Upper Chesapeake Health

BACKGROUND

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

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

For the purposes of this report, the IRS defines a CHNA as a:

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

The written document (CHNA) must include the following:

A description of the community served by the hospital and how it was determined;

The University of Maryland Upper Chesapeake Health consists of two hospitals. UM Upper Chesapeake Medical Center is located in Bel Air, and Harford Memorial Hospital is located in Havre de Grace. The three of Harford Memorial Hospital's zip codes, 21001 (Aberdeen), 21078 (Havre de Grace), and 21040 (Edgewood), and Upper Chesapeake Medical Center's seven zip codes, 21014 (Bel Air), 21040 (Edgewood), 21009 (Abingdon), 21015 (Bel Air), 21050 (Forest Hill), 21001 (Aberdeen), 21085 (Joppa) collectively represent 60% of the hospitals' patient discharges that defines University of Maryland Upper Chesapeake Health's (UM UCH) primary service area. Additionally, UM UCH also serves the following areas and are also included as part of our Community Benefit Service Area: 21013 (Baldwin), 21017 (Belcamp), 21028 (Churchville), 21034

(Darlington), 21047 (Fallston), 21084 (Jarrettsville), 21154 (Street), 21160 (Whiteford), 21111 (Monkton) and 21161 (White Hall).

It was determined that the CHNA needed to include all of Harford County to identify health and economic indicators of persons residing in all of the zip codes noted, realizing that significant health challenges directly related to increased emergency room usage and poor health outcomes are prevalent throughout the county.

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

A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility, including a description of when and how the hospital consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

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

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

University of Maryland Upper Chesapeake Health (Upper Chesapeake Medical Center and Harford Memorial Hospital) maintains a key leadership role in Healthy Harford, *the Healthy Communities Initiative of Harford County,* established in 1995. The President/CEO of UM UCH is also the President of this non-profit 501(c)(3) with the Harford County Health Department Health Officer holding the Vice-President position.

In 1996, Healthy Harford began collecting community data via a comprehensive Community Health Assessment Project (CHAP) survey that measured the incidence of disease, preventive behaviors, and lifestyle behaviors of Harford County residents with an eye towards assessing community health and establishing health priorities in the community. CHAP data was subsequently collected in 2000, 2005, and 2010. The goals of the CHAP survey are multiple: assessing the overall health of Harford County adult residents, ensuring that health education and programming efforts in Harford County match actual needs, establishing a baseline of health indicators so that progress can be measured over time and aligning community stakeholders around the common goal of improving health in our community.

Following CHAP 2000, community report cards focused on preventive health and wellness, heart disease, and cancer were developed; goals were established for 2005 and 2010. Data from the 2010 CHAP survey was used to assess our progress, establish community goals for 2015 and 2020, and align community resources accordingly.

Data for the CHAP 2010 Survey was collected from a random sample of adults age 18 and older (one per household) through a telephone survey. Healthy Harford contracted with Holleran Associates, a national survey consulting firm that specializes in community surveys and assessments. The survey was a randomized phone survey conducted between November 2010 and January 2011. Phone calls were made until a representative sample of the community mirroring demographics for age, race, income, education, gender, and zip code was achieved. A statistically valid representative sample of 875 surveys was collected.

In addition to the CHAP Survey, a secondary data profile was created utilizing sources that included data from the Harford County Health Department and the Local Health Improvement Coalition (LHIC), the Harford County Department of Community Services, 2010 US Census, Maryland Vital Statistics, the CDC Behavioral Risk Factor Surveillance System, National Health Interview Survey, Community Health Rankings, and the

Maryland Department of Health and Mental Hygiene State Health Improvement Plan (SHIP).

Information from Local Health Improvement Coalition and the resulting plan (LHIP) was used as a major source of information regarding community health needs. Directed by the Harford County Health Officer, this local health assessment utilized the Community Café model to bring together over 60 community representatives from a variety of backgrounds to focus on the most pressing health concerns in our community. Leadership from UM UCH played a significant role in this exercise and subsequently chaired two of the leading workgroups (Community Engagement under the Obesity priority, and Tobacco). Data from the SHIP was used as a basis for this exercise. The health areas that were deemed the most pressing for our community by the LHIC were **Obesity**, **Tobacco Use**, and **Behavioral Health** (mental health/substance abuse). Concurrent with this exercise an Obesity Task Force and Tobacco Work Group were initiated and chaired by UM UCH leadership. As a result of the Obesity Task Force, the County Council commissioned a county wide board, named the Healthy Community Planning Board, who reports directly to the County Council and is staffed by the County Council and is responsible for making recommendations for health policy planning and implementation in the county.

UM UCH's strategic plan fully supported and aligned with the three identified goals established through the LHIC process. Additionally, after the completion of the CHNA, UM UCH's strategic plan incorporated the following identified needs:

CHRONIC DISEASE (addressed by UM UCH and HCHD)

- Heart Disease (addressed by UM UCH)
- Stroke (addressed by UM UCH)
- Hypertension (addressed by UM UCH)
- Diabetes (addressed by UM UCH)
- Obesity (addressed by UM UCH and HCHD) – Priority 1 as stated in CHNA
- Asthma/COPD (addressed by UM UCH)

CANCER – (addressed by UM UCH and HCHD)

- Tobacco Use (addressed by UM UCH and HCHD) – Priority 2 as stated in CHNA

ACCESS TO CARE – (addressed by UM UCH)

ILLNESS & INJURY PREVENTION (addressed by UM UCH)

BEHAVIORAL HEALTH/SUBSTANCE ABUSE (addressed by UM UCH and HCHD, but managed by HCHD

- Behavioral Health/Substance Abuse (not addressed by UM UCH – to be managed by HCHD) – Priority 3 as stated in CHNA

The LHIC community partners are as follows:

- Harford County Health Department
  - Susan Kelly, Health Officer
  - Bari Klein, Grant Administrator
  - Marcy Austin, Division of Administration
  - Mary Jo Beach, Care Coordination & Outreach Division
  - Cindy Dawson, HIV/AIDs/Homeless
  - Beth Jones, Behavior Health Division
  - Bill Wiseman, PIO/PH Education & Injury Prevention Division
- Harford County Government
  - Carole Boniface, Office of Community Services
  - Sharon Lipford, Deputy Director Department of Community Services
- University of Maryland Upper Chesapeake Health
  - Vickie Bands, Director of Community Outreach
  - Kathy Kraft, Director of Community Health Improvement
  - Kimberly Theis, Community Benefits Business Manager
  - Pat Thompson, Director of Behavioral Health
  - Robin Stokes Smith, Community Outreach
- Harford Community College - Kathy Burley, Physical Education & Outdoor Recreation
- Boys and Girls Club of Harford County – Tim Wills, Executive Director of Harford County Boys and Girl Club
- Rural Head Start – Tammy Duff, Health and Safety Manager
- Office of Mental Health, Core Service Agency – Terry Farrell, Executive Director
- Harford County Planning and Zoning – Janet Gleisner, Chief, Land Use and Transportation Planning Section
- Homecoming Project, Inc. – Robin Keener, Executive Director
- The Y of Central Maryland - Whitney Lang
- Harford County Government/Parks & Rec. - Arden McClune, Director
- Harford County Office of Sustainability – Marlena McKenna
- Harford County Chamber of Commerce – Vanessa Milio, President/CEO
- Brads Produce – Brad Milton

- Harford County Department of Public Works – Hudson Myers, Deputy Director
- Harford County Public Schools - Mary Nasuta, Nurse Coordinator
- The Arena Club – Keith Rawlings
- Town of Bel Air – Dr. Rob Reier
- Department of Social Service
  - Jerry Reyerson, Director
  - Jill Svjeck, Assistant Director
- Mason-Dixon, Inc. – Barbara Richardson
- Aberdeen Proving Ground – Gail Sauer
- The ARC – Chass Seymour
- LASOS – Melynda Velez
- Havre de Grace City Council – Hon. Barbara Wagner
- The City of Havre de Grace – Patrick Sypolt
- Harford County's Sherriff's Office – Capt. Keith Warner
- Harford County Office on Aging – Karen Winkowski, Administrator
- Private Physical Therapist – Dr. Anne Bizzano
- Private Occupational Therapist – Stephanie Stevenson
- FACE-IT – Pastor Carol Taylor
- Anita Leight Estuary Center – Dr. Kathy Baker-Brosh

The Healthy Harford Board, which is comprised of key community leaders across Harford County, is responsible for establishing the top health priorities based on the results of the CHAP. Key members of the Board include: UM UCH President/CEO, Harford County Health Department Health Officer, Harford County Government Director of Community Services, Harford County Public Schools Superintendent, and the UM UCH Chief Medical Officer. Additional health priorities are established through the Local Health Improvement Coalition (LHIC) comprised of over 60 community members from a wide variety of fields and interests in the community, which drafted the Local Health Improvement Plan (LHIP). (http://www.healthyharford.org/?page_id=11)

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

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);

(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(12) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(13) Survey of community residents; and
(14) Use of data or statistics compiled by county, state, or federal governments.

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

The IMPLEMENTATION STRATEGY must:

a. Be approved by an authorized governing body of the hospital organization;
b. Describe how the hospital facility plans to meet the health need; or
c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. **Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the**

most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Upper Chesapeake Health

Table I

Bed Designation	Inpatient Admissions	Primary Service Area Zip Codes	All other Maryland Hospitals Sharing Primary Service Area	Percentage of Uninsured Patients, by County	Percentage of Patients who are Medicaid Recipients, by County
Harford Memorial Hospital (HMH) (Provider #21-0006): Licensed beds: 89	HMH: 4,559	HMH: 21001 21078 21903 21904 21040	St. Joseph Health Center Greater Baltimore Medical Center Franklin Square Union of Cecil	HMH & UCMC: •Baltimore County 7.5% •Cecil County 3.0% •Harford County 5.0%	HMH & UCMC: •Baltimore County 22.8% •Cecil County 5.8% •Harford County 10.9%
Upper Chesapeake Medical Center (UCMC) (Provider #21-0049): Licensed beds: 181	UCMC: 12,042	UCMC: 21014 21040 21015 21009 21001 21050 21085			

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

   a. **Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1.) This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.**

   Please follow link below for CBSA

   http://www.healthyharford.org/wp-content/uploads/2011/06/12.11.12-UCH-Community-Benefits-Assessment-a.pdf

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

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

Upper Chesapeake Health

Table II – Harford County

Community Benefit Service Area (CBSA) Target Population (target population, by sex, race, and average age) (2013 US Census Data) US Census (2010 US Census Data) US Census	• Total Population: 249,215 (2013 estimate) • Sex ○ Female – 51% ○ Male - 49% • Race (2013 US Census Data) ○ White - 81.1% % ○ Black – 13.2% ○ Hispanic/Latino – 4.0% ○ Asian – 2.9% ○ American Indian/Alaskan Native – 0.3% ○ Native American/Pacific Islander – 0.1% • Age ○ 0 – 19: 27.3% ○ 20-34: 17.2% ○ 35-44: 13.9% ○ 45-54: 16.7% ○ 55-64: 12.5% ○ 65+ : 12.5%
Median Household Income within the CBSA US Census	$80,441 (2008-2012)
Percentage of households with incomes below the federal poverty guidelines within the CBSA 2011-2013 ACS Census	7.5% (Individuals) 6.8% (All Families) 10.9% (Families w/ related children under 18 years) 8.9% (Families w/related children under 5 years only) 22% (Families with female householder, no husband present) 28.4% (with related children under 18) 44.8% (w/related children under 5 years only)

Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: 2011-2013 ACS Census	6.1% Civilian Non-institutionalized Population 3.0% Civilian Non-institutionalized Population (under 18)
Percentage of Medicaid recipients by County within the CBSA. US Census	26%
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). SHIP 2014	Black: 77.1 White: 79.5
Mortality Rates by County within the CBSA. Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). SHIP 2014 VSA 2012	Represented per 100,000 population Age-Adjusted Mortality Rate from Cancer – 171.0 White: 173.8 Black: 197.9 Age-Adjusted Mortality Rate from Heart Disease – 176.1 White:108.7 Black:197.9 Stroke – 40.2 COPD – 33.4 Accidents – 33.4 Diabetes – 16.9 Influenza – 20.1
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local	• Amongst Harford County Youth 5.8% are not eating any fruit, & 5.6% are not eating any vegetables. (HS YRBSS, 2013),

or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information:	There are no official food deserts based on Federal HUD regulations, but there are noted food insecure areas due to lack of supermarkets and public transportation. These areas are in the northern rural areas of the county, i.e. Dublin, Darlington, Whiteford, etc. (Harford County Community Services report). • Harford is primarily rural and suburban with a strong car culture. Traffic speed and limited safe bike and pedestrian infrastructure has a severe impact on walking and biking as a means of transportation. Although the majority of public transit routes are located in areas with the highest concentration of low to moderate income families, along the route 40 corridor in the southern portion of the county, public transportation (i.e. busing) is limited in both routes and scheduling. Due to these restrictions work opportunities are limited and given the restricted scheduling it would be challenging for someone solely dependent on public transportation to work a full 8 hour day. All Harford County transit buses, however, are now equipped with bike racks to support multimodal transportation. (Harford County,

	Community Services Department). • Harford County Public Schools have a significant number of military families that struggle with extended deployments and frequent moves. Other youth health indictors include high minority obesity rates, high smoking rate, high rate of substance abuse and behavioral health issues that result in suicide. (DHMH SHIP - LHIC) • Homeownership in Harford County is at 80.4% with a median value of $290,700 for owner occupied housing units. There is an average of 2.7 people per household. (2008-2012 US Census ACS). 50% of Harford County households earn less than $75,000 and the inventory for affordable housing is limited. The high average housing price pushes many low and moderate income people out of the housing market, and there is an underreported population of families doubling up and children remaining in parent's household after graduation and marriage. There is only one public housing complex in the county and section 8, low, and moderate income renters must all compete for the limited affordable housing which is

	often concentrated in the poorer areas. • The US Army Aberdeen Proving Grounds (APG) is located in the southern part of Harford County and for most of the 20th and 21st centuries APG has been a site of manufacturing, testing and disposal of hazardous chemicals including Anticholinesterase nerve agents, mustard gas, and other chemical weapons. The area surrounding APG are some of the most impoverished in our community. • Harford County due to a number of factors including its geographical location and its proximity to Rt. I-95 has the second worst air quality in the State of Maryland.
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions.	• Primary Language Spoken ○ English: 92.9% ○ Other than English: 7.1% (38% of which is Spanish)
Adult Obesity (Percentage of adults that report BMI >30) (per 10,000 population) BRFSS 2012	**Harford: 30.1** MD: 27.6; US: 28.1 Lowest % of adults at a healthy weight in the State of MD
High Blood Pressure (per 10,000 population) BRFSS 2011	**Harford: 37.4** MD: 31.3; US:30.8
High Cholesterol (per 10,000 population) BRFSS 2011	**Harford: 40.4** MD:35.4; US:38.3

Diabetes (per 10,000 population) BRFSS 2011	**Harford: 15** MD:9.5; US:8.7
Physically active (per 10,000 population) BRFSS 2011	**Harford: 43.1** MD 48.7; US 51.6
Adult Smoking (> 18 years of age) (per 10,000 population) BRFSS 2012	**Harford: 21.7** MD: 16.2; US: 19.6
Adult Drinking (>= 2 drinks/day for men, >= 1 drink/day for women (per 10,000 population) BRFSS 2012	**Harford: 6.5**; MD: 5.5; US: 6.1
Cancer Mortality (per 100,000 population) (VSA 2012)	**Harford: 197.5** MD:176.8
Annual Average unemployment rate 2014 County Health Rankings	**Harford: 7.0%**; MD: 6.8%
Rate of Suicides per 100,000 population (VSA 2010-2012)	**Harford: 11.3**; MD: 8.8 (5th highest rate in MD)
Rate of drug induced death per 100,000 population (VSA 2009-2011)	15.4 (5th highest in MD)
Health Disparities Infant Mortality Rate (per 1,000 live births) Percentage of births that are low birth weight (per 1,000 live births) (VSA 2012) Percentage of births that are low birth weight (per 1,000 live birth) 2014 County Health Rankings Rate of hospital encounters for newborns with maternal drug/alcohol exposure (rate exposed per 1,000 newborns) (HSCRC Hospital Data 2000-2013)	 White/Non-Hispanic – 5.5% Black – 14.4% White/Non-Hispanic – 5.5% Black – 13.1% Hispanic – 10% 7.7% 35.8 Has increased by 45% from 2000-2013.

Emergency Department Visits related to domestic violence per 100,000 population Domestic violence Diabetes Hypertension Mental Health Asthma Addictions related conditions SHIP 2014	 White/Non-Hispanic – 29.8 Black – 82.3 White/Non-Hispanic – 133.8 Black – 303.9 White/Non-Hispanic – 157.9 Black – 601.6 White/Non-Hispanic – 3092.3 Black – 3292.7 White/Non-Hispanic – 29.4 Black – 129.2 White/Non-Hispanic – 1453.3 Black – 1849
Education Percentage of population graduating high school 2014 County Health Rankings US Census Bachelor's Degree or greater US Census	 87% (percentage of 9th graders that graduate in 4 years) 91.3% (percentage of those that graduate by age 25+) 31.5%
Percentage of children in poverty Children in single parent households 2014 County Health Rankings	11% 26%

Other	

Table II – Cecil County

Community Benefit Service Area (CBSA) Target Population (target population, by sex, race, and average age) (2010 US Census Data)	• Sex ○ Female – 50.3% ○ Male – 49.7% • Race ○ White – 89.7% ○ Black – 6.7% ○ Hispanic/Latino – 3.6% ○ Asian – 1.2% ○ American Indian/Alaskan Native – 0.4% ○ Native American/Pacific Islander – 0.1% • Age ○ 0 – 19: 27.5% ○ 20-29: 12.9% ○ 30-39: 10.5% ○ 40-49: 16.2% ○ 50-59: 15.0% ○ 60-64: 5.9% ○ 65+ : 12.0%
Median Household Income within the CBSA (2010 US Census Data)	$66,025
Percentage of households with incomes below the federal poverty guidelines within the CBSA (2008-2012 ACS 5 year estimate)	9.6% persons 6.5% families 11.2% (Families w/ related children under 18 years) 15.2% (Families w/related children under 5 years only) 18% (Families with female

	householder, no husband present) 24.4% (with related children under 18) 47.8% (w/related children under 5 years only)
Please estimate the percentage of uninsured people by County within the CBSA. (2008-2012 ACS 5 year estimate)	9.8% Civilian Non-institutionalized Population 6.4% Civilian Non-institutionalized Population (under 18)
Percentage of Medicaid recipients by County within the CBSA. (2008-2012 ACS 5 year estimate)	27.6%
Life Expectancy by County within the CBSA. SHIP 2014	77.0 years
Mortality Rates by County within the CBSA. (Maryland Vital Statistics 2010)	Represented per 100,000 population • Heart Disease – 188.9 • Cancer – 196.8 • Stroke – 27.7 • COPD – 63.3 • Accidents – 40.6 • Diabetes – 25.7 • Influenza - *** data not available
Access to healthy food, quality of housing, and transportation by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources). US Census	• 5.9% of census tracts in Cecil County have food deserts. (MDHMH, 2011 Cecil Baseline Data SHIP) • Homeownership in Cecil County is at 74% with a median value of $261,900 for owner occupied housing units. There is an average of 2.77 people per household. • No public transportation exists in Cecil County and the average commute to work is 29 minutes. (2007-2011 US Census ACS)

Other	

As noted in Table 1, the service area for UM Upper Chesapeake Health (UM UCMC and UM HMH) includes a limited number of zip codes and census areas from western Cecil County. For clarification, demographic and social determinant information for Cecil has been included in Table II.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

   _X_ Yes
   ____No

   Provide date here. 07/31/12 (mm/dd/yy)

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

http://umuch.org/~/media/SystemHospitals/UCHS/PDFs/About%20Us/CommunityBenefitsAssessment.pdf

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

   _X Yes 07/01/12 (mm/dd/yy) Enter date approved by governing body here:
   ___No

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

http://umuch.org/~/media/SystemHospitals/UCHS/PDFs/About%20Us/CommunityBenefitsPlan2013.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

1. **Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?**

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

_X_ Yes
___ No

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

i. Senior Leadership
   1. _X_ CEO
   2. _X_ CFO
   3. Other (please specify)
      a. Senior VP of Medical Affairs

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

iii. Community Benefit Department/Team
   1. _X_ Individual (2 FTE)
   2. _X_ Committee (please list members)
      a. Kathy Kraft, Director Community Health Improvement
      b. Vickie Bands, Director Community Outreach
      c. Shelley Rainey, Clinical Nurse Manager
      d. Bari Klein, Grants Administrator
      e. Kimberly Theis, Community Benefits/CHI Business Manager
      f. Judy Lauer, Events Coordinator
      g. Charles Elly, Finance
      h. Curt Ohler, Finance
   3. _X_ Other – Community Benefit Advisory Board
      a. The Advisory Board is comprised of department leaders from all the clinical service lines and finance within UM UCH.

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

Spreadsheet _X_ yes ___ no

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Narrative _X_ yes ___ no

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

Spreadsheet X yes ___ no
Narrative X yes ___ no

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. **Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting.**
   Please see attached examples of how to report.

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

a. **Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.**

b. **Name of Initiative: insert name of initiative.**

c. **Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (Use several pages if necessary)**

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

e. **Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.**

f. **How were the outcomes of the initiative evaluated?**

g. **Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?**

h. **Continuation of Initiative: Will the initiative be continued based on the outcome?**

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

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

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

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

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

V. PHYSICIANS

1. **As required under HG19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.**

   UM UCH does not experience a specialty shortage, however there are still many patients in Harford County who require specialty care and are unable to access the care needed. The UM UCH HealthLink Primary Care Clinic assists those patients in obtaining the needed care.

   The UM UCH HealthLink Primary Care Clinic is a primary care clinic that serves low income (300% of the Federal poverty level) uninsured, Medicare and Medicaid patients ages 19 and older. Our patients, due to lack of previous regular health care, mental illness, substance abuse, developmental impairment, etc. often present at our clinic with multiple medical problems that require a variety of specialty care appointments. Harford County does not currently have an FQHC, a Community Health Center, links to a medical resident program, or an abundance of hospital owned physician practices. Harford County depends on local private physicians and medical service providers to provide reduced cost services to our patients. Relationships established by the previous grant funded Specialty Care Network Coordinator remain in place for the UM UCH HealthLink Primary Care clinic patients allowing them to be referred to a needed specialist.

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

   Physician subsidies at UM UCH consist of the cost of on call coverage for physicians who would not work there unless compensated by the hospital. The amounts reported for 2014 include:

   Upper Chesapeake ED physician subsidies: $1,298,885

Upper Chesapeake ANS physician subsidies: $2,096,160
Harford Memorial ED/BHU physician subsidies: $809,257
Harford Memorial ANS physician subsidies: $898,354

VI. APPENDICES (please see attached)

To Be Attached as Appendices:

To Be Attached as Appendices:

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

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

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

b. Include a copy of your hospital's FAP (label appendix II).

c. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).

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

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Obesity Prevention Enhanced Nutrition Increase in Physical Activity
Hospital Initiative	Healthy Harford Obesity Workgroup, Healthy Community Planning Board
Primary Objective	The primary objective of the initiative is to: • decrease the rates of obesity and overweightness in Harford County; • improve the nutritional habits of children, youth, and adults living in Harford County; • increase the physical activity levels of children, youth and adults living in Harford County; • increase access to healthy foods; • increase opportunities for Harford County residents to be physically active. • Create a *community of wellness* through community engagement
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	HC=Harford County HC Sheriff's Office HC Public Library HC Dept. of Community Services Office of the County Executive Boys & Girls Club HC Health Department. HC Council HC Dept. of Parks & Recreation University of Maryland Upper Chesapeake Health ARC Northern Region Town of Bel Air

	HC Public Schools Greta Brand & Associates, Inc. Harford Community College HC Dept. of Planning & Zoning Y of Central Maryland HC Dept. of Public Works The Arena Club Greater Edgewood Education Foundation Klein's Shoprite LASOS – immigrant support services Bel Air Farmers' Market Chesapeake Spokes Cycling Club Greg Krause Helmet Foundation US Army Test and Evaluation Command APG Community Health Promotion Council The Arena Club The Laurrapin Grill Farm to Table Restaurant University of Maryland Master Gardner's Program Dr. Rebecca Hartwig, Pediatrician Brad's Produce Apostolic Voice of Truth Church Aberdeen Bible Baptist Church Baltimore Metropolitan Council – Street Smart Campaign DineKind Harford Abundant Living Program – SDA Wilna Church People's Republic of Orange – MS Support Group Harford Lyme Advocates Frito Lay Farm Bureau
How were the outcomes evaluated?	Outcomes were evaluated through longitudinal data from the Maryland Behavioral Risk Factor Surveillance System Survey (BRFSS), comparing county rates to Maryland (MD) State goals and Healthy People 2020 goals; MD 2014 Target: 35.7%, Healthy People 2020 Target: 33.9.

Outcomes (Include process and impact measures)	Percentage of adults who are at a healthy weight, not overweight or obese rose from 24.9% in 2011 to 29.5% (2011-2013) * Note: in 2011 BRFSS data began a new weighting methodology, not compatible with prior years.	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $1,140.00	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Obesity Prevention Enhanced Nutrition Increase in Physical Activity
Hospital Initiative	Healthy Harford Day
Primary Objective	To increase the community's awareness and knowledge of health and wellness issues including obesity prevention, proper nutrition and the importance of regular physical activity. To Introduce the community to locally grown fresh produce, and learn about healthy resources within the local community.
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	University of Maryland Upper Chesapeake Health Harford County Health Department Harford County Government Bel Air Farmers' Market WAMD Radio Town of Bel Air, and Councilman Dr. Rob Reier Bel Air Police Department Harford County Public Libraries The Y of Central Maryland The Arena Club Zumba at the Bel Air Armory, Juan Alzamora Klein's Shoprite Open Door Café and Chef Jenn Williams Charm City Run The Greg Krause Helmet Foundation Chesapeake Spokes Bicycle Club

	Harford County Sheriff's Office Community Policing Unit The Baltimore Blast Harford County Planning and Zoning Bel Air Downtown Alliance Town of Bel Air Planning and Zoning Harford Community College Harford Lyme Advocates and County Council President Billy Boniface Harford County Office of Recycling and Office of Sustainability Lindy Ford, RD, LDN - Nutrition and Wellness The Fitness Craze - personal and small group training Gold Medal Physical Therapy Remedy Wellness CrossFit Everlasting Harford County Parks and Recreation. Sappari Solutions professional organizing services Harford County Sheriff's Office Wellness Program University of Maryland Cooperative Extension - Horticulturist Joyce Browning Advance Eye Care Smoothie King Upper Chesapeake Respiratory Therapy The Bike Shop of Bel Air Baltimore Metropolitan Council Street Smart Program Dine Kind Harford Holistic Moms The Nutrition Magician Gerry McNally Maryland Insurance Administration The Bel Air Athletic Club Leukemia and Lymphoma Society Senator Barry Glassman
How were the outcomes evaluated?	Community Engagement outcomes were evaluated by the number of people that attended and vendors that attended the event, an evaluative survey for attendees was distributed at the 2014 event.

Outcomes (Include process and impact measures)	Over 1,000 community residents attended the event and 45 vendors participated, up from 300 attendees and 25 vendors last year. We are adding an evaluation component for more specific outcomes in FY15.	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $2,286.00	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Obesity Prevention Enhanced Nutrition Increase in Physical Activity
Hospital Initiative	Health Fairs
Primary Objective	To provide education and health screenings to the community at large. The screenings provided were: A1C Blood Glucose Blood Pressure Body Fat Composition Cholesterol Colorectal Screening CO Monitor Diabetes Risk Assessment Foot & Eye Hearing & Vision Osteoporosis – Bone Density Prostate Screening Skin Cancer Screening Stroke Risk Assessment Sleep Apnea/Epworth
Single or Multi-Year Initiative Time Period	On-going as requested

Key Partners in Development and/or Implementation	UM UCH Community Outreach Faith Based Community Harford County Government Harford County Schools, and groups, clubs and organizations throughout Harford County.
How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the completion of the event. Additionally, health statistics in the 2015 CHNA will provide outcome information. A new method for data collection that evaluates outcomes has been completed and will be implemented for FY15.
Outcomes (Include process and impact measures)	Heart disease death rates are down 20% in Harford County in the past 5 years. Stroke mortality rates are down 9.5% in Harford County over the past 5 years. 1,700 screenings were provided. Blood Pressures Screenings - 352 participants Body Fat Composition - 55 participants Cancer Education - 715 participants Cholesterol Screenings - 9 participants Diabetes Risk Assessments - 9 participants Flu Vaccinations – 3 participants Glucose - 6 participants Health Wheel – 80 participants How Sweet It Is - 299 participants KATU – 112 participants Sleep Apnea Risk Assessments - 16 participants Smoking Out the Truth - 15 participants Stroke Risk Assessments - 29 participants
Continuation of Initiative	Yes

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $3,745.00	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Obesity Prevention Enhanced Nutrition Increase in Physical Activity
Hospital Initiative	HealthLink Wellness Center
Primary Objective	HealthLink provides a Wellness Center in Bel Air out of the Medical Mobile Van one evening a month targeting those Harford County residents without a Primary Care Provider. Several screenings are provided including blood pressures, cholesterol, body composition analysis, osteoporosis and sleep risk assessments. Participants were counseled on weight reduction measures, nutrition and increasing physical activity if indicated.
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	UM UCH Community Outreach
How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the end of the screening. The survey provides them with an opportunity to comment about their knowledge learned and any health changes they plan to make. A new method for data collection that evaluates outcomes has been completed and will be implemented for FY15.

Outcomes (Include process and impact measures)	Heart disease death rates are down 20% in Harford County in the past 5 years. Stroke death rates are down 9.5% in Harford County over the past 5 years. 97 screenings provided • Blood pressure screenings – 51 participants • Body fat analyses – 19 participants • Cholesterol screenings – 21 participants • Diabetes risk assessments – 1 participant • Osteoporosis screenings – 3 participants • Sleep apnea risk assessments – 1 participant • Stroke risk assessments – 1 participant	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $3,463.00	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Obesity Prevention Enhanced Nutrition Increase in Physical Activity
Hospital Initiative	"How Sweet It Is"
Primary Objective	HealthLink provided the "How Sweet It Is" program at 10 different locations in the community. The locations consisted of churches, schools, women's groups, and the Harford Mall. Participants interacted by matching the drink to the actual content of sugar in each drink. The objective of this program is to educate and increase the participant's awareness of the hidden calories and sugar content present in certain popular drinks.
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	UM UCH Community Outreach Harford County Public Schools Faith Based Community and a variety of other community groups.
How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the end of the screening and the survey provides them an opportunity to comment about their knowledge learned and any health changes they plan to make. New method for data collection to evaluate outcomes has been completed and will be implemented for FY15.

Outcomes (Include process and impact measures)	2,100 participants	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $1,538.00	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Cardiovascular Disease Including Hypertension, Heart Disease and Stroke
Hospital Initiative	Cardiovascular Disease (CVD) Education and Prevention
Primary Objective	HealthLink provided monthly blood pressure screenings, and numerous body composition and cholesterol screenings throughout Harford County, including six Harford County Senior Centers, six Soup Kitchens, Senior Housing and various other sites. The primary objective of these screenings was to educate, counsel and refer participants as needed. Counseling and referrals are based on the seventh report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure and the National Heart Lung Blood Institute through the National Institute of Health.
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	UM UCH UM UCH Community Outreach The Harford County Office on Aging First Fridays Fairbrooke Senior Housing Parkview at Bel Air Senior Housing Box Hill Senior Housing Avondell Retirement Community Brightview Assisted Living Perryman Station Ripken Stadium Inner County Outreach Harford Mall Klein's ShopRite locations.

How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the end of the screening and the survey provides them an opportunity to comment about their knowledge learned and any health changes they plan to make. New method for data collection to evaluate outcomes has been completed and will be implemented for FY15.	
Outcomes (Include process and impact measures)	2,967 blood pressures screenings completed. 316 cholesterol screenings completed. 119 body compositions completed. Will seek additional outcome measures moving forward.	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $19,544 Blood Pressure Screenings $3,816 Cholesterol Screenings $1,580 Body Fat compositions	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Cardiovascular Disease Including Hypertension, Heart Disease and Stroke
Hospital Initiative	Stroke Risk Education Program
Primary Objective	Stroke Risk Assessments are offered throughout Harford County at various locations including Senior Housing, Senior Centers, Soup Kitchens and faith based communities. This included a paper assessment, B/P measurement, educational information, and referrals. CVD Support Groups (Stroke and Heart) Stroke education was provided to various groups including US Army and the Maryland Institute for Emergency Medical Services Systems. The primary objective for the Stroke Risk Education Program is to reduce the community's risk for stroke by educating them on the risk factors and the importance of life style modification.
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	UM Upper Chesapeake Health UM UCH Community Outreach Community Physicians
How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the completion of the event. CHNA 2015

Outcomes (Include process and impact measures)	Heart disease death rates are down 20% in Harford County in the past 5 years. Stroke death rates are down 9.5% in Harford County over the past 5 years. 203 Stroke Risk Assessments completed Will seek additional outcome measures moving forward. Heart Club – 19 participants Stroke Club - 118 participants 559 community members were educated	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $996 Stroke Risk Assessments $400 Heart Club $890 Stroke Club $2,071 Education	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Cardiovascular Disease Including Hypertension, Heart Disease and Stroke
Hospital Initiative	Vascular Screenings
Primary Objective	Monthly event held at HMH and UCMC which community participants rotate through multiple stations of assessments for CV disease; included are BP, EKG rhythm, PAD, AAA, Carotid Disease and Risk Factor Analysis. Results are stratified according to accepted parameters and discussed with participant by an RN or RVT. Copies of the results are given to the participants and forwarded within 24 hours to their primary physician. Abnormal results are noted with suggestions for follow up testing and critical results are immediately reported to the primary care physician and/or cardiologist/vascular surgeon on site. Results are kept on file for one year. The following are the goals for the CVD initiatives: • to increase knowledge of cardiovascular disease and associated risk factors; • to learn ways to aid in prevention and decrease the risk for the disease through diet, exercise, medication and regular appointments with a physician; • to learn the signs and symptoms associated with a stroke and what to do in the event that someone exhibits signs or symptoms; • to learn what the personal risks are for heart disease and stroke; • to decrease the incidence rates of CVD in Harford County.

Single or Multi-Year Initiative Time Period	On-going	
Key Partners in Development and/or Implementation	UM UCH Service Lines UM UCH Community Outreach Community Physicians	
How were the outcomes evaluated?	Vascular screenings are evaluated on an individual basis. The results are evaluated by a UM UCH cardiologist at the time of the screening. The participant is provided an immediate result and recommendation. Participants are counseled as to their risk for vascular disease, stroke and lifestyle changes as indicated. Participants with abnormal results are given.	
Outcomes (Include process and impact measures)	217 participants .3% required immediate care and/or follow-up.	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $28,776	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Cardiovascular Disease Including Hypertension, Heart Disease and Stroke
Hospital Initiative	Dining with Docs
Primary Objective	A lecture series where community physicians address a variety of health topics for the community. The lectures provide opportunity for participants to ask questions and address issues related to the topic. Topics included lectures on stroke, cancer, environment issues, heart disease and erectile dysfunction, and a variety of orthopedic issues.
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	UM UCH affiliated physicians and clinical services.
How were the outcomes evaluated?	Participants had the opportunity to complete a lecture evaluation form.
Outcomes (Include process and impact measures)	73 participants
Continuation of Initiative	Yes

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $2,125	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Diabetes
Hospital Initiative	Diabetes Health Fair
Primary Objective	The Diabetes and Endocrine Center conducted a Diabetes Health Fair. This community event provided individuals with the opportunity to talk to Diabetes Center Educators and Pharmaceutical Representatives on the many ways diabetes affects their health, get information on diabetes supplies, technology, medications and educational programs. 15 minutes mini session on eye disease presented by Seidenberg Protzko Eye Associated. Free literature and samples.
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	Diabetes and Endocrine Center
How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the end of the screening and the survey provides them an opportunity to comment about their knowledge learned and any health changes they plan to make. New method for data collection to evaluate outcomes has been completed and will be implemented for FY15.
Outcomes (Include process and impact measures)	396 participants
Continuation of Initiative	Yes

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $3,707	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative I CHRONIC DISEASE

Identified Need	Diabetes	
Hospital Initiative	Diabetes Support Groups	
Primary Objective	HealthLink provided Diabetes Support Groups at three Senior Center locations, which include, McFaul Senior Center, Edgewood Senior Center and Aberdeen Senior Center	
Single or Multi-Year Initiative Time Period	On-going	
Key Partners in Development and/or Implementation	UM UCH Community Outreach	
How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the end of the screening and the survey provides them an opportunity to comment about their knowledge learned and any health changes they plan to make. New method for data collection to evaluate outcomes has been completed and will be implemented for FY15.	
Outcomes (Include process and impact measures)	277 participants	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $1,638	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative II CANCER

Identified Need	Cancer
Hospital Initiative	Community Colorectal Cancer Screenings and Education
Primary Objective	Colorectal screening kits were distributed in the Mobile Van Wellness Center in two areas of the County. The goals for all of these programs and activities are to: • increase knowledge and awareness about colorectal cancer and prevention strategies; • decrease the incidence of colorectal cancer rates in Harford County.
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	UM UCH Community Outreach
How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the end of the screening and the survey provides them an opportunity to comment about their knowledge learned and any health changes they plan to make. New method for data collection to evaluate outcomes has been completed and will be implemented for FY15.
Outcomes (Include process and impact measures)	46 kits distributed. Unable to obtain any feedback as to how many of the kits were used and returned to their physician.
Continuation of Initiative	Yes

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $82.00 per person	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative II CANCER

Identified Need	Cancer
Hospital Initiative	Cancer Education
Primary Objective	Cancer LifeNet provided cancer education at various events throughout the county and military installation. The primary objectives for these programs was to: • increase knowledge and awareness about various types of cancer and prevention strategies; • decrease the incidence of cancer rates in Harford County Cancer LifeNet provides support groups for the following: Blood Cancer Breast Cancer CLIMB Family and Friends General Cancer Just for Me Stage 4 Breast Cancer Look Good Feel Better Prostate Cancer
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	Cancer LifeNet and Community Outreach
How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the end of the screening and the survey provides them an opportunity to comment about their knowledge learned and any health changes they plan to make. New method for data collection to evaluate outcomes has been completed and will be implemented for FY15.

Outcomes (Include process and impact measures)	While the county's cancer rates are still worse than the states, cancer death rates in Harford County are down by 9% over the last 5 years. 2,570 participants received cancer education 579 community members attended the support groups	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $8,344 Breast Education $39,567 Support Groups	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative II CANCER

Identified Need	Cancer
Hospital Initiative	Community Skin Cancer Screenings and Education
Primary Objective	HealthLink provided Skin Cancer Screenings in various locations in Harford County. HealthLink presented our "Sun Sense" program at a variety of locations throughout Harford County. The program presented information on the harmful effects of the sun, types of skin cancers, and the importance of using sun protection. The participants were able to see the effects of sun damage to their own skin by utilizing a Skin Analyzer Machine. Packets of sun screen were distributed. The goals for all of these programs and activities are to: • increase knowledge and awareness about skin cancer and prevention strategies; • decrease the incidence of skin cancer rates in Harford County
Single or Multi-Year Initiative Time Period	Annual events On going
Key Partners in Development and/or Implementation	UM UCH Community Outreach
How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the end of the screening and the survey provided them an opportunity to comment about their knowledge learned and any health changes they plan to make. New method for data collection to evaluate outcomes has been completed and will be implemented for FY15.

Outcomes (Include process and impact measures)	85 participants	
Continuation of Initiative	No	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $638	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative II CANCER

Identified Need	Smoking and Tobacco Use	
Hospital Initiative	Community Smoking Education and Prevention Awareness	
Primary Objective	The **Smoking Out the Truth** program provides an interactive table-top presentation. It consists of educational boards, props and handouts. The objective is to educate youth about the dangers associated with tobacco use, smokeless tobacco products, hookah pipes, and electronic cigarettes.	
Single or Multi-Year Initiative Time Period	Ongoing	
Key Partners in Development and/or Implementation	UM UCH Community Outreach	
How were the outcomes evaluated?	Maryland Youth Risk Behavior Survey CHNA 2015	
Outcomes (Include process and impact measures)	40 youths were educated during these events. Maryland average for youth using tobacco is 16.9**%.** Harford County's youth tobacco use rate was 14.9 % in 2013, a decrease from 17.3% in 2012.	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $105	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative II CANCER

Identified Need	Smoking and Tobacco Use
Hospital Initiative	Community Smoking Education and Prevention Awareness
Primary Objective	Additionally, HealthLink has provided tobacco education in many different venues in the Community. The information provided was age appropriate utilizing the "Kids Against Tobacco Use" (KATU) and "Smoking Out the Truth" programs. Different presentation styles were used, including lectures, interactive table-top displays and demonstrations. The HealthLink's Health Wheel asked participants age-appropriate health questions (including tobacco) and was used as an educational tool. Prizes were given to participants who answer questions correctly. The goals for all of these programs and activities are to: • increase knowledge and awareness about the dangers associated with tobacco use; • decrease the incidence of tobacco use rates in Harford County
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	UM UCH Community Outreach Harford County Public School
How were the outcomes evaluated?	All participants had an opportunity to complete an evaluation form at the completion of the event. CHNA 2015

Outcomes (Include process and impact measures)	759 community residents educated. According to our 2012 CHNA, 20.3% of Harford County adults smoke compared to 15.1% state average. In fact smoking rates in the county increased over the last 10 years with only a slight drop detected in 2010 while the state rate steadily declined.	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $1,763	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative II CANCER

Identified Need	Smoking and Tobacco Use Cont.
Hospital Initiative	Smoking Cessation
Primary Objective	Cancer LifeNet provided smoking education and prevention awareness through their Smoking Cessation Program. The goal of this multi week program is to aid participants in the process of quitting tobacco use.
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	Cancer LifeNet Harford County Health Department
How were the outcomes evaluated?	Outcomes were evaluated based on number of participants, number of participants attending more than one time, and number of participants who had quit by the end of class. CHNA 2015
Outcomes (Include process and impact measures)	3 six-week cessation classes Total number of participants – 81 69 participants attended the cessation classes more than once (85%). Number of participants quit by the end of class – 20 (25%).
Continuation of Initiative	Yes

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $11,103	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative II CANCER

Identified Need	Smoking and Tobacco Use
Hospital Initiative	Harford County Tobacco Work Group
Primary Objective	Director of UM UCH Community Outreach is the chair person for the Harford County Tobacco Work group which was established through the LHIC initiatives. The objectives of the work group are • tobacco public awareness campaign • tobacco policy change • establishment of smoke free low income housing • development of a position paper for E-cigarette safety and use
Single or Multi-Year Initiative Time Period	On-going
Key Partners in Development and/or Implementation	UM UCH Harford County Community Services Harford County Health Department Healthy Harford, Town of Aberdeen Town of Havre de Grace County Council
How were the outcomes evaluated?	Public Awareness Campaign The focus continues to be public awareness of Harford County's tobacco issue. Policy change – Harford County is working towards changing the sale of tobacco to minors from a criminal offense to a civil offense. The current County Council champion is actively working with tobacco law attorneys. This change will lead to a better response from the court system. Low Income Housing – Work group has identified two low income housing neighborhoods and is currently working with both to

	determine the feasibility for the neighborhoods to go smoke free. Harford County is working on developing an information and educational position paper regarding E-cigarettes.	
Outcomes (Include process and impact measures)	The 2015 CHNA will provide work group with data addressing the decline of smoking rates in Harford County. Smoke free housing and criminal versus civil outcomes are still pending.	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $2,791	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative III ACCESS TO CARE

Identified Need	Access to Care
Hospital Initiative	HealthLink Primary Care Clinic
Primary Objective	The UM UCH HealthLink Primary Care Clinic provides primary care services to the uninsured and underserved residents of Harford County who are <300% of the Federal Poverty Level guidelines. The clinic operates 5 days a week, including one ½ Saturday. It is comprised of a stationary clinic located in the city of Havre de Grace, and a mobile medical van that functions as a mobile clinic at various locations throughout the community.
Single or Multi-Year Initiative Time Period	On-going, but will be closing in FY15.
Key Partners in Development and/or Implementation	UM UCH Local Harford County physicians Health Care for the Homeless Harford County Health Department
How were the outcomes evaluated?	Number of Health Care for the Homeless patients enrolled in the clinic. Number of uninsured Harford County residents (<300% of FPL) enrolled in the clinic. Number of self-pay patients referred from the Emergency Department to the clinic. Number of people we have been successful in being insured. Number of billable visits.
Outcomes (Include process and impact measures)	Health Care for the Homeless Patients - 446 patient visits Primary Care Clinic Patients – 3,291 patient visits Ed Diversion – 6,546 self-pay patients data has been reviewed; however please note that this is not individual patients but rather patient encounters (a single patient could have their data

	reviewed more than once in a given year if they have returned to the Emergency Department numerous times.	
Continuation of Initiative	The HLPCC will be closing in FY15. Patients will be encouraged to transition to new FQHC in Havre de Grace, Beacon Health.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative Expense included with Primary Care Clinic costs below. $467,437 Primary Care Clinic $140,720 ED Diversion	B. Direct offsetting revenue from Restricted Grants

Upper Chesapeake Health

Table III A. Initiative III ACCESS TO CARE

Identified Need	Illness and Injury Prevention	
Hospital Initiative	Flu Vaccination Clinics	
Primary Objective	To provide Harford County residents with flu vaccinations at convenient locations and at a reduced cost.	
Single or Multi-Year Initiative Time Period	On-going	
Key Partners in Development and/or Implementation	UM UCH	
How were the outcomes evaluated?	Because Harford County and the State of Maryland are not required to report individual seasonal flu cases or deaths of people older than 18 years of age to the Centers of Disease Control (CDC), it is difficult to measure the impact of this type of initiative on the community. The CDC recommends annual influenza vaccination for all people aged six months and older to lower the annual incidence of flu in the community.	
Outcomes (Include process and impact measures)	1,421 community residents received vaccinations or flu mist.	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $6,601	B. Direct offsetting revenue from Restricted Grants

Charity Care Policy Summary

Financial Assistance

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

Purpose

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

Criteria

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

Process

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

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

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

Upper Chesapeake Health

Subject: Financial Assistance Policy

Effective Date: 01/2013

Approved by: _____

Joseph E. Hoffman, Sr. VP CFO

_____

Board of Directors

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

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

review of the patient's existing medical expenses and obligations, including any accounts having gone to bad debt.

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

2. Program Eligibility

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

ii. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, Motor Vehicle or other insurance programs that deny access to UCH due to insurance plan restrictions/limits
iii. Refusal to be screened for other assistance programs prior to submitting an application to the FA program

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

h. If a patient requests the application be reconsidered after a denial determination made by the Financial Counselor, the Director of Patient Accounting will review the application for final determination.
i. Payment plans can be offered for all self-pay balances by our Self Pay Vendor. Payment plans are available to uninsured patients with family income between 200 to 500 FPL.

3. Presumptive Financial Assistance

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

xiv. Self-Administered Drugs (in the outpatient environment only)
xv. Medical Assistance Spenddown amounts

b. Specific services or criteria that are ineligible for Presumptive FA include:
    i. Purely elective procedures (e.g. cosmetic procedures) are not covered under the program
    ii. Uninsured patients seen in the ED under EP will not be considered under the presumptive FA program until the Maryland Medicaid Psych program has been billed

4. Procedures

a. The Financial Counselor will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage
b. The Financial Counselor will consult via phone or meet with patients who request FA to determine if they meet preliminary criteria for assistance.
    i. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility
    ii. All applications will be tracked and after eligibility is determined, a letter of final determination will be submitted to the patient
    iii. Patients will have fifteen days to submit required documentation to be considered for eligibility. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to
c. There will be one application process for UCH. The patient is required to provide a completed FA application. In addition, the following may be required:
    i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return)
    ii. Proof of disability income (if applicable)
    iii. A copy of their three most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income
    iv. A Medical Assistance Notice of Determination (if applicable)
    v. Proof of U.S. citizenship or lawful permanent residence status (green card)
    vi. Reasonable proof of other declared expenses may be taken in to consideration
    vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

viii. A Verification of No Income Letter (if there is no evidence of income)
ix. Three most recent bank statements

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

5. Financial Hardship

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

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

DEVELOPER:

Patient Financial Counselor, UCH

Reviewed / Revised: 09/2013

ORIGIN DATE: 10/2010

NEXT REVIEW DATE: 12/2014

At Upper Chesapeake Health (UCH), we are dedicated to creating a healing and compassionate environment by providing the finest in care, courtesy, and service to all of our patients. In order for us to provide the quality care that is appropriate for your needs, it is important that you understand your RIGHTS and RESPONSIBILITIES and the role you play in your recovery. By working together, we can achieve the best possible outcome for you.

PATIENT RIGHTS

Access to Care

At UCH, we believe that you should have:

- Access to necessary healthcare without discrimination based on age, race, sex, religion, national origin, marital status, sexual preference, mental or physical disability, or source of payment.
- Care that is compassionate, respectful, courteous, and efficient.
- Care that promotes your dignity, privacy, safety, and comfort.
- Care that is free of all forms of abuse and harassment.
- The best possible management of pain and symptoms.
- Confidentiality about all information related to your care.
- Your family and friends treated with dignity, respect, and emotional support.
- A prompt and courteous response to any complaints concerning your care or service at Upper Chesapeake Medical Center (UCMC) or Harford Memorial Hospital (HMH).
- Care that is continuous, coordinated, and appropriate both during and after your hospitalization.
- Access to pastoral care and other spiritual services.

INFORMATION

As a patient at a UCH hospital, you have the right to:

- Participate fully in your healthcare decisions.
- Be informed about the nature of your illness and treatment options, including potential risks, benefits, alternatives, and costs.
- Access to interpreting and/or translation services
- The name(s), position(s), and function(s) of the doctors(s) and hospital team members responsible for your care.
- Instruction regarding a plan of care that is easy for you to understand and to follow. Children will receive a plan of care that reflects their need to grow, play, and learn.
- Be informed of any proposed research or experimental treatment that may be considered in your care, and to consent or refuse to participate.

PRIVACY

You can expect:

- That your privacy will be respected at all times.
- That you will be asked to identify who you want informed about your presence in the hospital.
- That you will be asked to identify what information may be shared regarding your condition.

PROTECTION

You have the right to:

- Create an Advance Directive to give instructions regarding your care or appoint a healthcare agent, and to expect that your Advance Directive will be followed when applicable.
- Expect that appropriate surrogate decision-makers will be sought in case you lack decision-making ability and have not created an Advance Directive.
- Consult the UCH Ethics Committee regarding any care issues of an ethical nature.

Examples of Ethical Issues Include:

- What is in the best interest of a patient whose wish is not known.
- Trying to choose between two treatment options that are drastically different from one another.
- Issues related to cultural values and healthcare treatment such as refusing blood transfusions for religious reasons.

CONSENT

You have the right to all necessary information about a procedure, operation, or mode of treatment before you receive it. This will help you make an informed and educated decision prior to giving consent. This information should include:

- Risks and benefits
- Possible alternatives
- Potential side effects
- Prognosis with or without the procedure
- Those who will perform the procedure, operation, or treatment.

CONSENT (continued)

Please Note: Except in emergencies, no patient should be subjected to any procedure without voluntary, competent consent. In the case of pediatric or other patients who cannot decide for themselves, the consent of their legally authorized representative will be obtained.

TO SHARE CONCERNS OR COMPLAINTS

At Upper Chesapeake Health we want to ensure that your rights as a patient are protected. If at any time during your stay at Harford Memorial Hospital (HMH) or Upper Chesapeake Medical Center (UCMC), you have questions or concerns about your rights as a patient, or you wish to file a grievance, please do not hesitate to contact our Guest Services Department. At HMH, please call 443-843-5618 or at UCMC please call 443-643-2400. We want to assure you that you can feel free to contact these offices without fear of retaliation.

You may also directly contact the Office of Healthcare Quality, Department of Health and Mental Hygiene, 55 Wade Avenue, Bland Bryant Building, Catonsville, MD 21228. The phone number is 1-877-402-8218 or via the internet at www.dhms.state.md.us. You may also contact the following organizations that regulate or accredit the hospitals: The Joint Commission at 1-800-994-6610, Centers for Medicare and Medicaid Services at 800-633-4227, Office for Civil Rights at 215-861-4441, or the U.S. Food and Drug Administration at 888-463-6332.

CONSULTATION

You may want to consult with another physician during the course of your care. This is your right and we will assist you in identifying an alternate provider.

PAIN MANAGEMENT

The effective management of pain during your hospital stay is an important part of your care. Members of our healthcare team will be talking to you in more detail about your pain relief needs.

TRANSFER

If it is necessary for you to be transferred to another facility, you or your authorized decision maker will receive a complete explanation prior to being transferred. The institution to which you will be going must also accept this transfer.

REFUSAL OF TREATMENT

You have the right to refuse treatment to the extent permitted by law.

- If you refuse treatment, a doctor will let you know the medical consequences of your decision.
- In most cases you are free to leave the hospital. You will be asked to sign a form called a Release From Responsibility.
- You may also refuse observation by anyone not directly involved in your care.

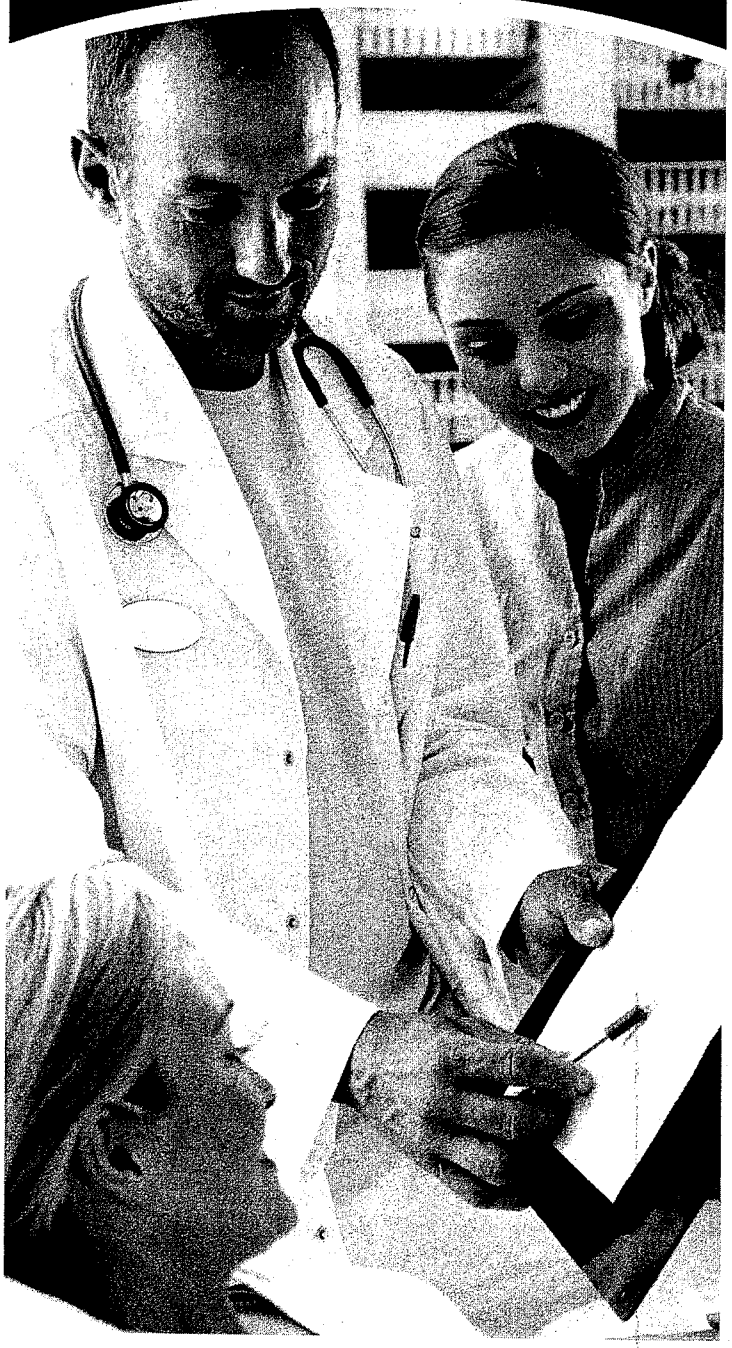
PATIENTS RESPONSIBILITIES

How to Actively Participate in Your Health Care

You are responsible for:

- Providing a complete personal and family health history and information needed to provide you with the appropriate care.
- Participating to the best of your ability in making decisions about your medical treatment, expressing concerns, and following the agreed upon plan.
- Asking questions of your physician and other healthcare providers when you do not understand information, the care plan, or instructions.
- Accepting consequences if you or your family do not follow the recommended treatment plan.
- Respecting the dignity of others by treating your healthcare providers and others receiving treatment with courtesy.
- Respecting the privacy, confidentiality, and property of fellow patients and their families.
- Informing your physician or other healthcare providers if you desire a transfer of care to another facility.
- Following the policies and procedures of our hospital including those regarding smoking, noise, and visitors.
- Assuring that your financial obligations concerning your hospital care are met.

PATIENT RIGHTS & RESPONSIBILITIES



Upper Chesapeake Health

www.uchs.org

Appendix IV:

UPPER CHESAPEAKE HEALTH MISSION, VISION, VALUE

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

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

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

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

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

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

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

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

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