Q1.

Introduction:

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) 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 developed a two-part community benefit reporting system that includes an inventory spreadsheet that collects financial and quantitative information and a narrative report to strengthen and supplement the inventory spreadsheet. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. This reporting tool serves as the narrative report. The instructions and process for completing the inventory spreadsheet remain the same as in prior years. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

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

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

Q3. Please confirm the information we have on file about your hospital for FY 2018.

	Is this information correct?		If no, please provide the correct information here:
	Yes	No	
The proper name of your hospital is: UM Upper Chesapeake Health	◉	○	
Your hospital's ID is: Harford - 210006, Upper Chesapeake - 210049	◉	○	
Your hospital is part of the hospital system called University of Maryland Medical System.	◉	○	

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

Q5. (Optional) Please describe any other community health statistics that your hospital uses in its community benefit efforts.

Quantitative Data - Existing Secondary Data: A Statistical Secondary Data Profile depicting population and household statistics, education, and economic measures, morbidity rates, incident rates, and other health statistics for the Harford County community was compiled from publicly available sources including, but not limited to, the United States Census Bureau, Maryland State Health Improvement Plan, Maryland Vital Statistics, the Maryland Behavioral Risk Factor Surveillance Survey, the Injuries in Maryland report, and national County Health Rankings. Harford County Community Health Survey: An online Community Survey of Harford County residents was conducted between October 2017 and February 2018. The survey was designed to assess health status, health risk and behaviors, preventative health practices, and health care access primarily related to chronic disease and injury. A total of 1,741 resident surveys were completed, representing the geographical, gender, and ethnic diversity of the community.

Q6. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

FY19 Community Health Statistics.docx
3.3MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q7. ## Section I - General Info Part 2 - Community Benefit Service Area

Q8. Please select the county or counties located in your hospital's CBSA.

☐ Allegany County	☐ Charles County	☐ Prince George's County
☐ Anne Arundel County	☐ Dorchester County	☐ Queen Anne's County
☐ Baltimore City	☐ Frederick County	☐ Somerset County
☐ Baltimore County	☐ Garrett County	☐ St. Mary's County
☐ Calvert County	☑ Harford County	☐ Talbot County

☐ Caroline County	☐ Howard County	☐ Washington County
☐ Carroll County	☐ Kent County	☐ Wicomico County
☑ Cecil County	☐ Montgomery County	☐ Worcester County

Q9. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q11. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

☐ 21901	☐ 21916
☐ 21902	☐ 21917
☑ 21903	☐ 21918
☑ 21904	☐ 21919
☐ 21911	☐ 21920
☐ 21912	☐ 21921
☐ 21913	☐ 21922
☐ 21914	☐ 21930
☐ 21915	

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

☑ 21001	☑ 21028	☑ 21085
☑ 21005	☑ 21034	☑ 21087

☑ 21009 ☑ 21040 ☑ 21111

☑ 21010 ☑ 21047 ☑ 21130

☑ 21013 ☑ 21050 ☑ 21132

☑ 21014 ☑ 21078 ☑ 21154

☑ 21015 ☐ 21082 ☑ 21160

☑ 21017 ☑ 21084 ☑ 21161

☑ 21018

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q26. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q33. How did your hospital identify its CBSA?

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

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

☐

Based on patterns of utilization. Please describe.

[   ]

☑ Other. Please describe.

UM Upper Chesapeake Health functions as one organization with 2 hospitals located in and serving all of Harford County. Each of the two facilities offers certain services solely at that institution. Harford County residents, no matter their zip code, requiring a specific service must receive that specific service at the facility that offers that service, e.g. cancer services at the Kaufman Cancer Center at Upper Chesapeake Medical Center in Bel Air or behavioral health services at Harford Memorial Hospital in Havre de Grace. As a result of how services are provided between the two facilities, the CHNA was completed as a joint document for the two facilities.

The Harford County CHNA includes all 21 Harford County zip codes. This includes the zip codes where our most vulnerable populations reside (21009, 21040, 21001 and 21078). In keeping with University of Maryland Upper Chesapeake Health's mission of maintaining and improving the health of the people in its communities and providing high quality care to all, the CBSA was identified as all of Harford County. While the above four zip codes are identified as containing concentrated areas of poverty, there are pockets of poverty throughout many of the Harford County zip codes particularly in the northern zip codes where it is very rural.   Identifying all of Harford County as the CBSA gives the organization a better opportunity to meet the needs of the vulnerable residents of Harford County.

Q34. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

The demographic profile of the respondents who completed the online survey: Approximately 55% of all respondents reside in zip codes 21014, 21015, 21009, 21078, and 21050. An additional 13.8% of respondents live in an "Other" zip code, the most common of which are 21901, 21918, and 21921. Of the total 1,735 respondents, 80.29% are female and 19.71% are male. Whites comprise 83.77% of study participants and Blacks/African-Americans represent 11.55%. Approximately 3% of all respondents identify as Latino/Hispanic. Approximately 49% of all respondents are between the ages of 45 and 64 years. An additional 34.8% of all respondents are between the ages of 25 and 44 years. The marital status, education level, employment status, and income level was also assessed for each respondent. The majority of respondents (63.09%) are married. Approximately 15% of respondents are single (never married) and 11.71% are divorced. 2.07% of respondents attained less than a high school diploma or GED. Approximately one-third (29.76%) of respondents attained some college, technical school or nursing school and 51.69% of respondents have an undergraduate degree or higher. The majority (72.29%) of respondents are currently employed and working full-time. In addition, half of respondents have an annual household income of $75,000 or more. Less than 14% of respondents have an income less than $25,000. / / A high proportion of respondents have health care coverage (97.92%) and at least one person who they think of as their personal doctor or health care provider (88.44%). In addition, 76.33% of respondents had a routine checkup within the past year and 13.95% had one within the past two years. The top 3 zip codes that our Medicaid population comes from are 21001, 21040 and 21078. The top 3 zip codes where our readmission high utilizers are coming from are 21014, 21001 and 21078. These 3 zip codes contain high concentrations of the Medicare population. While our primary service area contains two Cecil County zip codes, our CBSA does not. Due to limited resources, these zip codes were not included in the CBSA. There is a hospital located in Cecil County that serves these two zip codes. There is a collaboration between Cecil and Harford County hospitals to address the high utilizers through the WATCH Team, which is a team of community health workers and RN that performs home visits to address the social determinants of health that prevent these patients from being able to successfully manage their health care.

Q35. ## Section I - General Info Part 3 - Other Hospital Info

Q36. Provide a link to your hospital's mission statement.

https://www.umms.org/uch/about/mission-vision-values

Q37. Is your hospital an academic medical center?

○ Yes
◉ No

Q38. (Optional) Is there any other information about your hospital that you would like to provide?

University of Maryland Upper Chesapeake Health includes the University of Maryland Upper Chesapeake Medical Center and the Patricia D. and M. Scot Kaufman Cancer Center on its Bel Air campus. Most recently, it opened The Klein Family Harford Crisis Center in Bel Air offering services for behavioral health. The Senator Bob Hooper House in Forest Hill is an assisted living facility that specializes in hospice. The University of Maryland Harford Memorial Hospital has been operating in the community for over a century and is located in Havre de Grace. The leading health care system and largest private employer in Harford County, UM Upper Chesapeake Health offers a broad range of health care services, specialty care, technology and facilities to the residents of northeastern Maryland.

Q39. (Optional) Please upload any supplemental information that you would like to provide.

Q40. Section II - CHNA Part 1 - Timing & Format

Q41.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

◉ Yes
○ No

Q42. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q43. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

05/22/2018

Q44. Please provide a link to your hospital's most recently completed CHNA.

https://www.umms.org/uch/community/assessment-and-implementation-plan

Q45. Did you make your CHNA available in other formats, languages, or media?

◉ Yes
○ No

Q46. Please describe the other formats in which you made your CHNA available.

Paper versions are available and the CHNA Community Survey was in Spanish.

Q47. Section II - CHNA Part 2 - Participants

Q48. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

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

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	✔	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	✔	☐	☐	☐	✔	☐	☐	Preliminary reviewer of the CHNA.
Senior Executives (CEO, CFO, VP, etc.) (system level)	✔	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	✔	Provide final approval of the CHNA and Implementation Pl
Board of Directors or Board Committee (system level)	✔	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	✔	☐	☐	☐	✔	✔	☐	☐	
Clinical Leadership (system level)	✔	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Population Health Staff (facility level)	☐	☐	✔	☐	☐	☐	✔	✔	☐	☐	
Population Health Staff (system level)	✔	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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

Q49. Section II - CHNA Part 2 - Participants (continued)

Q50. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here:	✔	☐	☐	☐	☐	☐	☐	☐	☐	
Local Health Department -- Please list the Local Health Departments here: Harford County Health Department	☐	✔	✔	✔	✔	✔	✔	✔	☐	
Local Health Improvement Coalition -- Please list the LHICs here: Harford County Local Health Improvement Coalition consists of 3 workgroups: Chronic Disease & Wellness, Family Health & Resilience, and Behavioral Health.	☐	✔	✔	✔	✔	✔	✔	☐	☐	
Maryland Department of Health	✔	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Human Resources	✔	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	✔	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	✔	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Transportation	✔	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Education	✔	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Area Agency on Aging -- Please list the agencies here: Harford County Office on Aging							✔			
Local Govt. Organizations -- Please list the organizations here: Harford County Community Services; Harford County Government; and, Department of Community Services		✔				✔	✔			
Faith-Based Organizations		✔				✔	✔			
School - K-12 -- Please list the schools here:	✔									
School - Colleges and/or Universities -- Please list the schools here:	✔									
School of Public Health -- Please list the schools here:	✔									
School - Medical School -- Please list the schools here:	✔									
School - Nursing School -- Please list the schools here:	✔									
School - Dental School -- Please list the schools here:	✔									

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Behavioral Health Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Social Service Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Post-Acute Care Facilities -- please list the facilities here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community/Neighborhood Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q51. Section II - CHNA Part 3 - Follow-up

Q52. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

◉ Yes
○ No

Q53. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

05/22/2018

Q54. Please provide a link to your hospital's CHNA implementation strategy.

https://www.umms.org/uch/community/assessment-and-implementation-plan

Q55. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q56. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

☑ Access to Health Services: Health Insurance	☐ Environmental Health	☐ Oral Health
☐ Access to Health Services: Practicing PCPs	☐ Family Planning	☑ Physical Activity
☑ Access to Health Services: Regular PCP Visits	☐ Food Safety	☑ Respiratory Diseases
☐ Access to Health Services: ED Wait Times	☐ Global Health	☐ Sexually Transmitted Diseases
☐ Access to Health Services: Outpatient Services	☐ Health Communication and Health Information Technology	☐ Sleep Health
☐ Adolescent Health	☐ Health Literacy	☐ Telehealth
☑ Arthritis, Osteoporosis, and Chronic Back Conditions	☑ Health-Related Quality of Life & Well-Being	☑ Tobacco Use
☑ Behavioral Health, including Mental Health and/or Substance Abuse	☑ Heart Disease and Stroke	☐ Violence Prevention
☑ Cancer	☐ HIV	☐ Vision
☐ Children's Health	☑ Immunization and Infectious Diseases	☐ Wound Care
☐ Chronic Kidney Disease	☑ Injury Prevention	☐ Housing & Homelessness
☐ Community Unity	☐ Lesbian, Gay, Bisexual, and Transgender Health	☐ Transportation
☐ Dementias, Including Alzheimer's Disease	☑ Maternal & Infant Health	☐ Unemployment & Poverty
☑ Diabetes	☑ Nutrition and Weight Status	☑ Other Social Determinants of Health
☐ Disability and Health	☑ Older Adults	☐ Other (specify) _____
☐ Educational and Community-Based Programs		

Q57. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

While the actual priorities have not changed, the categories expanded to include additional identified needs. For example, in 2015 chronic disease, tobacco use, mental health/addictions, access to care, maternal and child health, and injury and illness prevention were the identified needs in this order. In 2018, the priorities were identified as behavioral health, prevention and wellness and family stability and resilience in this order. Behavioral health rose to the top as the number 1 identified health need (includes mental health and addictions) where in 2015 it was 3rd. Prevention and wellness, the number 2 identified need, incorporates chronic disease, tobacco use, access to care, cancer, stroke, diabetes, heart disease, respiratory diseases, and injury and prevention. Family Health and Resiliency, the 3rd and new identified need, incorporates substance exposed newborns, access to care, housing, transportation, family stress, childhood trauma, and nutrition and lifestyle.

Q58. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q59. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q60. Section III - CB Administration Part 1 - Participants

Q61. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

	Activities	

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

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Several of our employed physicians participated in community education programs, such as Dining with Docs (a community education conversation with physicians). The HPV vaccination collaborative is championed by the Chief of Pathology.
Nurse(s)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Social Workers	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Community Benefit Task Force	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hospital Advisory Board	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Other (specify) [____]	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q62. Section III - CB Administration Part 1 - Participants (continued)

Q63. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: [____]	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Local Health Department -- Please list the Local Health Departments here: Harford County Health Department	☐	☑	☑	☑	☑	☑	☑	☐	☑	Assisted in facilitated focus groups.

Organization	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Chronic Disease & Wellness, Family Health & Resilience, and Behavioral Health	☐	☑	☑	☐	☐	☑	☑	☑	☐	
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Area Agency on Aging -- Please list the agencies here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Local Govt. Organizations -- Please list the organizations here: Harford County Department of Community Services, Housing and Community Development, Harford County Sheriff's Department	☐	☑	☑	☐	☐	☐	☐	☐	☐	
Faith-Based Organizations	☐	☑	☑	☐	☐	☐	☐	☐	☐	

School/Organization	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - K-12 -- Please list the schools here: Harford County Public Schools	☐	☑	☑	☐	☐	☐	☐	☐	☐	
School - Colleges and/or Universities -- Please list the schools here: Harford County Community College	☐	☑	☑	☐	☐	☐	☐	☐	☐	
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Behavioral Health Organizations -- Please list the organizations here: Core Service Agency of Harford County	☐	☑	☑	☐	☐	☐	☐	☐	☐	
Social Service Organizations -- Please list the organizations here: Department of Social Services	☐	☑	☑	☐	☐	☐	☐	☐	☐	
Post-Acute Care Facilities -- please list the facilities here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community/Neighborhood Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

Consumer/Public Advocacy Organizations - - Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here: Harford County Emergency Operation	☐	☑	☑	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q64. Section III - CB Administration Part 2 - Process & Governance

Q65. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

☑ Yes, by the hospital's staff

☑ Yes, by the hospital system's staff

☑ Yes, by a third-party auditor

☐ No

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

◉ Yes

○ No

Q67. Please describe the community benefit narrative audit process.

The Director of Community Health Improvement and Community Outreach and the Community Benefit and Community Health Improvement Business Manager are responsible for the oversight and management of data collection and reporting of all activities. Data is collected throughout the year and validated and entered into CBISA, Lyon's Software's Community Benefit Inventory for Social Accountability program. The director and manager refer to the Catholic Health Association's "A Guide for Planning & Reporting Community Benefit" guide to determine which category is most appropriate for reporting activities. Once the narrative is complete, it is reviewed by the internal hospital Community Benefit Reporting Advisory Committee and the UMMS Senior Vice President of Government and Regulatory Affairs and Community Health. It is then presented through the Quality Care Council for the Board of Director's approval.

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

◉ Yes

○ No

Q69. Please explain:

This question was not displayed to the respondent.

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

◉ Yes

○ No

Q71. Please explain:

This question was not displayed to the respondent.

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

◉ Yes

○ No

Q73. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

University of Maryland Upper Chesapeake Health incorporates community benefit planning into the annual strategic and operational planning process each Spring. This includes creating annual tactics that are tracked on a quarterly basis in the following fiscal year. In addition, UM UCH updates a long term strategic plan every couple of years in association with the community health needs assessment. The planning process allows the organization to invest in and develop programs that increase patient access to existing services, introduce new services, optimize prevention programs and explore how technology can be used to support the health needs of our patients. The planning process runs concurrently with the annual capital and operating budget process to ensure that these ideas are incorporated into the fiscal plan.

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

Q75. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

Q76. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Q77. Based on the implementation strategy developed through the CHNA process, please describe *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q78. Section IV - CB Initiatives Part 1 - Initiative 1

Q79. Name of initiative.

Living Well - Chronic Disease Self-Management, Diabetes Self-Management & Chronic Pain Self-Management

Q80. Does this initiative address a community health need that was identified in your most recently completed CHNA?

- ◉ Yes
- ○ No

Q81. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Regular PCP Visits, Arthritis, Osteoporosis, and Chronic Back Conditions, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Immunization and Infectious Diseases, Injury Prevention, Maternal & Infant Health, Nutrition and Weight Status, Older Adults, Physical Activity, Respiratory Diseases, Tobacco Use, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

☐ Access to Health Services: Health Insurance	☑ Heart Disease and Stroke
☐ Access to Health Services: Practicing PCPs	☐ HIV
☐ Access to Health Services: Regular PCP Visits	☐ Immunization and Infectious Diseases
☐ Access to Health Services: ED Wait Times	☐ Injury Prevention
☐ Access to Health Services: Outpatient Services	☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Adolescent Health	☐ Maternal and Infant Health
☑ Arthritis, Osteoporosis, and Chronic Back Conditions	☐ Nutrition and Weight Status
☐ Behavioral Health, including Mental Health and/or Substance Abuse	☐ Older Adults
☑ Cancer	☐ Oral Health
☐ Children's Health	☐ Physical Activity
☑ Chronic Kidney Disease	☑ Respiratory Diseases
☐ Community Unity	☐ Sexually Transmitted Diseases

☐ Dementias, including Alzheimer's Disease	☐ Sleep Health
☑ Diabetes	☐ Telehealth
☑ Disability and Health	☑ Tobacco Use
☐ Educational and Community-Based Programs	☐ Violence Prevention
☐ Environmental Health	☐ Vision
☐ Family Planning	☐ Wound Care
☐ Food Safety	☐ Housing & Homelessness
☐ Global Health	☐ Transportation
☐ Health Communication and Health Information Technology	☐ Unemployment & Poverty
☐ Health Literacy	☐ Other Social Determinants of Health
☑ Health-Related Quality of Life & Well-Being	☑ Other (specify) Hypertension

Q82. When did this initiative begin?

February 1, 2016

Q83. Does this initiative have an anticipated end date?

◉ No, the initiative has no anticipated end date.

◯ The initiative will end on a specific end date. Please specify the date. [ ]

◯ The initiative will end when a community or population health measure reaches a target value. Please describe.

◯ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

◯ The initiative will end when external grant money to support the initiative runs out. Please explain.

◯ The initiative will end when a contract or agreement with a partner expires. Please explain.

◯ Other. Please explain.

Q84. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

The initiative is for adults who currently exhibit chronic conditions, such as heart disease, diabetes, arthritis and cancer. This initiative will continue to address participants who will be newly diagnosed with a chronic condition in the future. Harford County has a population of 252,160, of which 77.6% are adults age 18 and older (2019 County Health Rankings). Harford County Data: • 167.1 heart disease deaths in Harford County per 100,000 population (2015-2017 Vital Statistics) • 36.6 stroke deaths in Harford County per 100,000 population (source: 2015-2017 Vital Statistics) • 165.5 ED visits due to diabetes per 100,000 population (source: 2014 Maryland DHMH) • 164.1 cancer deaths in Harford County per 100,000 population (Source: 2015-2017 Vital Statistics). Direct measurement from 2018 CHNA suggests: • 1.76% of adult residents in Harford County diagnosed with stroke • 7.4% adult residents in Harford County diagnosed with heart disease • 9.35% adults in Harford County diagnosed with diabetes • 22.78% of adult residents in Harford County diagnosed with arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia.

Q85. Enter the estimated number of people this initiative targets.

```
240
```

Q86. How many people did this initiative reach during the fiscal year?

```
108
```

Q87. What category(ies) of intervention best fits this initiative? Select all that apply.

- ☑ Chronic condition-based intervention: treatment intervention
- ☑ Chronic condition-based intervention: prevention intervention
- ☐ Acute condition-based intervention: treatment intervention
- ☑ Acute condition-based intervention: prevention intervention
- ☐ Condition-agnostic treatment intervention
- ☐ Social determinants of health intervention
- ☑ Community engagement intervention
- ☐ Other. Please specify.

Q88. Did you work with other individuals, groups, or organizations to deliver this initiative?

- ⦿ Yes. Please describe who was involved in this initiative.

  ```
  UM UCH Community Outreach / Kaufman
  Cancer Center / Harford County Office
  on Aging / Harford County Libraries /
  Harford County Parks and Recreation /
  DHMH / Faith based Community / The
  National Coalition of a 100 Black
  Women /
  ```

- ○ No.

Q89. Please describe the primary objective of the initiative.

This initiative educates participants on self-management strategies to improve their health and quality of life living with chronic diseases, diabetes and/or cancer. Better management of their conditions in turn will potentially have a positive impact on health care expenditures. 1) Work with the community PCPs to identify patients with chronic disease, diabetes and/or cancer that would benefit from the self-management program. a. In person visits to local PCP offices for program information and participant criteria. b. Medical Staff Office distributes a blast fax of program times and locations to PCP's and specialty physician offices. c. Class information disseminated through social media, faith based community, Office on Aging, Maryland Health Matters and current events calendar. 2) Provide five classes per year with a 60% completion rate. Program to be offered multi dates, locations and times to maximum accessibility. a. To collaborate with Office on Aging and county library for class locations. 3) Facilitate program to help participants gain self confidence in their ability to control their symptoms and learn how their health problems affect their lives. a. Program includes: i. Ways to maintain strength flexibility and endurance ii. Managing medications iii. Dealing with frustration, fatigue, pain and isolation iv. Improving effective communication with family friends and health professionals. v. Healthy eating and stress reduction

Q90. Please describe how the initiative is delivered.

Programs are offered in a community setting and meet for 2 1/2 hours per week for 6 weeks. Workshops are facilitated by two trained leaders.

Q91. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- ☑ Count of participants/encounters `108`
- ☑ Other process/implementation measures (e.g. number of items distributed) `No of participants who completed the program: 78 of 108 (72%)`
- ☑ Surveys of participants `78`
- ☑ Biophysical health indicators
- ☐ Assessment of environmental change
- ☐ Impact on policy change
- ☐ Effects on healthcare utilization or cost
- ☐ Assessment of workforce development
- ☐ Other

Q92. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

> A report on outcomes has been uploaded for this initiative.

Q93. Please describe how the outcome(s) of the initiative addresses community health needs.

> Chronic disease was the number one identified need through the 2015 CHNA, and the number two identified need through the 2018 CHNA. According to the CDC, six in ten adults in the US have a chronic disease and four in ten adults have two or more. 100% of the participants in the Living Well classes stated that they felt more prepared, confident and motivated in their ability to manage their health and symptoms then they did before they took the workshop.

Q94. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

> The total cost for FY19 Living Well was $21,018 of which $11,200 was offset by grant funds provided by the Harford County Office on Aging. The remaining $9,818 was incurred by the University of Maryland Upper Chesapeake Health Community Outreach and Health Improvement and Kaufman Cancer Center budgets.

Q95. (Optional) Supplemental information for this initiative.

Living Well_Initiative 1.pdf
1.3MB
application/pdf

Q96. Section IV - CB Initiatives Part 2 - Initiative 2

Q97. Name of initiative.

> The Klein Family Harford Crisis Center

Q98. Does this initiative address a need identified in your most recently completed CHNA?

- ● Yes
- ○ No

Q99. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Regular PCP Visits, Arthritis, Osteoporosis, and Chronic Back Conditions, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Immunization and Infectious Diseases, Injury Prevention, Maternal & Infant Health, Nutrition and Weight Status, Older Adults, Physical Activity, Respiratory Diseases, Tobacco Use, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

☐ Access to Health Services: Health Insurance	☐ Heart Disease and Stroke
☑ Access to Health Services: Practicing PCPs	☐ HIV
☐ Access to Health Services: Regular PCP Visits	☐ Immunization and Infectious Diseases
☐ Access to Health Services: ED Wait Times	☐ Injury Prevention
☐ Access to Health Services: Outpatient Services	☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Adolescent Health	☐ Maternal and Infant Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions	☐ Nutrition and Weight Status
☑ Behavioral Health, including Mental Health and/or Substance Abuse	☐ Older Adults
☐ Cancer	☐ Oral Health
☐ Children's Health	☐ Physical Activity
☐ Chronic Kidney Disease	☐ Respiratory Diseases
☐ Community Unity	☐ Sexually Transmitted Diseases
☐ Dementias, including Alzheimer's Disease	☐ Sleep Health
☐ Diabetes	☐ Telehealth

☐ Disability and Health	☐ Tobacco Use
☐ Educational and Community-Based Programs	☐ Violence Prevention
☐ Environmental Health	☐ Vision
☐ Family Planning	☐ Wound Care
☐ Food Safety	☐ Housing & Homelessness
☐ Global Health	☐ Transportation
☐ Health Communication and Health Information Technology	☐ Unemployment & Poverty
☐ Health Literacy	☐ Other Social Determinants of Health
☐ Health-Related Quality of Life & Well-Being	☐ Other (specify) [_____]

Q100. When did this initiative begin?

> 10/2018

Q101. Does this initiative have an anticipated end date?

- ◉ No, the initiative does not have an anticipated end date.
- ○ The initiative will end on a specific end date. Please specify the date. [_____]
- ○ The initiative will end when a community or population health measure reaches a target value. Please describe.

- ○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

- ○ The initiative will end when external grant money to support the initiative runs out. Please explain.

- ○ The initiative will end when a contract or agreement with a partner expires. Please explain.

- ○ Other. Please explain.

Q102. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

> Individuals 18 and older with behavioral health issues, such as anxiety and depression, alcohol and substance related disorders, as well as the lesser occurring issues, such as schizophrenia, and other psychotic disorders.

Q103. Enter the estimated number of people this initiative targets.

> 5000

Q104. How many people did this initiative reach during the fiscal year?

5968

Q105. What category(ies) of intervention best fits this initiative? Select all that apply.

- ☑ Chronic condition-based intervention: treatment intervention
- ☑ Chronic condition-based intervention: prevention intervention
- ☑ Acute condition-based intervention: treatment intervention
- ☑ Acute condition-based intervention: prevention intervention
- ☐ Condition-agnostic treatment intervention
- ☐ Social determinants of health intervention
- ☐ Community engagement intervention
- ☐ Other. Please specify.

Q106. Did you work with other individuals, groups, or organizations to deliver this initiative?

- ◉ Yes. Please describe who was involved in this initiative.

  Harford County Government, Healthy
  Harford/Healthy Cecil, Harford County
  Health Department, Office on Mental
  Health/Core Service Agency of Harford
  County, Inc., and the Affiliated Sante
  Group.

- ○ No.

Q107. Please describe the primary objective of the initiative.

To treat and manage individuals with behavioral health/mental health or substance use issues, including walk-in urgent care and residential crisis services, and a 24/7 crisis hotline.

Q108. Please describe how the initiative is delivered.

24/7 crisis hotline and mobile crisis team, a 24/7 walk-in urgent care clinic, scheduled outpatient services and short-stay residential services for adult guests requiring an extended period of concentrated care.

Q109. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- ☑ Count of participants/encounters 5968
- ☑ Other process/implementation measures (e.g. number of items distributed) 437 face to face assessments, 5480 telephone contacts, 51 public education
- ☑ Surveys of participants 518
- ☐ Biophysical health indicators
- ☐ Assessment of environmental change
- ☐ Impact on policy change
- ☑ Effects on healthcare utilization or cost Of 473 patients, 69% had no prior Behavioral Health Unit or ED visits
- ☐ Assessment of workforce development
- ☐ Other

Q110. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

A report on outcomes has been uploaded for this initiative.

Q111. Please describe how the outcome(s) of the initiative addresses community health needs.

Behavioral Health was the number three identified need through the 2015 CHNA, and the number one identified need through the 2018 CHNA. According to the National Institute of Mental Health, 1 in 5 people suffers from a behavioral health issue; anxiety and depression are two of the most commonly occurring; the majority of people admitted to UM Upper Chesapeake Health hospitals have an underlying behavioral health issue, including mood disorders and alcohol/drug use; our community receives over 5000 calls every year from people in crisis.

Q112. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

The total cost for the FY19 Klein Family Harford Crisis Center was $5,242,794 of which $2,207,672 was offset by revenue. The remaining $3,035,122 was incurred by University of Maryland Upper Chesapeake Health.

Q113. (Optional) Supplemental information for this initiative.

Crisis Center Initiative 2.XLSM
473.6KB
application/vnd.ms-excel.sheet.macroenabled.12

Q114. Section IV - CB Initiatives Part 3 - Initiative 3

Q115. Name of initiative.

Diabetes Prevention Program

Q116. Does this initiative address a need identified in your most recently completed CHNA?

◉ Yes
○ No

Q117. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Regular PCP Visits, Arthritis, Osteoporosis, and Chronic Back Conditions, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Immunization and Infectious Diseases, Injury Prevention, Maternal & Infant Health, Nutrition and Weight Status, Older Adults, Physical Activity, Respiratory Diseases, Tobacco Use, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

☐ Access to Health Services: Health Insurance	☐ Heart Disease and Stroke
☐ Access to Health Services: Practicing PCPs	☐ HIV
☐ Access to Health Services: Regular PCP Visits	☐ Immunization and Infectious Diseases
☐ Access to Health Services: ED Wait Times	☐ Injury Prevention
☐ Access to Health Services: Outpatient Services	☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Adolescent Health	☐ Maternal and Infant Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions	☐ Nutrition and Weight Status
☐ Behavioral Health, including Mental Health and/or Substance Abuse	☐ Older Adults
☐ Cancer	☐ Oral Health
☐ Children's Health	☐ Physical Activity
☐ Chronic Kidney Disease	☐ Respiratory Diseases
☐ Community Unity	☐ Sexually Transmitted Diseases
☐ Dementias, including Alzheimer's Disease	☐ Sleep Health
☑ Diabetes	☐ Telehealth
☐ Disability and Health	☐ Tobacco Use
☐ Educational and Community-Based Programs	☐ Violence Prevention
☐ Environmental Health	☐ Vision
☐ Family Planning	☐ Wound Care
☐ Food Safety	☐ Housing & Homelessness

☐ Global Health   ☐ Transportation

☐ Health Communication and Health Information Technology   ☐ Unemployment & Poverty

☐ Health Literacy   ☐ Other Social Determinants of Health

☐ Health-Related Quality of Life & Well-Being   ☐ Other (specify) [_____]

Q118. When did this initiative begin?

[08/27/2014]

Q119. Does this initiative have an anticipated end date?

◉ No, the initiative does not have an anticipated end date.

○ The initiative will end on a specific end date. Please specify the date. [_____]

○ The initiative will end when a community or population health measure reaches a target value. Please describe.

[   ]

○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

[   ]

○ The initiative will end when external grant money to support the initiative runs out. Please explain.

[   ]

○ The initiative will end when a contract or agreement with a partner expires. Please explain.

[   ]

○ Other. Please explain.

[   ]

Q120. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

[Adults with metabolic syndrome, pre diabetic (have an A1c of 5.7 - 6.4), strong family history of diabetes or a gestational diabetic.]

Q121. Enter the estimated number of people this initiative targets.

[80]

Q122. How many people did this initiative reach during the fiscal year?

[51]

Q123. What category(ies) of intervention best fits this initiative? Select all that apply.

☑ Chronic condition-based intervention: treatment intervention

☐

Chronic condition-based intervention: prevention intervention

☑ Acute condition-based intervention: treatment intervention

☑ Acute condition-based intervention: prevention intervention

☐ Condition-agnostic treatment intervention

☐ Social determinants of health intervention

☐ Community engagement intervention

☐ Other. Please specify.

Q124. Did you work with other individuals, groups, or organizations to deliver this initiative?

◉ Yes. Please describe who was involved in this initiative.

> Harford County Pubic Libraries
> Harford County Office on Aging Harford
> County Health Department   Harford
> Primary Care   UMUCH Diabetes and
> Endocrine Department Bel Air Athletic
> Club   Faith based community

◯ No.

Q125. Please describe the primary objective of the initiative.

> To educate the participants on their risk for developing diabetes, prevention strategies including weight loss and increased activity.

Q126. Please describe how the initiative is delivered.

> 16 weekly sessions in a group, classroom setting facilitated by trained lifestyle coaches who teach participants how to lose weight, eat healthier, be more physically active, and manage stress.

Q127. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

☑ Count of participants/encounters 51

☐ Other process/implementation measures (e.g. number of items distributed)

☐ Surveys of participants

☑ Biophysical health indicators Percentage Weight Loss: 75% of participants had a weight loss; 30% had a 7% or greater weight loss

☐ Assessment of environmental change

☐ Impact on policy change

☐ Effects on healthcare utilization or cost

☐ Assessment of workforce development

☐ Other

Q128. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

> 7.00%+ Weight Loss:30%, 5.00%-6.99% Weight Loss: 10%, 3.00%-4.99% Weight Loss: 20%, 1.00%-2.99% Weight Loss: 15, Decrease in A1c level: 33% A report on additional outcomes has been uploaded for this initiative.

Q129. Please describe how the outcome(s) of the initiative addresses community health needs.

> According to the CDC, about 84 million americans 18 years and older (about 1 in 3) have pre-diabetes, a condition that if not treated can lead to type 2 diabetes within 5 years.

Q130. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

The total cost for the FY19 Diabetes Prevention Program was $15,450.

Q131. (Optional) Supplemental information for this initiative.

DPP Initiative 3.pdf
165.4KB
application/pdf

Q132. Section IV - CB Initiatives Part 4 - Other Initiative Info

Q133. Additional information about initiatives.

Q134. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

Q135. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- ◉ Yes
- ○ No

Q136.
In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Regular PCP Visits, Arthritis, Osteoporosis, and Chronic Back Conditions, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, Immunization and Infectious Diseases, Injury Prevention, Maternal & Infant Health, Nutrition and Weight Status, Older Adults, Physical Activity, Respiratory Diseases, Tobacco Use, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q137. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q138. Do any of the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? Specifically, do any activities or initiatives correspond to a SHIP measure within the following categories?

See the SHIP website for more information and a list of the measures:
https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx

	Select Yes or No	
	Yes	No
Healthy Beginnings - includes measures such as babies with low birth weight, early prenatal care, and teen birth rate	◉	○
Healthy Living - includes measures such as adolescents who use tobacco products and life expectancy	◉	○
Healthy Communities - includes measures such as domestic violence and suicide rate	◉	○
Access to Health Care - includes measures such as adolescents who received a wellness checkup in the last year and persons with a usual primary care provider	◉	○
Quality Preventive Care - includes measures such as annual season influenza vaccinations and emergency department visit rate due to asthma	◉	○

Q139. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q140. Section V - Physician Gaps & Subsidies

Q141. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

- ☐ No gaps
- ☐ Primary care
- ☐ Mental health
- ☐ Substance abuse/detoxification
- ☐ Internal medicine
- ☐ Dermatology
- ☐ Dental
- ☐ Neurosurgery/neurology
- ☐ General surgery
- ☐ Orthopedic specialties
- ☐ Obstetrics
- ☐ Otolaryngology
- ☐ Other. Please specify. [   ]

Q142. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand.

Hospital-Based Physicians	The subsidized hospital-based physicians for UMUCH are Radiology, Lab, Team Heatlh Anesthesiology, Behavioral Heatlh, Psych and OB. These services are exclusively contracted. UMUCH odes not have employed or owned physicians for these services. UMUCH would not be able to provide these critical services if not for the exclusive contract which has performance criteria.
Non-Resident House Staff and Hospitalists	[ ]
Coverage of Emergency Department Call	Providing subsidies to non-employed phsician special groups to take emergency room call and provide follow-up services for those patients, is the only way to provide emergency speciality care.
Physician Provision of Financial Assistance	This is for payment related to providing coverage for patients in the ED who need consultation, procedures, and follow-up when referred by the ED physician while this Physician in on call. This is for self-pay patients who don't pay or for patients with insurance companies that these physicians do not participate with.
Physician Recruitment to Meet Community Need	The total amount for direct salary expenses for medial staff recruiters is $69,177.
Other (provide detail of any subsidy not listed above)	[ ]
Other (provide detail of any subsidy not listed above)	[ ]
Other (provide detail of any subsidy not listed above)	[ ]

Q143. (Optional) Is there any other information about physician gaps that you would like to provide?

[   ]

Q144. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Q145. Section VI - Financial Assistance Policy (FAP)

Q146. Upload a copy of your hospital's financial assistance policy.

FINANCIAL ASSISTANCE POLICY.pdf

Q147. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

Q148. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL). Please select the percentage of FPL below which your hospital's FAP offers free care.

	100	150	200	250	300	350	400	450	500
Percentage of Federal Poverty Level									

200
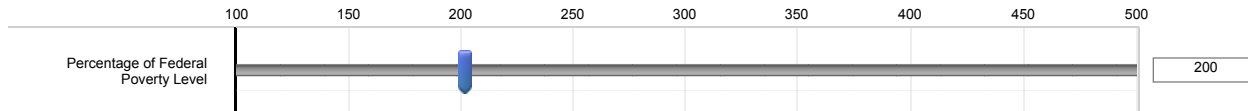
Q149. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.

	200	250	300	350	400	450	500
Lowest FPL							
Highest FPL							

300
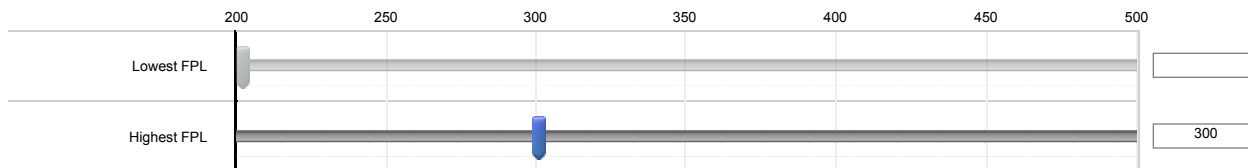
Q150. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.

	100	200	300	400	500	600	700
Lowest FPL							
Highest FPL							

500

Q151. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.

	0	10	20	30	40	50	60	70	80	90	100
Debt as Percentage of Income											

25
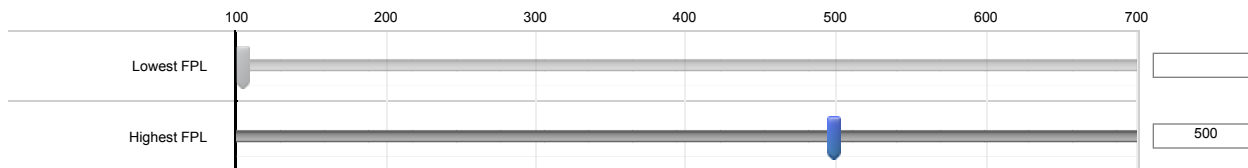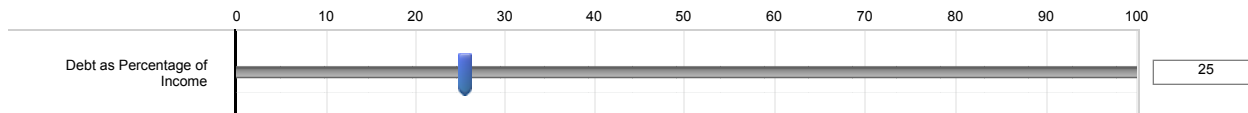
Q152. Has your FAP changed within the last year? If so, please describe the change.

⦿ No, the FAP has not changed.

○ Yes, the FAP has changed. Please describe: [_____]

Q153. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

[_____]

Q154. (Optional) Please attach any files containing further information about your hospital's FAP.

Summary & Report Submission

<p style="color:red; text-align:center;">Attention Hospital Staff! IMPORTANT!</p>

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

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

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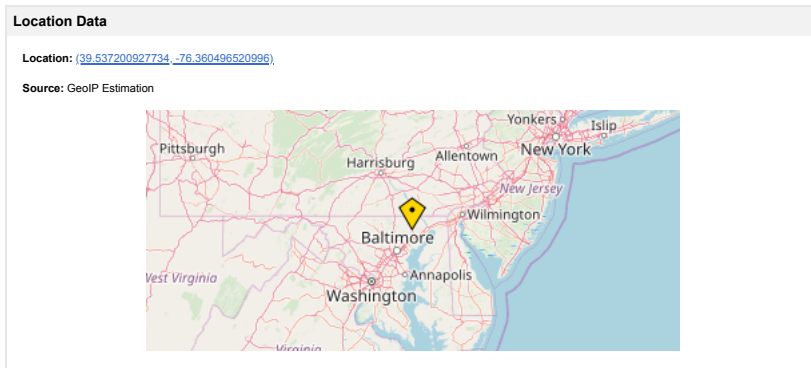
Location Data

Location: (39.537200927734, -76.360496520996)

Source: GeoIP Estimation

Report This Email

Responses are indicated as requested below in **red**. Please let me know if you require anything additional. -Kim

- In Question 81 on pages 17 and 18 of the attached, where you select the CHNA needs addressed by the Living Well initiative, you indicated that two of the CHNA needs addressed by this initiative are "Disability and Health" and "Chronic Kidney Disease." Your response to Question 56 on page 11 does not include these as needs identified in the CHNA. Please indicate whether "Disability and Health" and "Chronic Kidney Disease" should have been selected in Question 56, or should not have been selected in Question 81.
  "Disability and Health" and "Chronic Kidney Disease" should also be checked in response to Question 56 on page 11.

- In Question 84 on page 18 of the attached, you wrote that the Living Well initiative targets "adults who currently exhibit chronic conditions, such as heart disease, diabetes, arthritis and cancer." In the next question, Question 85, you wrote that the initiative targets 240 people. Please clarify whether the initiative is targeted to all such individuals or is limited to a sub-set.
  The number of 240 is the number of people that could have benefited based on the number of classes that we are able to offer throughout the Fiscal Year. We offer 12 classes per year with a maximum enrollment per class of 20 participants. However, the classes are open to anyone and their caregivers who identify as having a chronic disease.

- In Question 99 on pages 20 and 21 of the attached, where you select the CHNA needs addressed by the Klein Family Harford Crisis Center initiative, you indicated that one of the CHNA needs addressed by this initiative is "Access to Health Services: Practicing PCPs." Your response to Question 56 on page 11 does not include this as a need identified in the CHNA. Please indicate whether "Access to Health Services: Practicing PCPs" should have been selected in Question 56, or should not have been selected in Question 99.
  "Access to Health Services: Practicing PCPs" should not have been selected in Question 99.

- In Question 120 on page 24 of the attached, you wrote that the Diabetes Prevention Program initiative targets "Adults with metabolic syndrome, pre diabetic (have an A1c of 5.7 - 6.4), strong family history of diabetes or a gestational diabetic." In the next question, Question 121, you wrote that the initiative targets 80 people. Please clarify whether the initiative targets all such individuals or is limited to a sub-set.
  The number of 80 is the number of people that could have benefited based on the number of classes that we are able to offer throughout the Fiscal Year. We offer 4 classes per year with a maximum enrollment per class of 20 participants. However, the classes are open to anyone and their caregivers who identify as having a prediabetes.

- Question 141 on page 27 of the attached had no response. Please provide a response.

  "Mental health" and "Substance abuse/detoxification" should have been selected.

- In Question 149 and Question 150 on page 28 of the attached, you did not provide a response to the lower bound of the aid category. Please provide responses in the form of percentages of federal poverty level.

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Friday, February 28, 2020 2:12 PM
To: Davidson, Kimberly <Kimberly.Davidson@umm.edu>; Jacobs, Donna <djacobs@umm.edu>
Cc: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: Clarification Required - UM Upper Chesapeake FY 19 CB Narrative

> **CAUTION:** This message originated from a non UMMS, SOM, or FPI email system. Hover over any links before clicking and use caution opening attachments.

Thank you for submitting University of Maryland Upper Chesapeake Health's FY 2019 Community Benefit Narrative Report. Upon reviewing your report, we require clarification of certain issues:

- In Question 81 on pages 17 and 18 of the attached, where you select the CHNA needs addressed by the Living Well initiative, you indicated that two of the CHNA needs addressed by this initiative are "Disability and Health" and "Chronic Kidney Disease." Your response to Question 56 on page 11 does not include these as needs identified in the CHNA. Please indicate whether "Disability and Health" and "Chronic Kidney Disease" should have been selected in Question 56, or should not have been selected in Question 81.
- In Question 84 on page 18 of the attached, you wrote that the Living Well initiative targets "adults who currently exhibit chronic conditions, such as heart disease, diabetes, arthritis and cancer." In the next question, Question 85, you wrote that the initiative targets 240 people. Please clarify whether the initiative is targeted to all such individuals or is limited to a sub-set.
- In Question 99 on pages 20 and 21 of the attached, where you select the CHNA needs addressed by the Klein Family Harford Crisis Center initiative, you indicated that one of the CHNA needs addressed by this initiative is "Access to Health Services: Practicing PCPs." Your response to Question 56 on page 11 does not include this as a need identified in the CHNA. Please indicate whether "Access to Health Services: Practicing PCPs" should have been selected in Question 56, or should not have been selected in Question 99.
- In Question 120 on page 24 of the attached, you wrote that the Diabetes Prevention Program initiative targets "Adults with metabolic syndrome, pre diabetic (have an A1c of 5.7 - 6.4), strong family history of diabetes or a gestational diabetic." In the next question, Question 121, you wrote that the initiative targets 80 people. Please clarify whether the initiative targets all such individuals or is limited to a sub-set.
- Question 141 on page 27 of the attached had no response. Please provide a response.
- In Question 149 and Question 150 on page 28 of the attached, you did not provide a response to the lower bound of the aid category. Please provide responses in the form of percentages of federal poverty level.

Please provide your clarifying answers as a response to this message. Thank you for your attention to this matter.