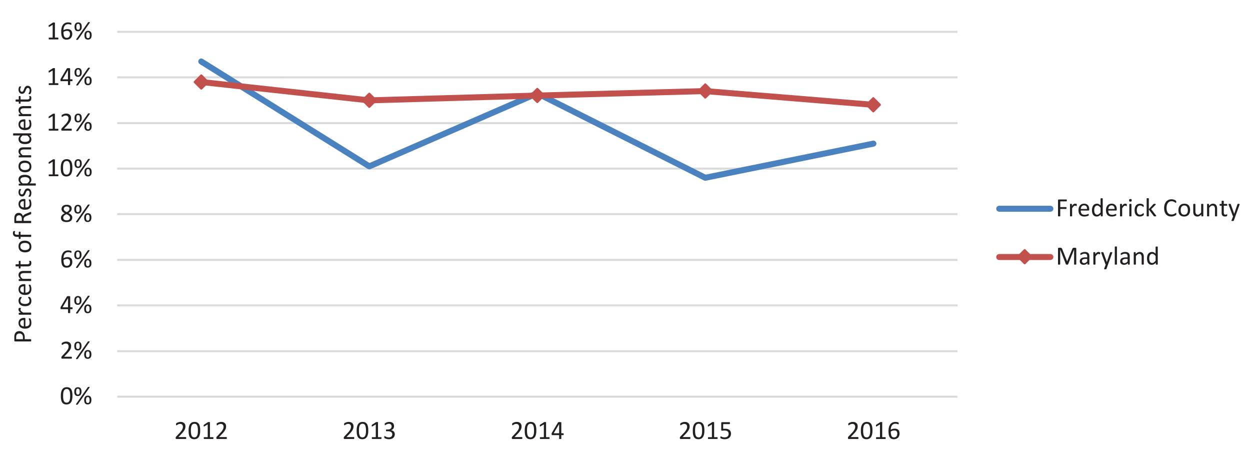
Source: Maryland HIV Annual Epidemiological Profile. Incidence rate indicates new diagnoses of HIV in adults and adolescents.



Mental Health

Mental Health in Frederick County, MD						Maryland
	2012	**2013**	**2014**	**2015**	**2016**	**2016**
Mental Health Not Good 8-30 days per month	14.7%	10.1%	13.3%	9.6%	11.1%	12.8%

Source: Behavioral Risk Factor Surveillance Survey. Question: NUMBER OF DAYS MENTAL HEALTH NOT GOOD.



Health Factors: Socio-Economic

Education

Population estimates, July 1, 2017	Frederick County	Maryland	United States
High school graduate or higher, percent of persons age 25+ (2013-2017)	92.6%	89.8%	87.3%
Bachelor's degree or higher, percent of persons age 25+ (2013-2017)	40.5%	39.0%	30.9%

Data Source: U.S. Census Bureau: State and County Quick Facts; 2017 Population Estimates; American Community Survey 5-year Estimates.

Income

Population estimates, July 1, 2017	Frederick County	Maryland	United States
Median Household Income (2013-2017)	$88,502	$78,916	$57,652
Owner-occupied housing unit rate (2013-2017)	74.8%	66.8%	63.8%
Persons per household (2013-2017)	2.68	2.68	2.63
Persons in Poverty (2012-2016)	6.9%	9.3%	12.3%
Unemployment Rate, May 2018*	3.5%	3.9%	3.8%

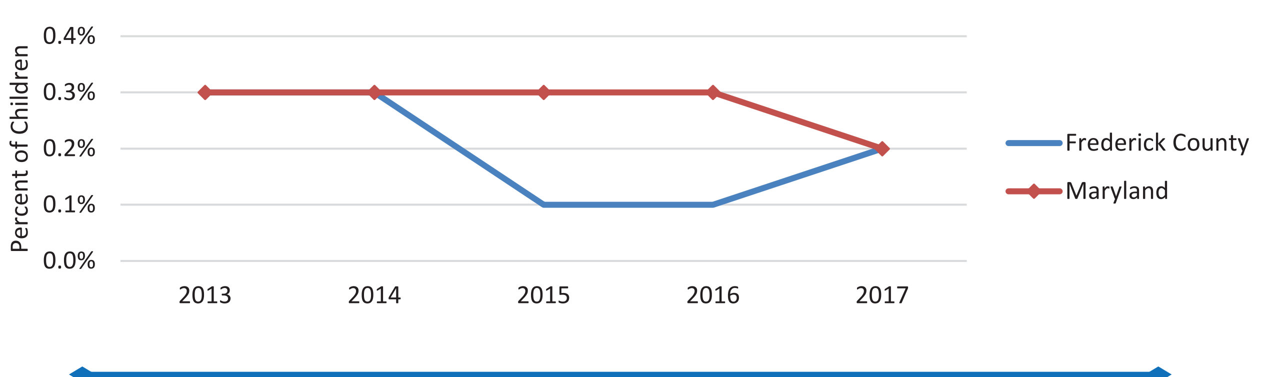
Data Source: U.S. Census Bureau: State and County Quick Facts; 2017 Population Estimates; American Community Survey 5-year Estimates; United States Department of Labor; Bureau of Labor Statistics (*not seasonally adjusted preliminary unemployment rates)

Health Factors: Physical Environment

Lead Levels

Lead Levels in Frederick County, MD						Maryland
	2013	2014	2015	2016	2017	2017
Children* with positive lead levels	0.3%	0.3%	0.1%	0.1%	0.2%	0.3%

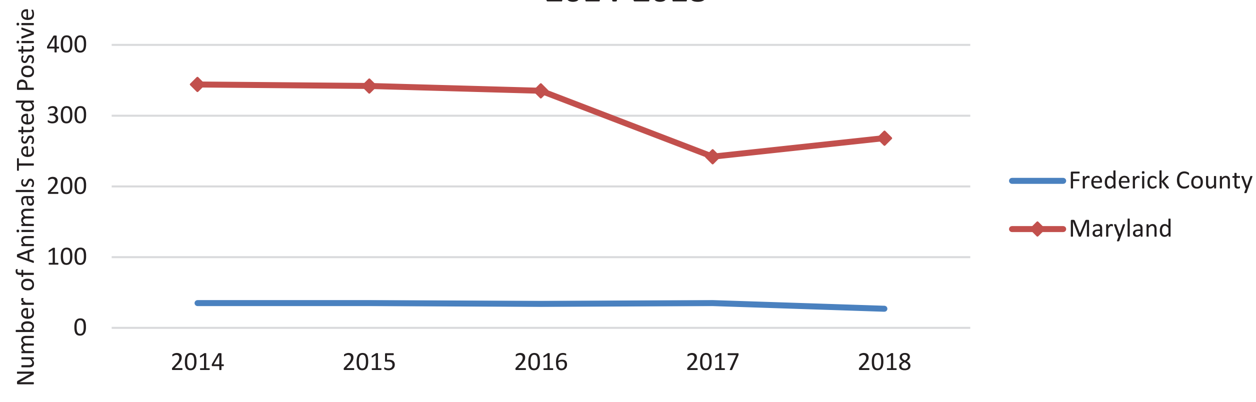
Source: Maryland Department of the Environment Annual Report on Childhood Blood Lead Surveillance in Maryland.
https://mde.maryland.gov/programs/Land/Pages/LandPublications.aspx
*Number of children (0-72 months old) with blood lead levels > 10 µg/dL



Rabies

Rabies in Frederick County, MD						Maryland
	2014	2015	2016	2017	2018	2017
Animals testing positive for Rabies	35	35	34	35	27	268

Source: Maryland Center for Zoonotic and Vectorborne Diseases Laboratory Confirmed Rabies in Maryland Reports.
https://phpa.health.maryland.gov/OIDEOR/CZVBD/pages/Data-and-Statistics.aspx

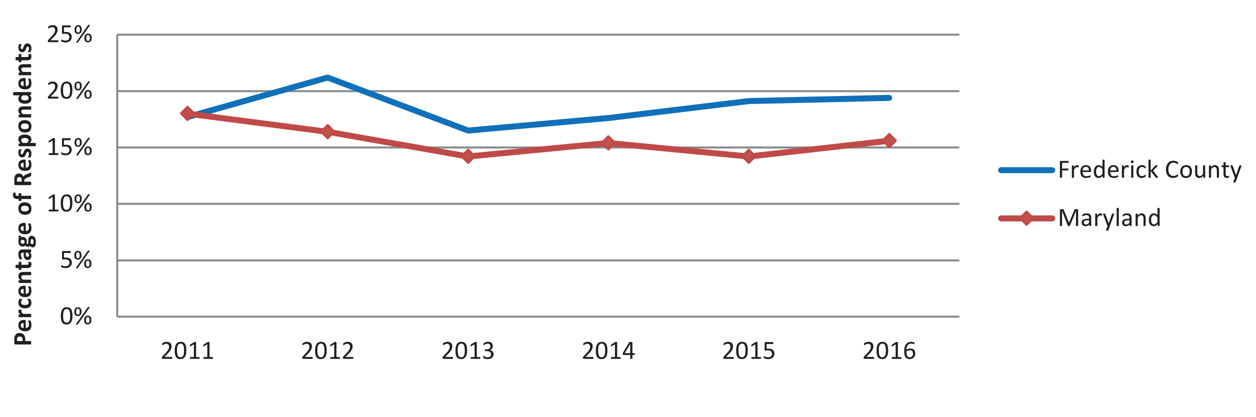


Health Factors: Health Behaviors

Alcohol

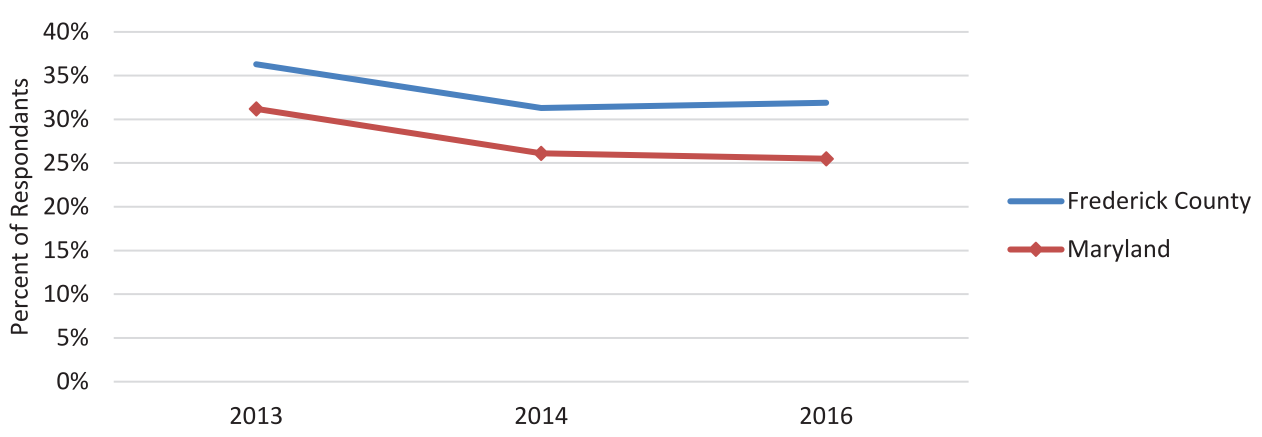
Alcohol Use (Adults) in Frederick County, MD						Maryland
	2012	2013	2014	2015	2016	2016
Binge Drinking (Adults)	21.2%	16.5%	17.6%	19.1%	19.4%	15.6%

Source: Behavioral Risk Factor Surveillance Survey. Question: BINGE DRINKERS (MALES HAVING FIVE OR MORE AND FEMALES HAVING FOUR OR MORE DRINKS ON ONE OCCASION IN THE PAST MONTH.



Alcohol Use (Adolescents) in Frederick County, MD				Maryland
	2013	2014	2016	2016
High School Students Who Drank Alcohol in Last Month	36.3%	31.3%	31.9%	25.5%

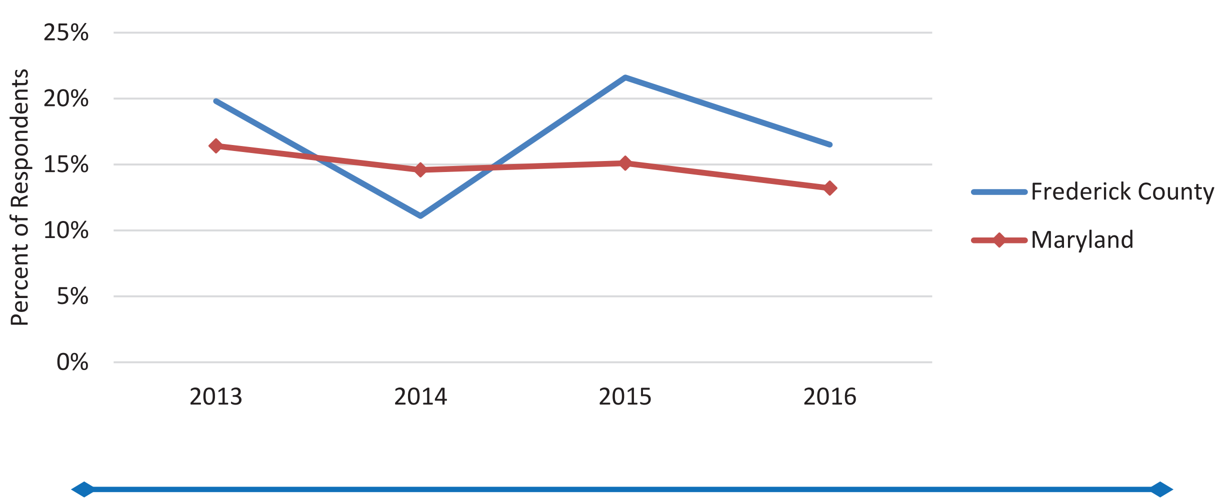
Source: Youth Risk Behavior Survey. Question: Percentage of students who had at least one drink of alcohol on one or more of the past 30 days.



Tobacco Use

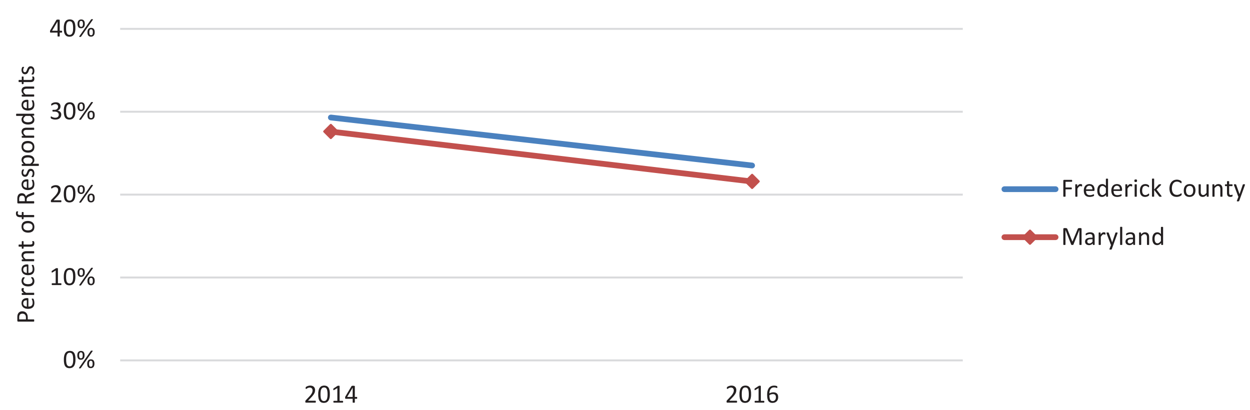
Current Smoker (Adults) in Frederick County, MD						Maryland
	2012	2013	2014	2015	2016	2016
Current Smoker (Adults)		19.8%	11.1%	21.6%	16.5%	13.2%

Source: Behavioral Risk Factor Surveillance Survey. Question: SMOKING STATUS.



Tobacco Use (Adolescents) in Frederick County, MD			Maryland
	2014	2016	2016
High School Students Currently Using Tobacco Products	29.3%	23.5%	21.6%

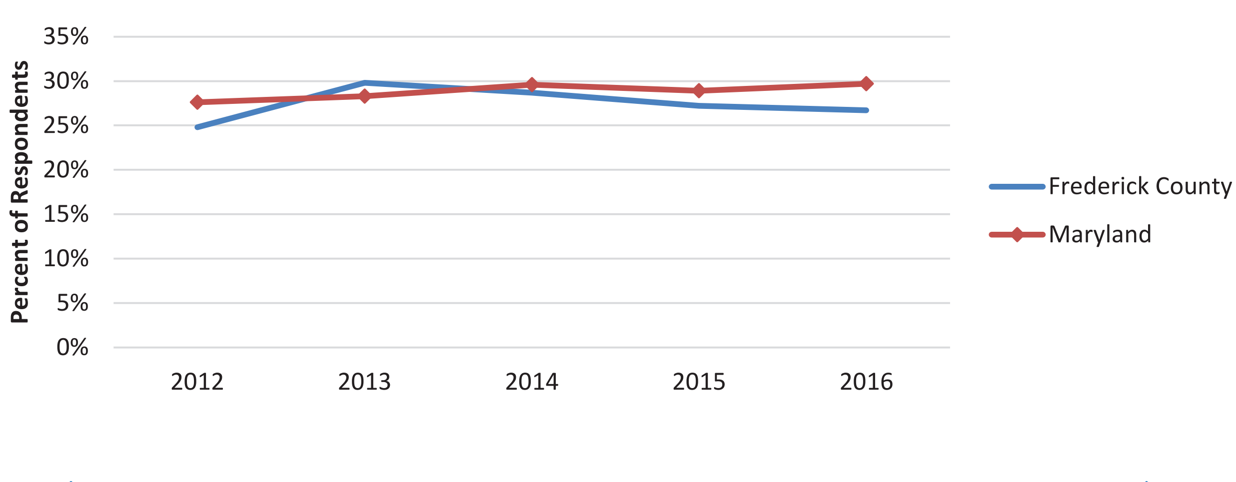
Source: Youth Risk Behavior Survey. Question: Percent of students who currently smoked cigarettes or cigars or used smokeless tobacco or electronic vapor products (on at least 1 day during the 30 days before the survey).



Diet & Exercise

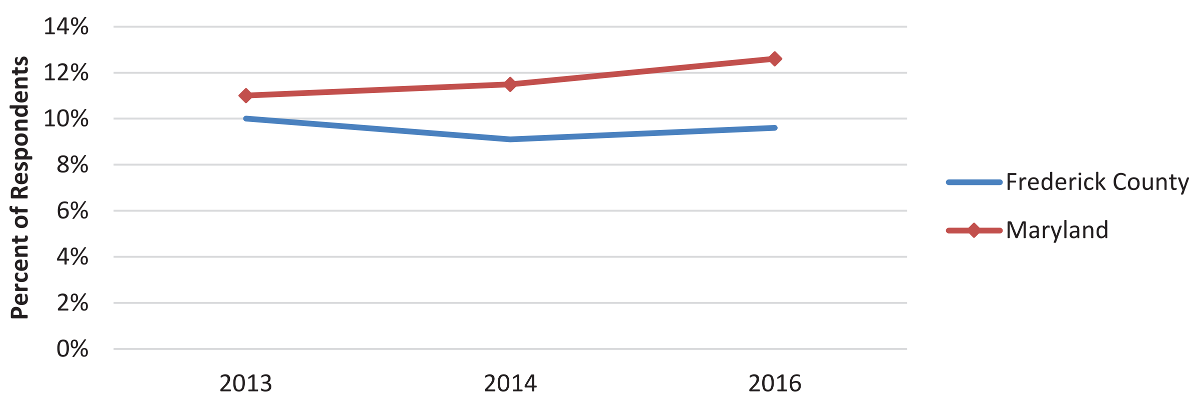
Obesity (Adults) in Frederick County, MD						Maryland
	2012	2013	2014	2015	2016	2016
Obesity (Adults)	24.8%	29.8%	28.7%	27.2%	26.7%	29.7%

Source: Behavioral Risk Factor Surveillance Survey. Question: WEIGHT CLASSIFICATION.



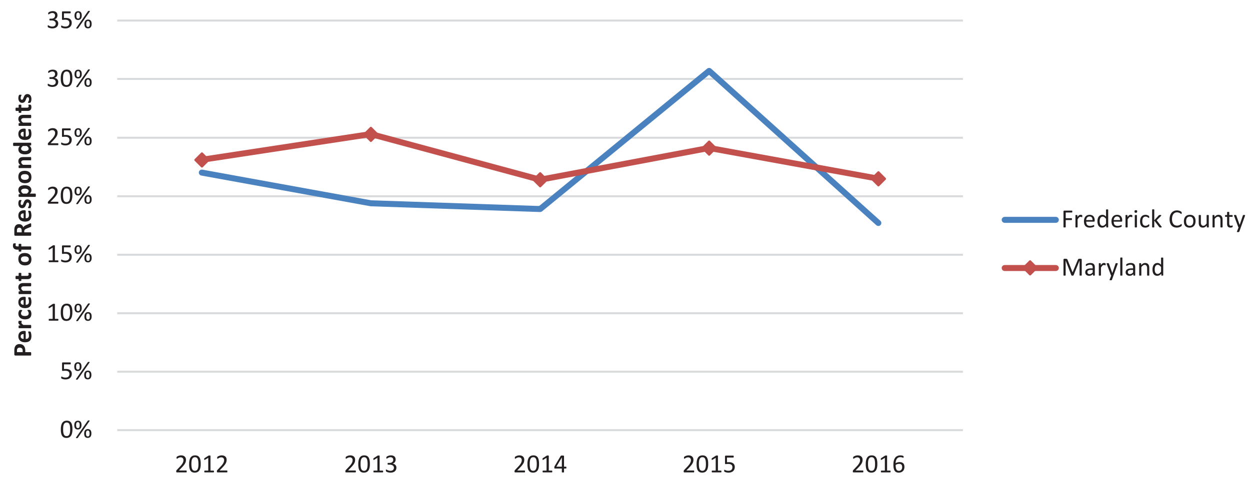
Obesity (Adolescents) in Frederick County, MD				Maryland
	2013	2014	2016	2016
High School Students with Obesity	10.0%	9.1%	9.6%	12.6%

Source: Youth Risk Behavior Survey. Question: Percentage of students who had obesity.



No Physical Activity (Adults) in Frederick County, MD						Maryland
	2012	2013	2014	2015	2016	2016
No Physical Activity (Adults)	22.0%	19.4%	18.9%	30.7%	17.7%	21.5%

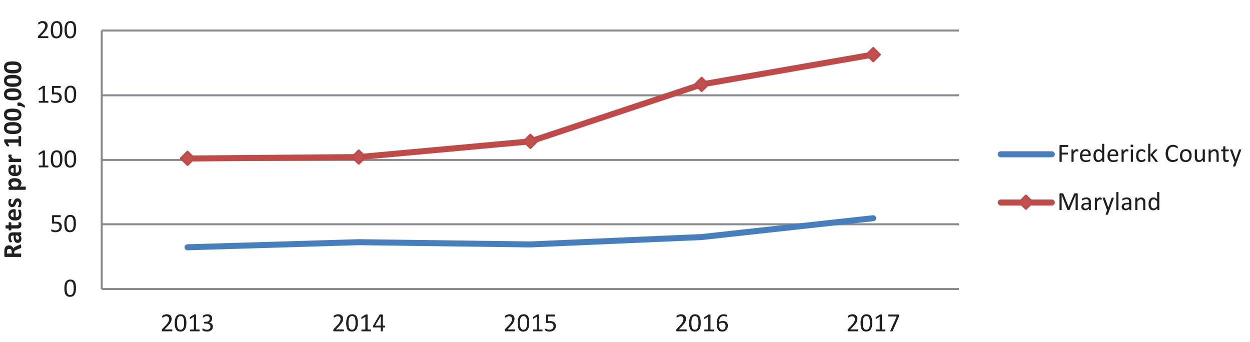
Source: Behavioral Risk Factor Surveillance Survey. Question: NO LEISURE TIME ACTIVITY.

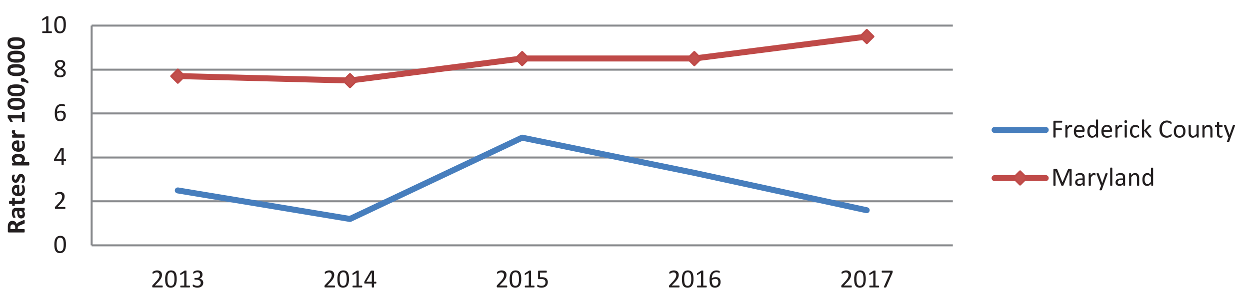


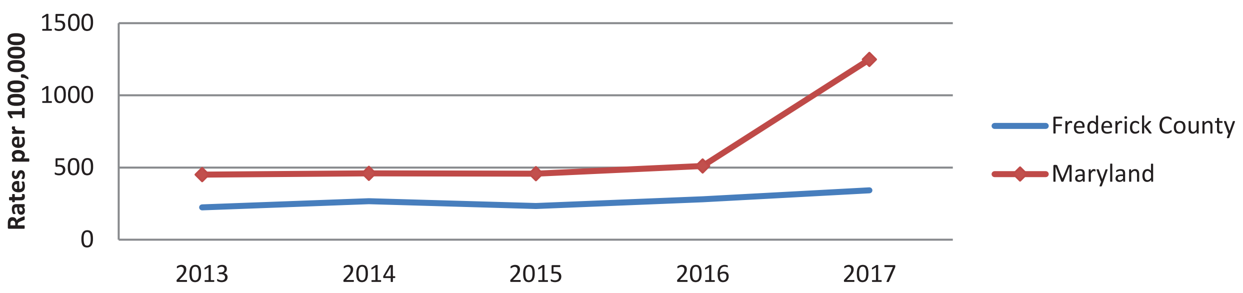
Sexual Health

Rates of Sexually Transmitted Infections in Frederick County, MD						Maryland
Rates per 100,000	**2013**	**2014**	**2015**	**2016**	**2017**	**2017**
Gonorrhea	32.3	36.2	34.6	40.2	54.8	181.4
Syphilis (Primary and Secondary)	2.5	1.2	4.9	3.3	1.6	9.5
Chlamydia	223.9	265.8	232.7	280.1	342.0	1248.4

Source: Maryland STI Data and Statistics. https://phpa.health.maryland.gov/OIDPCS/CSTIP/Pages/STI-Data-Statistics.aspx





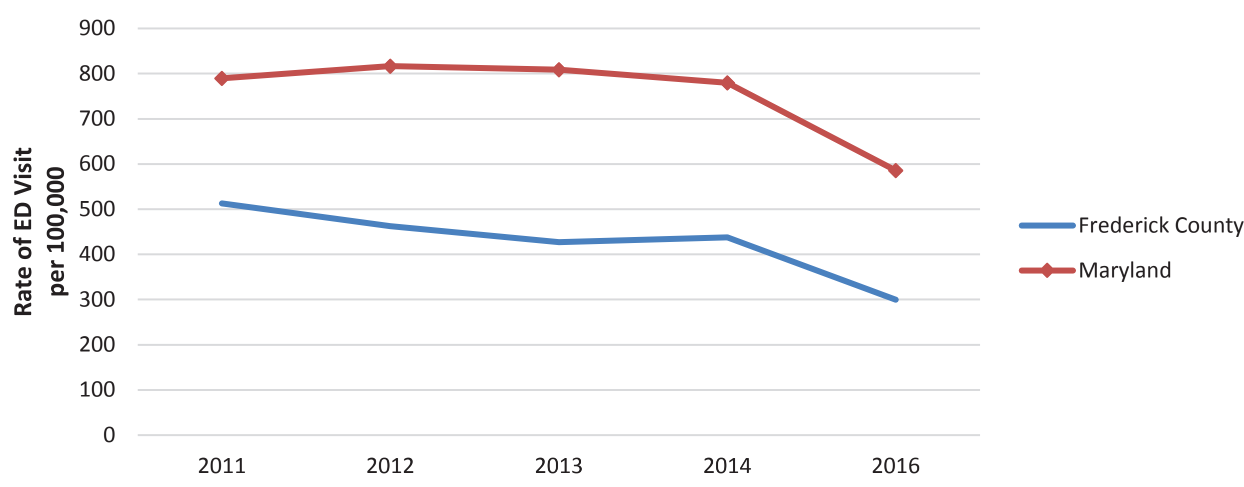


Health Factors: Clinical Care

Oral Health

Emergency Department Visits for Dental Care in Frederick County, MD						Maryland
Rates per 100,000	**2011**	**2012**	**2013**	**2014**	**2016**	**2016**
ED Visits Rate for Dental Issues	512.8	462.4	427.3	437.4	299.7	585.7

Source: Maryland Health Services Cost Review Commission (HSCRC), Research Level Statewide Outpatient Data Files. http://frederick.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship46.
Note: No data available for 2015.



Appendix 3. Frederick County Health Indicators: Prioritization Matrix

Health Indicators	Source	Size	Rate	Number affected*	% of FC population	Severity	Severity notes	Trend	Trend notes	Impact on other indicators	Impact notes	Variance vs benchmark	Benchmark	Community Perception	Notes	Disparity	Notes	Score	Rank
Alcohol Use (adolescents)	2016 MD YRBS	2	31.9% high school student	4094 high school students	0.45%	2	Intervention strongly recommended	2	slight increase from 2014, decrease from 2013	3	Increases risk of cerebralvascular disease and some cancers	0	No benchmark set	2		3	Higher in males, Black, Hispanic	14	1
Breast Cancer (incidence)	2017 MD CRF Report	1	124.2	313	0.12%	3	Intervention urgent	3	trend worsening, especially for blacks	2	Higher risk of other cancers	1	death: HP 2020 20.7/100,000 (FC 21.3)			3		13	2
Syphilis	2017 MDH Report	1	1.6	4	0.00%	3	Intervention urgent	3	trend worsening	3	dementia, blindness	0	No benchmark set			3	higher in White, males	13	3
Obesity (adolescents)	2016 MD YRBS	1	9.6% of high school students	1,232 high school students	0.13%	2	Intervention strongly recommended	2	slight increase from 2014, decrease from 2013	3	Increases risk of heart disease, some cancers	0	No benchmark set	2		3	No disparity data available	13	4
Hypertension	2016 BRFSS	3		52,578	27.2%	2	Intervention strongly recommended	3	Slight worsening trend	3	Increases risk of stroke, demensia, kidney problems, heart disease	1	HP2020 26.9%				No disparity data available	12	5
Gonorrhea	2017 MDH Report	1	54.8	138	0.05%	2	Intervention strongly recommended	3	trend worsening	3	infertility, pregnancy complications	0	No benchmark set			3	Higher in Blacks, males	12	6
Cancer, all (incidence)	2017 MD CRF Report	1	431.8	1,088	0.43%	3	2nd leading cause of death	1	Trending down since 2010 but up in last year	2	Impact on quality of life, treatment side effects	1	death: MD SHIP 147.4/100,000 (FC 156)			3		11	7
Overdose deaths	Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report 2017	1	30.9	78	0.03%	3		3	trend worsening	1		1	MD SHIP 12.6 per 100,000	2			No disparity data available	11	8
Melanoma Cancer (incidence)	2017 MD CRF Report	1	23.1	58	0.02%	3	Intervention urgent	3	trend worsening	1		0	death: HP 2020 2.4/100,000 (FC 2.4)			3		11	9
Infant mortality	2017 MD Vital Stats	1	6.3	17	0.63%	3	Intervention urgent	3	trend worsening	1		0	MD SHIP 6.3 per 1,000			3		11	10
HIV	2017, MD Annual HIV Epidemiological Profile	1	8.5	18	0.01%	3	Intervention urgent	3	trend worsening	2	risk of coocurring STIs	-1	MD SHIP 26.7 per 100,000 (incidence)			3		11	11

Health Indicators	Source	Size	Rate	Number affected*	% of FC population	Severity	Severity notes	Trend	Trend notes	Impact on other indicators	Impact notes	Variance vs benchmark	Benchmark	Community Perception	Notes	Disparity	Notes	Score	Rank
Tobacco Use (adolescents)	2016 MD YRBS	2	23.5% high school student	3,016 high school students	0.33%	1		1	trend improving	3	Increases risk of cerebralvascular disease and some cancers	1	MD SHIP 15.2%			3	Higher in males, Black, Hispanic	11	12
Chlamydia	2017 MDH Report	1	342.0	862	0.34%	1		3	trend worsening	3	infertility, pregnacy complications	-1	MD SHIP 431 per 100,000			3	Higher in females	10	13
Obesity (adults)	2016 BRFSS	3		51,611	26.7%	2	Intervention strongly recommended	1	trend is improving	3	Increases risk of heart disease, some cancers	-1	HP2020 30.5%	2			No disparity data available	10	14
Intentional Self-Harm/ Suicide	2017 MD Vital Stats	1	10.3	26	0.01%	3	10th leading cause of death	3	trend worsening	1		-1	HP2020 10.2/100,000			3		10	15
Colorectal Cancer (incidence)	2017 MD CRF Report	1	39.5	100	0.04%	3	Intervention urgent	1	trend improving	1		1	death: HP 2020 14.5/100,000 (FC 15.5)			3		10	16
Low birth weight	2017 MD Vital Stats	1		187	6.9%	2		2	overall trending better, but most recent year worse	3	increased risk of obesity, hypertension, diabetes, heart disease	-1	MD SHIP 8.0%			3		10	17
Alcohol Use (adults binge)	2016 BRFSS	2		37,500	19.40%	1		3	trend worsening	3	Risk of liver disease, heart damage, some cancer	-1	HP2020 24.2%	2			No disparity data available	10	18
Oral Cancer (incidence)	2017 MD CRF Report	1	9.5	24	0.01%	3	Intervention urgent	2	trend consistnet	1		0	No benchmark set			3		10	19
Mental Health (8-30 days not good/month)	2016 BRFSS	2		21,456	11.10%	2		2	trend steady	2	Linked to higher unemployment, poverty, disability	0	No benchmark set	2			No disparity data available	10	20
Adverse Childhood Experiences (ACEs) (3+)	2016 BRFSS	3		52,578	27.2%	2	Early life impact can cause chronic, generational issues, intervention strongly rec		Not enough data for trend	3	Increases risk for chronic disease, early death	0	no benchmark set	2	33%		No disparity data available	10	21
Preterm birth	2017 MD Vital Stats	1	9.3% of all births	252 births	0.10%	2		1	slight decline/improvement	3	risk of respiratory distress, devopmental delays	-1	HP2020 9.4%			3		9	22

Health Indicators	Source	Size	Rate	Number affected*	% of FC population	Severity	Severity notes	Trend	Trend notes	Impact on other indicators	Impact notes	Variance vs benchmark	Benchmark	Community Perception	Notes	Disparity	Notes	Score	Rank
Arthritis	2016 BRFSS	3		48,712	25.2%	2	Chronic condition that increases in severity, can cause disability	3	Worsening trend	1	linked to anxiety and depression	0	No benchmark set				No disparity data available	9	23
Heart disease (deaths)	2017 MD Vital Stats	1	165.1	416	0.17%	3	Leading cause of death	3	trending up since 2010	1	Increased risk of stroke	0	MD SHIP 166.3 (FC better), P2020 103.4/100,000 (FC worse)				No disparity data available	8	24
Lung Bronchus Cancer (incidence)	2017 MD CRF Report	1	48.1	121	0.05%	3	Intervention urgent	1	trend improving	1		-1	death: HP 2020 45.5/100,000 (FC 37.9)			3		8	25
Prostate Cancer (incidence)	2017 MD CRF Report	1	103.0	260	0.10%	3	Intervention urgent	1	trend improving	1		-1	death: HP 2020 21.8/100,000 (FC 21.3)			3		8	26
Dental Care (ED visits)	2016 MD SHIP	1	299.7	755	0.30%	1		1	trend improving	3	increase risk of heart attack, stroke	-1	MD SHIP 792.8/100,000			3	Higher in Blacks, males	8	27
Early Prenatal Care	2017 MD Vital Stats	1	80% of all births	2171 births	0.86%	1		1	trend improving	3	reduces pregnancy complications	-1	MD SHIP 66.9%			3		8	28
Teen birth rate	2017 MD Vital Stats	1	8.3/1000	71	0.03%	1	potential for economic loss	1	trending down, improving	3	low birth weight, infant mortality	-1	MD SHIP 17.8 per 1,000			3	Higher in Black and Hispanic	8	29
Accident (deaths)	2017 MD Vital Stats	1	18.3	46	0.02%	3	5th leading cause of death	3	trend worsening	1		0	No benchmark set				No disparity data available	8	30
Alzheimer's Disease (deaths)	2017 MD Vital Stats	1	14.4	36	0.01%	3	8th leading cause of death	3	trend worsening	1		0	No benchmark set				No disparity data available	8	31
Nephritis, Nephrosis, and Neprotic Syndrome (deaths)	2017 MD Vital Stats	1	12.0	30	0.01%	3	9th leading cause of death	3	trend worsening	1		0	No benchmark set				No disparity data available	8	32
No Physical Activity	2016 BRFSS	2		34,214	17.7%	1		2		3	Increases risk of heart disease, some cancers	-1	HP2020 32.6%				No disparity data available	7	33
Tobacco Use (Current adult Smoker)	2016 BRFSS	2		31,895	16.5%	1		2	Trend steady	3	Increases risk of cerebralvascular disease and some cancers	-1	MD SHIP 15.5%				No disparity data available	7	34

Health Indicators	Source	Size	Rate	Number affected*	% of FC population	Severity	Severity notes	Trend	Trend notes	Impact on other indicators	Impact notes	Variance vs benchmark	Benchmark	Community Perception	Notes	Disparity	Notes	Score	Rank
Child lead levels	2016, Childhood Blood Lead Surveillance in Maryland Annual Report	1		5	0.002%	3	Intervention urgent	1	trend improving	3	increased risk of neurological and learning issues	-1	MDSHIP 0.28%				No disparity data available	7	35
C-section Births	2017 MD Vital Stats	1	30.8% of all births	836 births	0.33%	1		1	slight decline/improvement	1		0	No benchmark set			3		7	36
COPD	2016 BRFSS	1		9,665	5.0%	2	Chronic condition that increases in severity, can cause disability	2	overall trending slight improvement, but most recent year worse	2	heart attacks, strokes, and lung cancer	0	No benchmark set				No disparity data available	7	37
Diabetes	BRFSS, MD Vital Stats	1		20,414	8.1%	2	Chronic condition, can cause disability, death in small numbers	2	Incidence steady, mortality increasing	2	Causes problems in eyes, kidneys, feet, nerves	-1	HP2020 66.6 deaths per 100,000; FC at 18.3 in 2014-2016				No disparity data available	6	38
Septicemia (deaths)	2017 MD Vital Stats	1	9.2	23	0.01%	3	7th leading cause of death	1	trend improving	1		0	No benchmark set				No disparity data available	6	39
Cerebrovascular Disease (deaths)	2017 MD Vital Stats	1	36.0	91	0.04%	3	3rd leading cause of death	1	trend improving	1		0	No benchmark set				No disparity data available	6	40
Chronic Lower Respiratory Disease (deaths)	2017 MD Vital Stats	1	35.5	89	0.04%	3	4th leading cause of death	1	trend improving	1		0	No benchmark set				No disparity data available	6	41
Influenza and Pneumonia (deaths)	2017 MD Vital Stats	1	21.8	55	0.02%	2	6th leading cause of death	2	trend steady	1		0	No benchmark set				No disparity data available	6	42
Cervical Cancer (incidence)	2017 MD CRF Report	1	5.0	13	0.01%	3	Intervention urgent	1	trend improving	1		0	No benchmark set				No disparity data available	6	43
Asthma	2016 BRFSS	2		25,129	13.00%	2		1	trend improving	1	linked to anxiety and depression	0	No benchmark set				No disparity data available	6	44
Rabies (animals testing positive)	2017 MD CZVBD	0		35 animals positive	N/A	3	Intervention urgent	1	trend improving	1		0	No benchmark set				No disparity data available	5	45

*based on 2017 FC pop estimate
**BRFSS populations based on 18+ (76.7% = 193,300
***based on 2017-2018 high school population of 12,833
Cause of death mortality rates used because incidence/prevalence for FC not available.
Cancer incidence used because prevalence data for FC not available.

Appendix 4. Maryland State Health Improvement Plan (SHIP) Goals

Measure	MD SHIP Goal	Frederick County Value	Frederick County Year	Did FC Meet Goal?
Reduce infant mortality rate (per 1,000)	6.3	6.3	2017	Yes
Reduce the percent of low birth weight births	8.0%	6.9%	2017	Yes
Increase the percent of pregnancies starting care in the 1st trimester	66.9%	80%	2017	Yes
Reduce teen birth rate (per 1,000)	17.8	8.3	2017	Yes
Reduce high child lead levels	0.28%	0.002%	2016	Yes
Reduce the percent of adolescents who use tobacco products	15.2%	23.5%	2016	No
Reduce the percent of adults who are current smokers	15.5%	16.5%	2016	No
Reduce emergency department visits for dental care (per 100,000)	792.8	299.7	2016	Yes
Reduce chlamydia infection rate (per 100,000)	431	342.0	2017	Yes
Reduce HIV incidence rate (per 100,000)	26.7	8.5	2017	Yes
Reduce suicide rate (per 100,000)	9.0	10.3	2017	No
Reduce heart disease mortality (per 100,000)	166.3	165.1	2017	Yes
Reduce cancer mortality (per 100,000)	147.4	156.0	2014	No

http://dhmh.maryland.gov/SHIP/Pages/home.aspx

Appendix 5. Healthy People 2020 Goals Included in this Assessment

	Measure	HP2020 Goal	Frederick County Value	Frederick County Year	Did FC Meet Goal?
C-1	Reduce the overall cancer death rate to 161.4 deaths per 100,000 population.	161.4	156.0	2014	Yes
C-2	Reduce the lung and bronchus cancer death rate to 45.5 deaths per 100,000 population.	45.5	37.9	2010-2014	Yes
C-3	Reduce the female breast cancer death rate to 20.7 deaths per 100,000 population.	20.7	21.3	2010-2014	No
C-5	Reduce the colorectal cancer death rate to 14.5 deaths per 100,000 population.	14.5	15.5	2010-2014	No
C-7	Reduce the prostate cancer death rate to 21.8 deaths per 100,000 population.	21.8	21.3	2010-2014	Yes
C-8	Reduce the melanoma cancer death rate to 2.4 deaths per 100,000 population.	2.4	2.4	2010-2014	Yes
D-3	Reduce diabetes death rate to 66.6 deaths per 100,000 population.	66.6	18.3	2014-2016	Yes
HDS-2	Reduce coronary heart disease deaths to 103.4 deaths per 100,000 population	103.4	165.1	2017	No
HDS-5	Reduce the proportion of persons in the population with hypertension to 26.9%.	26.9%	27.2%	2016	No
MHMD-1	Reduce the suicide rate to 10.2 suicides per 100,000 population	10.2	10.3	2017	No
MICH-1.3	Reduce rate of infant deaths to 6.0 deaths per 1,000 live births	6.0	6.3	2017	No
MICH-8.1	Reduce low birth weight births to 7.8% of births	7.8%	6.9%	2017	Yes
MICH-9.1	Reduce total preterm births to 9.4% of live births	9.4%	9.3%	2017	Yes
MICH-10.1	Increase the proportion of pregnant women who receive early and adequate prenatal care to 77.9%	77.9%	80.0%	2017	Yes
NW-9	Reduce the proportion of adults who are obese to 30.5%	30.5%	26.7%	2016	Yes
SA-14.3	Reduce the proportion of persons engaging in binge drinking during the past 30 days—adults aged 18 years and older	24.2%	19.4%	2016	Yes
TU-1.1	Reduce cigarette smoking by adults to 12%	12.0%	16.5%	2016	No

http://www.healthypeople.gov/2020/topics-objectives

Appendix 6. Disparities

At this time, county level data is not available to examine the role of income, education, and other social determinants of health for health disparities. Some data is available for certain topics by gender, race and/or ethnicity. The following list shows health disparities in Frederick County. Other disparities may exist, but this list consists of topics where data was available at the county level for both genders and/or at least two races.

Health Indicator	Data Source	Disparities Identified	
		Gender	Race/ Ethnicity
Alcohol Use (adolescents)	2016	≠	≠
C-section Births	2017	N/A	≠
Cancer, all (incidence and mortality)	2014	≠	≠
Cancer, Female Breast (incidence)	2010-2014	N/A	≠
Cancer, Colorectal (incidence)	2010-2014	≠	≠
Cancer, Lung Bronchus (incidence)	2010-2014	≠	≠
Cancer, Melanoma (incidence)	2010-2014	≠	Insuff. data
Cancer, Oral (incidence)	2010-2014	≠	Insuff. data
Cancer, Prostate (incidence)	2010-2014	N/A	≠
Chlamydia	2017	≠	≠
Early Prenatal Care	2017	N/A	≠
Emergency Department Visits for Dental Care	2016	≠	≠
Gonorrhea	2017	≠	≠
HIV	2017	≠	≠
Infant mortality	2017	Data not available	≠
Intentional Self- Harm/ Suicide	2017	≠	≠
Low birth weight	2017	N/A	≠
Preterm birth	2017	N/A	≠
Syphilis	2017	≠	≠
Teen birth rate	2017	N/A	≠
Tobacco Use (adolescents)	2016	≠	≠

For detailed data, go to the Secondary Data.

Appendix 7. Online Survey

2018 Frederick Community Health Survey

The purpose of this survey is to get the opinions of Frederick County residents about the community health issues in Frederick County, Maryland. The Frederick County Health Care Coalition, Frederick County Health Department and Frederick Regional Health System will use this information to identify health priorities and to address these priorities through community action. All questions are optional and your answers are anonymous and confidential. Please take 10 minutes to complete this survey.

Community Health

1. Overall, how would you rate the health of people who live in your community?

○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

2. What do you think makes a healthy community? *Check up to 4 answers.*

- ☐ Absence of discrimination (racism, sexism)
- ☐ Affordable housing
- ☐ Arts and cultural events
- ☐ Churches and religious organizations
- ☐ Clean environment (clean water, air, etc.)
- ☐ Good hospitals, doctors, clinics
- ☐ Good jobs
- ☐ Good public transportation
- ☐ Good schools
- ☐ Healthy foods in all neighborhoods (stores with fresh fruits and vegetables)
- ☐ Low crime/safe neighborhoods
- ☐ Places to get help (such as social services, food pantries and charities)
- ☐ Places to meet with people (community centers, social clubs, sports groups)
- ☐ Safe places to play and be active
- ☐ Other (please specify) ______________________________

3. What do you think are the most important health issues in your community? (Problems that have the greatest impact on overall health.) *Check up to 4 answers.*

- ☐ Adverse childhood experiences (negative stressful events that impact lifelong health)
- ☐ Alcohol and drug use
- ☐ Breathing or lung problems (asthma, COPD, etc.)
- ☐ Cancer
- ☐ Dental problems
- ☐ Diabetes
- ☐ Heart disease and stroke
- ☐ HIV / AIDs
- ☐ Infant death or premature birth
- ☐ Infectious disease (Hepatitis, TB)
- ☐ Mental Health problems (depression, anxiety, etc.)
- ☐ Overweight or obesity
- ☐ Preventable injuries (car accidents, accidental injury at home or work)
- ☐ Sexually transmitted diseases (STDs)
- ☐ Stress
- ☐ Suicide
- ☐ Teen pregnancy
- ☐ Violence (in the home, community, or workplace)
- ☐ Other (please specify) ____

4. Which of the following unhealthy behaviors in the community concern you the most? *(Those behaviors that have the greatest impact on overall community health.) Check up to 4 answers.*

- ☐ Alcohol abuse
- ☐ Child abuse
- ☐ Domestic violence
- ☐ Drug abuse
- ☐ Lack of exercise
- ☐ Not getting professional mental health help
- ☐ Not getting shots to prevent disease
- ☐ Not seeing a dentist
- ☐ Not seeing a doctor
- ☐ Poor eating habits (eating "junk" food, not eating vegetables, etc.)
- ☐ Sexual assault
- ☐ Tobacco use (cigarettes, cigars, e-cigarettes, chewing tobacco, dip, etc.)
- ☐ Unprotected or unsafe sex
- ☐ Violence that is gang or drug related
- ☐ Other (please specify) ____

5. Which healthcare services are difficult to get in your community? *Check all answers that apply.*

- ☐ Alcohol or drug abuse treatment
- ☐ Alternative therapies (acupuncture, etc.)
- ☐ Dental care
- ☐ Emergency medical care
- ☐ Family doctor
- ☐ Family planning (including birth control)
- ☐ Hearing aids
- ☐ Help navigating the healthcare system
- ☐ Mental health services
- ☐ Physical therapy and rehabilitation
- ☐ Prescriptions (medicine)
- ☐ Services for the elderly
- ☐ Specialty medical care (cardiologist, neurologist, endocrinologist, etc.)
- ☐ Vision care (eye exam and glasses)
- ☐ Other (please specify) ______________________________

Access to Healthcare

6. What is the primary source of your health care insurance coverage?

- ○ I do not have health insurance
- ○ Insurance from an employer or union
- ○ Insurance that you pay for yourself (including "Obamacare" plans)
- ○ Indian or Tribal Health Services
- ○ TRICARE, military, or VA Benefits
- ○ Medicaid or Health Choice
- ○ Medicare (alone or with a Medicare supplement)
- ☐ Other (please specify) ______________________________

7. When you or someone in your family is sick, where do you go for healthcare? *Check all that apply.*

- ☐ My family doctor
- ☐ Hospital emergency room
- ☐ Free clinic (Mission of Mercy)
- ☐ I usually go without healthcare
- ☐ VA or military
- ☐ Urgent care
- ☐ Low cost option (Community Action Agency)
- ☐ Other (please specify) ______________________________

8. What do you feel are the problems for you getting healthcare for yourself or your family members? *Check all that apply.*

- I am able to get quality healthcare without problems
- I don't have health insurance
- I cannot afford my insurance copay or deductible
- Doctor or clinic doesn't take my insurance
- Wait time to get appointment is too long
- Lack of transportation (can't get ride to the doctor)
- Doctor not taking new patients
- Doctor or nurse does not speak my language
- I cannot afford medicine (prescriptions)
- I cannot find the specialist I need nearby
- Other (please specify) ____

Your Health

9. How would you rate your own health?

- Poor
- Fair
- Good
- Very good
- Excellent

10. What are some of the major stressors in your life? *Check all that apply.*

- None
- Not having stable housing
- Providing care for elderly or disabled family members
- Responsibility providing care for children
- Cost of providing care for children
- Not having a stable job or income
- Ongoing health problems
- Unsafe home
- Unsafe neighborhood
- Not having reliable transportation
- Unable to afford / have access to healthy food
- Poor sleep
- Long commute / traffic
- Other (please specify) ____

11. It is recommended that everyone spends at least 30 minutes per day 5 days a week exercising. How much do you exercise?

- None
- Very little (less than 10 min/day)
- Some (about 15 min/day)
- About what's recommended
- A lot (more than 40 min/day
- Don't know

Exercise

12. Why is it hard for you to get 30 minutes of exercise 5 days a week? *Please check all that apply.*

- ☐ Costs too much
- ☐ I have physical problems that keep me from exercising
- ☐ Don't have safe places to exercise (park, sidewalks, etc.)
- ☐ I lack motivation
- ☐ Don't have someone to exercise with
- ☐ I never think about it
- ☐ I don't enjoy it
- ☐ Too busy / no time
- ☐ Other (please specify) ____

Healthy Eating Habits

13. It is recommended that everyone eats at least 5 servings of fruits and vegetables per day. How many servings do you typically eat per day? ***(For example, one serving is 1/2 cup cooked green vegetables, 1 cup leafy greens, or 1 banana.)***

- ○ 0 servings
- ○ 1-2 servings
- ○ 3-4 servings
- ○ 5 or more servings
- ○ Don't know

14. Why do you eat fewer than 5 servings of fruits and vegetables per day? *Check all that apply.*

- ☐ Cost too much
- ☐ I don't like the taste
- ☐ I never think about it
- ☐ Where I shop doesn't have a good selection
- ☐ Other (please specify) ____

Health Screenings and Preventive Care

15. If you are female, have you gotten your recommended Pap smear routinely? *Current recommendation for screening for cervical cancer in women age 21 to 65 years is a Pap smear every 3 years.*

- ○ I am not female
- ○ I am female but not in the testing age OR I don't have a cervix
- ○ Yes, I've gotten my Pap within the last 3 years
- ○ No, I haven't gotten my Pap within the last 3 years

16. Why have you not gotten your Pap as recommended?

- ☐ I can't get an appointment with my doctor
- ☐ I'm nervous/scared/don't want to
- ☐ I'm not sure if it's really needed
- ☐ I'm too busy to schedule it
- ☐ It's too expensive
- ☐ My doctor hasn't told me I need it
- ☐ Other (please specify) ____

17. If you are female, have you gotten your recommended mammogram? *Current recommendation for screening for breast cancer in women age 50 to 74 years is a mammogram every 2 years.*

- ○ I am not female
- ○ I am female but not in the testing age OR I've had a double mastectomy
- ○ Yes, I've gotten my mammogram within 2 years
- ○ No, I haven't gotten my mammogram within 2 years

18. Why have you not gotten your mammogram as recommended?

- ☐ I can't get an appointment with my doctor
- ☐ I'm nervous/scared/don't want to
- ☐ I'm not sure if it's really needed
- ☐ I'm too busy to schedule it
- ☐ It's too expensive
- ☐ My doctor hasn't told me I need it
- ☐ Other (please specify) ____

19. Have you gotten your recommended colon cancer screening? *Current recommended screening for colorectal cancer is fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.*

- ○ I am not old enough to start colon cancer screening yet
- ○ Yes, I've been screened for colon cancer as recommended by my doctor
- ○ No, I haven't been screened for colon cancer

20. Why have you not gotten your colonoscopy as recommended?

- ☐ I can't get an appointment with my doctor
- ☐ I'm nervous/scared/don't want to
- ☐ I'm not sure if it's really needed
- ☐ I'm too busy to schedule it
- ☐ It's too expensive
- ☐ My doctor hasn't told me I need it
- ☐ Other (please specify) ____

Demographics

Not all members of the community have the same experiences. Answering the following questions will help us better understand how health may be different by our zip code, gender, race or education so that we can offer better services

21. What is the zip code where you live? ____________

22. What kind of transportation do you regularly use? *Check all that apply.*

- ○ I have a reliable car
- ○ I have an unreliable car (doesn't always run)
- ○ Public transportation
- ○ Walking
- ○ Rides from friends or family
- ○ Bicycle
- ☐ Other (please specify) ____

23. What is your age? ______________________

24. What is your gender?
- Man
- Woman
- Transgender man
- Transgender woman
- Prefer not to answer

25. Do you consider yourself to be…
- Heterosexual/Straight
- Bisexual
- Gay or Lesbian
- Prefer not to answer

26. What is your race / ethnicity? *Check all that apply.*
- White / Caucasian
- Black / African-American
- American Indian / Alaska Native
- Asian
- Native Hawaiian and other Pacific Islander
- Some other race
- Hispanic

27. What is the highest level of school you have completed or highest degree you have received?
- I never attended school
- Some college
- Some school / did not graduate high school
- College degree
- High school diploma / GED
- Graduate or professional degree
- Vocational / technical training after high school

28. What is your current employment status
- Disabled / unable to work
- Self-Employed
- Employed Full-Time
- Stay-at-home parent
- Employed Part-Time
- Student
- Retired
- Unemployed

29. What is your annual household income?
- Less than $25,000/year
- $25,001 - $50,000/year
- $50,001 - $75,000/year
- $75,001 or more/year

30. How many people live in your household (including yourself)?
- 1
- 2
- 3
- 4
- 5+

Thank you for completing this survey!

Appendix 8. Planning Process Participants

The 2019 Frederick County Community Health Needs Assessment (CHNA) is the result of a collaborative community-wide effort involving a variety of organizations. The Frederick County Health Care Coalition thanks the following for their participation.

CHNA Planning Committee – responsible for guiding CHNA process, planning and oversight.
• Kathleen Allen, Frederick County Public Schools Judy Center
• Gloria Bamforth, Frederick Regional Health System
• Denise Barton, Frederick Regional Health System*
• Peter Brehm, The Frederick Center
• Barbara Brookmyer, MD, Frederick County Health Department
• Nick Brown, Religious Coalition for Emergency Human Needs
• Manuel Casiano, MD, Frederick Regional Health System*
• Elizabeth Chung, Asian American Center of Frederick
• Betsy Day, Community Foundation of Frederick County
• Decision Support Department, Frederick Regional Health System*
• Miriam Dobson, RN, Frederick County Health Department
• Kristen Fletcher, Frederick Regional Health System*
• Malcolm Furgol, United Way of Frederick County
• Monica Grant, Frederick County Citizen Services
• Janet Harding, Frederick Regional Health System*
• Maria Herrera, Spanish Speaking Community of Frederick*
• Jamie Hitchner, Frederick County Public Schools
• Janet Jones, Frederick Community Action Agency
• Liz Kinley, Frederick Regional Health System
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• Thea Ruff, Senior Support Work Group Lead
• Linda Ryan, Mission of Mercy
• Carrie Sprinkle, Frederick County Parks & Recreation
• Mike Spurrier, Frederick Community Action Agency
• Cynthia Terl, Wells House, Behavioral Health Work Group Lead
• Jenifer Waters, Frederick County Public Schools
• Rissah Watkins, Frederick County Health Department*

*Members of the CHNA Data Subcommittee, responsible for data analysis

Priority Planning Summit Attending Organizations – responsible for reviewing data, providing feedback, and setting priorities	
AACF and Church of the Nazarene –Latino Advocate	Frederick Regional Health System: Cancer Services
Advocates for the Aging in Frederick County	Frederick Regional Health System: CorpOHS
Asian American Center of Frederick (AACF)	Frederick Regional Health System: Frederick Memorial Hospital
Asian American Center of Frederick/ FMH	Frederick Regional Health System: Home Health Care
Boys & Girls Club of Frederick County	Frederick Regional Health System: Hospice of Frederick County
Brook Lane Health Services	Frederick Regional Health System: Monocacy Health Partners
Chamber of Commerce	Girls on the Run Mid Maryland
Chi Theta Omega / Frederick County Social Services Board	Hood College
Children of Incarcerated Parents Partnership	Housing Authority of the City of Frederick
Community Collaboration Center	Human Relations Commission
Community Engagement & Consultation Group Inc.	Justice Jobs of Maryland
Community Member	Leidos Biomedical Research, Inc.
Continuum Recovery Center	Masters Specialty Pharmacy
Core Service Agency	MD Heroin Awareness Advocates
crossedBRIDGES	Mental Health Association of Frederick County
Delta Sigma Theta Sorority, Inc.	Mission of Mercy
Department of Juvenile Services	New Midway Volunteer Fire Department
East Frederick Rising	Potomac Case Management Services, Inc.
Frederick Birth Center	Potomac Sprout Company
Frederick Community Action Agency	Religious Coalition
Frederick Community Action Agency, Health Center	Restoration Family Chiropractic
Frederick County Child Advocacy Center	Richard Carbaugh's Hope Foundation
Frederick County Citizens Services Division	Senior Services Advisory Board
Frederick County Department of Social Services	Seton Center
Frederick County Division of Fire and Rescue Services	Spanish Community of MD
Frederick County Family Partnership	Student Homeless Initiative Partnership (SHIP)
Frederick County Health Department	The Community Foundation of Frederick County
Frederick County Office for Children and Families	The Frederick Center, Inc.
Frederick County Office of Sustainability and Environmental Resources	The Frederick News-Post
Frederick County Office of the County Executive	The Ranch
Frederick County Parks and Recreation	United Way of Frederick County
Frederick County Pediatrics & IECC	University of Maryland Extension
Frederick County Public Schools	Wells House, Inc.
Frederick County Senior Services Division	YMCA of Frederick County
Frederick County Senior Services Division Advisory Board	Zeta Phi Beta Sorority, Inc. - Frederick County Chapter
Frederick County Sheriff's Office	
Frederick Integrated Healthcare Network	

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RESOLUTION OF THE BOARD OF DIRECTORS
OF FREDERICK MEMORIAL HOSPITAL, INC.

The Board of Directors of Frederick Memorial Hospital, Inc. ("Hospital") adopts the following resolutions at a meeting duly held on March 26th, 2019, at which a quorum of Directors was present.

RECITALS

A. Section 501(r) of the Internal Revenue Code and the regulations promulgated hereunder imposes certain requirements on 501(c)(3) "hospital organizations" and "hospital facilities"(as those terms are defined in 501(r). Each hospital facility is required, among other things, to conduct a community health needs assessment ("CHNA") and adopt an implementation strategy to meet the identified health needs at least once every three tax years.

B. Pursuant to 501(r), the Hospital conducted a CHNA for the community it serves. The CHNA was facilitated by the Frederick County Health Care Coalition, in collaboration with the Hospital, Frederick County Health Department and other community organizations. The collaboration fulfills the requirements of the Hospital as delineated in 501(r) for collaborative planning processes.

C. The Hospital completed the following steps in conducting the CHNA in compliance with 501(r): 1) defining the community served, 2) assessing the health needs of that community, 3) soliciting and taking into account input received from persons who represent the broad interests of the community, including those with special knowledge or expertise in public health, and 4) documenting the CHNA in a written report.

NOW, THEREFORE, in consideration of the foregoing:

BE IT RESOLVED that the Board of Directors hereby approves and adopts the CHNA attached as

_____.

BE IT FURTHER RESOLVED that the officers and management of Hospital are hereby authorized and directed to make the CHNA widely available to the public in compliance with 501(r).

The above resolutions are adopted this 26th day of March, 2019, and made effective as of the same day.

[signature]
Secretary

Frederick Memorial Hospital
Community Health Needs Assessment
Implementation Strategy
FY 2020-2022

Introduction

Frederick Memorial Hospital ("Hospital") is a sole community provider, and therefore plays a critical role in delivering health care services and community benefit to Frederick County residents. This implementation strategy describes how the Hospital will address significant community health needs identified in the 2019 Community Health Needs Assessment (CHNA) conducted by the Frederick County Health Care Coalition.

This document delineates the Hospital's intended actions to address the identified priority health needs from the CHNA, and also those needs that will not be addressed. Frederick Memorial Hospital will review progress against the action plan on a periodic basis, and amend this implementation strategy if necessary. Certain community health needs may become more pronounced during the next three years and merit revisions to the described strategic initiatives. Alternatively, other organizations may decide to increase resources devoted to addressing one or more of the significant community health needs, and as a result the Hospital may amend its strategies and focus on other identified needs.

Significant Health Needs Identified in the CHNA

The 2019 CHNA identified a number of significant health needs in the community through an analysis of Frederick County health data and input from residents, advocates and community organizations. The top ten identified health needs were presented at a Community Priority Setting Summit on January 15, 2019 and were as follows:

- Adverse Childhood experiences (ACEs)
- Cancer (Breast, Melanoma, Colorectal, Oral)
- HIV
- Hypertension
- Infant Health (Infant Mortality, Low Birth Weight)
- Mental Health
- Obesity (Adults and Adolescents)
- Sexually Transmitted Infections (Syphilis, Gonorrhea, and Chlamydia)
- Substance Use (Alcohol, Tobacco, Overdose)
- Suicide

At the conclusion of the event, three health improvement priorities were identified, incorporating several of the needs listed above. The three local health improvement priorities (LHIP) are as follows:

- Adverse Childhood Experiences & Infant Health
- Behavioral Health- to include Mental Health, Substance Use and Suicide
- Chronic Conditions- to include Obesity and Colorectal Cancer.

Significant Health Needs the Hospital Will Address

LHIP Priority#1 : Chronic Disease Screening in Disparity Communities

LHIP Goal: Increase early screening in populations experiencing a health disparity to reduce the incidence of and mortality from chronic diseases.

Objective: Increase the number of persons screened and treated for colorectal cancer and hypertension; engage providers at community awareness events; and, increase long term preventive follow-up rates in disparity communities.

Background: Chronic disease is defined as a condition that lasts 1 year or more and requires ongoing medical attention or limits activities of daily living or both.[1] Colorectal Cancer and Hypertension are two chronic conditions that affect Frederick County Residents in numbers above goals established by Healthy People 2020.[2]

Cancer continues to be the second leading cause of death in Frederick County.[3] The incidence of colorectal cancer in Frederick County is higher in Blacks and men.[4] Reducing risk factors and initiating early screening are keys to reducing preventable cancers, including colorectal cancer.

In 2016, 27.19% of Frederick County residents had Hypertension.[5] This is a common, but dangerous condition, as it increases the risk of heart disease, stroke, dementia and kidney problems.

Activity	Target Date	Anticipated Impact or Result
Engage community physicians to conduct colorectal cancer education and risk assessments in disparity communities.	June 30, 2020	• 250 individuals from the identified disparity communities will complete colorectal cancer risk assessment screening.
Educate community providers on current cancer screening recommendations, local disparity data, cultural barriers/bias, and local referral process and treatment options.	June 30, 2021	• Conduct four continuing medical education (CME) programs for community providers.
Implement an effective follow-up procedure for periodic re-screening of "at risk" individuals. •Establish baseline population through initial screening.	June 30, 2020	• 100% of individuals who participated in initial screening

[1] CDC National Center for Chronic Disease Prevention and Health Promotion
[2] Health People 2020
[3] Maryland Vital Statistics Report 2017
[4] Maryland Cancer Report
[5] Maryland Behavioral Risk Factor Surveillance System (BRFSS)

Activity	Target Date	Anticipated Impact or Result
		"at risk" for colorectal cancer will be targeted for ongoing screening.
• Provide periodic education and screening opportunities to high risk individuals.	June 30, 2021	• 50% of high risk individuals will participate in subsequent screening.
• Track high risk populations over time using a Community Resource Coordination Registry database.	June 30, 2022	• 80% of high risk individuals will participate in screening for two consecutive years.
Integrate Hypertension screening at colorectal education and risk assessment events.		
• Measure baseline blood pressure of participants at events.	June 30, 2020	•90% of attendees at colorectal cancer events will also be screened for hypertension.
• Establish a follow-up process for participants who screen positive for hypertension and track using a Community Resource Coordination Registry database.	June 30, 2020	• 75% of participants who had an elevated blood pressure reading will complete recommended follow-up.
•Conduct at least four education events on the risk of hypertension in communities where disparity has been identified.	June 30, 2021	• Increased community knowledge of the risk of hypertension as evidenced by successful completion of a post-test by 80% of attendees.

Evidence Based Sources:

https://health.maryland.gov/vsa/Pages/reports.aspx
https://www.healthypeople.gov/
https://pophealth.health.maryland.gov/Pages/SHIP.aspx
https://www.cdc.gov/chronicdisease/about/index.htm
https://phpa.health.maryland.gov/cancer/SiteAssets/Pages/surv_data-reports/2017_CRF_Cancer_Report_(20170827).pdf
http://phpa.dhmh.maryland.gov/ccdpc/Reports/Pages/brfss.aspx

Resources Required: Funding for staff participation in events, program development, FIT KIT (at home colorectal screening test) and maintenance of a Community Resource Coordination Registry database, i.e. Shared Village.

Alignment with State and National Priorities

Healthy People 2020	Maryland State Health Improvement Process (SHIP)
C-9 Reduce invasive colorectal cancer C-16 Adults receiving colorectal cancer screening based on the most recent guidelines HDS 4-Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high HDS 5.1- Reduce the proportion of adults with hypertension	Cancer Mortality Rate - This indicator shows the age-adjusted mortality rate from cancer per 100,000 population. Age-Adjusted Mortality Rate From Heart Disease - This indicator shows the age-adjusted mortality rate from heart disease per 100,000 population.

Partnerships Required: Mission of Mercy, Community Action Agency, Frederick County Health Department, American Cancer Society and local Gastroenterology Medical Providers.

LHIP Priority#1: Healthy Eating and Living Practices

LHIP Goal: Reduce unhealthy behaviors and increase healthy behavior choices as evidenced by the 2020 Youth Risk Behavior Survey (YRBS) in Frederick County youth.

Objective: Healthy eating and behavior practices will be demonstrated by Frederick County youth and families.

Background: Diet and body weight are related to health status. Individuals who are not at a healthy weight are more likely to develop chronic diseases, such as diabetes and heart disease, experience complications during pregnancy and be at risk for premature death.

LiveWell Frederick's 5-2-1-0 program is a behavior awareness approach to making key lifestyle changes that will lead to the attainment of this goal. The program focuses on increasing fruit and vegetable consumption, reducing ingestion of sugar added beverages, reducing recreational screen time and increasing physical activity.

Activity	Target Date	Anticipated Impact or Result
Increase middle school youth engagement in 5-2-1-0 program. • Present at least four 5-2-1-0	June 30, 2020	• Increased community knowledge of 5-2-1-0 as evidenced by successful

education events targeting middle school age children and their families. • Sponsor a 5-2-1-0 community challenge to promote healthy eating/living habits.	June 30, 2022		completion of a post-test by 80% of attendees. • 50% of individuals in the targeted population will register for and complete the challenge.
Collaborate with Frederick County Public Schools to adopt wellness goals that align with the 5-2-1-0 initiative.	June 30, 2021		• 10 of 13 (80%)of Frederick County Public Schools middle schools that have established wellness goal related to health eating/living habits.

Evidence Based Sources:

https://health.maryland.gov/vsa/Pages/reports.aspx
https://www.healthypeople.gov/
https://pophealth.health.maryland.gov/Pages/SHIP.aspx
https://www.cdc.gov/chronicdisease/about/index.htm
http://phpa.dhmh.maryland.gov/ccdpc/Reports/Pages/brfss.aspx
https://www.cdc.gov/healthyyouth/data/yrbs/index.htm

Resources Required: Funding for staff participation in events, program development, education and awareness materials (website, brochures, etc.).

Alignment with State and National Priorities

Healthy People 2020	State Health Improvement Process (SHIP)
NSW 10.4 – Reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese. NSW 14- Increase the contribution of fruits and vegetables to the diets of the population aged 2 years and older. NSW 17.2- Reduce consumption of calories from added sugars. PA 3.3 - Increase the proportion of adolescents who meet current physical activity guidelines for aerobic physical activity and muscle strengthening activity. PA 8.3- Increase the proportion of children and adolescents aged 6-14 who use a computer or play computer games outside of school (for non-school work), no more than 2 hours per day.	11. Reduce the percentage of children who are considered obese. (high school only)

Partnerships Required: *LiveWell Frederick*, Frederick County Public Schools and School Health Council, Farm to School Network, Food Security Network, Local Food Banks, Local Pediatricians, YMCA, United Way, The Boys and Girls Club, and Frederick County Government Departments including Health, Public Library, Parks and Recreation, and University of Maryland Extension Service.

LHIP Priority#2: Targeting Behavioral Health Needs

LHIP Goal: Establishment of effective, targeted responses to behavioral health needs.

Objective: Implement data- driven planning and treatment processes that will address behavioral health issues, including substance use disorder, suicide prevention and mental health disorders.

Background: Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices.

Mental health is important at every stage of life, from childhood and adolescence through adulthood.[6] 11.1% of Frederick county adults reported their mental health wasn't good for 8-30 of the last 30 days when surveyed in 2016.[7] Mental health issues may manifest as behavioral issues such including substance use and suicidal ideation. In Frederick County 78 people died of drugs/alcohol and 28 from suicide in 2017, both of which are above the Healthy People 2020 goal.[8]

Activity	Target Date	Anticipated Impact or Result
Develop data-driven planning process for behavioral health conditions. •Establish comprehensive community database in collaboration with local health and treatment providers. •Provision of health system data related to treatment of behavioral health concerns (as permitted by privacy regulations).	June 30, 2022	The Community will be able to identify Key Performance Indicators when establishing priorities for Behavioral Health Care in Frederick County.
Implement Medication Assisted Treatment (MAT) protocol for Opioid Use Disorder in the Emergency Department. • Draft protocol for screening and medication treatment with Buprenorphine (Suboxone). Identify and establish relationships with community treatment programs.	December, 2019	•Two community based treatment programs will agree to participate in MAT pilot by January 1, 2020.

[6] CDC- Center for Disease Control
[7] Maryland Behavioral Risk Factor Surveillance System (BRFSS)
[8] Healthy People 2020

Activity	Target Date	Anticipated Impact or Result
•Pilot MAT program	January- March, 2020	•10% of patients presenting to the Emergency Department with opioid use as the primary reason for the visit will be enrolled in the Pilot Program.
•Revise protocols as needed; educate Emergency Department staff and providers on MAT.	April-June, 2020	• 75% of targeted staff and providers will complete education as evidenced by successful completion of a post-test.
•Full implementation of MAT program based on results of pilot.	July, 2020	•70% of patients treated with the MAT protocol will enroll in a community treatment program.

Evidence Based Sources:

https://www.samhsa.gov/
https://www.cdc.gov/mentalhealth/index.htm
https://www.healthypeople.gov/

Resources Required: Funding for staff participation in community data base development, operational expenses related to outpatient addictions treatment in the emergency department and post-partum support group.

Alignment with State and National Priorities:

Healthy People 2020	Maryland State Health Improvement Process (SHIP)
MHMD 1 - Reduce the suicide rate MHMD 4- Reduce the proportion of persons who experience major depressive episodes MHMD 9- Increase the proportion of adults with mental health disorders who receive treatment MHMD-10 Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.	18. Reduce the suicide rate 32. Reduce drug induced mortality 33. Reduce mental health related emergency department visit rates 34. Reduce addictions related emergency department visit rates.

Partnerships Required: Frederick County Health Department, Mental Health Association, Frederick County Healthcare Coalition

LHIP Priority#3: Promote Healthy Practices to Diminish Adverse Childhood Experiences (ACEs)

LHIP Goals:

1. Provide evidence-based education to health care providers to increase awareness, prevention and treatment of ACEs.
2. Implement early intervention strategies that will mitigate the effects of and /or prevent the occurrence of ACEs.

Objective: Establish a baseline measurement to increase awareness of childhood trauma and its lifelong effect on the individual in the health community and to diminish the prevalence of childhood trauma by providing early intervention measures.

Background: Adverse Childhood Experiences (ACEs) are traumatic incidents in a child's life that cause toxic stress--especially abuse, neglect, and exposure to violence. Without healthy support from adults, toxic stress can overwhelm a child's ability to cope when exposure to adversity happens, increasing the risk of negative physical and mental health outcomes. In Frederick County, 52, 578 adults or 27.2% of respondents to a 2015 survey[9] reported three or more ACEs; multiple ACEs increases risk for negative behavioral and mental outcomes, chronic disease, and premature death.

The physical and mental health of a newborn child and their mother lays the groundwork for all future experiences. Early identification of health conditions among infants and mothers can prevent death or disability and enable children to reach their full potential.

Activity	Target Date	Anticipated Impact or Result
Disseminate survey to local health care providers to determine current understanding of ACEs.	October 2019	•Number of surveys returned will provide a baseline measurement of awareness of ACEs and interest in continuing education.
Implement ACEs Awareness Education for: •Employees and medical staff who provide care to the maternal/child population, including the Emergency Department and Behavioral Health Unit. • Bridges Community Lay Health Educators	December, 2020 Annually through June 2022	• 80% of targeted employees and medical staff complete training as evidenced by successful (Pass) completion of a post-test. • 75% of active lay health educators will complete training as evidenced by successful completion (Pass) of a post-test.
Participation in LHIP workgroup	Ongoing through June, 2022	•Attendance at all LHIP workgroup meetings.

[9] 2015 Maryland Behavioral Risk Factor Surveillance System (BRFSS)

Activity	Target Date	Anticipated Impact or Result
Implement a facilitated Perinatal Mood Disorder (PMD) support group. • *This activity also supports suicide prevention action plan.*	June 2020	•Pre and Post support group survey will be implemented; evidence of success will be a score of 10 or less on the Edinburgh Post Natal Depression Scale on the post survey.
	June 2021	•Women treated for pregnancy related mental health disorders at FMH will decrease from 13% to 8% within one year of implementing the program.
Universal newborn home visiting model in collaboration with Healthcare Coalition Partners	June 2021	•Infant mortality rate will be below SHIP goal of 6.3%/1000. •Child maltreatment rate will be below SHIP goal of 8.3 per 1000.

Evidence Based Sources:

https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD_BRFSS_Questionnaire_2015.pdf
http://phpa.dhmh.maryland.gov/ccdpc/Reports/Pages/brfss.aspx
https://www.cdc.gov/violenceprevention/acestudy/ace_brfss.html
https://www.healthypeople.gov/
https://pophealth.health.maryland.gov/Pages/SHIP.aspx

Resources Required: Staff participation in the LHIP group; funding for CME programming, educational program development, and operational expenses related to post-partum support group and universal newborn home visits.

Alignment with State and National Priorities:

Healthy People 2020	Maryland State Health Improvement Process (SHIP)
MICH 1.3- Reduce the rate of all infant deaths within the first year. MICH 1.4- Reduce the rate of neonatal deaths within the first 28 days of life. MICH-34 Decrease the proportion of women delivering a life birth who experience post-partum depressive syndromes. MHDH-1 Reduce the suicide rate.	Infant Death Rate - This indicator shows the infant mortality rate per 1,000 live births. Child maltreatment rate - This indicator shows the rate of children who are maltreated per 1,000 population under the age of 18. Suicide rate- This indicators shows the suicide rate per 100,000.

Partnerships Required:

Frederick County Health Department, Frederick County Public Schools, Child Advocacy Center, Mental Health Association, Frederick County Healthcare Coalition.

Needs the Hospital Will Not Address

The mission of Frederick Memorial Hospital is to promote the well-being of every individual in Frederick County. This implementation strategy does not include specific plans to address breast, melanoma and oral cancers, HIV, sexually transmitted infections, alcohol use and tobacco use identified as significant community health needs in the 2019 CHNA. These health issues were not selected as health priorities in the Local Health Improvement Plan, which is the community-wide action plan associated with the CHNA.

However, Frederick Memorial Hospital does provide diagnosis and treatment of patients with cancer, HIV, sexually transmitted disease, and alcohol use emergency detoxification. In addition, the Hospital offers smoking cessation classes. As an active member of the Frederick County Health Care Coalition, the Hospital will continue to work with community partners to address the health needs of our residents whenever that is possible.

Implementation Strategy Adoption

This implementation strategy was recommended by the Quality Committee of the Frederick Memorial Hospital Board of Trustees on September 13, 2019, and approved by the FMH Board of Trustees on September 24, 2019.

Chair, FMH Board of Directors

Skip To Content
Menu
Menu

- Home
- Policies
  - Policies by Title
  - Policies by Area
  - Policies by Owner
  - Policies by References
- Reports
  - New & Recently Revised

- On
  New PolicyStat
- Help
  - Help with this Page
  - SupportHUB
  - Maintenance
-
- Login

Frederick Health

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Search policies

StatusActive
PolicyStat ID13356789
Print
Share

Origination
01/2011
Last Approved
03/2023
Effective
03/2023
Last Revised
09/2022
Next Review
09/2024
Owner
McCardell, Shawn: AVP Revenue Cycle
Area
Finance

Financial Assistance Policy, FN 100

This policy is intended as a guideline to assist in the delivery of patient care or management of hospital services. It is not intended to replace professional judgment in patient care or administrative matters.

PURPOSE:

Frederick Health is committed to providing quality health care for all patients regardless of their ability to pay and without discrimination on the grounds of race, color, national origin or creed. The purpose of this document is to present a formal set of policies and procedures designed to assist Patient Financial Services personnel in the day-to-day application of this commitment. The procedures describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications. This policy is intended to comply with Section 501(r) of the Internal Revenue Code and applicable Maryland law and has been adopted by the Frederick Health Board of Directors.

POLICY:

This policy applies to all patients seeking emergency or other medically necessary care at Frederick Health Hospital. This policy also applies to patients seeking professional medical services from Frederick Health Medical Group. For this policy document only, Frederick Health Hospital and Frederick Health Medical Group are collectively referred to herein as "FHH/FHMG."

The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs, but whose outstanding "self-pay" balances exceed their own ability to pay. The underlying principle is that a person, over a reasonable period of time, can be expected to pay only a maximum percentage of their disposable income towards charges incurred while in the hospital. Any "self-pay" amount in excess of this percentage would place an undue financial hardship on the patient or their family and may be adjusted off as Financial Assistance. The Board of Directors of the Hospital shall review and approve the financial assistance and debt collection policies of the hospital at least every 2 years. All changes to the financial assistance or debt collection policies require approval by the Board of Directors.

PROCEDURE:

1. **OVERVIEW**
    1. Financial Assistance can be offered before, during, or after services are rendered. After submission of an application, FHH/FHMG will send an acknowledgment letter to the patient within two (2) business days and an eligibility determination will be made within fourteen (14) days of a completed application.
        1. For purposes of this policy, "Financial Assistance" refers to healthcare services provided without charge or at a reduced charge to qualifying patients.
        2. FHH/FHMG maintains a list of all providers who may care for patients while at FHH/FHMG available at https://www.frederickhealth.org/find-a-provider/. Only providers employed by FHH/FHMG are covered under this policy and are indicated on the provider list. Non-FHH/ FHMG providers bill separately for their services and not all participate in the FHH/FHMG Financial Assistance Program. If a provider is not covered under this policy, patients should contact the provider's office to determine if Financial Assistance is available.
        3. Should a patient need assistance applying for Financial Assistance, help is available at our physical location 400 West Seventh St. Frederick, MD 21701. Patients can also call 240-566-4214 with any inquiries regarding the Financial Assistance application process.
    2. Notice of the Availability of Financial Assistance:
        1. FHH/FHMG will make available brochures informing the public of its Financial Assistance Policy. Such brochures will be available throughout the community and within FHH/FHMG locations.
        2. Notices of the availability of Financial Assistance will be posted at appropriate admission areas, the Patient Financial Services department, and other key patient access areas.
        3. Notice of the Financial Assistance Policy will be provided to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the bill.

4. A statement on the availability of Financial Assistance will be included on patient billing statements.
5. A Plain Language Summary of the FHH/FHMG Financial Assistance Policy will be provided to patients receiving inpatient services with their Summary Bill and will be made available to all patients upon request.
6. The FHH/FHMG Financial Assistance Policy, a Plain Language Summary of the policy, and the Financial Assistance Application are available to patients upon request at FHH/FHMG, through mail (postal service), and on the FHH/FHMG website at https://www.frederickhealth.org/about/billing-financial-assistance/
7. The FHH/FHMG Financial Assistance Policy, Plain Language Summary, and Financial Assistance Application are available in Spanish.
    1. On an annual basis, FHH/FHMG shall assess the needs of our limited English proficiency community and determine whether additional translations are needed.

3. Availability of Financial Assistance: FHH/FHMG retains the right, in its sole discretion, to determine a patient's ability to pay, in accordance with Maryland and Federal law.
    1. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.
    2. All patients presenting for emergency services will be treated regardless of their ability to pay.
        1. For emergent services, applications for Financial Assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.
4. Limitation of Charges: Individuals eligible for reduced-cost care under this policy will not be charged more than the hospital's standard charges, as set by Maryland's Health Services Cost Review Commission (HSCRC).
    1. The Frederick Health Hospital rate structure is governed by the HSCRC rate setting authority. As an "all- payer system", all patient care in the regulated hospital setting is charged according to the resources consumed in treating them regardless of the patient's ability to pay.
    2. Regulated hospital charges are developed based on a relative predetermined value set by the HSCRC at the approved unit rate developed by the HSCRC.

2. **PROGRAM ELIGIBILITY**
    1. FHH/FHMG strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. FHH/FHMG reserves the right to grant Financial Assistance without formal application being made by patients. These patients may include the homeless or returned mailed with no forwarding address.
    2. Patients who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care may be eligible for the FHH/FHMG Financial Assistance Program.
    3. Healthcare services that are eligible for Financial Assistance are emergency medical care and other medically necessary services delivered by Frederick Health Hospital and Frederick Health Medical Group.
        1. For these purposes, emergency medical care means care provided by Frederick Health Hospital for emergency medical conditions, which means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, emergency medical conditions means that: (i) there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) transfer may pose a threat to the health or safety of the woman or the unborn child.
        2. For these purposes, medically necessary services means services that are reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient that (i) endanger life; (ii) cause suffering or pain; (iii) result in illness or infirmity; (iv) threaten to cause or aggravate a handicap; or (v) cause physical deformity or malfunction.
    4. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance program include the following:
        1. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid);

1. Exceptions to this exclusion may be made, in FHH/FHMG's sole discretion, considering medical and programmatic implications.
2. Unpaid balances resulting from cosmetic or other non-medically necessary services;
3. Patient convenience items.

5. Ineligibility: Patients may become ineligible for Financial Assistance, for a specific date of service, for the following reasons:
    1. After being notified by FHH/FHMG, refusal to apply for or provide requested documentation or information required to complete a Financial Assistance Application within the 240 days after the patient receives the first post-discharge billing statement (approximately 8 months). (If an individual submits an incomplete Financial Assistance Application within 240 days after the patient receives the first post-discharge billing statement, FHH/FHMG shall give the individual a reasonable period of time to complete the application.)
    2. Unless seeking emergency medical services, having insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to FHH/ FHMG due to insurance plan restrictions/limits.
    3. Failure to pay co-payments as required by the Financial Assistance Program.
    4. Failure to keep current on existing payment arrangements with FHH/FHMG, as further detailed in the Self Pay Collections Policy.
    5. Failure to make appropriate arrangements on past payment obligations owed to FHH/FHMG (including those patients who were referred to an outside collection agency for a previous debt).
    6. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program, unless FHH/FHMG can readily determine that the patient would fail to meet the eligibility requirements.
6. Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a collection agency if the balance remains unpaid in the agreed upon time periods.
7. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section D.2 below).
    1. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership for approval.
    2. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.
8. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines.

3. **PATIENT FINANCIAL ASSISTANCE GUIDELINES**
    1. Services eligible under this Policy will be made available to the patient on a sliding fee scale as described in this section and in ***Appendix A***.
    2. A patient's eligibility for Financial Assistance shall be calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial medical bill is provided.
    3. Additionally, payment plans based on a patient's ability to pay are available on an individual basis to those patients with a family income between 200% and 500% of the federal poverty level who request assistance, irrespective of a patient's insurance status. Additional details regarding payment plans can be found in the Self Pay Collections Policy.
    4. US Federal Poverty guidelines are updated annually by the Department of Health and Human Services and are available at https://www.healthcare.gov/glossary/federal-poverty-level-fpl/.
4. **PRESUMPTIVE FINANCIAL ASSISTANCE**
    1. Patients may be eligible for Financial Assistance on a presumptive basis. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance application and/or supporting documentation on file. Often there is adequate information provided by the patient or other sources that is sufficient for determining Financial Assistance eligibility.
        1. In the event there is no evidence to support a patient's eligibility for Financial Assistance, FHH/ FHMG reserves the right to use outside agencies, or propensity to pay modeling in determining Financial Assistance eligibility.

    2. Patients who are determined to satisfy presumptive eligibility will receive free care on that date of service. Presumptive Financial Assistance eligibility shall only cover the patient's specific date of service.
  2. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
    1. Active Medical Assistance pharmacy coverage;
    2. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);
    3. Homelessness;
    4. Maryland Public Health System Emergency Petition patients;
    5. Being a beneficiary/recipient of the following means-tested social service programs: Women, Infants and Children Programs ("WIC"); Food Stamp/Supplemental Nutritional Assistance Program; households with children in the free or reduced lunch program; low-income-household energy assistance program; Primary Adult Care Program ("PAC"), until such time as inpatient benefits are added to the PAC benefit package; or other means-tested social services programs deemed eligible for hospital free care policies by the Maryland Department of Health and the HSCRC, consistent with HSCRC regulations;
    6. Eligibility for other state or local assistance programs;
    7. Deceased with no known estate; and
    8. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.
  3. Patients deemed to be presumptively eligible for Financial Assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.
  4. Exclusions from consideration for presumptive eligibility include:
    1. Purely elective procedures (e.g., cosmetic procedures).
5. **MEDICAL HARDSHIP PROGRAM**
  1. In addition to, but separate from, Patient Financial Assistance described elsewhere in this policy, eligible patients may qualify for the Medical Hardship Program.
    1. Patients may qualify for this program if they have incurred collective family medical debt at FHH/FHMG, exceeding 25% of the combined household income, during a 12-month period, regardless of income.
      1. Medical debt is defined as out-of-pocket expenses for medically necessary care received at FHH/FHMG, including co-payments, co-insurance, and deductibles.
  2. FHH/FHMG applies the medical debt criteria set forth above to a patient's balance after any insurance payments have been received.
  3. If determined eligible, patients and their immediate family qualify for a 20% reduction in the cost of medically necessary care, for a 12-month period effective on the date the medically necessary care was initially received.
  4. In situations where a patient is separately eligible for both the Medical Hardship Program and the standard Financial Assistance Program, FHH/FHMG will apply the reduction in charges that is most favorable to the patient.
  5. Patients are required to notify FHH/FHMG of their potential eligibility for the Medical Hardship Program.
6. **ASSISTANCE BASED ON INDIVIDUAL CIRCUMSTANCES**: FHH/FHMG reserves the right to consider individual patient and family financial circumstances to grant reduced-cost care in excess of State and this policy's established criteria.
  1. The eligibility, duration, and discount shall be patient-situation specific.
  2. Patient balance after insurance accounts may be eligible for consideration.
  3. Cases falling into this category require management review and approval.
7. **ASSET CONSIDERATION**
  1. Household monetary assets are generally not considered as part of Financial Assistance eligibility etermination unless they are deemed substantial enough to cover all or part of the patient's responsibility without causing undue hardship. When household monetary assets are reviewed, individual patient financial circumstances, such as the ability to replenish the asset and future income potential, are taken into

consideration.

2. The following monetary assets that are convertible to cash are exempt from consideration:
   The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.
   Up to $150,000 in primary residence equity.
   Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.

   One motor vehicle used for the transportation needs of the patient or any family member of the patient.
   Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act.
   Prepaid higher education funds in a Maryland 529 Program account.
3. Monetary assets excluded from consideration shall be adjusted annually for inflation in accordance with the Consumer Price Index effective as of January 1, 2021.

8. **APPEALS**
   1. Patients whose Financial Assistance applications are denied have the option to appeal the decision. Appeals should be made in writing and mailed to: Frederick Health 400 West Seventh Street Frederick, MD 21701 Attn: Financial Counseling Team.
   2. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
   3. Appeals are documented and reviewed by the next level of management for additional reconsideration.
   4. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
   5. Appeals can be escalated up to the Chief Financial Officer who will render the final decision.
   6. Patients who have formally submitted an appeal will receive a letter of the final determination.
   7. Patients have thirty (30) days after denial to submit their appeal.
   8. The Health Education and Advocacy Unit ("HEAU") is available to assist patients and their authorized representatives in filing and mediating reconsideration requests/appeals. The HEAU can be contacted using the following information:
      Office of the Attorney General Consumer Protection Division Health Education and Advocacy Unit 200 Saint Paul Place
      Baltimore, Maryland 21202-2021
      Phone number: 410-528-1840 or 1-877-261-8807 Email address: heau@oag.state.md.us
      Fax number: 410-576-6571
      Website: https://www.marylandattorneygeneral.gov/pages/cpd/heau/default.aspx
   9. Patients may file a complaint against a hospital for an alleged violation of its Financial Assistance policy by sending the complaint to the Maryland Health Services Cost Review Commission at hscrc.patient-complaints@maryland.gov. Complaints may also be filed jointly with the HEAU using

9. **PATIENT REFUND**
   1. If, within a two (2) year period after the date of service, a patient is found to be eligible for free or reduced-cost care under FHH/FHMG's Financial Assistance Program, for that date of service, the patient shall be refunded payments in excess of their financial obligation where such refund is greater than $5. For purposes of clarification and avoidance of doubt, the patient's eligibility for Financial Assistance for purposes of this sub-section shall be calculated consistent with Section C(2).
      1. The two (2) year period may be reduced to 240 days (approximately 8 months) after receipt of the first post-discharge billing statement where FHH/FHMG's documentation demonstrates a lack of cooperation by the patient, or guarantor, in providing documentation or information necessary for determining patient's eligibility.
   2. If a patient is found to be eligible for Financial Assistance after FHH/FHMG has initiated extraordinary collection actions (ECA), such as reporting to a credit agency, liens, or lawsuits, FHH/ FHMG will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken as also set forth in the Self Pay Collections Policy. For purposes of clarification and avoidance of doubt, the patient's eligibility for Financial Assistance for purposes of this sub-section shall be calculated consistent with Section C(2).

10. **OPERATIONS**
    1. FHH/FHMG will designate a trained person or persons who will be responsible for taking Financial Assistance Applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, or other designated trained staff.
    2. Every effort will be made to determine eligibility prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
        1. Staff will complete an eligibility check with the applicable state Medicaid program to determine whether patients have current coverage or may be eligible for coverage.
            1. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations).
        2. FHH/FHMG will provide patients with the Maryland State Uniform Financial Assistance Application and a checklist of what paperwork is required for a final determination of eligibility.
            1. In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:
                1. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income);
                2. Proof of disability income (if applicable);
                3. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income or documentation of how they are paying for living expenses;
                4. Proof of social security income (if applicable);
                5. A Medical Assistance Notice of Determination (if applicable);
                6. Reasonable proof of other declared expenses; and
                7. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
    3. If a patient has not submitted a completed Financial Assistance application or any required supporting documentation within 30 days after a formal request, a letter will be sent reminding the patient that Financial Assistance is available and informing the patient of the collection actions that will be taken if no documentation is received.
        1. A deadline for submission, prior to initiation of collection actions, will be included in the letter. Such deadline will be no earlier than 30 days after the date the reminder letter is provided.
        2. No extraordinary collection actions, such as reporting to a credit agency, liens, or lawsuits, will be taken prior to 180 days after the first post-discharge billing statement (approximately 6 months).
        3. If documentation is received after collection actions have been initiated, but within 240 days after the patient's receipt of the first post discharge billing statement, FHH/FHMG shall cease all collection actions and determine whether the patient is eligible for financial assistance.
    4. A Plain Language Summary of this policy shall be included with the letter and FHH/FHMG staff must make a reasonable effort to orally notify the individual of FHH/FHMG's Financial Assistance program.
    5. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for determination of eligibility based on FHH/FHMG guidelines.
        1. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.
        2. For complete applications, the patient will receive a letter notifying them of approval/denial within 14 days of submitting the completed applications. FHH/FHMG shall suspend any billing or collections actions while eligibility is being determined.
        3. If an application is determined to be incomplete, the patient will be contacted regarding any additional required documentation or information
            1. If a patient is determined to be ineligible prior to receiving services, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
            2. If a patient is determined to be ineligible after receiving services, a payment arrangement will

be offered on any balance due by the patient.

6. Except as noted below, once a patient is approved for Financial Assistance, such Financial Assistance shall be effective as of the date treatment is received and the following twelve (12) calendar months.
    1. Presumptive Financial Assistance cases will apply to the date of service only.
    2. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive Financial Assistance.
7. The following may result in the reconsideration of Financial Assistance approval:
    1. Post approval discovery of an ability to pay; and
    2. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to FHH/FHMG.
8. FHH/FHMG will track patients' qualification for Financial Assistance or Medical Hardship. However, it is ultimately the responsibility of the patient to inform FHH/FHMG of their eligibility status (and any updates to such eligibility) at the time of registration, upon receiving a statement, or at any other time.
9. FHH/FHMG will not use a patient's citizenship or immigration status as an eligibility requirement for Financial Assistance or withhold Financial Assistance or deny a patient's application for Financial Assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

1. **CREDIT & COLLECTIONS POLICY**
    1. FHH/FHMG maintains a separate Credit & Collections Policy that outlines what actions FHH/FHMG may take in the event a patient fails to meet their financial responsibility.
    2. A copy of the Credit & Collections policy may be obtained by requesting a copy from FHH/FHMG staff or by visiting FHH/FHMG's website.
    3. FHH/FHMG maintains a list of all non-FHH/FHMG providers who may care for patients while at FHH/FHMG. Non-FHH/FHMG providers bill separately for their services and not all participate in FHH/FHMG's Financial Assistance Program.
        1. A copy of this list may be obtained by requesting a copy from FHH/FHMG staff or by visiting FHH/FHMG's website at https://www.frederickhealth.org/find-a-provider/.

Attachments

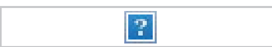
2023 Appendix A FA FPL Matrix Guidelines.pdf

Standards

Approval Signatures

Step Description
Approver
Date
Senior Leader Approval
Hannah Jacobs: Senior Vice President CFO
03/2023
Owner Approval
Shawn McCardell: AVP Revenue Cycle
03/2023

Older Version Approval Signatures



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From: Kirby, Heather
To: Hilltop HCB Help Account
Subject: RE: Clarification Required - FY 22 Frederick Health Narrative and Financials
Date: Monday, May 8, 2023 3:28:17 PM
Attachments: image001.png

Report This Email

Hello,

I apologize for the confusion. Upon further investigation we do indeed subsidize Pediatrics for "coverage of emergency department call", so the answer on the narrative should be yes. The information on the financial report is correct.

Please don't hesitate to reach out if you have any additional questions.

Thank you,

Heather

Heather Kirby
Vice President of Integrated Care Delivery &
Chief Population Health Officer
P: 240-566-3679

400 W 7th Street
Frederick, MD 21701

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Monday, May 8, 2023 3:22 PM
To: Kirby, Heather <HKirby@Frederick.health>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: [EXTERNAL EMAIL] - RE: Clarification Required - FY 22 Frederick Health Narrative and Financials

STOP!!!	**WARNING**: This email originated outside of Frederick Health's email system. **DO NOT CLICK** any links or open any attachments unless you trust the sender and know the content is safe. **NEVER** provide your user name or password.

Thank you for clarifying these points; we've updated our record of your responses accordingly.

Could you please further clarify regarding the Pediatrics physician subsidy? We've copied our question and your response (in red) below:

> The narrative selected "Pediatrics" specialty with subsidy type "Non-resident house staff and hospitalists." The financial report listed "Pediatrics" with subsidy type "Coverage of Emergency Department Call." Please clarify which subsidy type is correct. - not subsidized so should be a "no" on the narrative report

Does this response indicate that the inclusion of Pediatrics as a line item on the Physician Subsidies tab of Frederick's financials was an error, meaning that it should be deleted from both the narrative and financials submissions for Frederick Health? Please clarify.

From: Kirby, Heather <HKirby@Frederick.health>
Sent: Friday, May 5, 2023 1:54 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: RE: Clarification Required - FY 22 Frederick Health Narrative and Financials

Hello,

I apologize for the confusion, thank you for reaching out for clarification. Our responses are in red below.

Please do not hesitate to reach out if you have any additional questions.

Best,

Heather

Heather Kirby
Vice President of Integrated Care Delivery &
Chief Population Health Officer
P: 240-566-3679

400 W 7th Street
Frederick, MD 21701

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Thursday, May 4, 2023 11:06 AM
To: Kirby, Heather <HKirby@Frederick.health>; Jacobs, Hannah R <HJacobs@Frederick.health>
Cc: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: [EXTERNAL EMAIL] - Clarification Required - FY 22 Frederick Health Narrative and Financials

STOP!!!	**WARNING**: This email originated outside of Frederick Health's email system. **DO NOT CLICK** any links or open any attachments unless you trust the sender and know the content is safe. **NEVER** provide your user name or password.

Thank you for submitting the FY 2022 Hospital Community Benefit report for Frederick Health Hospital. In reviewing the narrative and financial reports, we encountered items that require clarification:

Narrative Report

- In question 79 on pages 15 and 16, you indicated that many physician specialties are subsidized by your hospital. When reviewers compared these selections with the "Physician Subsidies" tab of the financial report, the following questions arose:
  - The narrative selected "Emergency Medicine" specialty with a subsidy type of "Non-resident house staff and hospitalists." This specialty does not appear in the financial report. Our Hospitalist and Emergency Medicine service are all provided by one integrated group, thus all subsidies are attributed to the "Hospitalist" on the financial report.
    - The only specialties listed in the financial report with subsidy type "Non-resident house staff and hospitalists" are "Hospitalist" and "Interventional Cardiologists."
    - "Interventional Cardiology" is listed in the Narrative report under "Other" with a subsidy type of "Coverage of emergency department call." Interventional Cardiology should be listed as "coverage of emergency department call"
    - Please clarify.
  - The narrative selected "Family Practice/General Practice" specialty with subsidy type "Non-resident house staff and hospitalists."
    - "Family Practice/General Practice" does not appear in the financial report. Please clarify which specialty in the financial report matches this narrative selection. "Family Practice/General Practice" should be changed to "no" on the narrative report as we do not subsidize this service.
  - The narrative selected several specialties with subsidy type "Coverage of emergency department call." These specialties were not found in the financial report. Please clarify whether the hospital subsidizes these specialties, what type of subsidy it provides, and the direct and indirect costs of those subsidies:
    - Oncology - not subsidized so should be a "no" on the narrative report
    - Psychiatry - not subsidized so should be a "no" on the narrative report
    - Radiology - not subsidized so should be a "no" on the narrative report
  - The narrative selected "Pediatrics" specialty with subsidy type "Non-resident house staff and hospitalists." The financial report listed "Pediatrics" with subsidy type "Coverage of Emergency Department Call." Please clarify which subsidy type is correct. - not subsidized so should be a "no" on the narrative report
- We realize that the slider we provided for the FPL for question 88 on page 17 maxes out at 700% FPL. We assume that you selected 700% FPL because that was the maximum value provided, but based on your FAP documents, there is actually no upper income limit for your financial hardship policy. Please confirm that this assumption is correct. Your assumption is correct, we do not have an upper income level limit
- There was no response to question 89 on page 17. The uploaded FAP document shows that financial hardship provision requires that medical debt must reach 25% of household income. Please confirm that 25% is the correct response. 25% is correct

Financial Sheet

- The hospital-based indirect cost ratio (ICR) in cell E114 of the main tab of the financial sheet is larger than the ICRs that most hospitals reported. Please refer to page 7 of the attached Community Benefit Reporting Guidelines and check that the reported indirect cost ratio was calculated correctly. We have double checked the calculation and it is correct. I have ask one more person to review and confirm. I will be in touch if there is a change.
- No offsetting revenue was reported for the items in the physician subsidy category. Please refer to page 8 of the attached Community Benefit Reporting Guidelines and confirm that there is no offsetting revenue to report. There is no offsetting revenue.

Please provide your clarifying answers as a response to this message.

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