Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

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

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

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

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

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

	Is this information correct? Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Grace Medical Center	◉	○	
Your hospital's ID is: 210013	◉	○	
Your hospital is part of the hospital system called LifeBridge Health	◉	○	
The primary Narrative contact at your hospital is Sharon McClernan	◉	○	
The primary Narrative contact email address at your hospital is smcclernan@lifebridgehealth.org	◉	○	
The primary Financial contact at your hospital is UNKNOWN	○	◉	Julie Sessa
The primary Financial email at your hospital is jsessa@lifebridgehealth.org	◉	○	

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

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

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

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

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

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

- [x] 21201
- [x] 21202
- [ ] 21203
- [ ] 21205
- [ ] 21206
- [ ] 21207
- [ ] 21208
- [ ] 21209
- [ ] 21210
- [ ] 21211
- [ ] 21212
- [ ] 21213
- [ ] 21214
- [ ] 21215
- [x] 21216
- [x] 21217
- [ ] 21218
- [ ] 21222
- [x] 21223
- [ ] 21224
- [ ] 21225
- [ ] 21226
- [ ] 21227
- [ ] 21228
- [x] 21229
- [x] 21230
- [ ] 21231
- [ ] 21233
- [ ] 21234
- [ ] 21236
- [ ] 21237
- [ ] 21239
- [ ] 21251
- [ ] 21263
- [ ] 21270
- [ ] 21278
- [ ] 21281
- [ ] 21287
- [ ] 21290

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

- [x] Based on ZIP codes in your global budget revenue agreement. Please describe.

  Yes, our global budget revenue agreement denotes the zip codes within our primary and secondary service areas.

- [ ] Based on patterns of utilization. Please describe.

- [ ] Other. Please describe.

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

https://www.lifebridgehealth.org/Main/AboutLifeBridgeHealth.aspx

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

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

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

- (●) Yes
- ( ) No

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

This question was not displayed to the respondent.

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

06/30/2020

Q41. Please provide a link to your hospital's most recently completed CHNA.

https://www.lifebridgehealth.org/Uploads/Public/Documents/Population%20Health/Grace%20Medical%20Center_CHNA_Final.pdf

Q42. Please upload your hospital's most recently completed CHNA.

Grace Medical Center_CHNA_Final.pdf
2.2MB
application/pdf

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

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

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

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

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

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

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

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

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

Refer to the FY 2021 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is optional for FY 2021, but will be mandatory for FY 2022.

	Level of Community Engagement						Recommended Practices							
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here: UMMC, Medstar Health, St. Agnes, Johns Hopkins, Mercy, Mt. Washington Pediatric Hospital,	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Department -- Please list the Local Health Departments here: Baltimore City Health Department	☑	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐
Local Health Improvement Coalition -- Please list the LHICs here: Baltimore City LHIC	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maryland Department of Health	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other State Agencies -- Please list the agencies here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Local Govt. Organizations -- Please list the organizations here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Faith-Based Organizations	☑	☑	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here: Behavioral Health Systems of Baltimore	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Consumer/Public Advocacy Organizations -- Please list the organizations here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other -- If any other people or organizations were involved, please list them here: Bon Secours Community Works	☑	☑	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress

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

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

- (●) Yes
- ( ) No

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

4/29/2021

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

https://www.lifebridgehealth.org/Uploads/Public/Documents/Population%20Health/Grace%20Medical%20Center_CHNA_Implementation%20Plan.pdf

Q222. Please upload your hospital's CHNA implementation strategy.

Grace Medical Center_CHNA_Implementation Plan.pdf
172.5KB
application/pdf

Q53. 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.

Q54. Please select the CHNA Priority Area Categories most relevant to your most recent CHNA. The list of categories is based on the Healthy People 2030 objectives available here. This list is not exhaustive. Please select "other" and describe any CHNA Priority Area Categories that are not captured by this list. Select all that apply even if a need was not addressed by a reported initiative.

- ☑ Health Conditions - Addiction
- ☐ Health Behaviors - Drug and Alcohol Use
- ☐ Populations - Women

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

Q56. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q57. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q58. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q59. Please use the questions below to provide details regarding the initiatives to address the CHNA Priority Area Categories selected in the previous question.

For those hospitals completing the ***optional*** CHNA financial reporting in FY 2021, please ensure that these tie directly to line item initiatives in the financial reporting template.

For those hospitals **not** completing the ***optional*** CHNA financial template, please provide this information for as many initiatives as you deem feasible.

Please note that hospitals will be required to report on each CHNA-related initiative in FY 2022.

Q163. Please describe the initiative(s) addressing Health Conditions - Addiction.

	Health Conditions - Addiction Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	SBIRT Program	Peer recovery coaches connect SUD patients with treatment and community resources.	Unique patients seen 5606 2. Number of unique patient encounters 7834 3. SBIRT screens completed 2468 4. Number of referrals to treatment by SBIRT PRC/PRS 5. Number of treatment intakes attended confirmed by SBIRT PRC/PRS	Unique patients seen b. Number of unique patient encounters c. SBIRT screens completed d. Number of referrals to treatment e. Number of treatment intakes attended/appointments kept f. 30 Day follow up calls by PRC/PRS g. Number of positive drug screens h. Number of nonfatal overdoses presented in ED i. Number of overdoses referred to OSOP peer or street outreach coach j. Overdoses engaged by OSOP street/outreach coach k. Number of overdoses actively engaged by OSOP peer or street outreach coach

Initiative B	Buprenorphine induction program	Initiate buprenorphine induction in the ED	28	Number of patients referred for MAT (Buprenorphine) in the ED and Number of patients to receive Buprenorphine induction in ED
Initiative C	Alcohol and drug use screening during primary care visits	Routinely screen patients at primary care visits for alcohol and drug use.	Alcohol and Drug Use Identified Persons a. ETOH [115] b. Marijuana [189] c. Opioid [5606] d. Cocaine [1881] e. Other [2468] 2. Brief Interventions - 738	Unique patients seen b. Number of unique patient encounters c. SBIRT screens completed
Initiative D	GBRICS - Greater Baltimore Regional Integrated Crisis System	Provide alternative to ED for individuals in crisis; includes call line.	New Program, no outcomes yet	
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q182. Please describe the initiative(s) addressing Health Conditions - Arthritis.

This question was not displayed to the respondent.

Q183. Please describe the initiative(s) addressing Health Conditions - Blood Disorders.

This question was not displayed to the respondent.

Q184. Please describe the initiative(s) addressing Health Conditions - Cancer.

This question was not displayed to the respondent.

Q185. Please describe the initiative(s) addressing Health Conditions - Chronic Kidney Disease.

This question was not displayed to the respondent.

Q186. Please describe the initiative(s) addressing Health Conditions - Chronic Pain.

This question was not displayed to the respondent.

Q187. Please describe the initiative(s) addressing Health Conditions - Dementias.

This question was not displayed to the respondent.

Q188. Please describe the initiative(s) addressing Health Conditions - Diabetes.

	Health Conditions - Diabetes Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Diabetes wellness and management education	Focus on Diabetes prevention, wellness, and self-management throughout LBH service areas; partnership with Diabetes Resource Centers and Local ADA chapter. Includes "Diabetes Wednesdays" educational calls, a weekly series with telephonic classes with a Diabetes Educator on various subjects pertinent to managing diabetes.		
Initiative B	Diabetes Patient Guide (new) developed and distributed	Ensure individuals with diabetes have knowledge to best manage diabetes and their overall health	Guidebooks distributed to LifeBridge primary care offices throughout Baltimore City and County.	
Initiative C	Endocrinologist-led Webinar education series for Primary Care Providers: Diabetes best practice management	Endocrinologists educate LBH primary and specialty care providers on best practice for diabetes pt management.	Endocrinologists educate LBH primary and specialty care providers on best practice for diabetes pt management.	Primary care provider attendance
Initiative D	Community Mobile Health Clinic	Mobile health initiative reaches traditionally underserved communities that face a variety of access and other SDOH barriers. Groups are typically at higher risk for chronic disease and potentially avoidable hospital utilization.		Referrals to providers and social resources.
Initiative E	Barbershops and Salons partnership in West Baltimore	Extend health screening and services to residents at risk of complications from diabetes and other chronic conditions.		A1c levels; referrals to providers and social resources.
Initiative F	Diabetes Prevention and Education - HSCRC Program	To identify community members at risk of diabetes and support them with education and support programs.	55 referrals	# of referrals to Diabetes Prevention Program
Initiative G				
Initiative H				
Initiative I				
Initiative J				

All Other Initiatives				

Q189. Please describe the initiative(s) addressing Health Conditions - Foodborne Illness.

This question was not displayed to the respondent.

Q190. Please describe the initiative(s) addressing Health Conditions - Health Care-Associated Infections.

This question was not displayed to the respondent.

Q191. Please describe the initiative(s) addressing Health Conditions - Heart Disease and Stroke.

	Health Conditions - Heart Disease and Stroke Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Cardiologist-led Webinar education series for Primary Care Providers: Heart Failure best practice management	Cardiologists educate LBH primary and specialty care providers on best practice for cardiac pt management.	30-45 primary care providers attending each of the 6 Cardiologist-led webinars	Primary care provider attendance
Initiative B	Heart Failure Patient Guide (new) developed and distributed	Ensure individuals with heart failure have knowledge to best manage heart failure and their overall health	Guidebooks distributed to LifeBridge primary care offices throughout Baltimore City and County.	
Initiative C	Community Mobile Health Clinic	Mobile health initiative reaches traditionally underserved communities that face a variety of access and other SDOH barriers. Groups are typically at higher risk for chronic disease and potentially avoidable hospital utilization.		Referrals to providers and social resources.
Initiative D	Barbershops and Salons in West Baltimore	Extend health screening and services to residents at risk of complications from hypertension, heart disease and other chronic conditions.		Blood pressure levels; referrals to providers and social resources.
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q192. Please describe the initiative(s) addressing Health Conditions - Infectious Disease.

This question was not displayed to the respondent.

Q193. Please describe the initiative(s) addressing Health Conditions - Mental Health and Mental Disorders.

	Health Conditions - Mental Health and Mental Disorders Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Ambulatory Care Management	Care management services for high-risk community members. Collaboration with internal and external mental health practices; referrals to community resources	68%	% of Successful linkage to resources and compliance with engagement with resource.
Initiative B	Integrated Behavioral Health Services with Primary Care Providers	As part of MDPCP program, working to identify a network of providers who will work with LBH Clinically Integrated Network for behavioral health services.		
Initiative C	Screening for Depression in Primary Care	Identify depression during primary care appointments and provide follow-up if needed.	85%	% of primary care patients screened with PHQ-2/9 annually.
Initiative D	GBRICS - Greater Baltimore Regional Integrated Crisis System	Improve access to appropriate support for individuals in behavioral health crisis.	Data not yet available.	
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q194. Please describe the initiative(s) addressing Health Conditions - Oral Conditions.

This question was not displayed to the respondent.

Q195. Please describe the initiative(s) addressing Health Conditions - Osteoporosis.

This question was not displayed to the respondent.

Q196. Please describe the initiative(s) addressing Health Conditions - Overweight and Obesity.

This question was not displayed to the respondent.

Q197. Please describe the initiative(s) addressing Health Conditions - Pregnancy and Childbirth.

This question was not displayed to the respondent.

Q198. Please describe the initiative(s) addressing Health Conditions - Respiratory Disease.

This question was not displayed to the respondent.

Q199. Please describe the initiative(s) addressing Health Conditions - Sensory or Communication Disorders.

This question was not displayed to the respondent.

Q200. Please describe the initiative(s) addressing Health Conditions - Sexually Transmitted Infections.

This question was not displayed to the respondent.

Q201. Please describe the initiative(s) addressing Health Behaviors - Child and Adolescent Development.

This question was not displayed to the respondent.

Q202. Please describe the initiative(s) addressing Health Behaviors - Drug and Alcohol Use.

This question was not displayed to the respondent.

Q203. Please describe the initiative(s) addressing Health Behaviors - Emergency Preparedness.

This question was not displayed to the respondent.

Q204. Please describe the initiative(s) addressing Health Behaviors - Family Planning.

This question was not displayed to the respondent.

Q205. Please describe the initiative(s) addressing Health Behaviors - Health Communication.

Health Behaviors - Health Communication Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Health Education Team	Prioritizing health education needs in the community and providing Health, Wellness, and Prevention education events, classes and risk assessments; connecting participants to resources to maintain health, and with medical providers and/or other programs.	793 via telelearning.	Attendance, Behavior change, knowledge gained (self-report), also healthcare system engagement
Initiative B	Mental Health Mondays	Partnership with Mental Health practitioners in the area as well as LBH staff to offer classes on various mental health topics, created at the request of community members and faith leaders in our service areas.	166 participants since Oct 2020.	attendance, lifestyle change, engagement with health care system
Initiative C	TeleLearning - Faith Edition	Education on various topics geared towards faith leaders in our communities to aid in forming congregational plans, wellness ministries, and health-related activities in faith-based organizations.		attendance, lifestyle change, referral plans for congregations
Initiative D	Work Out Wednesdays	TeleLearning program focused on physical activity with instructions for various types of exercises		attendance, lifestyle change, engagement with health care system
Initiative E	...Quarterly newsletter	Provide health education materials to senior housing units in target areas to increase awareness of health conditions and encourage healthy behaviors.	2000 newslettters distributed	attendance, lifestyle change, engagement with health care system
Initiative F	Lets' Talk About It	health education topics presented via teleconference calls	361	attendance, lifestyle change, engagement with health care system
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q206. Please describe the initiative(s) addressing Health Behaviors - Injury Prevention.

This question was not displayed to the respondent.

Q207. Please describe the initiative(s) addressing Health Behaviors - Nutrition and Healthy Eating.

This question was not displayed to the respondent.

Q208. Please describe the initiative(s) addressing Health Behaviors - Physical Activity.

This question was not displayed to the respondent.

Q209. Please describe the initiative(s) addressing Health Behaviors - Preventive Care.

	Health Behaviors - Preventive Care Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Health Screening Events-Nurse Clinics	Provide screenings and risk assessments at multiple locations throughout the LBH service areas, reaching all outreach markets, working with local businesses and organizations based on prioritized needs. Collaborating with LBH call center to provide follow-up, also providing real time nurse consultations.	157	Attendance, number of people reached for follow-up by call center, decrease in ER visits
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q210. Please describe the initiative(s) addressing Health Behaviors - Safe Food Handling.

This question was not displayed to the respondent.

Q211. Please describe the initiative(s) addressing Health Behaviors - Sleep.

This question was not displayed to the respondent.

Q212. Please describe the initiative(s) addressing Health Behaviors - Tobacco Use.

This question was not displayed to the respondent.

Q213. Please describe the initiative(s) addressing Health Behaviors - Vaccination.

	Health Behaviors - Vaccination Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	LBH Mobile Health	Clinical mobile health initiative reaches traditionally underserved communities that face a variety of access and other SDOH barriers. Groups are typically at higher risk for chronic disease and potentially avoidable hospital utilization.		
Initiative B	Live Chair barbershop/salon partnerships	Live Chair is a business partner that works with a network of barbershops and salons in the Baltimore area to support increased health screenings, prevention, and better access to health care for traditionally underserved populations.		
Initiative C	Population Health Community Vaccination	Community-based clinical touches covering COVID vaccinations, testing, and various use cases for LBH Mobile Health	1521	Number of people tested during mobile COVID 19 clinics, # of people vaccinated during mobile vaccinations clinics
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				

Initiative J				
All Other Initiatives				

Q214. Please describe the initiative(s) addressing Health Behaviors - Violence Prevention.

	Health Behaviors - Violence Prevention Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Hospital Violence Response Team (Center for Hope)	Hospital based violence response team working with Cure Violence framework to provide bedside intervention for victims of domestic violence as well as victims of shootings, stabbings and assault. Efforts made to prevent re-victimization through case management, treatment, and workforce development	450 clients	number of clients; feedback; future ACE/Resilience/Hope assessment
Initiative B	Neighborhood Violence Intervention - Belvedere Neighborhood (Center for Hope)	Cure Violence model neighborhood violence interrupters respond to and prevent shootings from occurring in designated hot spots in coordination with City of Baltimore through outreach efforts and community mediation.		
Initiative C	Community Case Management (Center for Hope)	Baltimore Links (for children under 18) and Park Heights Case Management connects referrals from Child Fatality Review and other neighborhood referrals to case management services to prevent future homicide and violence		reduced re-victimization, reduced criminal justice contacts, reduced homicides
Initiative D	Elder Abuse Multi-Disciplinary Team (Center for Hope)	Creating and implementing a coordinated team response with partners from law enforcement, social services, prosecution, community organizations and Center for Hope staff to respond to allegations of elder abuse with forensic interviews, medical exams, and case management. New program and in starting stages with team reviews of cases currently happening		
Initiative E	Community Education & Outreach (Center for Hope)	Team approach to providing training and education on topics to prevent various forms of abuse to community members, organizations, and professionals	9,538 trained	post-training assessment
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q215. Please describe the initiative(s) addressing Populations - Adolescents.

This question was not displayed to the respondent.

Q216. Please describe the initiative(s) addressing Populations - Children.

This question was not displayed to the respondent.

Q217. Please describe the initiative(s) addressing Populations - Infants.

This question was not displayed to the respondent.

Q218. Please describe the initiative(s) addressing Populations - LGBT.

This question was not displayed to the respondent.

Q219. Please describe the initiative(s) addressing Populations - Men.

This question was not displayed to the respondent.

Q220. Please describe the initiative(s) addressing Populations - Older Adults.

This question was not displayed to the respondent.

Q221. Please describe the initiative(s) addressing Populations - Parents or Caregivers.

This question was not displayed to the respondent.

Q222. Please describe the initiative(s) addressing Populations - People with Disabilities.

This question was not displayed to the respondent.

Q223. Please describe the initiative(s) addressing Populations - Women.

This question was not displayed to the respondent.

Q224. Please describe the initiative(s) addressing Populations - Workforce.

This question was not displayed to the respondent.

Q225. Please describe the initiative(s) addressing Settings and Systems - Community.

This question was not displayed to the respondent.

Q226. Please describe the initiative(s) addressing Settings and Systems - Environmental Health.

This question was not displayed to the respondent.

Q227. Please describe the initiative(s) addressing Settings and Systems - Global Health.

This question was not displayed to the respondent.

Q228. Please describe the initiative(s) addressing Settings and Systems - Health Care.

This question was not displayed to the respondent.

Q229. Please describe the initiative(s) addressing Settings and Systems - Health Insurance.

	Settings and Systems - Health Insurance Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Insurance Counseling	Assist patients with insurance signups.	367 approvals for MD Medicaid	# of MD Medicaid approvals
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q230. Please describe the initiative(s) addressing Settings and Systems - Health IT.

This question was not displayed to the respondent.

Q231. Please describe the initiative(s) addressing Settings and Systems - Health Policy.

This question was not displayed to the respondent.

Q232. Please describe the initiative(s) addressing Settings and Systems - Hospital and Emergency Services.

	Settings and Systems - Hospital and Emergency Services Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	SBIRT Program	Peer Recovery Coaches support patients with substance use disorder to promote recovery and connect patients to community resources (OSOP included) and treatment options (BUP included)	Unique patients seen 5606 2. Number of unique patient encounters 7834 3. SBIRT screens completed 2468 4. Number of referrals to treatment by SBIRT PRC/PRS 5. Number of treatment intakes attended confirmed by SBIRT PRC/PRS	Unique patients seen b. Number of unique patient encounters c. SBIRT screens completed d. Number of referrals to treatment e. Number of treatment intakes attended/appointments kept f. 30 Day follow up calls by PRC/PRS g. Number of positive drug screens h. Number of nonfatal overdoses presented in ED i. Number of overdoses referred to OSOP peer or street outreach coach j. Overdoses engaged by OSOP street/outreach coach k. Number of overdoses actively engaged by OSOP peer or street outreach coach
Initiative B	ED Navigation/Care Transitions	Reduce ED revisits, prevent health complications of chronically ill and high risk patients, provide discharge planning and home follow ups	Avg - 37 per month; Care Transition enrollment at 100% for qualified patients being discharged from ED YTD	# of ED revisits within 72hrs monthly; % of Care Transitions eligible patients enrolled from ED/Obs discharges
Initiative C				
Initiative D				

Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q233. Please describe the initiative(s) addressing Settings and Systems - Housing and Homes.

	Settings and Systems - Housing and Homes Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Live Near Your Work Program	Employer-Incentive program for LifeBridge Health employees to purchase homes near LifeBridge facilities to promote neighborhood stability, community revitalization, and generational wealth creation.		Number of employees participating. Employee homeownership rates in nearby communities.
Initiative B	Health and Housing (to stay in homes...)	health and wellness for seniors in housing units	157 encounters (Jan 2021 - June 30, 2021 post COVID); 1310 preCOVID baseline0	approx # of encounters
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q234. Please describe the initiative(s) addressing Settings and Systems - Public Health Infrastructure.

This question was not displayed to the respondent.

Q235. Please describe the initiative(s) addressing Settings and Systems - Schools.

This question was not displayed to the respondent.

Q236. Please describe the initiative(s) addressing Settings and Systems - Transportation.

	Settings and Systems - Transportation Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Ambulatory Care Management	Care management services to address social needs for high-risk community members, including coordination of transportation to medical appointments and social services.	68%	% of patients Successful linkage to resources and compliance with engagement with resource.
Initiative B	LBH Mobile Health	Clinical mobile health initiative reaches traditionally underserved communities that face a variety of access and other SDOH barriers. Groups are typically at higher risk for chronic disease and potentially avoidable hospital utilization.		
Initiative C	Live Chair community barbershop partnership	Live Chair is a business partner that works with a network of barbershops and salons in the Baltimore area to support increased health screenings, prevention, and better access to health care for traditionally underserved populations.		
Initiative D	Partnerships with Uber and Lyft	To transport patients for medical needs		
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q237. Please describe the initiative(s) addressing Settings and Systems - Workplace.

This question was not displayed to the respondent.

Q238. Please describe the initiative(s) addressing Social Determinants of Health - Economic Stability.

	Social Determinants of Health - Economic Stability Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Workforce Development (Center for Hope, Kujichagulia Program)	Workforce development model to provide skills training and job readiness working within Center for Hope programs and with Sinai's VSP program to mentor, train, and place for employment inside and outside of hospital		Number of clients connected to jobs
Initiative B	LifeBridge VSP job program	To provide jobs for community residents.		
Initiative C	LifeBridge Talent Acquisition Program	To work with community partners to fill LifeBridge job openings.		
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q239. Please describe the initiative(s) addressing Social Determinants of Health - Education Access and Quality.

This question was not displayed to the respondent.

Q240. Please describe the initiative(s) addressing Social Determinants of Health - Health Care Access and Quality.

	Social Determinants of Health - Health Care Access and Quality Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Ambulatory Care Management	Care management services for high-risk community members. Collaboration with internal and external mental health practices; referrals to community resources; coordination of transportation to medical appointments and Social Services.	68%	% of patients Successful linkage to resources and compliance with engagement with resource.
Initiative B	LifeBridge Mobile Health	Clinical mobile health initiative reaches traditionally underserved communities that face a variety of access and other SDOH barriers. Groups are typically at higher risk for chronic disease and potentially avoidable hospital utilization.		
Initiative C	Live Chair community barbershop partnership	Live Chair is a business partner that works with a network of barbershops and salons in the Baltimore area to support increased health screenings, prevention, and better access to health care for traditionally underserved populations.		
Initiative D	Collaboration with community faith-based organizations	Partnering with community faith-based groups to improve residents' access to health education and services.		
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q241. Please describe the initiative(s) addressing Social Determinants of Health - Neighborhood and Built Environment.

This question was not displayed to the respondent.

Q242. Please describe the initiative(s) addressing Social Determinants of Health - Social and Community Context.

	Social Determinants of Health - Social and Community Context Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Clothing Closet	Provide clothing items to patients	1584 items distributed across all departments	# of clothing items distributed

Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q243. Please describe the initiative(s) addressing other priorities.

This question was not displayed to the respondent.

Q130. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q131.

In your most recently completed CHNA, the following community health needs were identified:
Health Conditions - Addiction, Health Conditions - Diabetes, Health Conditions - Heart Disease and Stroke, Health Conditions - Mental Health and Mental Disorders, Health Behaviors - Health Communication, Health Behaviors - Preventive Care, Health Behaviors - Vaccination, Health Behaviors - Violence Prevention, Settings and Systems - Health Insurance, Settings and Systems - Hospital and Emergency Services, Settings and Systems - Housing and Homes, Settings and Systems - Transportation, Social Determinants of Health - Economic Stability, Social Determinants of Health - Health Care Access and Quality, Social Determinants of Health - Social and Community Context
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.

Q132. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

This question was not displayed to the respondent.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

This question was not displayed to the respondent.

Q129. If you wish, you may upload a document describing your community benefit initiatives in more detail.

This question was not displayed to the respondent.

Q60. Section III - CB Administration

Q61. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

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

Q246. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q62. Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

Q63. Please describe the community benefit narrative audit process.

The community benefit narrative is reviewed regularly by the health system's Community Benefit Committee that makes recommendation for approval of the Community Benefit Report by the LifeBridge Health Community Mission Committee of the LifeBridge Health Board.

Q64. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (●) Yes
- ( ) No

Q65. Please explain:

This question was not displayed to the respondent.

Q66. Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

Q67. Please explain:

This question was not displayed to the respondent.

Q68. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (●) Yes
- ( ) No

Q69. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

The Community Health Needs Assessment results are prioritized by community leaders and system leadership. A Community Benefit plan is created from this prioritization process. The community benefit plan is used to identify needs and priorities for the organizational strategy.

Q70. If available, please provide a link to your hospital's strategic plan.

Q133. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents
- [x] Opioid Use Disorder - Improve overdose mortality
- [x] Maternal and Child Health - Reduce severe maternal morbidity rate
- [x] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

Q134. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q135. Section IV - Physician Gaps & Subsidies

Q223. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ○ No
- ◉ Yes

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

This question was not displayed to the respondent.

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

This question was not displayed to the respondent.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

This question was not displayed to the respondent.

Q140. Section VI - Financial Assistance Policy (FAP)

Q141. Upload a copy of your hospital's financial assistance policy.

LBH Financial Assistance Policy English 012821.pdf
277.4KB
application/pdf

Q220. Provide the link to your hospital's financial assistance policy.

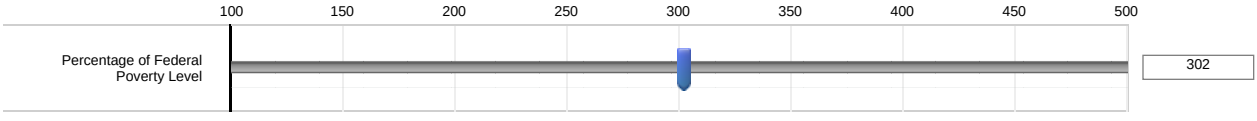
https://www.lifebridgehealth.org/Main/LifeBridgeHealthFinancialAssistance.aspx

Q147. 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:

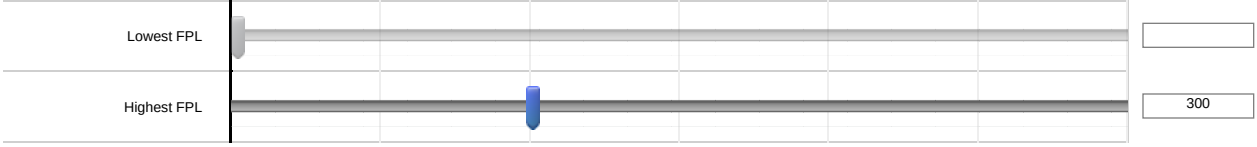
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



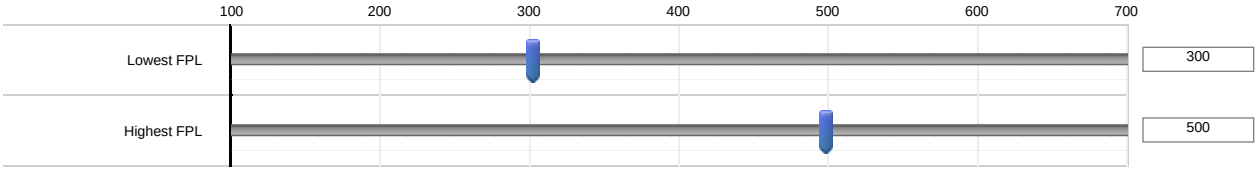
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

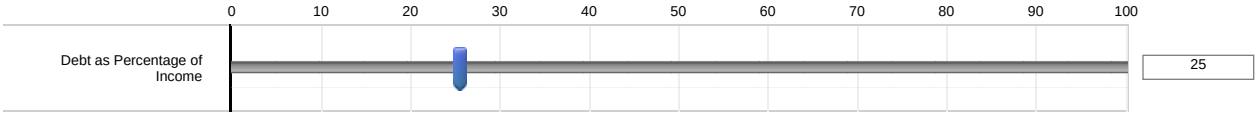


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

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



Q146. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q221. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding tax able year (select all that apply)

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

Q150. Summary & Report Submission

Q151.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (38.658294677734, -77.248100280762)

Source: GeoIP Estimation

LifeBridge Health

Grace Medical Center

Community Health Needs Assessment

2021

Executive Summary

Grace Medical Center is a 69-bed facility licensed in the state of Maryland providing acute, primary and specialty care services to residents in various communities in and near West Baltimore. Grace Medical Center includes a community-based primary care site, behavioral medicine program with multiple substance abuse treatment sites, renal dialysis services, and preventive health and education programs. Grace Medical Center is part of LifeBridge Health, Inc. which also includes Sinai Hospital of Baltimore, Levindale Hebrew Geriatric Center and Hospital, Northwest Hospital and Carroll Hospital.

On November 1, 2019 LifeBridge Health acquired Bon Secours Hospital (Bon Secours) from the Bon Secours Mercy Health System and renamed the hospital Grace Medical Center. Prior to the acquisition Bon Secours conducted a Community Health Needs Assessment (CHNA) in the spring and summer of 2019. Following the acquisition and establishment of LifeBridge Health leadership at Grace Medical Center, a review of the 2019 CHNA occurred including the Prioritization of Identified Needs. This was accomplished in March 2020 and an Implementation Plan was completed and adopted by the Board of Grace Medical Center in June 2020.

The Baltimore City Health Department and the resident health systems previously collaborated on a Community Health Needs Assessment in 2017-2018 and have sought to do so again in 2020-21 though in a more limited manner due to the COVID-19 virus. As part of the LifeBridge Health system participation in this collaborative effort, Grace Medical Center has participated in the City-wide survey, focus groups and stakeholder interviews. This Executive Summary and document incorporate both the original (and still relevant) findings as well as any updates conducted. The 2020 Grace Medical Center Implementation Plan and the original 2019 CHNA follow the Executive Summary.

2019 Community Health Needs Assessment

Approach and Methodology: Similar to the CHNAs conducted in 2013 and 2016, in 2019 Bon Secours used an inclusive approach to complete the CHNA to ensure that the CHNA was conducted in a way that best identifies west Baltimore's health needs and meets the IRS CHNA requirements for not-for-profit hospitals. Bon Secours leadership recognized the importance of continuity with previous CHNAs and the corresponding Implementation Plans (IP). The goals and actions of those IPs responded to identified

needs that could be categorized as *Healthy People, Healthy Economy, and Healthy Environment*. (A report on the impact of actions taken under the 2016 Implementation Plan can be found page 17.)

Bon Secours utilized its established Bon Secours Community Works CHNA Advisory Board (Advisory Board) as well as representation from community leaders, community anchor institutions, faith-based organizations, and the Baltimore public health department to serve in an advisory capacity for the CHNA initiative. Bon Secours staff met with partner healthcare organizations, St. Agnes Hospital and Kaiser Permanente, as well as the local primary schools to provide input and to establish identified health and social needs of west Baltimore. Along with input from the Bon Secours Hospital Board and Community Works Board, leadership prioritized the identified community health needs for the 2019 CHNA.

As part of the CHNA methodology, Bon Secours collected and analyzed both primary and secondary data for ten Community Statistical Areas (CSAs) that more accurately comprised the Bon Secours service area than the zip code population of the 2016 CHNA. The following CSAs make up the Grace Medical Center CHNA Service Area as well: Edmondson Village, Forest Park/Walbrook, Greater Mondawmin, Greater Rosemont, Penn North/Reservoir Hill, Poppleton/The Terraces/Hollins Market, Sandtown-Winchester/Harlem Park, Southwest Baltimore, Upton/Druid Heights, and Washington Village/Pigtown.

Key Findings from Secondary Data Analysis: Key findings from the secondary data analysis are summarized below.

The 2010 US Census indicates the population of the ten CSAs (primary service area) to be 105,816 or approximately 17.1% of the total population of the City of Baltimore. Demographically, this service area reflects Baltimore City in age and gender but is different in terms of race/ethnicity and income.

According to the American Community Survey (2013 – 2017), the Grace Medical Center service area has a larger percentage of household income below $25,000 (42%) than the City as a whole (29.5%) and a larger proportion of African Americans (88%) than Baltimore City (62%) and the state of Maryland (29.4%). The CSAs also experiences a higher rate of public insurance coverage (57.6%) than across the entire City (29.6%).

West Baltimore health outcomes and socio-economic factors were less favorable to those of Baltimore City across all categories. In particular:

- The Service Area has worse health outcomes, particularly life expectancy and mortality compared to Baltimore City and Maryland.
- Grace Medical Center's CSAs ranks worse amongst families living below the poverty level, children in poverty and number of vacant properties.
- The Service Area has seen increases in all-cause mortality, cancer, and homicide rates since the last CHNA process which are related to health behavior and socioeconomic factors.

Community and Stakeholder Involvement: The CHNA team used a multi-pronged approach to solicit input from the west Baltimore community regarding their health needs. Data collection methodologies included surveys, stakeholder interviews, and focus groups.

The team engaged with representatives of the community with knowledge of public health (e.g., Maryland Department of Health and Mental Hygiene and the Baltimore City Health Department), the broad interests of the community served, and individuals with special knowledge of the medically underserved, as well as low-income and vulnerable populations and people with chronic diseases. The CHNA work group met with seniors, re-entry residents, faith-based stakeholders, community leaders, health care providers, neighborhood associations, representatives from community-based organizations and other key community stakeholders with an intimate knowledge of the west Baltimore community and its health needs. Two hundred seventy-three (273) surveys were collected within the defined service area. Eleven (11) stakeholder interviews and three (3) focus groups were conducted between January and March 2019. All methods focused on community health needs, community assets and resources available to respond to the community health needs, as well as barriers and challenges to accessing the community assets and resources, and the ways in which the hospital could help address the health needs.

In addition, a Baltimore city-wide survey of resident perceptions and needs was conducted in the fall of 2020. Approximately 20 percent (644 of 3,170) of survey participants were residents of the Grace Medical Center service area zip codes. The most important health problems affecting the health of the community are:

- Alcohol/Drug Addiction - 62 percent of respondents
- Mental Health (Depression and Anxiety) – 40 percent
- Diabetes/High Blood Sugar – 36 percent
- Heart Disease/Hypertension – 32 percent
- Smoking/Tobacco Use – 22 percent
- Overweight/Obesity – 21 percent

The most important social/environmental problems affecting the health of the community are:

- Lack of job opportunities – 31 percent of respondents
- Housing/Homelessness – 29 percent
- Neighborhood Safety/violence – 28 percent

The top three reasons residents in the community do not get health care are linked to the cost of health care (58 percent), a lack of insurance (54 percent), and/or a lack of transportation (30 percent). The responses of those in the Grace service area are similar, though to a lesser extent, to those across the whole City.

In addition, Grace Medical Center and its companion LifeBridge Health facilities conducted focus groups as well as conversations with key stakeholders within the primary service areas. Representatives included community leaders, associations, as well as expressed demographic groups – those with disabilities, re-entry residents, and Spanish-speaking employees.

Participants highlighted the following themes as top health concerns:

- High Blood Pressure, Diabetes, and High Cholesterol
- Mental Health and Illness, Depression, Loneliness
- Drug and Alcohol Addiction, Substance Abuse
- Additional concerns included Nutrition, Wellness, Cancer, HIV/AIDS, and stroke.

The leading social and environmental barriers referenced were:

- Unemployment, Poverty, as well as Crime and Trash
- Lack of Transportation
- Lack of open space, recreation, and a sense of community
- Language barriers

The top reasons for not accessing healthcare services included:

- Lack of Insurance, and underlying lack of funds
- A distrust in the healthcare system and corresponding misinformation and perceived discrimination
- Lack of education
- Lack of transportation and distance from doctors

Increased barriers as a result of COVID-19 include:

- Food insecurity and access to grocery stores
- General fearfulness, safety, depression, loneliness and mental health
- Housing security
- Domestic violence
- Transportation and resources for Spanish speaking populations

Suggestions made to improve health or healthcare systems were:

- More engagement with the community
- Services for new families, parenting classes
- Language resources
- Attention to senior wellness, prostate screenings.

West Baltimore Priority Health Needs

In 2016, Bon Secours Hospital identified the following health needs in the community:

- Crime and Related Trauma
- Behavioral Health/Substance Abuse
- Access to Primary Care Physicians
- Health Education
- Children's Health
- Access to Healthy Foods
- Expanded Housing
- Employment and Workforce Development
- Community Engagement
- Coordination of services across Bon Secours
- Advocacy, Policy, and Public Agency Dialogue, and
- Hospital Quality and Public Health

In 2016, the hospital and the local health system chose to prioritize all these needs and developed an Implementation Plan accordingly.
In 2019, the first ten needs (above) remained as Identified Needs of the community, and five additional needs (in green boxes) as well as modifications (in black text) were added. See Figure 1 below.

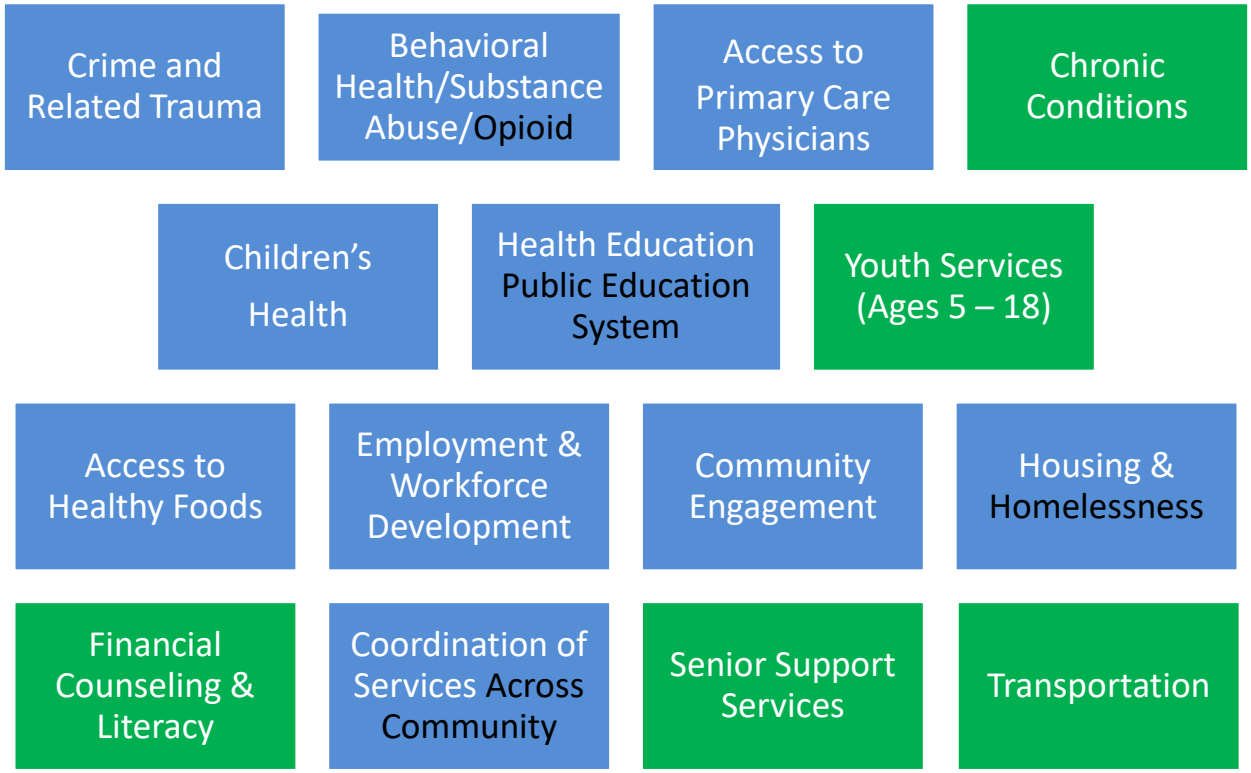


Figure 1 – Identified Needs of Community Served

The Bon Secours Baltimore CHNA work group met with members of the Bon Secours Hospital board on May 22, 2019 and the Community Works board on May 23, 2019. Utilizing the criteria below, board members were asked to select those identified needs for which there was **"High Need and High Feasibility"** (ability to impact). Board members expressed particular concern for Employment and Workforce Development, Behavioral Health, Substance Abuse and Opioids, as well as Crime and Safety in the community.

The following criteria were used to prioritize the community needs:

- Supported by Community Service Area data;
- Consistent with Public Health and health expert input, including the Baltimore City wide CHNA;
- In support of benefitting a significant population of the community;
- In support of continuity and progress made by 2013 and 2016 Implementation Plans; and
- In consideration of 2019 community survey results.

The following Identified Needs were selected as Priorities by Bon Secours:

1) Crime and Related Trauma
2) Employment and Workforce Development
3) Housing and Homelessness
4) Access to Healthy Foods
5) Health Education, and collaboration with the Public Education System
6) Services for Youth (ages 5 to 18)
7) Senior Support Services

Upon review of the Bon Secours CHNA and Identified Needs in the spring of 2020, the following Identified Needs were selected as Priorities by Grace Medical Center:

1) **Behavioral Health/Substance Abuse/Opioids**
2) **Access to Care Providers**
3) **Chronic Conditions**
4) **Community Engagement and Development**
5) **Crime and Related Trauma**
6) **Transportation**

Grace Medical Center leadership anticipates the 2020/2021 – 2024 Implementation Plan will address these needs in conjunction with both LifeBridge Health resources and with well-established community partners and organizations.

Parties recognize the significant need to continue to address longstanding social determinants of health exacerbated by the COVID-19 pandemic. In particular, Economic and Workforce Development as well as Homelessness and the shortage of Affordable Housing are significant needs within the community. Grace Medical Center envisions ongoing and supportive coordination with Bon Secours Community Works and Unity Properties to improve these conditions.

Grace Medical Center will also support the work of City agencies and collaborative organizations to advocate for and address additional Identified Needs not prioritized for its Implementation Plan.

Grace Medical Center CHNA Implementation Plan

Health

Prioritized Need - Behavioral Health/Substance Abuse/Opioids	
Goal – Reduce fatalities among residents of West Baltimore who accidentally overdose.	
Actions:	1. Provide Overdose Prevention Education and Training to 100% of all patients enrolled in Grace Medical Center operated OTP's. 2. Provide naloxone kits to enrollees within two business days after completing an overdose prevention training document.
Anticipated Impact:	Prevention of overdose fatalities among enrollees in OTP programs as well as the southwest Baltimore community in general.
Metrics Used to determine Progress:	# Naloxone Kits distributed #Total Enrollment in all OTP's.
Resources (Staff and/or Budget):	Existing OTP staff to provide overdose prevention education and training to all OTP enrollees. Naloxone kits procured with grant funds
Leader(s):	Tara Buchanan, RN Heather Young, FNP

Prioritized Need – Behavioral Health/Substance Abuse/Opioids	
Goal – Improve the health status of residents of southwest Baltimore by increasing the number of SBIRT Interventions and Overdose Survivor's Outreach Program (OSOP) referrals by 10% over FY 19 totals for individuals who screen positive during their ED visits.	
Actions:	1. Provide SBIRT Interventions and OSOP referrals in the Emergency Department and on the Observation unit at Grace Medical Center for individuals with a positive SBIRT screening. 2. Conduct follow-up telephone surveys to validate treatment referrals
Anticipated Impact:	Reduce ED visits for individuals diagnosed with identified Substance Use Disorders. Increase the number of Individuals who accept referrals to Substance Abuse Treatment.
Metrics Used to determine Progress:	# SBIRT/ OSOP referrals who kept referral appointments # SBIRT/ OSOP referrals
Resources (Staff and/or Budget):	Existing SBIRT Peer Recovery staff/ budget

Leader:	Dr. Nicole Wagner

Health

Prioritized Need – Access to Care Providers (Primary, Pediatric, Specialty)	
Goals: 1) Improve and expand access to Primary Care, Preventive Services, and Specialty Care 2) Improve the health of the community by increasing the number of people connected to a primary care medical home and increasing annual primary care visits	
Actions:	1. Increase capacity of services by reconstructing a new area to house Primary Care, and expanded Specialty Services including Ophthalmology, OB/GYN, and Pediatrics 2. Establish a Pediatric Clinic within our current Family Practice and protocols for referral 3. Establish OB/GYN Clinic 4. Establish Eye Clinic 5. Develop communications to the community in which we increase awareness of services and how to access 6. Ongoing referral coordination provided by Referral Coordinator in collaboration with Providers, and ED/Observation and Ambulatory Care Management teams. 7. Provide patient outreach by use of patient portal, letters, or phone calls to patients not seen in the practice within six months to schedule appointments 8. Referrals made from Community Programs and activities which identify patients without a medical home and/or patients at risk for chronic conditions 9. Conduct focused events (men's health, and women's health) and refer community members for utilization of services as needed 10. Community awareness and education provided to promote the importance of establishing a medical home, receiving preventive screenings and routine well visits 11. Transitions of Care activities from both ED/Observation Care - Transitions team and Ambulatory Care Management team to connect patients with Primary Care and Specialty Services to include appointment assistance, referrals, care coordination, and follow up with patients 12. Continue to assist patients with obtaining medical insurance via onsite vendor. Care Management teams identify and refer patients without insurance to the onsite vendor for assistance.
Anticipated Impact:	Overall improved access to Primary Care, Preventive Services, and Specialty Care.

Metrics Used to determine Progress:	1. Increased Primary Care and Specialty Care volumes 2. Decreased inappropriate ED utilization 3. Improved preventive screening rates i.e. CRC, Breast Cancer 4. % of patients with post discharge appointment within 7 days 5. Number of people referred to care from Community Programs
Resources (Staff and/or Budget):	1. Ambulatory Department 2. CHW Department 3. Care Management Team
Leader:	Dr. Sheikh and Michelle Berkley-Brown

Health

Prioritized Need – Chronic Conditions	
Goal – Improve the health status of southwest Baltimore residents by engaging the community in screenings and educational events that promote healthier lifestyles and better self-management of health and chronic conditions Goal – Improve management of Chronic Conditions by early identification of patients at risk, provision of care, and management of those with chronic conditions	
Actions:	1. Health Education programs, Community Screenings, and Chronic Disease Management programs will be conducted in the community, independent senior buildings, and faith-based organizations to promote healthier lifestyle and self-management of chronic illness. These programs include: Healthy Living Series, Chronic Disease Self-Management Program, Freedom from Smoking, Health and Housing Program, and Faith Community Partnership 2. Provision of blood pressure devices and education for patients to monitor blood pressure at home and communicate readings with provider. 3. Diabetic education provided by DM educator to diabetic patients in both ambulatory and observation care setting. 4. Provide educational programs to youth in public schools about proper nutrition, diet and exercise and the interplay with health and wellness. 5. Care Transitions team completes high risk assessment on all admissions to ED and Observation level of care; and team ensures a primary care appointment is obtained prior to discharge. This effort includes connecting to Community Care Management 6. Enrollment into Community Care Management programs for specific disease state education and management

	7. Care Transitions team will complete home visits to high risk community members with chronic conditions to ensure medication reconciliation, medication compliance, and follow up appointment compliance. 8. Care Transitions will assist with nutritional support through Meals on Wheels
Anticipated Impact:	Decreased morbidity and mortality from chronic conditions such as Diabetes, HTN, heart disease, and COPD.
Metrics Used to determine Progress:	1. Decreased readmission rate. 2. Decreased primary care no show rates. 3. Increased number of patients connected to primary care. 4. Decreased inappropriate ED utilization 5. Increased number of people reached through health fairs, educational workshops and events
Resources (Staff and/or Budget):	1. Community Health & Wellness team 2. Care Transitions Team 3. Ambulatory Care Management team 4. Ambulatory Providers
Leader:	Karen Jarrell, Michelle Berkley-Brown, and Rhonda Williams

Social and Environmental

Prioritized Need – Community Engagement [and Development]	
Goal - To address key health and socio-economic challenges in West Baltimore through community-based initiatives.	
Actions:	• In partnership with Population Health and Baltimore Child Abuse Center (BCAC); offer two health education-based workshops and/or events each year to the West Baltimore community. • Build partnerships with two workforce development organizations and conduct two outreach events per year to connect area residents to employment opportunities. • Test two new non-technological strategies to reduce information gaps and improve communication to both community members and medical personnel on hospital services, programs, and initiatives as well as community-based resources. • Promote quality, healthy food access in West Baltimore through an initiative, e.g. food education, food market or organizational partnership. • Expand LifeBridge Health *Live Near Your Work* program in the West Baltimore service area.
Anticipated Impact:	• Increase access to health education, child abuse prevention, violence prevention, and other outreach opportunities to West Baltimore residents.

	• Increase opportunities for skills training, workforce development and employment for West Baltimore residents. • Decrease communication barriers while increasing access to health resources within the community. • Enhance community and hospital stability, through neighborhood revitalization efforts. • Expand access to healthy food options and resources to west Baltimore residents
Metrics Used to determine Progress:	Reach: • # of people attending events • # of classes/workshops/events offered • # of communication strategies initiated • # of partnerships initiated Outcomes: • # of people completing post event surveys • % of participants completing classes/workshops • # of communication strategies implemented • # of partnerships cultivated and maintained
Resources (Staff and/or Budget):	• Dedicated HSCRC/Community Benefit funding • Foundation Board Members • Additional Partnerships as Needed
Leader:	Sommer/Merritt

Social and Environmental

Prioritized Need – Crime and Trauma	
Goal - To address existing trauma and to prevent future trauma caused by violence within the west Baltimore community (zip codes 21223, 21217, 21216 – in descending order)	
Actions:	1. Provide Violence Intervention & Prevention Awareness training for all GMC staff on all forms of violence & abuse 2. Assess need for onsite violence responders & community violence interrupters (i.e. establish a Safe Streets site) to ensure that patients who have been victims of gun violence, stabbings, domestic violence, elder abuse, and other forms of violence have the support needed while at Grace Medical and within the community 3. Provide Case Management, including individualized needs assessments, tailored case planning, and community-based client advocacy, for survivors of violence related trauma 4. Provide trauma-responsive mental health services for survivors of violence related trauma 5. Provide school-based violence prevention services, including academic enrichment opportunities, life skills training, and

<table>
<tr><td></td><td>student support groups through an evidence-based violence prevention curriculum</td></tr>
<tr><td>Anticipated Impact:</td><td>1. 100% of staff trained in violence-related risk and protective factors and other challenging dynamics within 12 months
2. Increase safety planning and continuity of community care with survivors of violence by 50% within 12 months
3. Increase school attendance rates for program participants by 40% within 24 months
4. Decrease arrests of program participants by 30% within 24 months
5. Decrease CPS referrals of program participants by 30% within 24 months
6. Increase community resource connections of program participants by 80% within 12 months
7. Increase access to mental health services for survivors of violence by 25% within 18 months</td></tr>
<tr><td>Metrics Used to determine Progress:</td><td>1. Number of staff trained in Violence Intervention and Prevention dynamics compared to total number of staff
2. Number of patients connected to hospital and community-based violence response compared to number of patients presenting with violence-related injuries
3. Client-reported school attendance rates; verified by school records
4. Client-reported arrests; verified by arrest records
5. Client-reported CPS referrals; verified by CPS records
6. Client-reported community resource connections made
7. Number of mental health clients compared to need assessed within community</td></tr>
<tr><td>Resources (Staff and/or Budget):</td><td><table>
<tr><td>Manager of Case Management Team (35%)</td><td></td></tr>
<tr><td>School-based Coordinator (100%)</td><td></td></tr>
<tr><td>Case Manager (100%)</td><td></td></tr>
<tr><td>Hospital-based Violence Responder (100%)</td><td></td></tr>
<tr><td>Trauma Therapist (100%)</td><td></td></tr>
<tr><td>Fringe (22%)</td><td></td></tr>
<tr><td>Total Cost</td><td>$ 295,240</td></tr>
</table></td></tr>
<tr><td>Leader:</td><td>Adam Rosenberg</td></tr>
</table>

Access

Prioritized Need – Transportation	
Goal – Provide transportation to community residents for clinic appointments and dialysis treatments	
Actions:	1) Further develop request system for rides to Primary Care and Specialty Care clinic appointments 2) Continue to provide transportation to dialysis patients to facilitate treatments 3) Assess fleet needs to accommodate additional riders who need transportation to physician appointments or outpatient dialysis 4) Assess community needs for transportation of family members to visit loved ones at Sinai, Northwest and Levindale hospitals.
Anticipated Impact:	Improved access by community for medical services at Grace Medical Center; Increased availability for hemodialysis services to the community; increased efficiency and effective use of Grace clinics
Metrics Used to determine Progress:	Patient ride volumes and reduced missed appointments
Resources (Staff and/or Budget):	4 drivers, 3 fourteen passenger buses
Leader:	Stephen Winstead/John Knapp

2019 Community Health Needs Assessment

1 Purpose of the CHNA Report

A community health needs assessment (CHNA) provides the foundation for improving and promoting the health of a community. Through the assessment process, Bon Secours Baltimore Health System ("Bon Secours") identifies and describes the health status of the community that it serves; any factors in the community that contribute to health challenges; and existing community assets and resources that can be mobilized to improve the health status of the community. The community health needs assessment, therefore, ensures that Bon Secours and partner resources are directed toward activities and interventions that address critical and timely community health needs. This Report documents the results of Bon Secours' CHNA for fiscal year 2019. This Report will inform Bon Secours' CHNA Implementation Strategy that will describe how Bon Secours plans to address identified health needs.

1.1 Federal CHNA Requirement

The Patient Protection and Affordable Care Act [§ 9007, 26 U.S.C. 501(c) (2010], (commonly referred to as "Obamacare") requires non-profit hospitals to conduct a community health needs assessment (CHNA) and adopt an implementation strategy (i.e., community health improvement plan (CHIP)) every 3 years to be considered a non-profit by the Internal Revenue Service (IRS). A CHNA defines the community a hospital serves, surveys the health of their community, and listens to their community members' opinions in order to decide what the greatest needs of their community are and what resources are available. An implementation strategy then describes how the hospital plans to address the greatest needs in their community.

The IRS describes a CHNA as:

> "The collection of information required for hospital organizations to receive the benefits of being described in section 501(c)(3) of the Internal Revenue Code (Code) and flows from section 501(r)(3), which requires a hospital organization to conduct a community health needs assessment (CHNA) and adopt an implementation strategy to meet the community health needs identified through the CHNA at least once every three years…The Affordable Care Act also added section 4959, which imposes a $50,000 excise tax on a hospital organization that fails to meet the CHNA requirements for any taxable year."

A CHNA will only meet the requirements of the law if it:

(i) Defines the community it serves.
(ii) Assesses the health needs of that community.
(iii) Reviews input from their community and local public health officials.
(iv) Documents the CHNA in a written report (CHNA Report) that is adopted for the hospital by an authorized body of the hospital facility.
(v) Makes the CHNA report widely available to the public.

1.2 Comments on FY2016 CHNA Report and Implementation Plan

Bon Secours prepared a CHNA and corresponding Implementation Plan in 2016. Both documents were made available to the public and posted online. Bon Secours received two comments indicating satisfaction with the FY2016 CHNA report and Implementation Plan.

2 Impact of Implementation Plan (2016 – 2019)

The current CHNA Implementation Plan has three categories – Healthy People, Healthy Economy, and Healthy Environment. Within each category are several goal areas. The progress of each goal, including Actions and Outcomes are as follows:

Healthy People

Goal 1 – Improve residents' access to healthy food and nutrition, and increase health education.

Actions to increase access to healthy foods in west Baltimore included successful completion of Hoop House with fresh produce, expansion of community gardens across four locations, and launch of mobile food truck, as well as provision of healthy foods market at hospital. Several partnerships formed with local non-profits and area churches.

Outcome: In addition to purchasers of fresh produce and fruits, bi-weekly delivery of fresh food to 26 families and pursuit of partnership with Maryland Food Bank for service to 75 more families.

Actions to increase youth and family education in nutrition, food selection and preparation resulted in:

- *Annual registration of 57 children in Early Head Start;*
- *15 Teen Parent educated (FY17) and 22 Teen Parent educated (FY18) within Family Support Program;*

- *30 youth educated on nutrition (FY17) and 58 youth educated on nutrition (FY18) through Summer Youth Works program;*
- *Education provided to 108 pre-kindergarten and kindergarten students at Frederick Elementary school.*

Actions to expand outreach education to up to six elementary schools.

Outcome: Annual education of 30 high school youth and 57 children on beneficial nutrition, food selection, and preparation.

Contract food service provider has held twice monthly produce market for past two years. Efforts to establish a virtual supermarket for residents have had limited success The Wayland Village housing location does operate the Virtual Supermarket for its residents.

Actions to support and advocate in conjunction with Baltimore Development Corporation for development of a grocery store in west Baltimore continue. This effort has a timeframe beyond the current CHNA and will require additional partners to accomplish.

Goal 2 – Improve the health status of southwest Baltimore residents by increasing awareness and treatment options surrounding mental illness and addiction, and empowering residents that suffer from mental illness and addiction through health promotion and education.

Actions to investigate and implement Behavioral Health screening services for both children and adults at Bon Secours Community Works resulted in creation of Behavioral Health screening tool by Bon Secours Department of Behavioral Medicine in FY17 that included component on adverse childhood events to identify childhood trauma. The tool was administered in FY18 across clients of Bon Secours Community Works.

Outcome: 742 assessments were completed through February 2019 with 24 referrals to the department of Behavioral Medicine.

Actions were directed to partner with the City of Baltimore Police Department (Western District) to provide annual training sessions for police officers' interactions with residents who have mental health issues or are in a mental health emergency / crisis.

Outcomes: In FY17 seventy-seven (77) were provided training and education. In FY18, Bon Secours participated in the Mayor's "Violence Reduction Initiative" and provided training and education to 56 officers. Through February 2019, 59 officers have been provided with training and education.

Actions were made to develop a more trauma-informed workforce through in-services and education regarding trauma-informed principles and corresponding protocols. Outcomes: In FY17, 217 workforce members, representing 25% of the total workforce received training. In FY18, another 15 training sessions were conducted reaching a total of 776 workforce members.

Goal 3 – Improve the health status of southwest Baltimore residents by engaging the community in screening and educational events that promote healthier lifestyles and better self-management of health and chronic illness.

Actions include a partnership with Kaiser Permanente, area schools, and community organizations to improve health outcomes through health education and health screenings.

Outcomes: In FY17, community school partnerships established with Frederick Elementary and Mary Ann Winterling Elementary (Kaiser). In FY18, 2,056 individuals received health screenings across thirteen senior housing sites, five health clinics, and seven faith based organizations. In addition, the Community Health and Housing Program was launched at Bon Secours housing residences to include smoking cessation classes, AED training, Narcan training, and HIV/AIDS education. In FY19, six local area school principals were funded to attend REACH Whole School Conference and 22 health screening events were conducted at faith-based communities.

Actions to inform the community of hospital quality and patient safety performance led to quarterly data reporting to community advisory board as well as link on hospital internet page.

Actions to maintain and expand capacity for emergency services resulted in continuation of contract with University of Maryland Medical Center.

Goal 4 – Improve the health status of southwest Baltimore youth by increasing awareness efforts and preventive measures related to children's health to promote healthy lifestyles for the entire family.

Actions to improve education and preventive measures included expanded engagement of the Family Health and Wellness Center, educational classes at the Women's Resource Center (WRC), and greater outreach and communication to community members.

Outcomes: In FY17, 248 women participated in monthly screenings and workshops at the WRC and 187 families attended Back to School Open House. The In FY18, the Family Health and Wellness Center participated in 8 community health fairs and

provided child safety education. WRC education classes were held twice a month, and the quarterly newsletter was distributed to 1200 households.

Actions to address infant mortality included in-home parenting skills training and education for 30 families annually through the Home Visiting Program with intent to increase babies born at full term by 5 percent annually.

Outcomes: In FY17, through a grant Bon Secours hired a Teen Parent Program coordinator. Twenty families were enrolled in the Home Visiting Program and of 17 babies born, 16 were full-term, an increase of 13% from FY16. Forty-one (41) young mothers received ongoing in-home parenting skills training for children under the age of three. In FY18, 15 teen parents participated in Program before funding ended. Home Visiting Program continued through FY18 and in FY19, thirty-two (32) families are presently being served through the Family League of Baltimore partnership.

Actions to expand behavioral health and substance abuse programs for children and youth included up to six annual presentations at the Bon Secours Family Support Center and establishment of new programs for Addiction Services for Adolescents and Child Psychiatric Rehabilitation Services.

Outcomes: In FY17, behavioral health and substance abuse staff made 26 presentations. In FY18, staff completed 452 assessments for Bon Secours Community Works clients and made 226 client referrals. In addition, staff screened 141 high risk/high utilizers for emergency services and with screening tools determined 32% of participants were at risk for anxiety, and 39% at risk for moderate or severe depression. In FY19, eight presentations have been made to date. Resources insufficient to continue development for intended new programs.

Healthy Economy

Goal 1 – Improve Baltimore residents' economic status by providing job readiness programs, ongoing adult education, and specific youth outreach, and participating in the creation of jobs in areas in which we have the most expertise and influence, namely, the health care field.

Actions to workforce development and economic status per above goal included job coaching assistance to community residents, increased enrollment in a CNA/GNA health care positions, and participation in Kaiser Future Baltimore Initiative.

Outcomes: In FY17, 73 residents were enrolled in CNA/GNA training and certification program, 63 completed the training, 60 obtained certification, and 56 were hired. Through workforce development coaching, 167 residents were placed in jobs averaging

$13.17 per hour wage. In FY18, 90 clients gained paid employment with job search and placement support; nine received paid urban landscaping training. Nine Patient Care Tech trainees were placed with jobs at the University of Maryland Medical Center. The Kaiser Future Baltimore Initiative enrolled 50 residents, 42 of whom completed training, and 35 participants received CNA certification and 18 participants obtained their GNA certifications. Through February in FY19, 62 residents have received employment support, and Kaiser Future Baltimore has enrolled 25 trainees in their most recent cohort.

Actions to increase pipeline of qualified candidates for health care jobs include CNA/GNA training programs funded by grants from the Workforce Innovation Opportunity Act (WOIA), and Ann E. Casey Foundation.

Outcomes: Across all funders, in FY17, there were 31 enrolled, 25 of whom completed training, 25 achieved certification, and 24 were placed in jobs. Seasonal job fairs were held for healthcare employers with average participation of 27 employers represented. In FY18, 35 individuals were enrolled, 28 of whom completed training, 26 of whom achieved certification, and 24 were placed in jobs. Through February of FY19, 52 participants were or are enrolled, 12 have completed training, 12 have achieved certification, and four individuals have obtained jobs with an average wage of $13/hour.

Actions to provide jobs and skills training for formerly incarcerated individuals include the Bon Secours Re-Entry Program, TYRO, with funding by the Department of Labor, and Kaiser Permanente.

Outcomes: In FY17, there were 117 enrolled participants and 60 completed TYRO programs. In FY18, a case manager was hired and 154 clients were enrolled in TYRO programs with 110 participants completing Individual Career Plans, 29 of whom received a degree or certificate, and 14 were employed. Two expungement workshops were conducted with 379 expunged offenses for 78 individuals.

Actions to incorporate job readiness into the Youth Works development program included enrollment of 16 – 24 year old CNA/GNA trainees in forty hour Pathway to Success training as well as occupational training and certificate preparation for up to eight annual trainees of the Clean and Green initiative.

Outcomes: In FY17, of the 24 WOIA students enrolled, 20 completed training, and 18 received CNA/GNA certifications. Of the eight Clean and Green trainees, five graduated and completed certification training. In FY18, 21 of the 24 CNA/GNA youth trainees graduated and all received CNA certification. In addition five received GNA

certification, and 9 obtained jobs in health care. In FY19, there are currently 30 recent high school graduated youth enrolled in CNA/GNA Baltimore Promise program.

Actions to enroll 50 participants in GED program with at least 5 percent obtaining their GED included efforts to partner with Baltimore City Community College and the South Baltimore Learning Center for referral of enrollees.

Outcomes: In FY17, nine enrolled participants. In FY18, twenty-seven (27) enrolled participants. In FY19, fourteen (14) adult students currently enrolled in GED program.

Goal 2 – Support the creation and preservation of affordable housing opportunities for families, seniors and special populations through the development of additional housing units.

Actions to expand the availability of affordable housing included construction and completion of the New Shiloh Family Apartments and development of an additional 200 units of rental apartments for families, seniors, and disabled persons.

Outcomes: In FY17 Bon Secours Gibbons Apartments opened and all 80 unites were leased in FY18. In FY18, New Shiloh Apartments opened and in FY19 all 73 units were leased. In FY17, feasibility studies were completed for Wayland II, Bon Secours Apartments V, and Southwest Partnership Lease-Purchase projects. In FY18 and FY19 tax credit applications to state were submitted. Awaiting approval.

Healthy Environment

Goal 1 – Increase the number of public green spaces that are safe and well-maintained by supporting the transformation of vacant lots to develop safe, public spaces for use by the community.

Actions to expand the conversion of vacant lots into clean and usable spaces included partnerships with community associations and targeting of 52 vacant lots.

Outcomes: In FY17, grant obtained to continue Clean & Green initiative. In FY18, vacant lots were prioritized with cooperation from Anchor Community Group. Fifty-seven lots were cleaned and maintained. In FY19, a new Workforce Development director was hired with plans to expand Clean & Green initiative.

Actions to raise environmental awareness across community included coordination of up to six workshops/projects with residents and community groups.

Outcomes: In FY17, team conducted six clean up and service day projects in partnership with various community groups and organizations. In FY18, team

conducted two clean up and service day projects in partnership with community groups. In FY19, team initiated student engagement in advocacy with legislators and Future Baltimore initiatives. Fifty-five (55) students and 117 individuals participated in meetings and workshops.

Actions to develop safe and well maintained spaces included Clean & Green program participants providing landscaping services at Unity Properties housing developments.

Outcomes: In FY17, trainees expanded landscaping services to include snow removal and urban agriculture. In FY18 and FY19, had and have six trainees enrolled in Clean & Green program with annual spring graduation.

Actions to address community concerns and needs included convening quarterly community forums in all segments of the service area.

Outcomes: In FY17, four Community Forums were held. In FY18, four Community Forums were held. Through February of FY19, two Community Forums have been held.

Goal 2— Address ongoing community resident concerns related to crime and sanitation.

Actions to address community concerns related to crime and sanitation included convening a minimum of ten (10) meetings per year with participation from at least three City agencies (non-police).

Outcomes: In FY17, staff convened 12 Crime and Grime meetings with between 3 to 5 City agencies representatives in attendance. In FY18 and FY19, monthly meetings have continued with average of 4+ City agencies in attendance across community associations.

Actions to convene and develop leadership across community associations included a leadership training program and establishment of Anchor Group Committee.

Outcomes: In FY17, increased participation by Celebration Church, Central Baptist Church, Fayette Street Outreach, Boyd Booth and Franklin Square association leaders. Anchor Group Committee began monthly meetings. In FY18, Leadership Training in partnership with Kaiser Permanente was initiated. Curriculum was provided to Anchor Group Committee leaders. Ten training sessions occurred in fiscal year. In FY19, Anchor Group conducts and leads monthly meeting and gives guidance to Bon Secours work and engagement.

Actions to strengthen relationships with police districts in Bon Secours service area included participation of police in Crime and Grime meetings as well as annual updates to community relations committees of each police district.

Outcomes: In FY17, Southwestern and Western District police departments were active participants in Crime and Grime meetings. In FY18, meetings continue and representatives of City Department of Justice and Violence Reduction Initiative attend as well. In FY19, meetings have continued.

Actions to continue Crime and Grime committee include twelve meetings per year and continued staff support by Bon Secours.

Outcomes: In FY17, twelve (12) meetings were held. In FY18, nine meetings were held. Meetings are monthly in FY19.

3 Overview of Bon Secours Hospital and the Bon Secours Baltimore Health System

Bon Secours Baltimore Hospital (Bon Secours) is a 69-bed facility licensed in the state of Maryland providing acute, primary and specialty care services to residents in various communities in and near west Baltimore. Bon Secours includes a community-based primary care site, behavioral medicine program with multiple substance abuse treatment sites, renal dialysis services, and preventive health and education programs. Bon Secours is part of the Bon Secours Baltimore Health System which also includes Unity Properties Housing, Bon Secours Community Works, and the Bon Secours Baltimore Health System Foundation. Bon Secours is a member of Bon Secours Mercy Health. On February 26, 2019 Bon Secours Mercy Health and LifeBridge Health signed a letter of intent for LifeBridge Health to acquire Bon Secours Hospital.

Mission

As a member of Bon Secours Mercy Health, the mission of the Bon Secours Baltimore Health System, including Bon Secours Hospital, is to extend the compassionate ministry of Jesus by improving the health and wellbeing of our communities and bring good help to those in need, especially those who are poor, dying and underserved.

With this mission in mind, Bon Secours stands proudly as an anchor institution in an area of west Baltimore that has suffered from disinvestment for many years. Its delivery of quality healthcare and community services is critical to the health and wellbeing of people in the area. In fulfilling its mission, Bon Secours also generates critical economic impact in the surrounding community and across Baltimore City.

Our team cares for west Baltimore residents through nonprofit subsidiaries comprising the Bon Secours Baltimore Health System, each with a separate Board of Directors responsible for fiscal and operational oversight.

- **Bon Secours Baltimore Hospital** focuses on acute, primary and specialty care. It includes a 69-bed acute care hospital, a community-based primary care site, behavioral medicine program with multiple substance abuse treatment sites, HIV/AIDS counseling and treatment, renal dialysis services, and preventive health and education programs.

- **Bon Secours Baltimore Health System Foundation** was established in 2012 as the fundraising arm for all Bon Secours Baltimore Health system entities, managing public and private grants, individual and corporate gifts, special events, and marketing. It serves as the fiscal agent for many grants.

- **Bon Secours Community Works** was launched in 1991 to provide programs that address the social determinants of health impacting West Baltimore residents. Although a client may come in requesting help with one issue, one of our strengths is our wide array of wraparound services: job readiness training, assistance with job placement and occupational training enrollment, tutoring in reading and math, GED preparation, financial education and counseling with help to enroll in public benefits, eviction prevention assistance, family strengthening programming including Early Head Start child development and parenting classes, a women's day shelter, and other services.

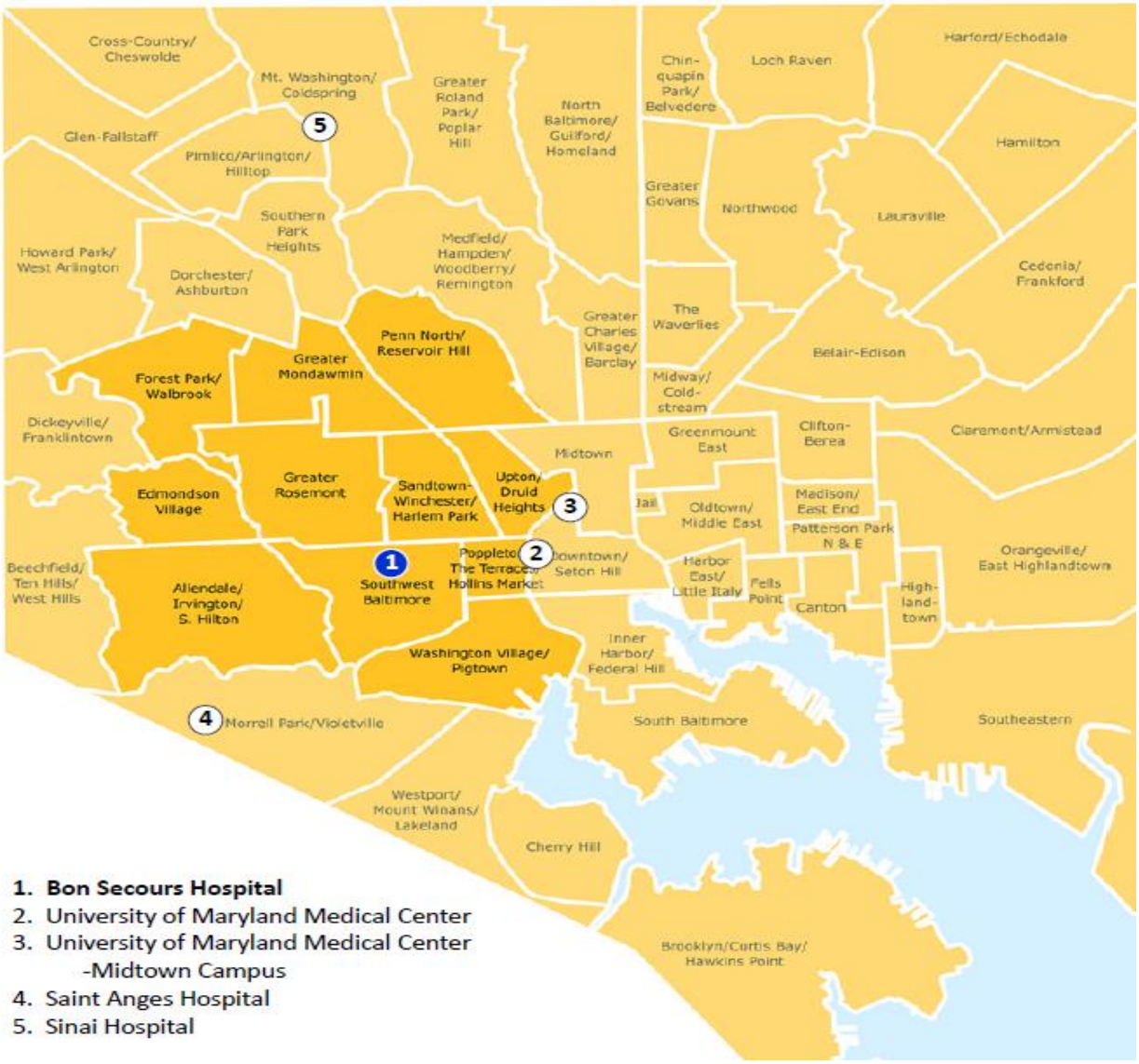
- **Unity Properties** is the housing and community development subsidiary, providing safe and affordable housing to low-income families, seniors and people with disabilities. Together, their supportive programs integrate with Bon Secours' health care services to make positive changes in individuals' physical and mental health.

3.1 Description of the Community Served

Baltimore City collects data across fifty-five (55) Community Statistical Areas ("CSAs"). These CSAs reflect neighborhood groupings. Bon Secours has determined that its primary service area is comprised of ten CSAs, depicted in Figure 2 (darker shaded area).

Bon Secours is the only hospital provider located within these ten CSAs though other hospitals and health systems are adjacent to the CSA population and provide corresponding and complementary services.

Figure 2 - Bon Secours Primary Service Area



1. **Bon Secours Hospital**
2. University of Maryland Medical Center
3. University of Maryland Medical Center
   -Midtown Campus
4. Saint Anges Hospital
5. Sinai Hospital

Service Area Demographics

Population

As of 2017 the population of Bon Secours' CSAs ("service area") is 105,816 residents, or 17.1% of Baltimore City's population. The CSAs have lost 3.5% of its population since the 2010 US Census.

Three CSAs - Greater Rosemont, Southwest Baltimore, and Sandtown-Winchester/ Harlem Park - comprise 44.8% of the service area population.

Table 1 – Service Area Population

Community Statistical Area (CSA)	Total Population
Edmondson Village	8,160
Forest Park/Walbrook	10,156
Greater Mondawmin	9,089
Greater Rosemont	17,348
Penn North/Reservoir Hill	10,569
Poppleton/The Terraces/Hollins Market	4,834
Sandtown-Winchester/Harlem Park	13,204
Southwest Baltimore	16,843
Upton/Druid Heights	10,210
Washington Village/Pigtown	5,403
Bon Secours Service Area	105,816
Baltimore City	619,796

Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute, Vital 17

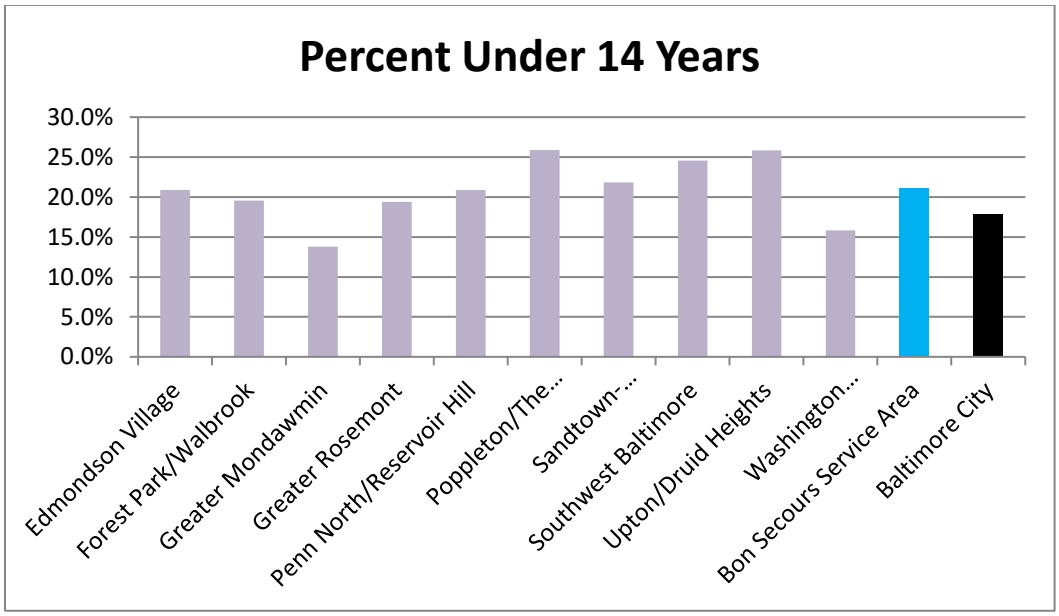
The service area is similar to Baltimore City in regards to gender with females constituting 53.5% and males 46.5% of the population. City-wide, males are 47% of the population.

Age

Across the service area the population is younger than Baltimore City as a whole.

- 21.1% of the population is under 14, versus 17.8% city-wide; Upton/Druid Heights and Poppleton/The Terraces/Hollins Market each have 25.9% population under 14 years of age. Greater Mondawmin has significantly less population (13.8%) under 14 years. (See Figure 3 below)
- The 60+ population (18%) is comparable (less than 1 percent variation) to all of Baltimore City, though Poppleton/The Terraces/Hollins Market has significantly fewer seniors (11.7%).

Figure 3 – Population Under Age 14



Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute

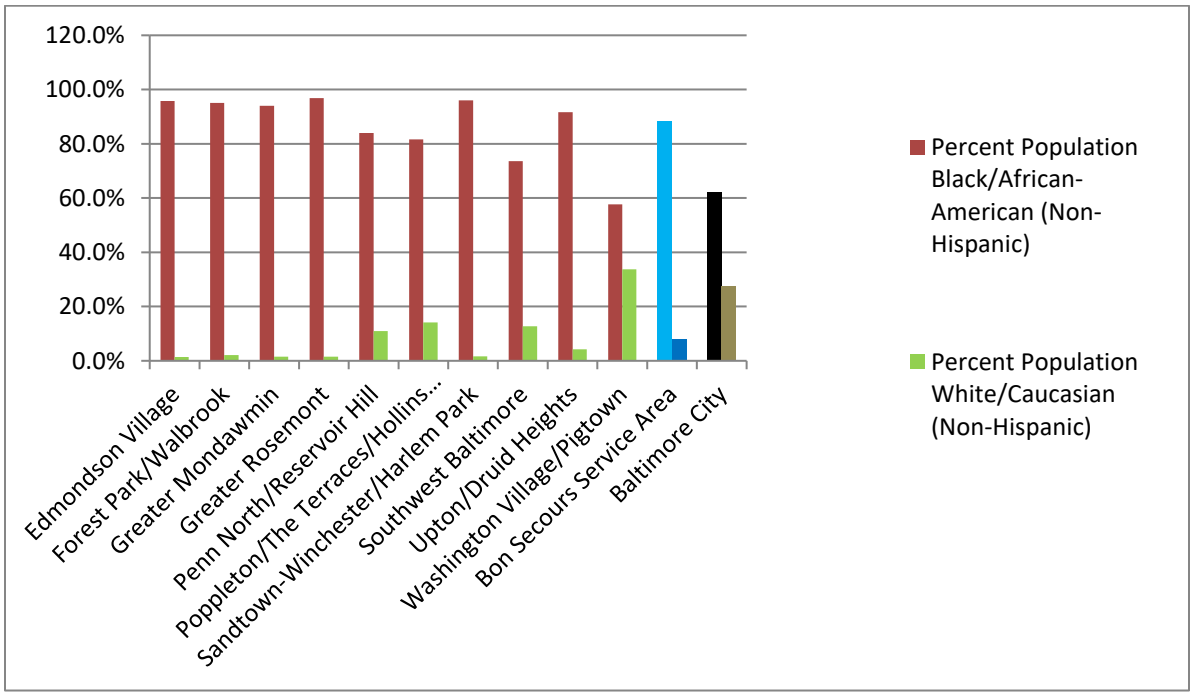
In addition, there are significant differences with regard to race/ethnicity, income, and access to insurance (Income will be discussed within the Socio-Economic section). Overall, the service area is a substantially African American, of lower income, and either uninsured or publicly insured.

Race/Ethnicity

The service area's race/ethnicity is substantially African American, with six CSAs exceeding 90 percent.

- 88.4% of the total service area is African American, which is greater than Baltimore City and the state of Maryland (62.3% and 29.4%, respectively). White/Caucasians constitute another 7.8% across the service area.
- Only Washington Village/Pigtown has a White/Caucasian population percentage greater than the City as a whole (33.7% vs. 27.6%).
- All other race and ethnic groups combined represent less than 4 percent of the service area's population.

Figure 4 – Race/Ethnicity by CSA and Baltimore City

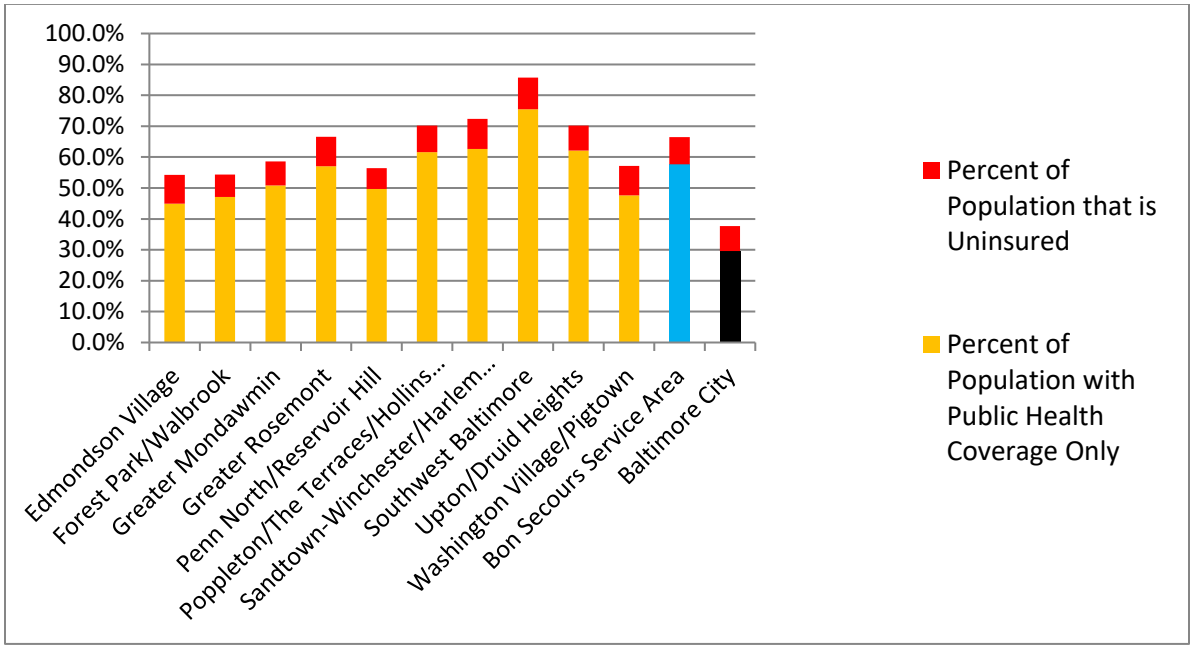


Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Access to Insurance

The service area has a much higher percent of individuals that have public insurance compared to Baltimore as a whole (57.6% vs. 29.6%). All CSAs have more than 40% of their population enrolled in public insurance, the vast majority being enrolled in Medicaid. The service area has a higher proportion of uninsured persons (8.8%) compared to Baltimore (8.0%).

Figure 5 – Percentage of Individuals with Public or No Insurance by CSA and Baltimore



Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute

4 CHNA Approach and Methodology

Bon Secours used a work group ("team") to complete the CHNA to ensure that the CHNA was conducted in a way that best identifies west Baltimore's health needs and meets the IRS CHNA requirements for not-for-profit hospitals. (Refer to Appendix 1 for the list of Bon Secours team members). The CHNA Advisory Board, which had representation from community leaders, community anchor institutions, faith-based organizations, as well as representatives of The Mayor's Office participated in discussion of community health needs and supported the prioritization of identified health needs. (Refer to Appendix 2 for the list of Community Advisory Board membership).

As part of the CHNA methodology to identify community health needs, the team collected and analyzed both qualitative and quantitative data via community input and review of secondary data sources. Quantitative data was provided by the Baltimore City Health Department as well as Baltimore Neighborhood Indicators Alliance – Jacob Francis Institute (BNIA).

The CHNA team used a multi-pronged approach to solicit input from the community across the service area regarding their health needs. Qualitative data collection methodologies included stakeholder interviews, focus groups, and a survey.

Methods were based on the intended target audience and information needs. Figure 6 below shows the data collection method used to meet CHNA requirements.

Figure 6 - CHNA Requirement and Data Collection Methodology

CHNA Requirement	Data Collection Methodology
Secondary Data sources reflecting health and social conditions of the community served.	• Baltimore City Health Dept; BNIA
At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health with knowledge, information, or expertise relevant to the health needs of that community;	• Stakeholder Interviews
Members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations;	• Stakeholder Interviews • Survey • Focus Groups

Input received from a broad range of persons located in or serving its community including but not limited to health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers, and community health centers, health insurance and managed care organizations, private businesses and labor and workforce representatives.	• Survey • Focus Groups

5 Qualitative Findings

Stakeholder Interviews

Qualitative in-depth interviews were conducted with key stakeholders to include city and state health department representatives, community leaders, and health care providers. The stakeholders were selected because they had special knowledge of or expertise in public health or represented the broad interest of the community served by Bon Secours, including the interests of medically underserved, low-income and minority populations with chronic disease needs.

The stakeholder interviews were conducted between January 2019 and March 2019.

Bon Secours obtained input from eleven (11) key Community Stakeholders regarding the health needs of the community. Interviewees were asked to identify available health resources in the community, gaps in resources, barriers to obtaining services, existing collaborations and expected changes or trends in the community. Interviews were conducted in-person (with the exception of two) and lasted approximately 45 minutes to 1 hour. A designee employed by Bon Secours Community Works conducted the interviews and provided each participant with the Bon Secours 2016 CHNA Report & Implementation Plan.

Overall, Bon Secours received positive feedback about the community health resources and investments made within Southwest Baltimore and surrounding community service areas. Despite, Bon Secours' strong commitment to address the health concerns of the community, stakeholders highlighted the following themes as top health concerns:

- **Behavioral Health, Substance Abuse, Mental Health and related Trauma** with a special emphasis on the opioid crisis, drug overdose, and violence reduction;
- **Addressing Social Determinants of Health** (stable housing, workforce development, increase access to healthy foods and physical activity);

- **Chronic Health Conditions** (childhood and adult obesity, cardiovascular disease, cancer, diabetes, hypertension, asthma).

A number of health resources in the community were highlighted in collaboration with the health department: direct medical and dental services, mobile clinics, urgent care/acute management, outreach workers/community health workers, homeless services, access to care, legal clinic services, EMS department, mental health, treatment programs, family planning and care coordination. Bon Secours was highlighted as a great partner and anchor institution to bring resources to the community. “Hospitals are available to serve the community” but there must be a coordinated effort to keep asset maps up-to date. **A recommendation was given to encourage community member to use “2-1-1 Maryland” as a centralized resource to received access to health and human services information.**

Although, key stakeholders were able to mention a variety of available health resources in the community there are still gaps that impact the health status of residents. Additionally, it was highlighted that there is a lack of connection between access to care and awareness of resources. The development of creative approaches to engage various partners and best utilize strategies for care coordination could assist with needs. The following were major themes:

- **The need for case management services** not only in the hospital but in community based programs to help persons navigate their health challenges; helping persons to access resources when they are ready for change; and providing safe spaces to address mental health, behavioral health treatment and trauma on-demand;
- **Building stronger youth programming** - childcare support should be affordable and high quality; provide access to “judgement free” health services for young people; provide recreational facilities and out-of-school-time program to play an important role in young people’s development;
- There is a **critical need for addressing the chronic homelessness** experienced due to a lack of stable and affordable housing options. When individuals and families are displaced it greatly impacts overall health status.
- There continues to be a **lack of available resources around food** (lack of fresh food and grocery stores), **and employment** (job training resources).

Stakeholders also gave recommendations for resources in the community that are not being used to their full capacity, including:

- Mental health and trauma related resources are underutilized possibly due to stigma and trust must be built;
- Treatment (substance abuse) for outpatient medication assistance programs need to be evidence-based and increase community members awareness/training around naloxone;
- Chronic disease management programs and community-based programs for cardiovascular disease and diabetes (traditional vs. non-traditional settings can impact success of reach and delivery);
- Services for returning citizens population to get connected to society, family and employment;
- Police department not used to full capacity because of communities' perceptions (fear, lack of trust).

Bon Secours understands that in an effort to address the central health needs of the community, barriers to obtaining health services in the community must be highlighted and addressed. **Community stakeholders highlighted the following barriers:** transportation; communication/messaging; related trauma; stigma, trust and awareness of resources; gaps in funding to support community; ability to navigate services; legal backgrounds; neighborhood barriers to seek services from other communities; services provided only during traditional hours; income and insurance inhibits seeking services; and lack of knowledge/low literacy.

Despite barriers all stakeholders remain hopeful for the future of southwest Baltimore. Stakeholders expected changes and trends will lead to revitalization around housing, blight elimination and increase in homeownership amongst minority populations. There is hope for the opioid epidemic to plateau and shifts in reduction of stigma/increase in access to treatment which impacts crime. Positive feedback was given about the Kaiser Permanente, Bon Secours, and Community relationship/partnership to strengthen the mission of making a better Baltimore. Lastly, "the community has strong advocates and capable people to help anchor institutions help the community with existing needs. There is a need for more partnership building between the community and its members. Focus should be placed on the community as a force that can truly help institutions move forward."

The interview questions can be found in Appendix 3. The list of stakeholders interviewed is provided in Appendix 4.

Focus Groups

The Bon Secours CHNA team held three focus group conversations on March 13, 2019, April 5, 2019 and April 10, 2019. The first conversation was with Behavioral Health and Substance Abuse professionals. The second conversation was with leadership of the "Anchor" organizations – community associations and church groups – of west Baltimore. The third focus group conversation was with CHNA Advisory Board members who have provided input over the past two CHNAs conducted by Bon Secours Baltimore.

For the Behavioral Health focus group the conversation was structured to elicit current views of the Opioid crisis, perspective on trends over the past three to five years, identification of barriers to treatment or disinclination to choose treatment, as well as open-ended opportunity to propose impactful actions at the clinical, regulatory, and macro/holistic level.

For both the "Anchor" as well as Advisory Board conversations, the participants reviewed the 2016 CHNA Implementation Plan goals and actions under *Healthy People*, *Healthy Economy*, and *Healthy Environment*. Participants were asked to provide feedback on the 29 actions, identify additional unmet needs, and in the last segment of the focus group to give input to the Prioritization process by selecting the one or two most significant actions or unmet needs.

The following issues/needs were recommended as significant Priorities:

- **Children's Health / Trauma** (specifically mental health/substance abuse), including youth;
- **Development and Advocacy for a neighborhood Grocery Store**/supermarket
    - Develop a food access strategy
    - Provide greater nutritional education, especially for children
    - Obesity prevention and reduction;
- **Crime and Related Trauma;**
- Increase financial resources for programs and services.

A record of the three focus group conversations can be found in Appendix 5.

Survey

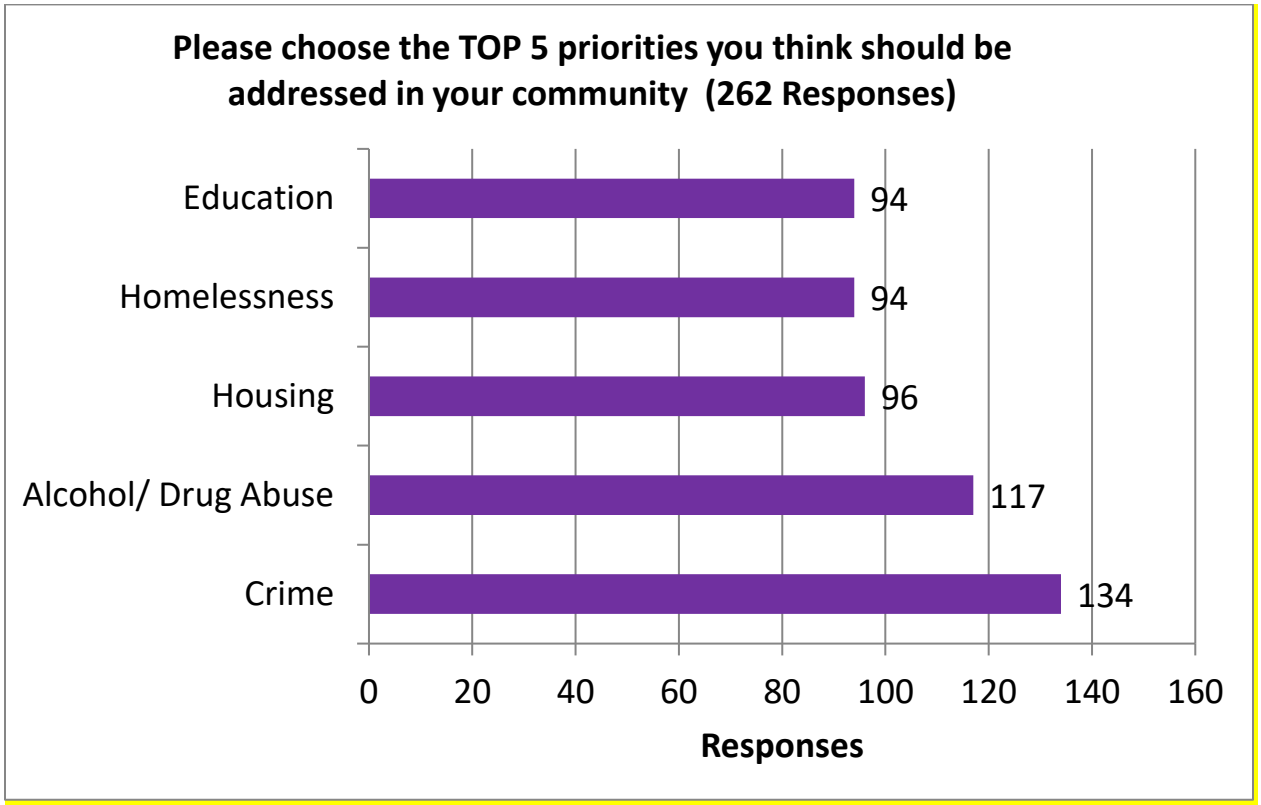
A web-based and hardcopy survey instrument used in 2016 to collect information from West Baltimore residents regarding their health and social needs was distributed again in 2019. The survey consisted of twenty-seven questions (both open and closed ended) covering the following categories: My Community, Community Support and Services,

Health Literacy, Community Safety, Community Priorities, Technology and Health and Demographics. Hardcopies of the survey were made available across the ten CSAs at various community partner and public entities, e.g. library.

A total of 273 surveys were collected between December 2018 and March 2019. Females represented 69% of the respondents, while 25% were older adults (between the ages of 65 – 79). Eighty-eight percent (88%) described themselves as Black, African-American, or African-Caribbean. Only 29% indicated they were working full-time, and 49% said they were renting their residence. Forty-one percent (41%) had obtained their high school diploma or GED. Aside from the skewed gender participants, the demographics of survey respondents are similar to the population of the service area.

Crime and Alcohol/Drug Abuse were the most significant concerns of respondents, listed 51% and 45% respectively. Housing, Homelessness, and Education were listed by more than one-third of all respondents (36-37%). See Figure 7. Four of the five concerns were among the TOP 5 concerns in 2016. Alcohol/Drug Abuse replaced Jobs with Fair Wages in 2019.

Figure 7 – Survey of Top 5 Priorities to be Addressed in Community



Responses to all Survey questions can be found in Appendix 6.

6 Secondary Data Analysis

Data Source

City and service area CSA data were gathered from publically available datasets, using the most recently available year(s). The Baltimore City Health Department, Neighborhood Health Profile Online Data, January 2019 (Baltimore City Health Department) served as source for all health data below.

The organizing entity for socio-economic data was Baltimore Neighborhood Indicators Alliance-Jacob Francis Institute (BNIA) (www.bniajfi.org). Their *Vital Signs 16* indicators come from sources that can be grouped into the following categories:

- City sources - CitiStat/Baltimore 311, Department of Public Works, Department of Parks and Recreation-TreeBaltimore, Board of Elections
- State sources - Maryland Department of Housing and Community Development, 2011-2015
- Federal sources - American Community Survey, 2012-2016

Unless noted otherwise, BNIA is cited for data across the social and economic tables and charts.

6.1 Health Outcomes

Life Expectancy: Overall life expectancy in Baltimore City is 73.6 years compared to 70.3 years in the Bon Secours Service area.

Table 2 – Life expectancy at birth by CSAs, Bon Secours Service Area and Baltimore City

Community Statistical Area (CSA)	Life expectancy at birth, in years
Edmondson Village	71.8
Forest Park/Walbrook	74.0
Greater Mondawmin	70.4
Greater Rosemont	70.6
Penn North/Reservoir Hill	71.6
Poppleton/The Terraces/Hollins Market	68.4
Sandtown-Winchester/Harlem Park	70.0
Southwest Baltimore	68.0
Upton/Druid Heights	68.2
Washington Village/Pigtown	70.1
Bon Secours Service Area	***70.3***
Baltimore City	**73.6**

Mortality Rate: The all-cause age-adjusted mortality rate in Baltimore City is 100 per 10,000 residents vs. 118 in the Bon Secours Service Area. The top causes of death in Baltimore City are due to heart disease, cancer, and drug-and/or alcohol-related. The number of homicides that occurred per 10,000 residents (all ages) per year in Baltimore City is 3.9. Homicide mortality rate is also a large health disparity in the Bon Secours Service Area with age-adjusted mortality rates as high as 7.7 (Poppleton/The Terraces/Hollins Market). Youth homicide mortality rate in Baltimore City is 31.3 per 100,000 youth under 25 years old.

Table 3 – All-cause mortality, homicide, and Drug/Alcohol Rate by CSAs, Bon Secours Service Area and Baltimore City

Community Statistical Area (CSA)	All-Causes Mortality Rate	Homicide Mortality Rate	Drug/Alcohol Mortality Rate
Edmondson Village	113.0	5.6	2.8
Forest Park/Walbrook	94.4	4.6	4.3
Greater Mondawmin	116.2	5.9	7.4
Greater Rosemont	115.5	6.8	8.1
Penn North/Reservoir Hill	109.7	5.8	3.9
Poppleton/The Terraces/Hollins Market	131.4	7.7	8.8
Sandtown-Winchester/Harlem Park	116.0	7.3	10.3
Southwest Baltimore	128.7	5.5	8.5
Upton/Druid Heights	131.6	6.5	6.8
Washington Village/Pigtown	121.6	3.2	7.6
Bon Secours Service Area	***117.8***	***5.9***	***6.9***
Baltimore City	**99.5**	**3.9**	**4.4**

Heart Disease, Cancer, HIV/AIDS: The percentage of deaths due to HIV/AIDS in the Bon Secours Service Area (3.2%) is almost twice the percentage in Baltimore City (1.8).

Table 4 – Percentage of Deaths due to Heart Disease, Cancer, and HIV/AIDS by CSAs, Bon Secours Service Area and Baltimore City

Community Statistical Area (CSA)	% of Deaths due to Heart Disease	% of Deaths due to Cancer	% of Deaths due to HIV/AIDS
Edmondson Village	23.9	21.9	2.2
Forest Park/Walbrook	26.7	14.9	1.8
Greater Mondawmin	23.0	20.1	3.9
Greater Rosemont	23.6	20.7	2.7
Penn North/Reservoir Hill	26.4	21.5	2.9
Poppleton/The Terraces/Hollins Market	23.3	19.4	3.1
Sandtown-Winchester/Harlem Park	22.4	18.7	4.8
Southwest Baltimore	21.2	19.8	2.9
Upton/Druid Heights	28.1	18.9	2.8
Washington Village/Pigtown	25.6	15.3	4.6
Bon Secours Service Area	*24.4*	*19.1*	*3.2*
Baltimore City	24.4	21.3	1.8

Infant Mortality Rate: Infant mortality before the age of one continues to be an alarming concern for addressing the health needs of Women and their babies in Baltimore. The Infant Mortality rate in the Bon Secours Service Area is comparable to Baltimore City rates. However, there are two CSAs in the Bon Secours Service Area with alarming rates, Poppleton/The Terraces/Hollins Market and Southwest Baltimore, 15.4 and 13.9 respectively.

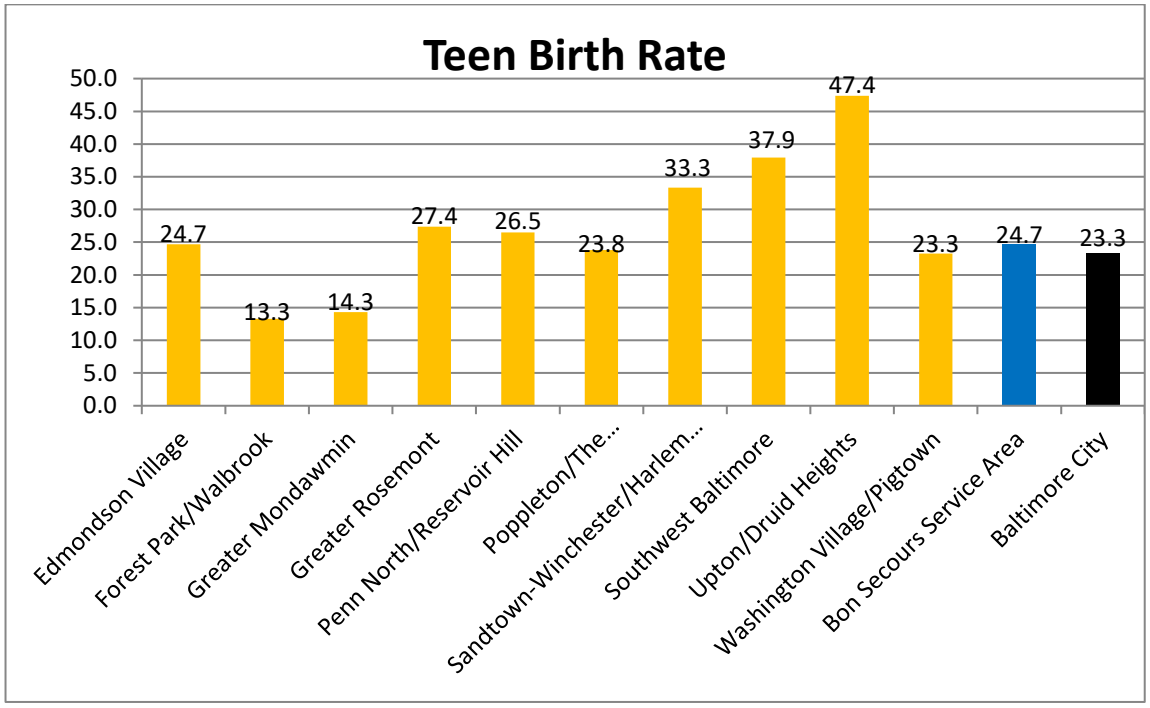
Table 5 – Infant Mortality Rate per 1,000 Live Births by CSA, Bon Secours Service Area and Baltimore City

Community Statistical Area (CSA)	Infant Mortality Rate, 1,000 live births
Edmondson Village	9.8
Forest Park/Walbrook	10.6
Greater Mondawmin	5.2
Greater Rosemont	11.3
Penn North/Reservoir Hill	9.9
Poppleton/The Terraces/Hollins Market	15.4
Sandtown-Winchester/Harlem Park	10.1
Southwest Baltimore	13.9
Upton/Druid Heights	10.0
Washington Village/Pigtown	4.6
Bon Secours Service Area	***10.1***
Baltimore City	**10.4**

Morbidity

Teen Birth Rate: Despite teen birth rates declining in the state of Maryland, the rate of female teens aged 15-19 that gave birth is 23.3 per 1,000 in Baltimore City. In the Bon Secours Service Area (24.7) there are some of the highest rates observed across Baltimore City. Upton/Druid Heights has a teen birth rate of 47.4 per 1,000 and Southwest Baltimore a teen birth rate of 37.9 per 1,000.

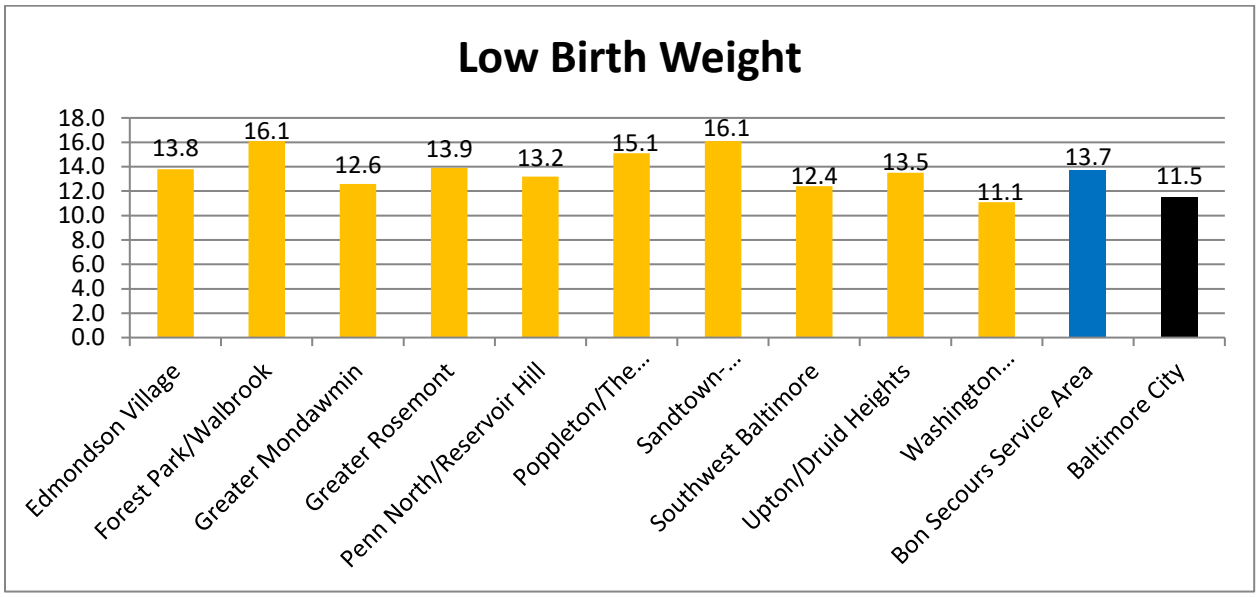
Figure 8 – Teen Births per 1,000 by CSA, Bon Secours Service Area, and Baltimore City



Source – Baltimore City Health Department

Low Birth Weight: Low birth weights (<5 lb., 8 oz) greatly impact the health status of children and within the Bon Secours Service Area the percentage of children with low birth weight is greater compared to Baltimore City. Three of the CSAs have the highest observed low birth weights across the entire City of Baltimore, Forest Park/Walbrook (16.1%), Sandtown-Winchester/Harlem Park (16.1%) and Poppleton/The Terraces/Hollins Market (15.1%).

Figure 9 – Percentage of Low Birth Weights by CSA, Bon Secours Service Area, and Baltimore City



6.2 Social and Economic Factors

Social and economic inequality, and its causes, are and have been a key focus of Bon Secours. The Bon Secours Service Area has been affected by decades of disinvestment and systemic racism that has contributed to significant health disparities for its population.

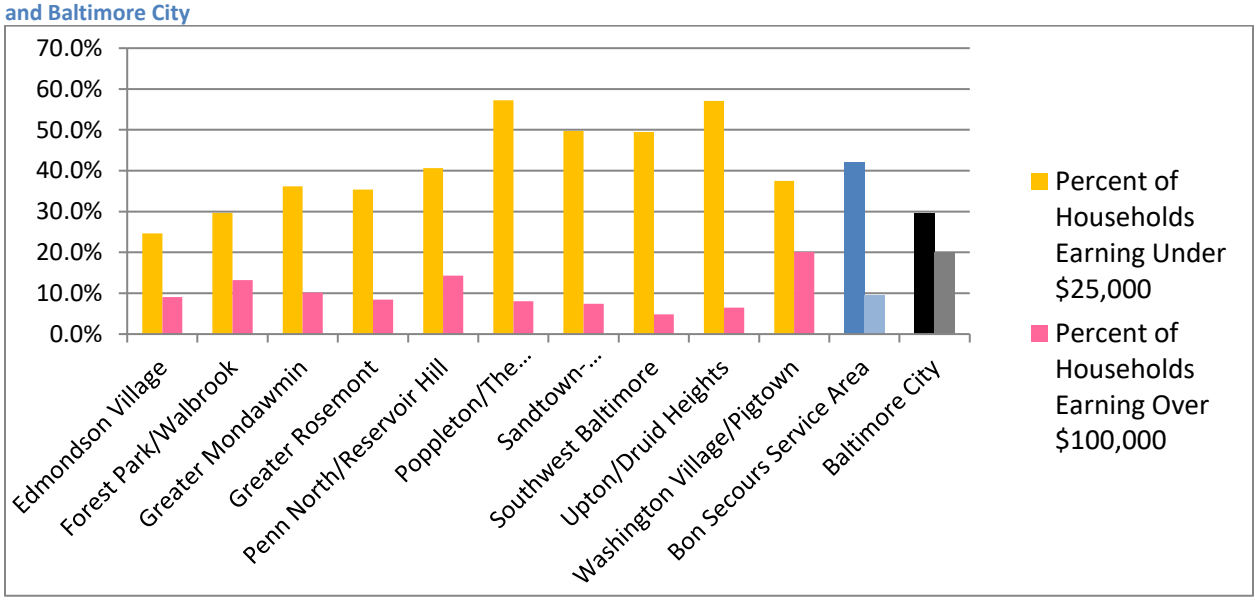
Inequalities exist among income, employment, education, and wealth gaps. The service area experiences more frequent crime and violence, and fewer affordable housing options than the City of Baltimore experiences as a whole. The deep poverty experienced by these residents has created conditions that undermine the health, economic, and educational success of families in the Bon Secours Service Area. While social and economic progress is being made much of it is incremental and will take additional decades to remedy.

Household Income/Poverty/Unemployment

Income, employment, and education, are key social determinants of health that impact the livelihood of Baltimore City residents.

In Bon Secours Service Area 42.1% of Households earn under $25,000 and 9.5% of households earn over $100,000 in comparison to 29.5% and 20% in Baltimore City, respectively. Consequently, for the Bon Secours Service Area more than 48% of children live below the poverty line compared to 33% for all of Baltimore City.

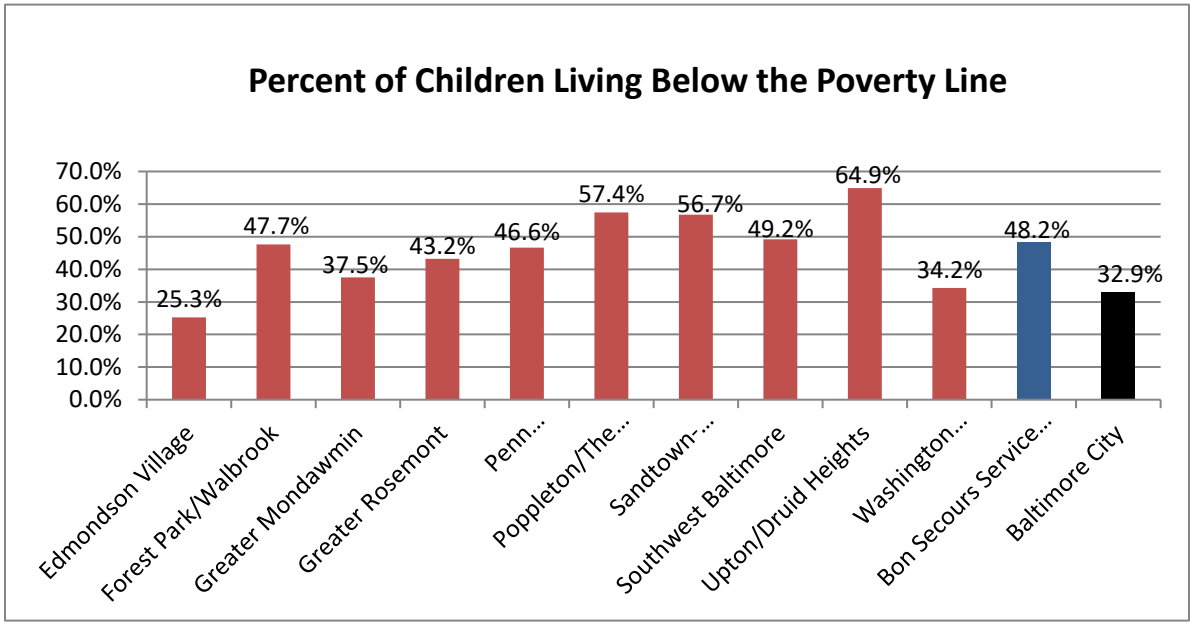
Figure 10 – Percentage of Households Earning less than $25,000 or greater than $100,000 by CSA, Bon Secours Service Area, and Baltimore City



Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Children Living Below Poverty: In certain neighborhoods, including Upton/Druid Heights, Poppleton/Hollins Market, Sandtown-Winchester/Harlem Park and Southwest Baltimore, more than half of all children live below the poverty line.

Figure 11 – Percentage of Children Living in Poverty by CSA, Bon Secours Service Area, and Baltimore City



Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

The **Unemployment Rate** is 10% in Baltimore City compared to 13.7% in the Bon Secours Service Area.

Table 6 – Percentage of Unemployed adults by CSAs, Bon Secours Service Area and Baltimore City

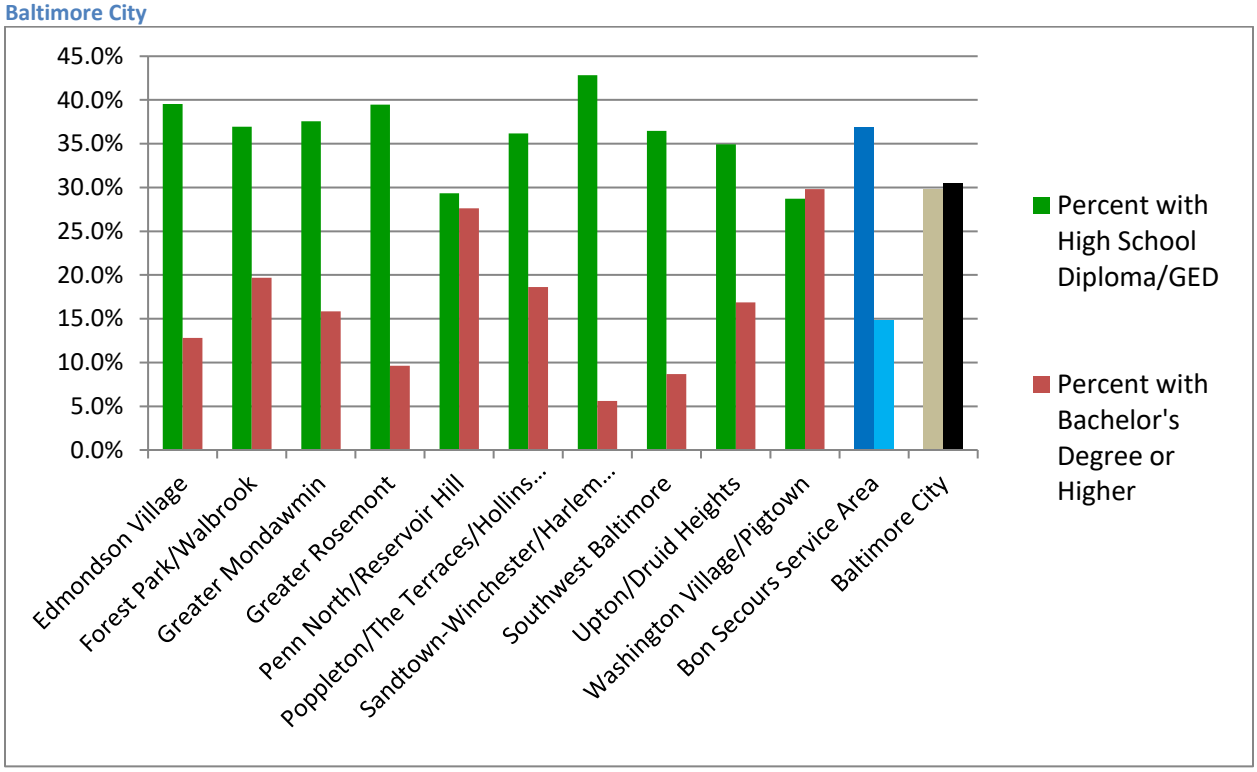
Community Statistical Area (CSA)	Unemployment rate, %
Edmondson Village	12.5%
Forest Park/Walbrook	11.4%
Greater Mondawmin	12.6%
Greater Rosemont	15.6%
Penn North/Reservoir Hill	12.0%
Poppleton/The Terraces/Hollins Market	16.1%
Sandtown-Winchester/Harlem Park	14.9%
Southwest Baltimore	15.1%
Upton/Druid Heights	12.0%
Washington Village/Pigtown	13.0%
Bon Secours Service Area	***13.7%***
Baltimore City	**10.0%**

Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Education Attainment

In terms of education, in the Bon Secours Service Area 36.8% of adults have obtained a **high school diploma or GED** and only 14.8% have obtained a **bachelor's degree or higher** compared to 29.7% and 30.4% in Baltimore City, respectively.

Figure 12 – Percentage of High School Graduates, Bachelor's Degree or Higher by CSA, Bon Secours Service Area, and Baltimore City

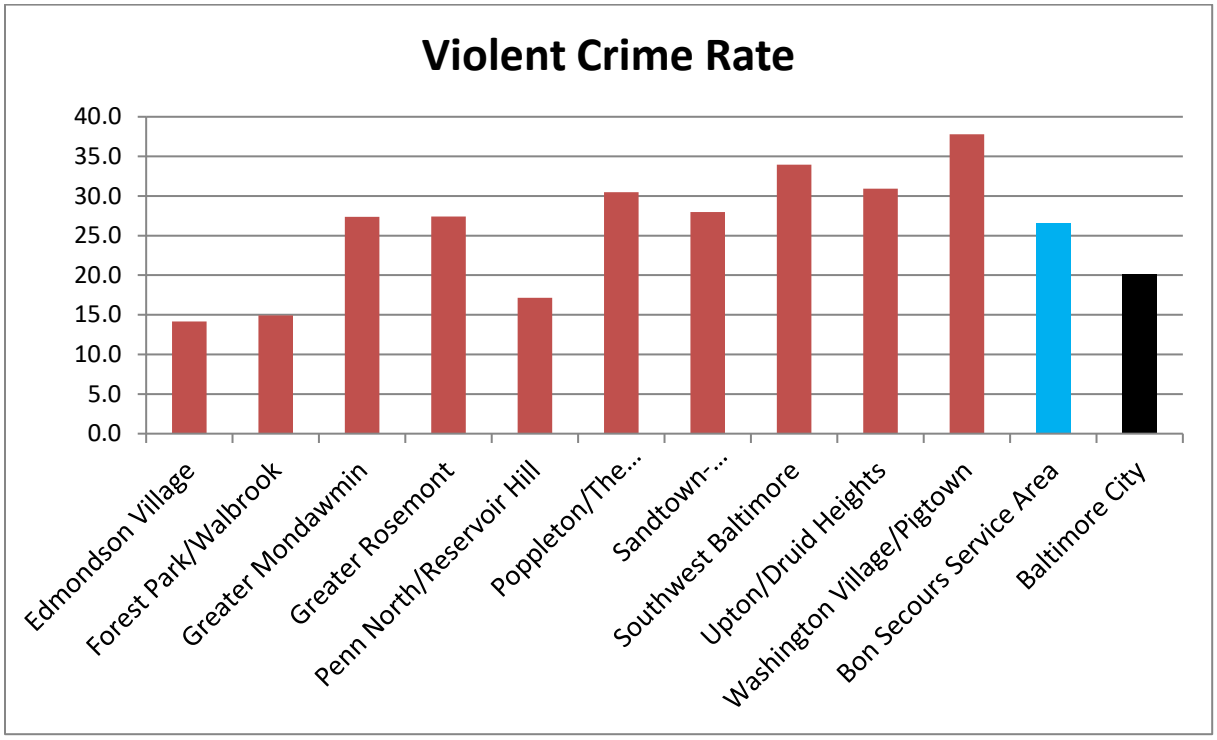


Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Violent Crime

Violent Crimes: The Bon Secours Service Area violent crime rate is 26.6 per 1,000 residents compared to 20.1 per 1,000 residents in Baltimore City. Violent crimes involve homicide, rape, aggravated assault, and robbery reported to the police department. Seven of the ten CSAs have violent crime rates higher than the rate for Baltimore City.

Figure 13 – Violent Crimes per 1,000 residents by CSAs, Bon Secours Service Area, and Baltimore City

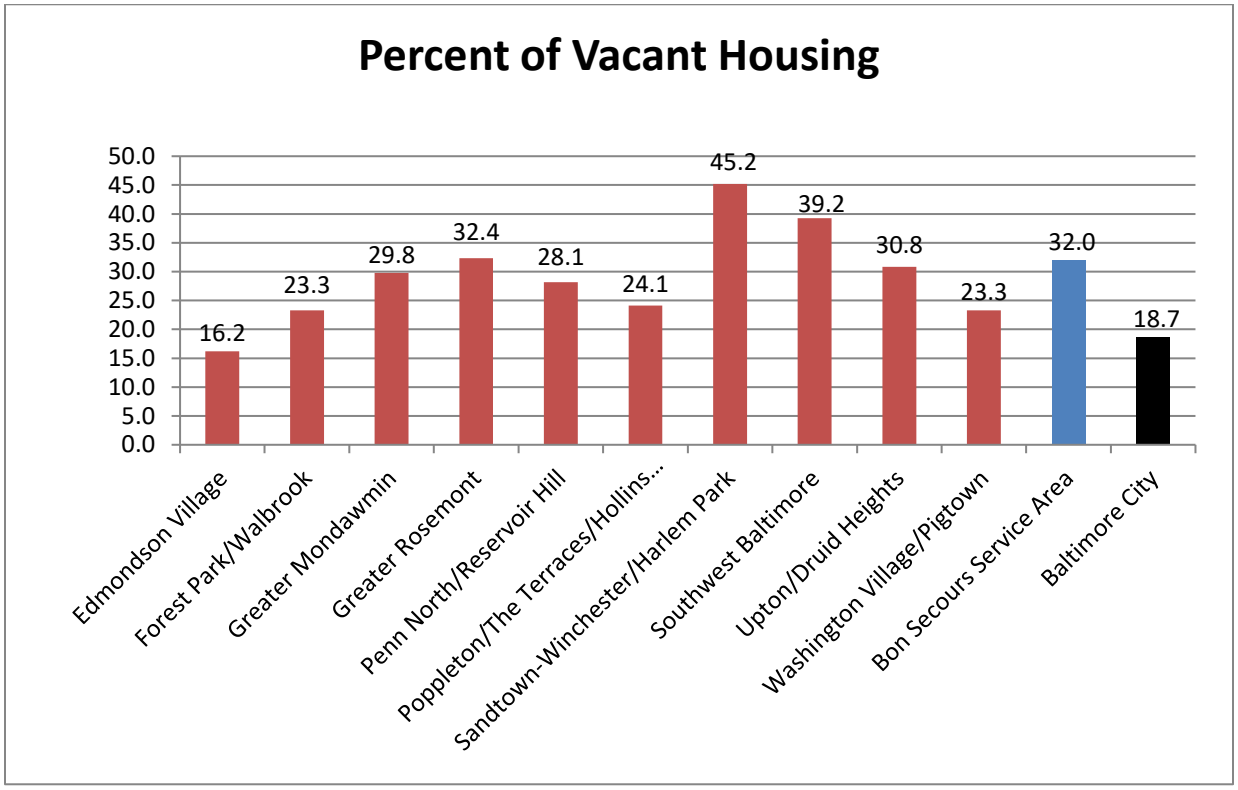


Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Housing Vacancy

Housing Vacancy: The Bon Secours Service Area (32.0%) has almost double the percent of housing vacancy in comparison to Baltimore City (18.7%). Within the service area there is wide variation in the percentage of vacant properties, though all but one CSA (Edmondson Village) has a vacant housing rate greater than Baltimore City.

Figure 14 – Percent of Housing Properties that are Vacant by CSAs, Bon Secours Service Area, and Baltimore City



Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

2-1-1 Calls

Of the 41,144 calls for assistance placed to United Way's 2-1-1 social services hot line between July 1,2018 and April 30,2019 (10 months), thirty-five percent (35%) of the calls (14,434) came from Bon Secours' neighbors in west Baltimore (zip code basis), a disproportionate share for all Baltimore City. The vast majority of calls throughout the city and in Bon Secours' service area were placed by women, and the top four requests were for assistance with Utilities, Housing, Taxes, and Food.

Hardship Index

Hardship Index: The Hardship Index is a measure of combined socioeconomic factors that include income, education, unemployment, poverty, crowded housing, and dependency (persons aged less than 18 years and 65+ years). As a multi-factor measurement, the Hardship Index more substantially reflects the wider context and varied dimensions of a community's overall health.

The Index has a range from 0 to 100, where a higher score reflects greater hardship across the community. In Baltimore City, the Hardship Index is 51. The Hardship Index for Bon Secours Service Area is 65 with the CSAs in the area ranging from 44-82.

Table 7 – Hardship Index by CSAs, Bon Secours Service Area and Baltimore City

Community Statistical Area (CSA)	Hardship Index, N
Edmondson Village	54
Forest Park/Walbrook	44
Greater Mondawmin	62
Greater Rosemont	65
Penn North/Reservoir Hill	65
Poppleton/The Terraces/Hollins Market	75
Sandtown-Winchester/Harlem Park	80
Southwest Baltimore	76
Upton/Druid Heights	82
Washington Village/Pigtown	56
Bon Secours Service Area	***65***
Baltimore City	**51**

7 West Baltimore Priority Health Needs

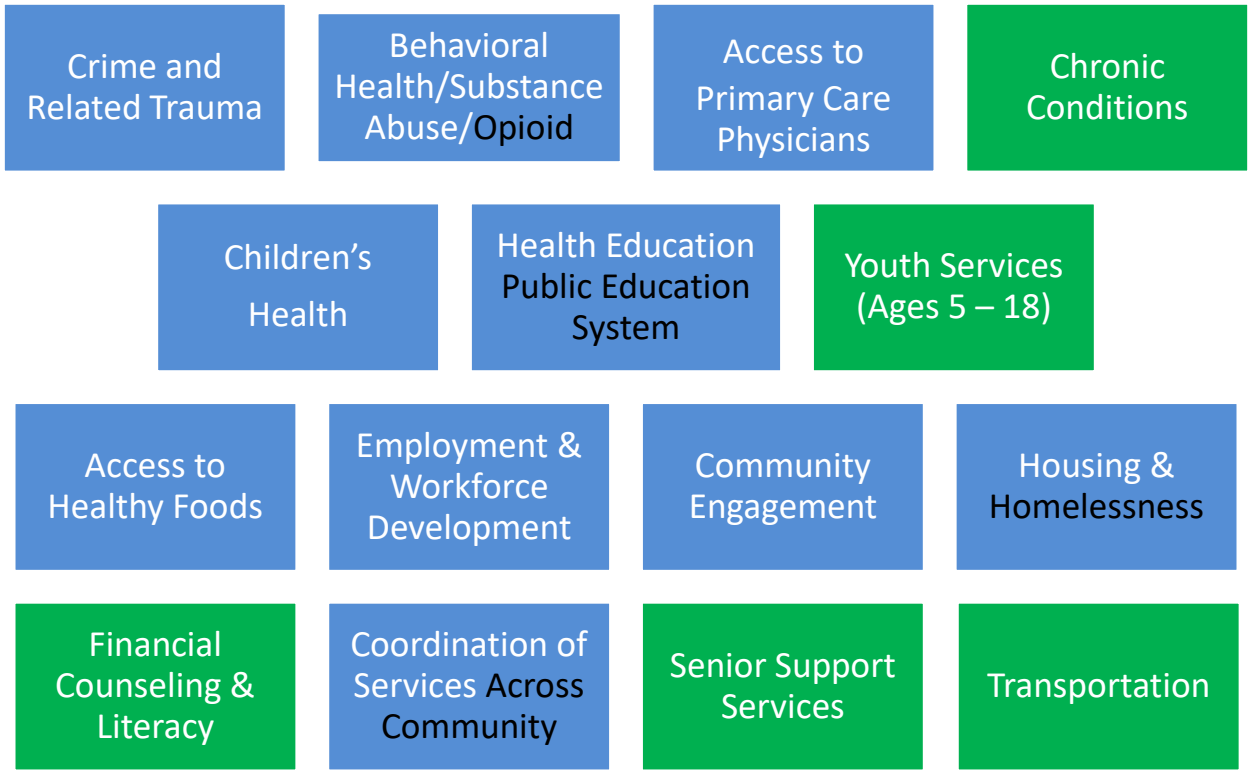
In 2016, Bon Secours Hospital identified the following health needs in the community:

- Crime and Related Trauma
- Behavioral Health/Substance Abuse
- Access to Primary Care Physicians
- Health Education
- Children's Health
- Access to Healthy Foods
- Expanded Housing
- Employment and Workforce Development
- Community Engagement
- Coordination of services across Bon Secours
- Advocacy, Policy, and Public Agency Dialogue, and
- Hospital Quality and Public Health

At that time the hospital and the local health system chose to prioritize all these needs and developed an Implementation Plan accordingly.

In 2019, the first ten needs (above) remained as **Identified Needs** of the community, and five additional needs (in green boxes below) as well as modifications (in black text) were added. See Figure 15 below.

Figure 15 – Identified Needs of Community Served



7.1 Prioritization Process and Criteria Used to Prioritize Needs

The Bon Secours Baltimore CHNA work group met with members of the Bon Secours Hospital board on May 22, 2019 and the Community Works board on May 23, 2019. Utilizing the criteria below, board members were asked to select those identified needs for which there was **"High Need and High Feasibility"** (ability to impact). Board members expressed particular concern for Employment and Workforce Development, Behavioral Health, Substance Abuse and Opioids, as well as Crime and Safety in the community.

The following **Criteria** were used to prioritize the community needs:

- Supported by Community Service Area data;
- Consistent with Public Health and health expert input, including the Baltimore City wide CHNA;

- In support of the Bon Secours Mercy Health strategic pillars and Key Performance Indicators (see Appendix 7);
- In support of benefitting a significant population of the community;
- In support of continuity and progress made by 2013 and 2016 Implementation Plans; and
- In consideration of 2019 community survey results.

7.2 Priorities for 2019 - 2021

The following **Identified Needs were selected as Priorities** by Bon Secours and will be included in the 2019 – 2021 Implementation Plan:

1. **Crime and Related Trauma**
2. **Employment and Workforce Development**
3. **Housing and Homelessness**
4. **Access to Healthy Foods**
5. **Health Education, and collaboration with the Public Education System**
6. **Program/Services for Youth (ages 5 to 18)**
7. **Senior Support Services**

Current management anticipates the 2019 – 2021 Implementation Plan will address these needs within the *Healthy People, Healthy Economy, and Healthy Environment* framework in conjunction with new ownership and management of the hospital. Unity Properties is the developer for affordable housing within the Bon Secours service area.

In addition, all parties recognize the significant need to address Behavioral Health / Substance Abuse and Opioid crisis. Bon Secours Community Works envisions supportive coordination with new hospital management for **Behavioral Health/Substance Abuse/Opioid** screening and interventions, **Children's Health** services as well as appropriate referrals and support to improve **Access to Primary Care Physicians** as well as to address **Chronic Conditions**. Bon Secours Community Works will also work with City agencies and collaborative organizations to advocate for and support improved **Transportation**.

Bon Secours Community Works will continue to offer **Financial Counseling and Literacy** services and to provide all its programs and services through processes that include **Community Engagement** and **Coordination of Services across the Community**.

8 Resources Available Within the Community Served to Meet Identified Needs

There are numerous programs and services available within the Bon Secours Baltimore Health System to address many of the identified community health needs. Additionally, there are a number of organizations and resources within the service area community with programs, services and or resources to address the needs identified via the CHNA. Bon Secours is prepared to partner with these organizations as needed to address the prioritized health needs of the community.

Bon Secours New Hope Treatment Center

Bon Secours New Hope Treatment Center has been rooted in west Baltimore for several decades and was one of the first Substance Abuse Treatment Programs funded by Behavioral Health Systems Baltimore to provide Methadone as a form of pharmacotherapy treatment to adult men and women diagnosed with a substance use disorder. Treatment & Medical Services include:

- Comprehensive Screening and Assessments
- Individual Counseling
- Standard & Intensive Group Counseling
- Gender-Specific group counseling
- Self-Help Support Groups-Methadone Anonymous
- Patient Advisory Board
- Overdose Prevention
- Smoking Cessation
- Relapse Prevention Family
- Education & Counseling
- Primary Care
- HIV education, counseling and testing

Bon Secours Family Support Center

Bon Secours Community Works' Family Support Center serves pregnant mothers and families with children up to age three. The Center offers Early Head Start services. At the Center, families receive support, encouragement and resources, such as GED preparation, developmental child care, parenting classes, employment readiness, counseling, tutoring, life skills training and money management. The Center's staff helps families make smart choices and become more self-sufficient by working with parents on child development and showing them best practices for raising children.

Bon Secours Housing (Unity Properties)

Bon Secours Apartments, Bon Secours Gibbons Apartments, and New Shiloh Village Apartments provide high-quality, low-cost rental housing to 272 low-and moderate-income families. This housing program began in 1997 when Bon Secours started acquiring and renovating large abandoned and severely dilapidated row houses near the hospital. The purpose is two-fold: to provide safe, decent and affordable housing and to improve a blighted neighborhood.

Bon Secours Baltimore Health System also offers several affordable independent living options for seniors and people with disabilities. Bon Secours has six properties in west Baltimore with over 530 apartment units. Each property is designed for people who want to enjoy a lifestyle filled with recreational, educational and social activities. These communities are for those who can live on their own, but who desire the security and conveniences of community living. Buildings are fully accessible and are close to shopping, recreation, educational opportunities, and many places of worship.

Other community resources include:

PUBLIC HEALTH DEPARTMENTS

The Maryland Department of Health and Mental Hygiene promotes and improves the health and safety of all Marylanders through disease prevention, access to care, quality management, and community engagement. The Public Health Services Division oversees vital public services to Maryland residents including infectious disease and environmental health concerns, family health services and emergency preparedness and response activities. The Behavioral Health Division promotes recovery, resiliency, health, and wellness for individuals who have emotional, substance use, addictive and/or psychiatric disorders. The Developmental Disabilities Administration provides a coordinated service delivery system to ensure appropriate services for individuals with developmental and intellectual disabilities. The Health Care Financing Division implements the Medicaid program, which features the department's HealthChoice and

Children's Health Program along with other initiatives, including those that help people with the cost of prescription medications.

The Baltimore City Health Department has a wide-ranging area of responsibility, including acute communicable diseases, animal control, chronic disease prevention, emergency preparedness, HIV/STD, maternal-child health, restaurant inspections, school health, senior services and youth violence issues. In collaboration with other city agencies, health care providers, community organizations and funders, the Health Department aims to empower all Baltimoreans with the knowledge, access, and environment that will enable healthy living.

COMMUNITY HOSPITALS AND ACADEMIC MEDICAL CENTERS

Baltimore has world-class hospitals and academic medical centers that provide the full range of emergency, inpatient and outpatient services as well as associated training, academic research, and community-oriented programs. There are 5 hospitals located in our West Baltimore CBSA. These hospitals are: University of Maryland Medical Center, University of Maryland Mid-Town, Bon Secours Hospital, Sinai Hospital of Baltimore, and Saint Agnes Hospital. In addition to these 5 hospitals, there are 6 other hospitals located in Baltimore that also serve Baltimore residents. These are: Mercy Medical Center, Harbor Hospital, The Johns Hopkins Hospital, Union Memorial Hospital, Good Samaritan Hospital, and Johns Hopkins Bayview Medical Center.

SAFETY NET PROVIDERS

Despite this wide dispersion and fragmentation, there is a group of 10-15 core safety net providers, dominated by Federally Qualified Health Centers (FQHC) and practices affiliated with the University of Maryland that are the heart of West Baltimore's safety net. The FQHCs and many of the hospital-based practices that serve the largest portion of West Baltimore residents, on the other hand, typically provide a broad range of enabling and supportive services such as outreach, health education, case management, interpreter services, and transportation. A number of the FQHCs also offer integrated behavioral health, dental and medical specialty care services.

STRONG NETWORK OF SOCIAL SERVICE, FAITH-BASED, AND OTHER COMMUNITY-BASED ORGANIZATIONS

Community dialogues reflected on the richness of West Baltimore's social service network and the long history of grassroots involvement in community development activities on behalf of West Baltimore's residents and neighborhoods. Faith-based organizations, community centers, Boys and Girls clubs, and schools are just some of the organizations that are at the core of this network. These organizations are and will continue to be a major asset for the community as safety net providers working to reach out and engage communities in primary care and other needed health care services.

ACADEMIC AND WORKFORCE TRAINING RESOURCES

There are numerous universities, colleges, and community colleges throughout Baltimore that provide a broad range of academic opportunities including degrees and training in health related professions. Many of these academic institutions are within the West Baltimore area. These academic programs provide a rich resource for the community in a variety of ways. Foremost are their contributions to educate and train residents of West Baltimore and beyond. They play a critical role in workforce development. They are also an invaluable resource and provide guidance, expertise, and support (financial and in-kind) to community endeavors. These institutions also provide student interns and volunteers that are a great service to the community. This helps to feed newly trained workers into the local force.

APPENDICES

Appendix 1 – Bon Secours CHNA Team

Organization	Staff Member/Title
Bon Secours Baltimore Health System	• Curtis Clark, Vice President, Mission (through December 2018) • George Kleb, Executive Director, Housing and Community Development
Bon Secours Community Works	• Talib Horne, Executive Director (through March 2019) • Maha Sampath, Executive Director (April 2019 forward) • Tatiana Warren, PhD, Business Intelligence Specialist • Hiwote Solomon, Graduate Resident
Bon Secours Health System	• Edward Gerardo, Facilitator • Amber Sain, Graduate Resident

Appendix 2 – Community Advisory Board Members

Name	Title	Organization
Tanya Terrell	GED provider	South Baltimore Learning Center
Carrie A. Williams	Employment Specialist	Project PLASE
Pastor Rodney Morton and Gail Edmonds	Pastor and Community Leader	Central Baptist Church
Reverend Bob Washington	Pastor and Community Leader	Celebration Baptist Church
Reverend Dr. Derrick Dewitt	Pastor and Community Leader	First Mount Calvary Baptist Church
Reverend Dr. Franklin Lance	Pastor and Community Leader	Mt. Lebanon Baptist Church
Joyce Smith	Chair, Community Leader	Operation ReachOut Southwest
Edith Gillard	President	Franklin Square Comm Assoc
Edna Manns	President	Fayette Street Outreach
Bertha Nixon	President	Boyd Booth Concerned Citizens
Celeste James	Director, Community Health	Kaiser Permanente
Camille Burke	Office of Chronic Disease	Baltimore City Health Department
Dr. Tyler Gray	Medical Director	Healthcare for the Homeless
Marianne Navarro	Anchor Institution Liaison & Coordinator	Mayor's Office of Economic & Neighborhood Development
John T. Bullock, PhD	District 9 Councilperson	Baltimore City Council
Dr. Ronald Williams	Interim Dean	Coppin State University, School of Business
Ashley Valis	Executive Director, Community Initiatives	University of Maryland
Roger Hartley	Dean of Public Affairs	University of Baltimore
Kimberly Hill	Principal	Lockerman Bundy Elementary School

Name	Title	Organization
George Kleb	Executive Director, Housing and Community Development	Bon Secours
Talib Horne, Maha Sampath	Executive Director, Community Works	Bon Secours
Tatiana Warren, PhD	Business Intelligence Specialist, Community Works	Bon Secours

Appendix 3 – Stakeholder Interview Questions

1) What is your current or past role in the Community?

2) What are the top three health concerns of the community?

3) What are the health resources available in the community?

4) What are the health resources that the community lacks?

5) What resources in the community are not being used to their full capacity?

6) What are the barriers to obtaining health services in the community?

7) What is the single most important thing that could be done to improve the health in the community?

8) What changes or trends in the community do you expect over the next three to five years?

9) What other information can be provided about the community that has not already been discussed?

Appendix 4 – Stakeholders Interview List

Name /Date of Interview	Organization / Affiliation	Special Knowledge / Expertise
Noel Brathwaite, PhD, MSPH 1/14/2019	Director, Maryland Office of Minority Health and Health Disparities	Maryland Department of Health
Darcy Phelan-Emrick, DrPH 1/30/2019	Chief Epidemiologist, Baltimore City Health Department	Baltimore City Health Department
Shelly Choo, MD, MPH 1/30/2019	Senior Medical Advisor, Baltimore City Health Department	Baltimore City Health Department
Marianne Navarro 2/06/2019	Anchor Institution Coordinator, Mayor's Office of Strategic Alliance	City's Anchor Institution Coordination/Special Assistant to Chief
Councilman John Bullock, PhD 2/06/2019	9th District Councilman, Baltimore City Council	Community Stakeholder
William Kellibrew IV 2/07/2019	Director, Office of Youth Violence Prevention	Baltimore City Health Department
Camille Burke 2/14/2019	Director, Office of Chronic Disease Prevention	Baltimore City Health Department – Division of Youth Wellness & Community Health

Brandi Welsh 2/14/2019	Community Liaison, Baltimore City Department of Public Works	Communications & Community Affairs
Reginald Williams 2/21/2019	Western District Liaison, Office of the State's Attorney for Baltimore City	Criminal Strategy Unit
Olivia Farrow, Esq 3/06/2019	Director of Community Engagement, St. Agnes Healthcare Baltimore	Healthcare
Maya Nadison, PhD, MHS 3/14/2019	Community Health Evaluation Research, Kaiser Permanente	Healthcare

Appendix 5 - Focus Group Notes

Substance Abuse & Mental Health Stakeholders - March 13, 2019

Organizations represented included Bon Secours Behavioral Health services staff, and Maryland Department of Behavioral Health representative

(Facilitator) Opioid Crisis – What is the current state of the crisis? What issues are underlying the crisis?

- Medicaid burden
- Fatal overdose increase
- Make sure patients have Naloxone
    - How will uninsured get it?
    - Reallocate BHS funds, if leftover, to purchase
- Education for patients and families
    - Involve the family in the treatment
    - Fentanyl added to screening- the addition of Fentanyl to drugs should be scary but the addicts don't think it'll kill them (competition of how much of the drug they can handle)
- Funding issues
    - Naloxone used to be free (multiple doses are sometimes needed, raising cost)
- Stigma is still there, resulting in the hiding of usage

(Facilitator) Has there been a decline over the past 3-5 years?

- Increase in OTP's (opioid treatment programs)
- Hard to gauge if it's working
    - Medicaid expansion getting more people care
- Deaths not decreasing
- They think the kit is a lifesaver so doesn't decrease drug usage, but fuels it (justifies their use)

(Facilitator) Barriers to treatment/ why addicted persons don't choose treatment

- Individual not ready for treatment
    - Help them understand disease and services
    - Come in for wrong reasons (addict is still an addict)
        - Methadone prescription or money from selling prescription

- Make them comfortable in group sessions to make them more inclined to stay
    - Incentives currently comes out of pocket (part of need for funding)
- Most without jobs
    - How do they have money for drugs?
    - Can be clever- how do we change the way they think
- They don't want to work the process, they want immediate results
- Diversion - not all bad
    - Still addicts (not ready)
    - At least they take methadone instead
- Some get treatment and still use substances
- Education is working
    - Peer recovery support specialist (good to use as an example)
    - Get families involved - team approach
        - Mend relationships
- Guidelines different than conditions
    - Clinical different than peer (harm reduction)
- Personal cheerleader
    - Patient Advocacy Program acts as a voice for the patients, they come in to speak to beginners

(Facilitator) "Magic Wand" Wish-list

- Clinicians who care (personnel as a whole who care)
- Stricter guidelines and quality measures for programs
    - People open programs for the wrong reasons- just to get bodies in the door, not to make a difference
    - Gas and Go programs - just get the medications and go
    - Don't need more programs. Just better ones
- Team approach
    - Clinicians, state funders, medical providers, etc.
- Funding (budget for incentives)
    - It is now harder to ask for it
- Stopping provider harm
    - Just writes prescriptions (check on CRISP)
- Regulators walk in addicts shoes
    - Help them understand what is going on
- Retain clients that come in for treatment
    - Not hop from program to program
- Opt out system

    - Only allow opting out of a program once
- Workforce development
    - Encourage staff (counselor pool)
    - Make field more attractive - it currently is not

(Facilitator) What needs to happen at the Macro Level

- State level - Governor wants to reduce deaths, so focus is not on stopping program
- Police - drugs keep police employed, will respond for guns but not for drugs, overworked and have a lot of rules to follow, all don't carry kit or are trained to use kit (why?)
- Schools- state funds education prevention, fine line of over exposure
- Treat whole issue, not just drugs
- Regulation out, accreditation in
- Social media - influencing kids
- Include spirituality

Community Focus Groups – April 5 and April 10, 2019

Anchor organizations represented include: Franklin Square Community Association, Fayette Street Outreach Organization, Inc., Celebration Church, Tabernacle of the Lord Church and Ministries, Bon Secours CommunityWorks Clean and Green Committee, Bon Secours Housing.

CHNA Advisory Group organizations represented include: Central Baptist Church, St. Agnes Hospital, University of Maryland Baltimore Medical Center, the Mayor's office of the City of Baltimore, and Bon Secours CommunityWorks.

Healthy People

<u>Feedback:</u>

- Goal 1 – Nutrition education and access
    - Continue emphasis on nutrition education for children
    - Greater focus on Prevention services and programs needed
    - Recognize and collaborate with several churches and schools with existing programs to access to healthy foods and nutrition classes
    - Consider partnering urban farm efforts with churches
    - Clarify difference between produce market at hospital & mobile market

    - Community Engagement Center- run by UMB, is within our service area
        - Be better at promoting it within Community Works
    - Continue advocacy for Grocery store
- Goal 2 – Behavioral and Mental Health / Substance Abuse services
    - What is the outcome we're looking at → establish measures and SMART goals
    - Increase efforts to address opioid use, substance abuse
    - Increase communication of services; recognize impact of the history of segregation
    - Need for outpatient detox programs

- Goal 3 – Chronic diseases, healthy lifestyle education and services
    - Expand school services
    - Health outcomes, but also prevention
    - More emphasis on diabetes education and prevention
- Goal 4 – Prevention, screening and services for children's health
    - Not enough attention given to Pediatrics and children's services
    - BMORE for Healthy Babies (Brawnwine)
        - What work are partners doing regarding infant mortality within the service area?

<u>Questions raised:</u>

- How are the police being held responsible with trauma informed care → BHSB can provide update, have them come in and present to C&G or Anchor Group
- How would we move forward with the family practice physician goal since Family Health and Wellness will be part of the acquisition?

<u>What Else (Unmet Needs):</u>

- Obesity & diabetes
- Children's mental health
- Pediatric services
- Increase partnership with schools, system approach
- Institute a "Health Committee" for trauma, chronic conditions, substance abuse, Alzheimer's

Healthy Economy

Feedback:

- Goal 1 – Workforce Development and Job Readiness, Financial literacy, Youth outreach
    - More workforce development programs to reach more people within the area
        - Other programs within the city to refer or direct people to
    - Small business development
- Goal 2 – Affordable Housing
    - Unity Properties as employer/job creator through apprenticeships
    - Consider funding program for residents who have difficulty paying rent (combine with literacy and behavior education)
    - Address vacant community buildings surrounding hospital

What Else (Unmet Needs):

- Include advance financial education regarding Promise Program – free tuition for community college
- Consider home improvement initiative for seniors

Healthy Environment

- Goal 1 – Public green spaces and transformation of vacant lots
  No feedback given
- Goal 2 – Crime and Sanitation
    - Need further career development (pathway) for Clean and Green participants

What Else (Unmet Needs):

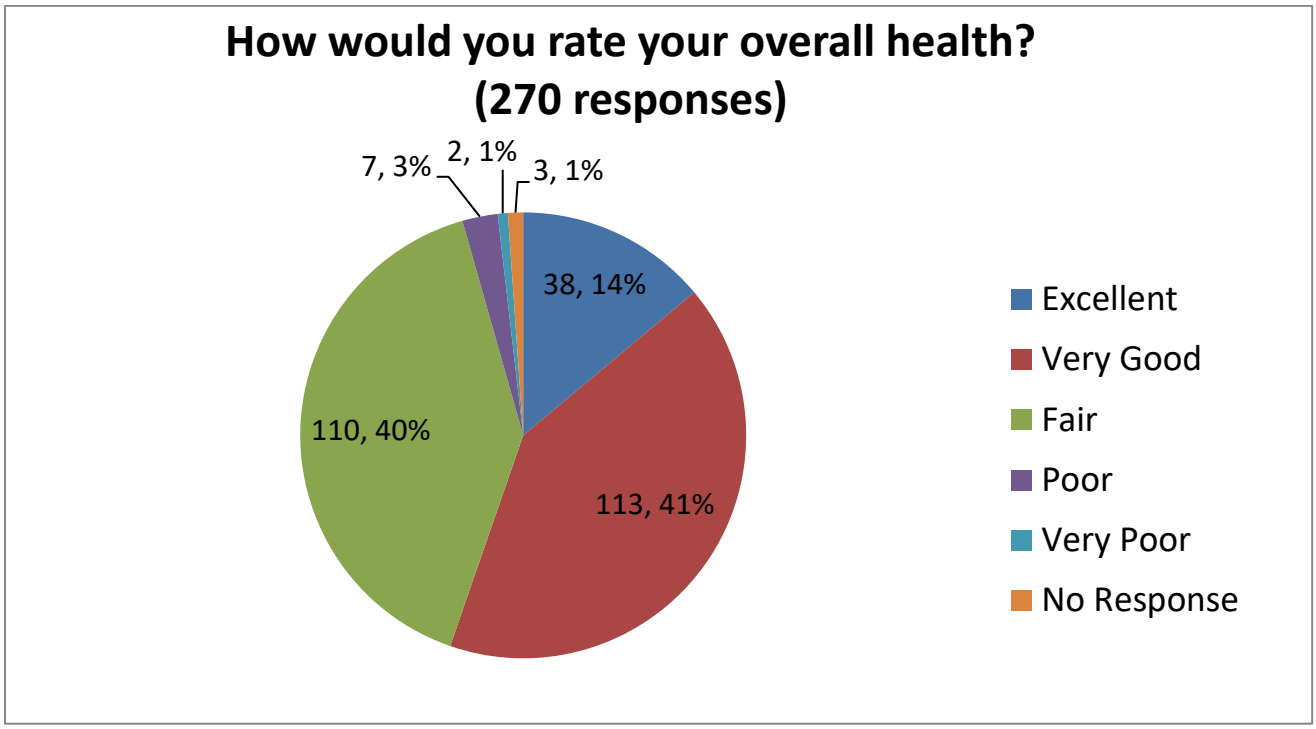
- Help to address Community cleanliness, work to end “dumping” on lots
- Expand environmental awareness
    - Climate change, storm water issues
- Work through Partnerships across community
- How to get kids to get involved in parks, both the clean-up and opportunities to play

Participants were asked to give input to the Prioritization process. The following issues/needs were recommended as significant Priorities:

- Children's Health / Trauma (specifically mental health/substance abuse), including Youth
- Development and Advocacy for a neighborhood Grocery Store/supermarket
    - Develop a food access strategy
    - Provide greater nutritional education, especially for children
    - Obesity prevention and reduction
- Crime and Related Trauma
- Increase financial resources for programs and services

Appendix 6 – CHNA Survey Results

1.



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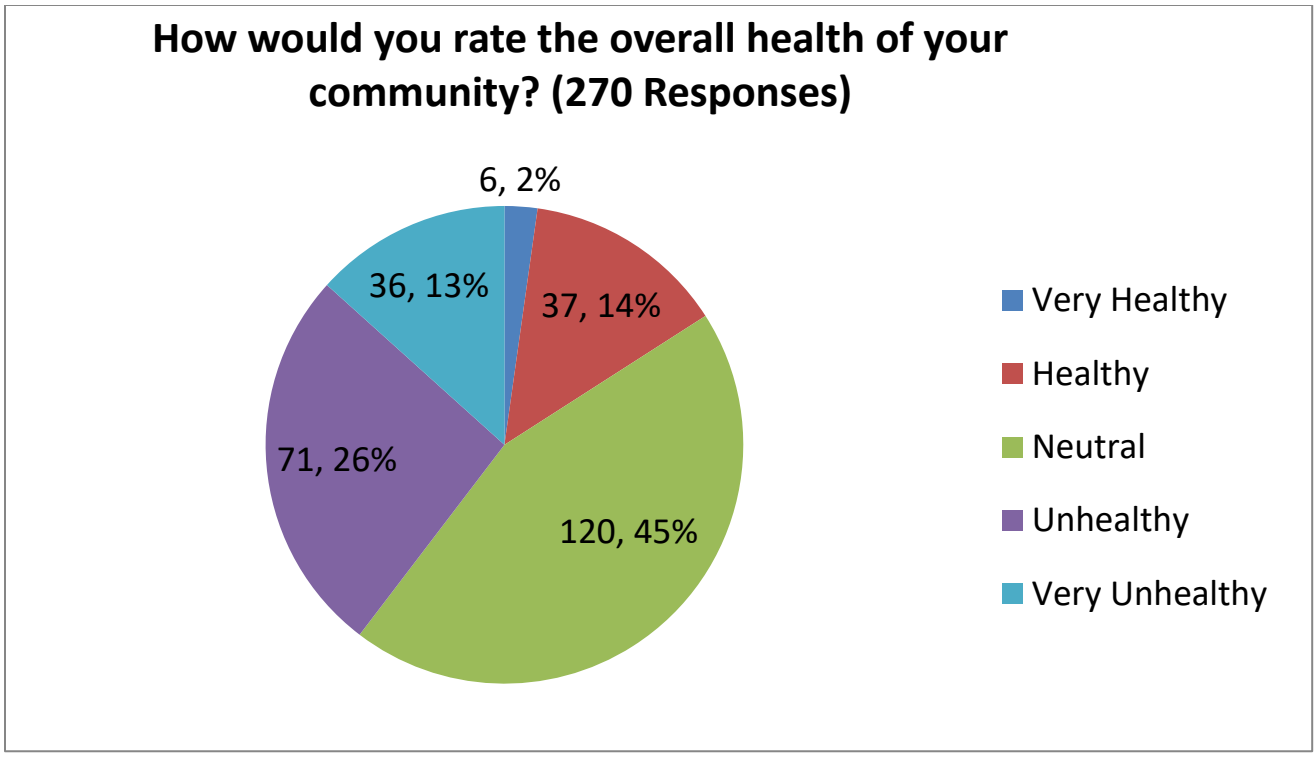
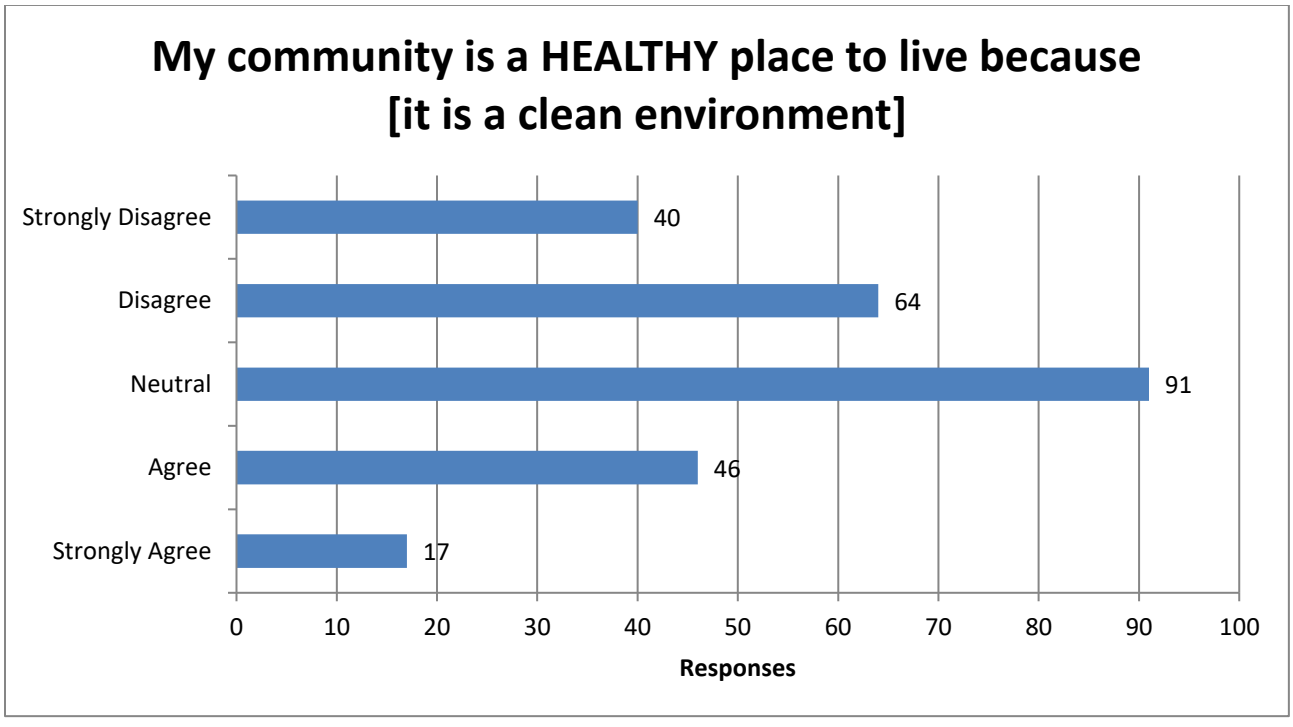
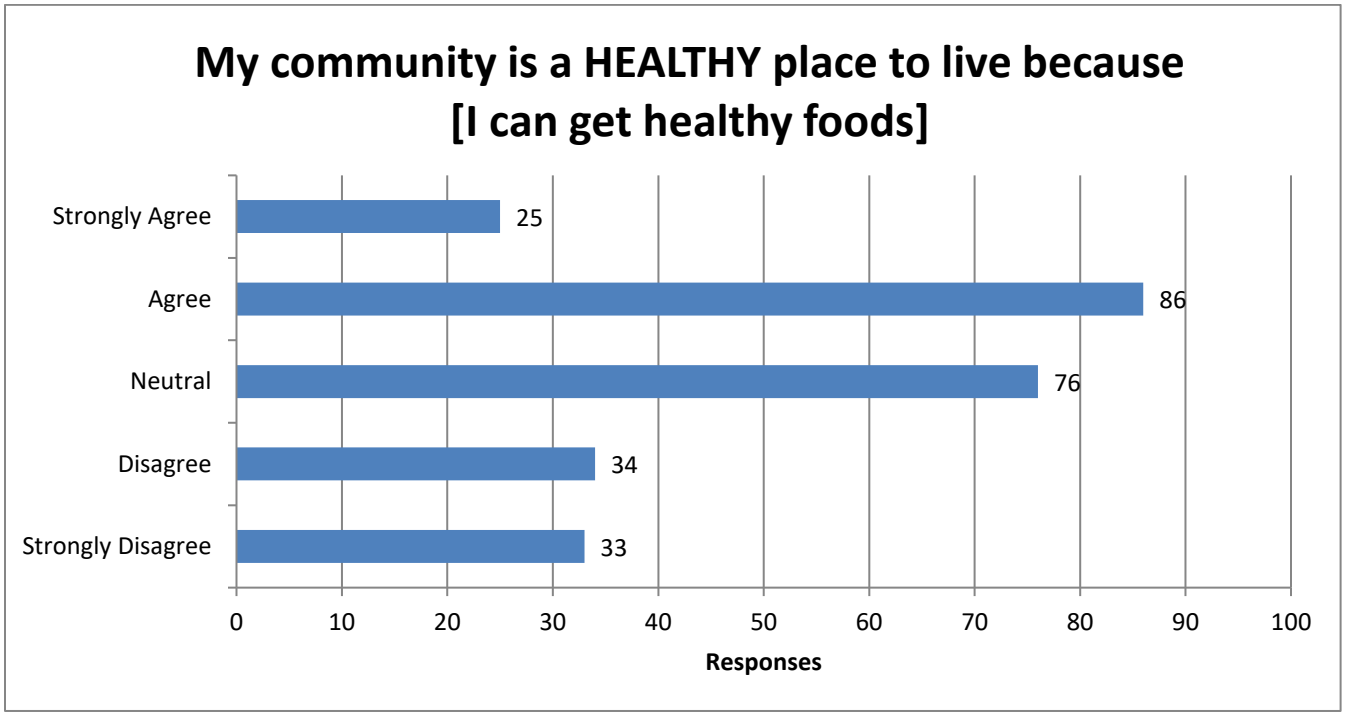
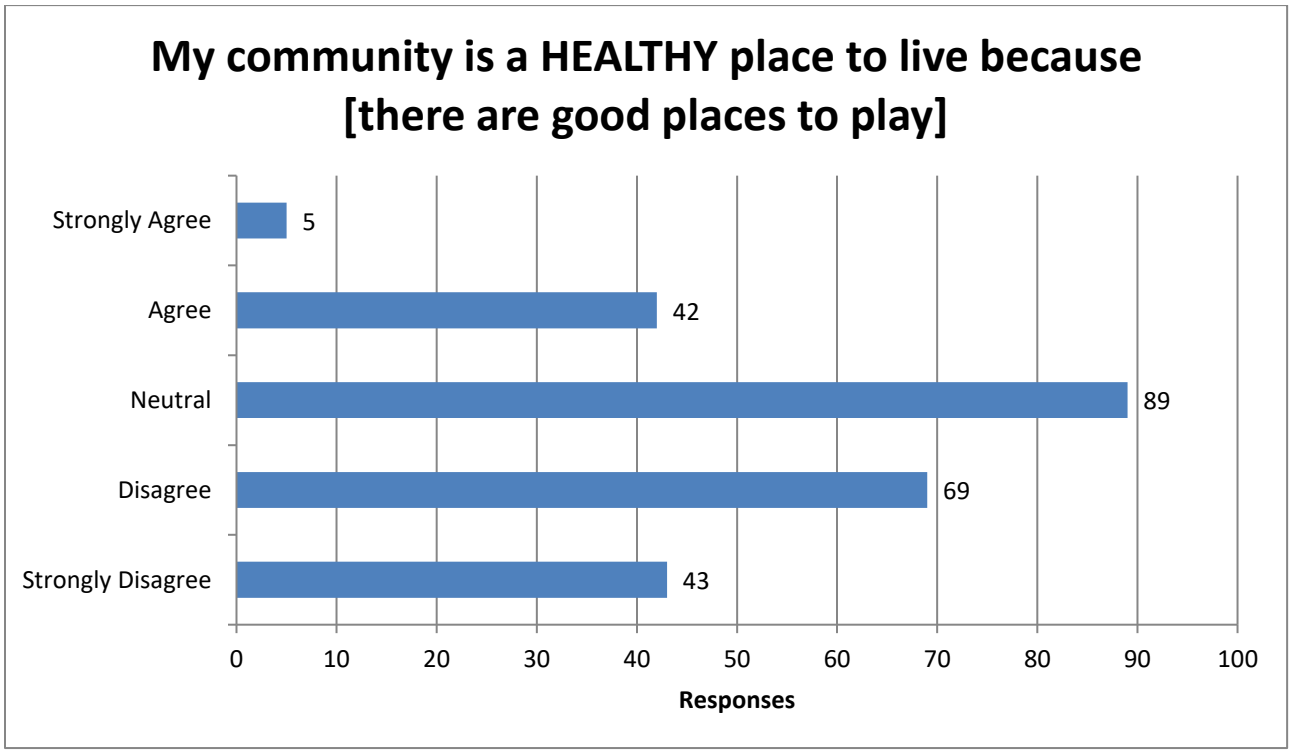
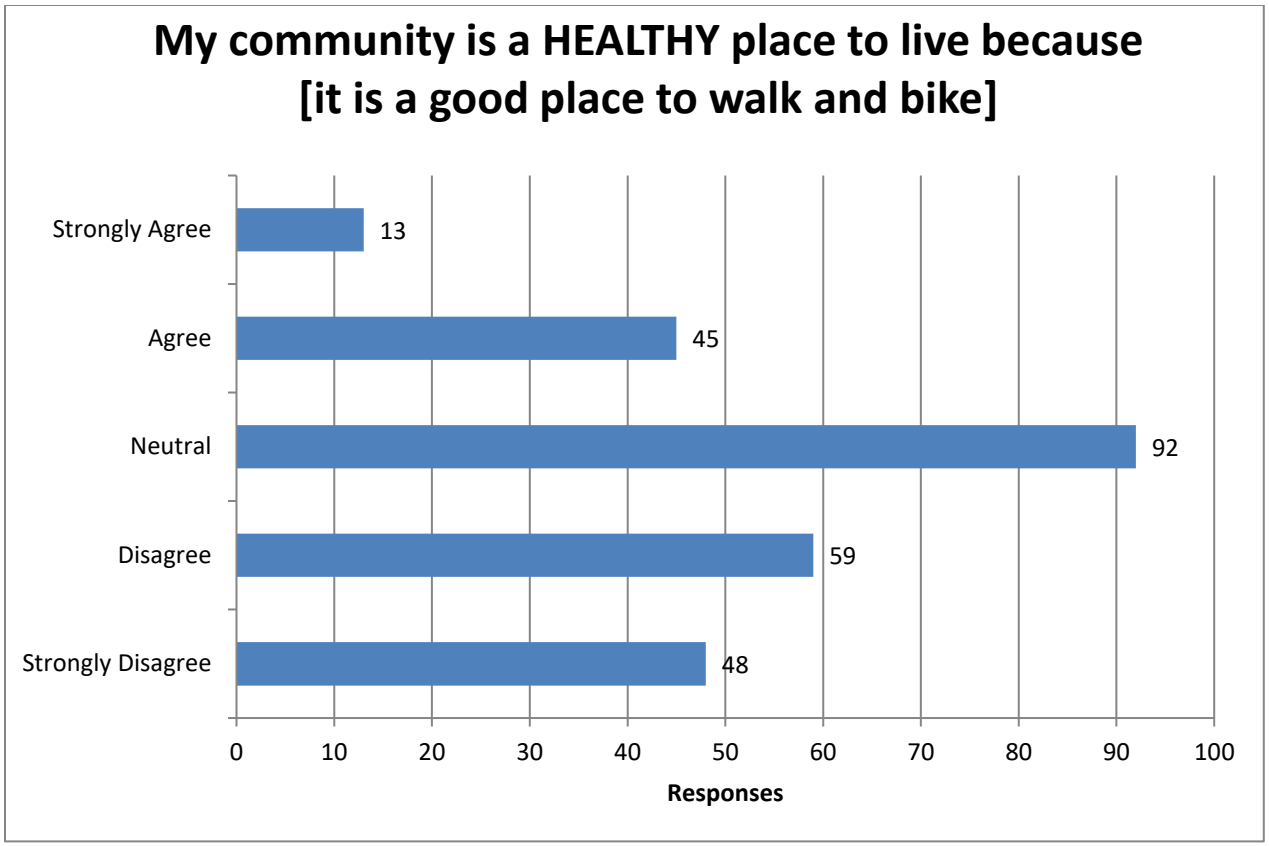

How would you rate the overall health of your community? (270 Responses)
6, 2%
37, 14%
120, 45%
71, 26%
36, 13%
Very Healthy
Healthy
Neutral
Unhealthy
Very Unhealthy

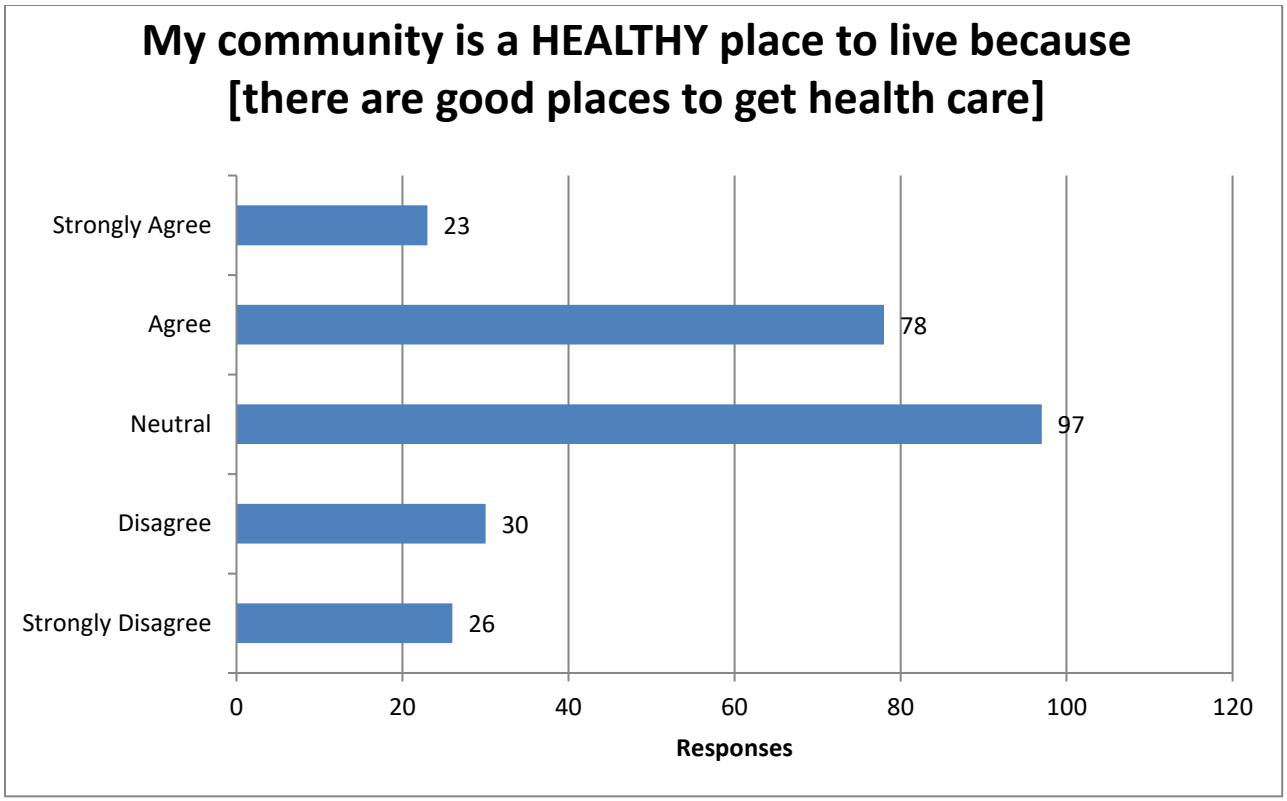
5.

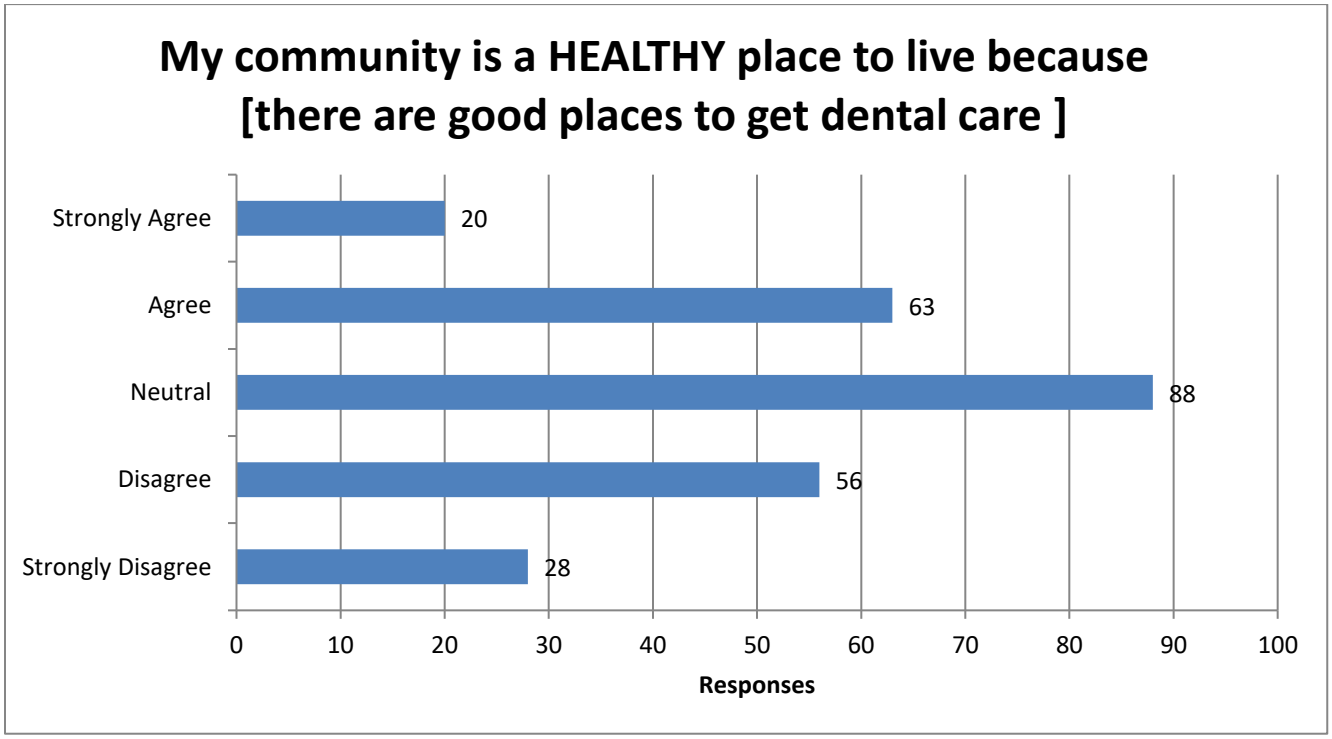

My community is a HEALTHY place to live because [it is a clean environment]
Strongly Disagree
Disagree
Neutral
Agree
Strongly Agree
40
64
91
46
17
0
10
20
30
40
50
60
70
80
90
100
Responses

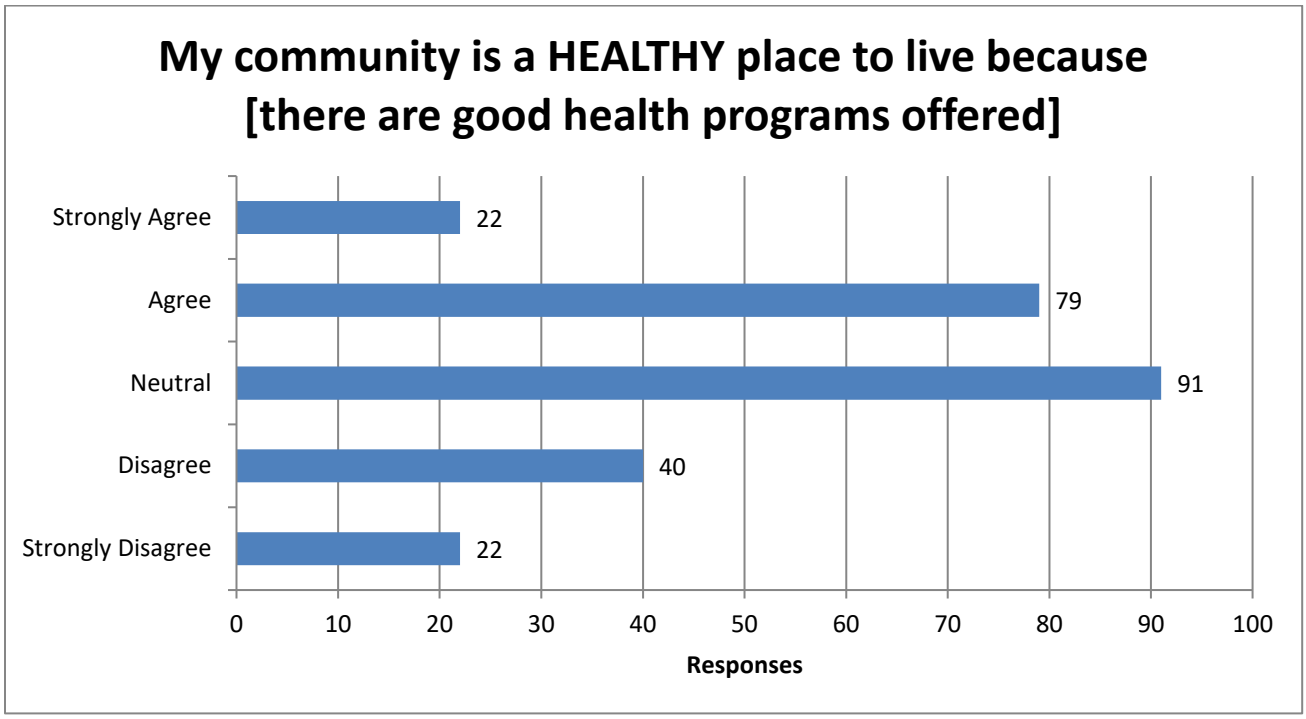

My community is a HEALTHY place to live because [I can get healthy foods]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
25
86
76
34
33
0
10
20
30
40
50
60
70
80
90
100
Responses

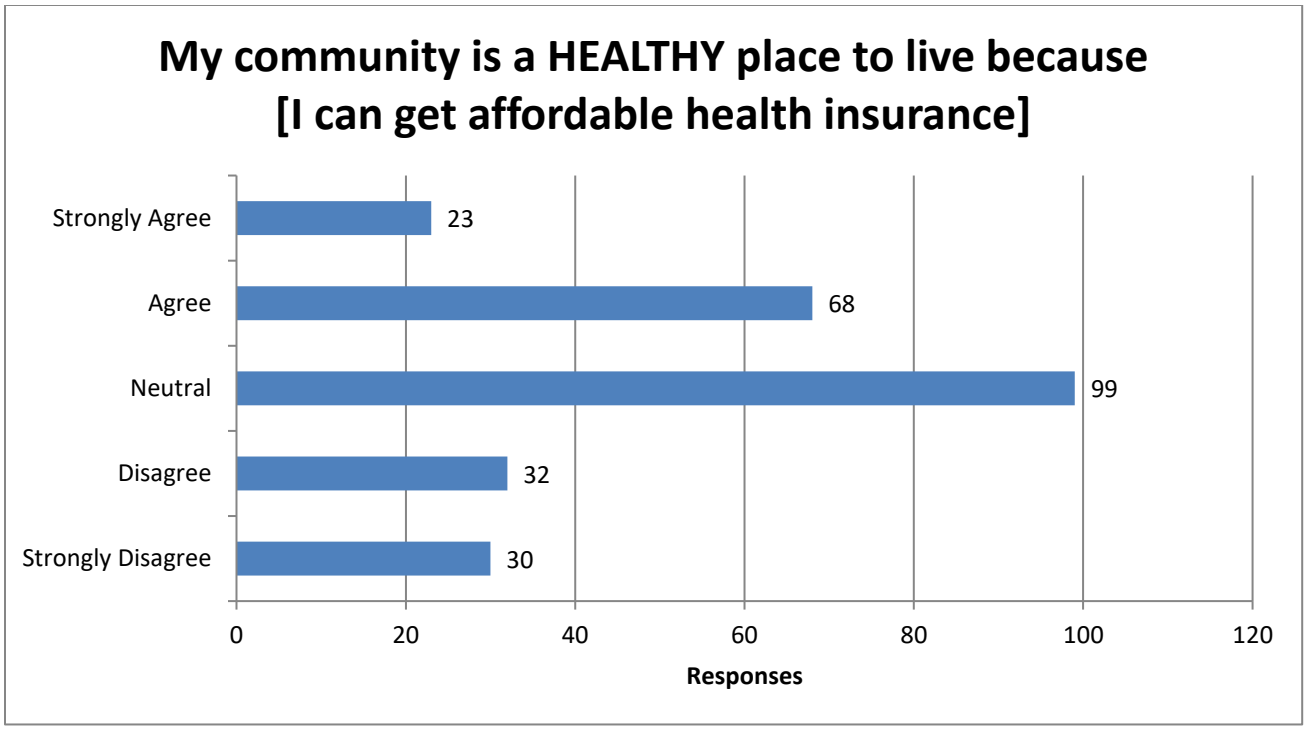

My community is a HEALTHY place to live because [there are good places to play]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
5
42
89
69
43
0
10
20
30
40
50
60
70
80
90
100
Responses


My community is a HEALTHY place to live because [it is a good place to walk and bike]
Strongly Agree
13
Agree
45
Neutral
92
Disagree
59
Strongly Disagree
48
0
10
20
30
40
50
60
70
80
90
100
Responses

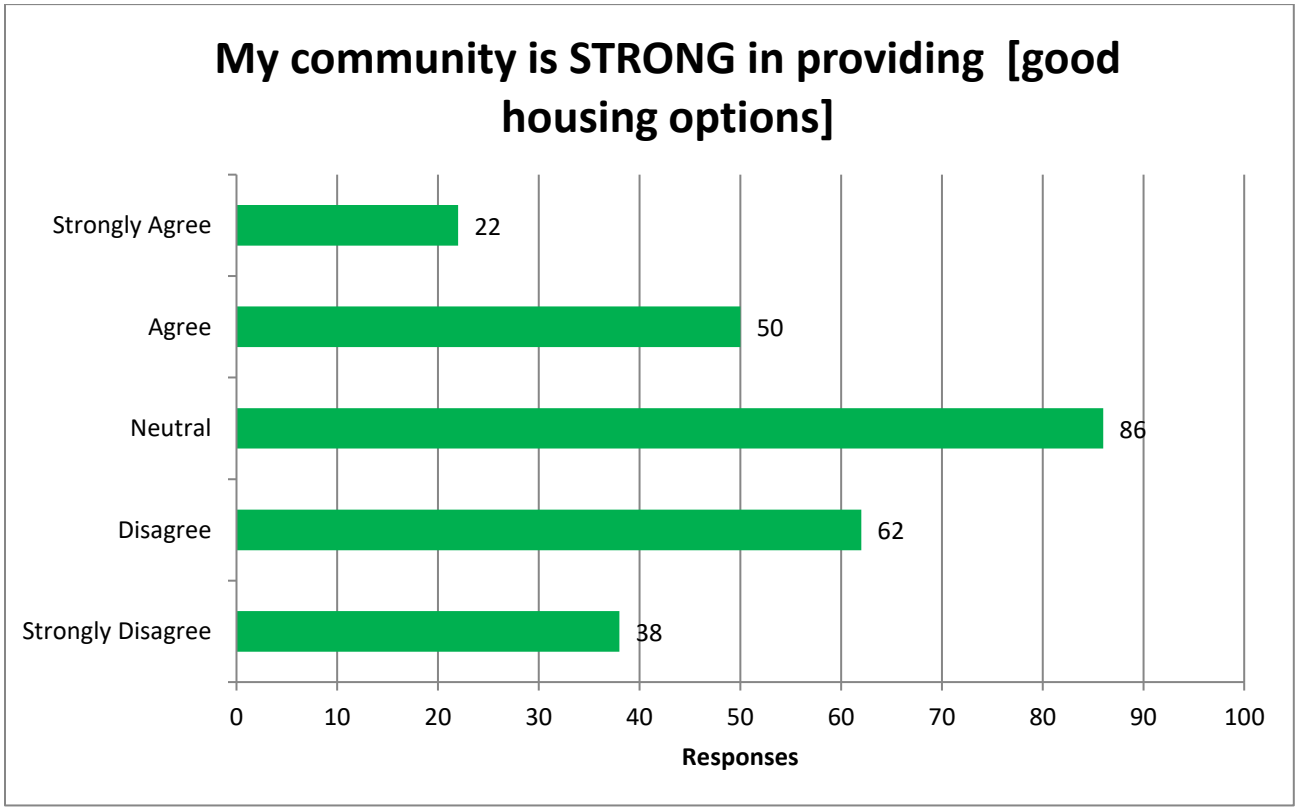

My community is a HEALTHY place to live because [there are good places to get health care]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
23
78
97
30
26
0
20
40
60
80
100
120
Responses

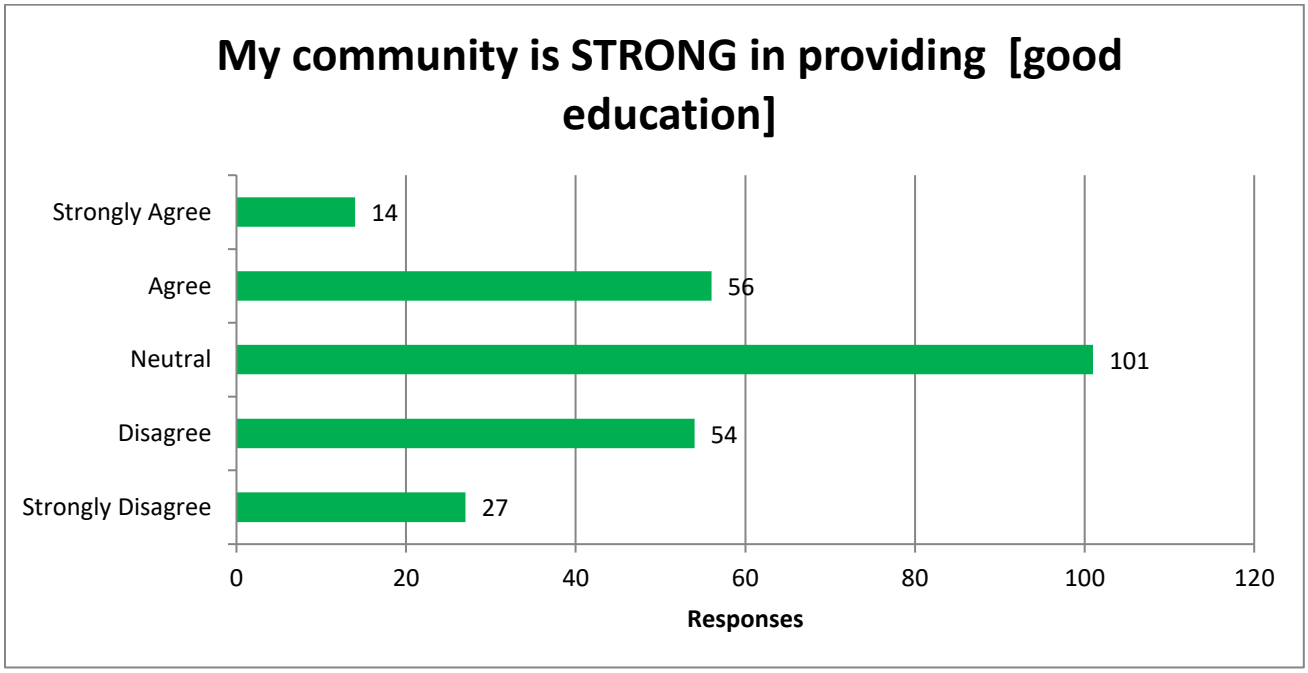

My community is a HEALTHY place to live because [there are good places to get dental care]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
20
63
88
56
28
0
10
20
30
40
50
60
70
80
90
100
Responses

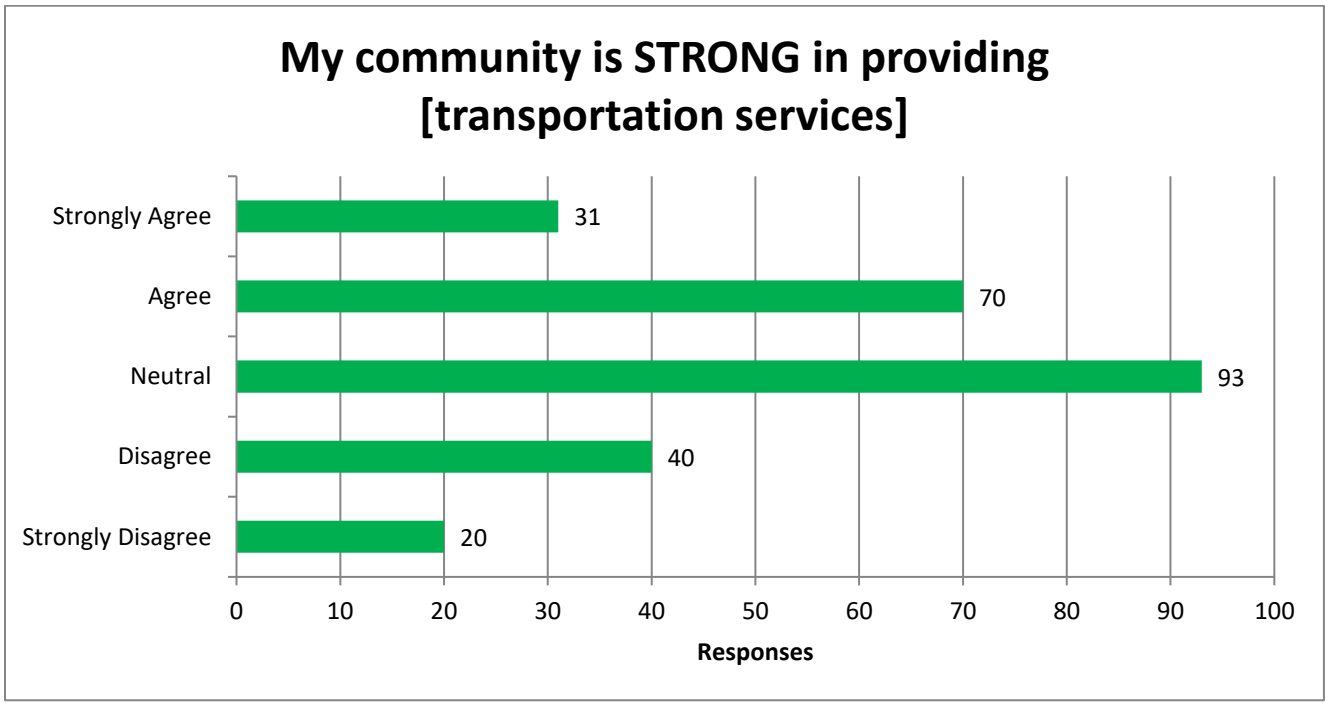

My community is a HEALTHY place to live because [there are good health programs offered]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
22
79
91
40
22
0
10
20
30
40
50
60
70
80
90
100
Responses

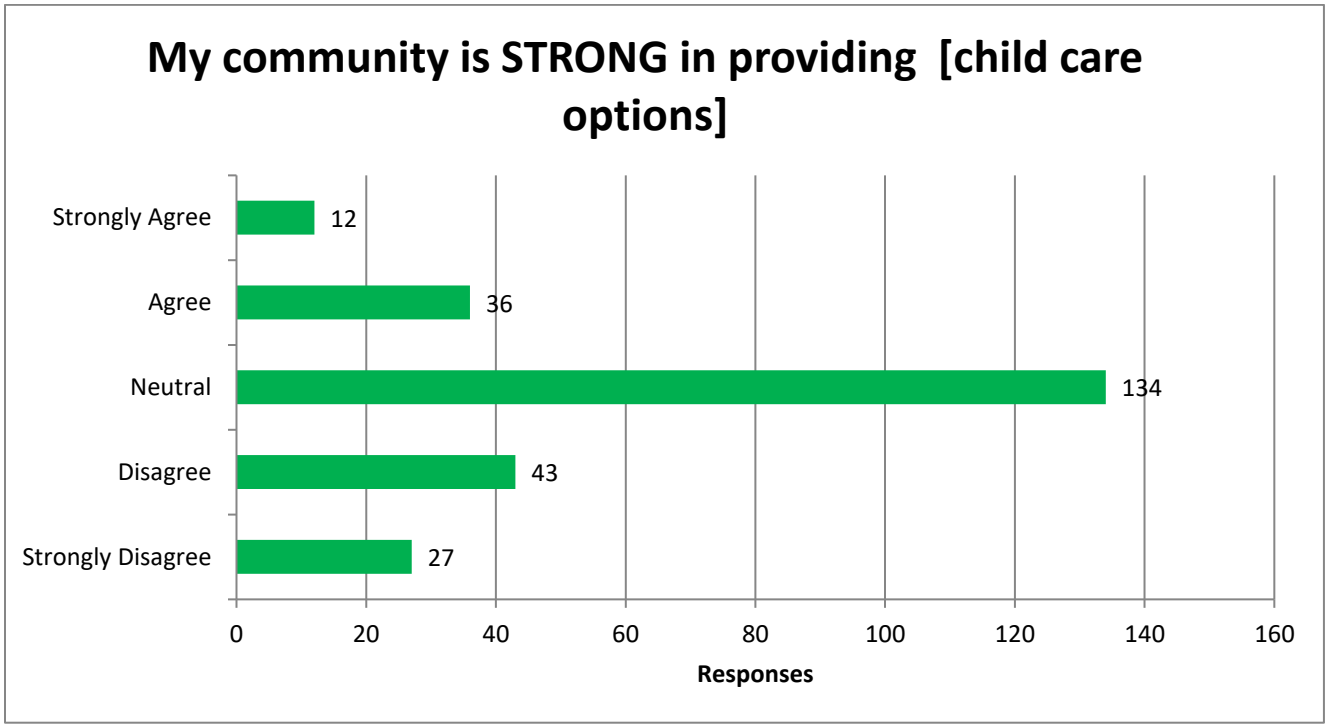

My community is a HEALTHY place to live because [I can get affordable health insurance]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
23
68
99
32
30
0
20
40
60
80
100
120
Responses

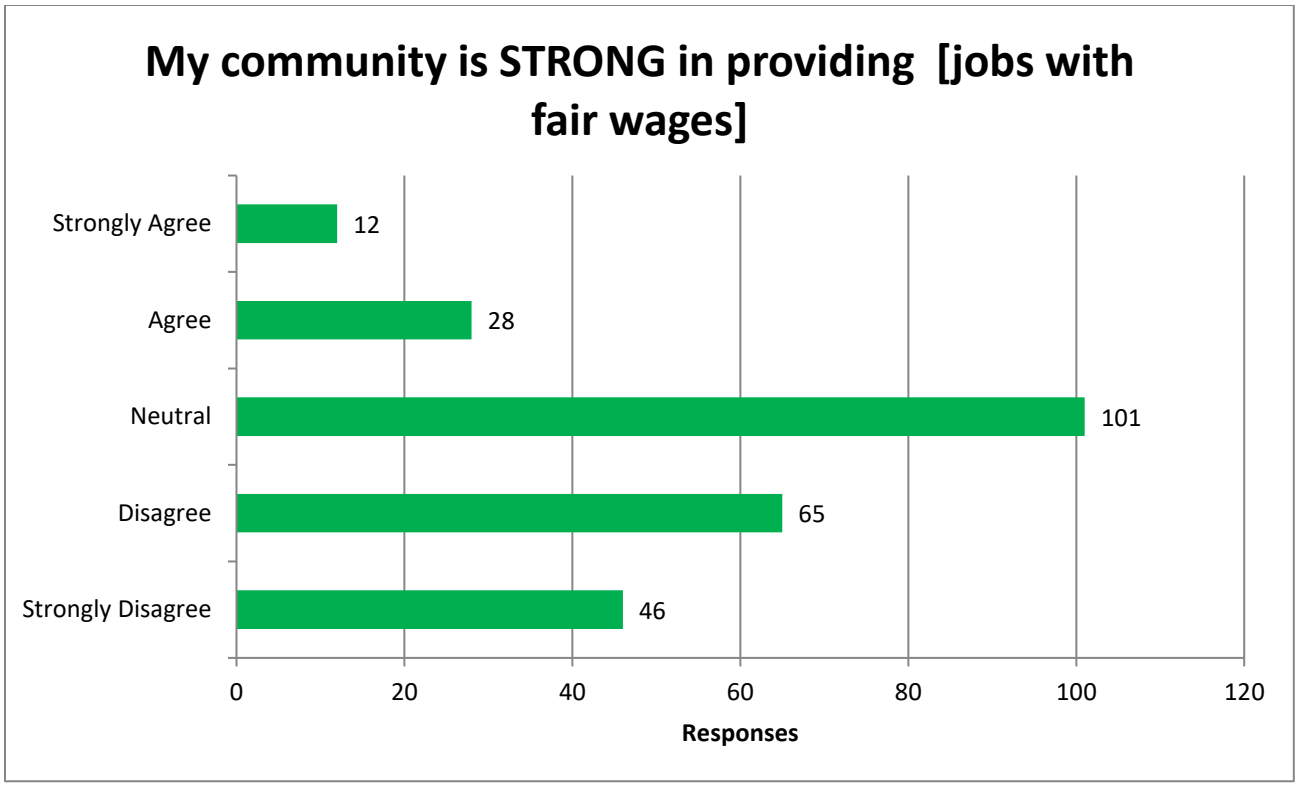
6.


My community is STRONG in providing [good housing options]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
22
50
86
62
38
0
10
20
30
40
50
60
70
80
90
100
Responses

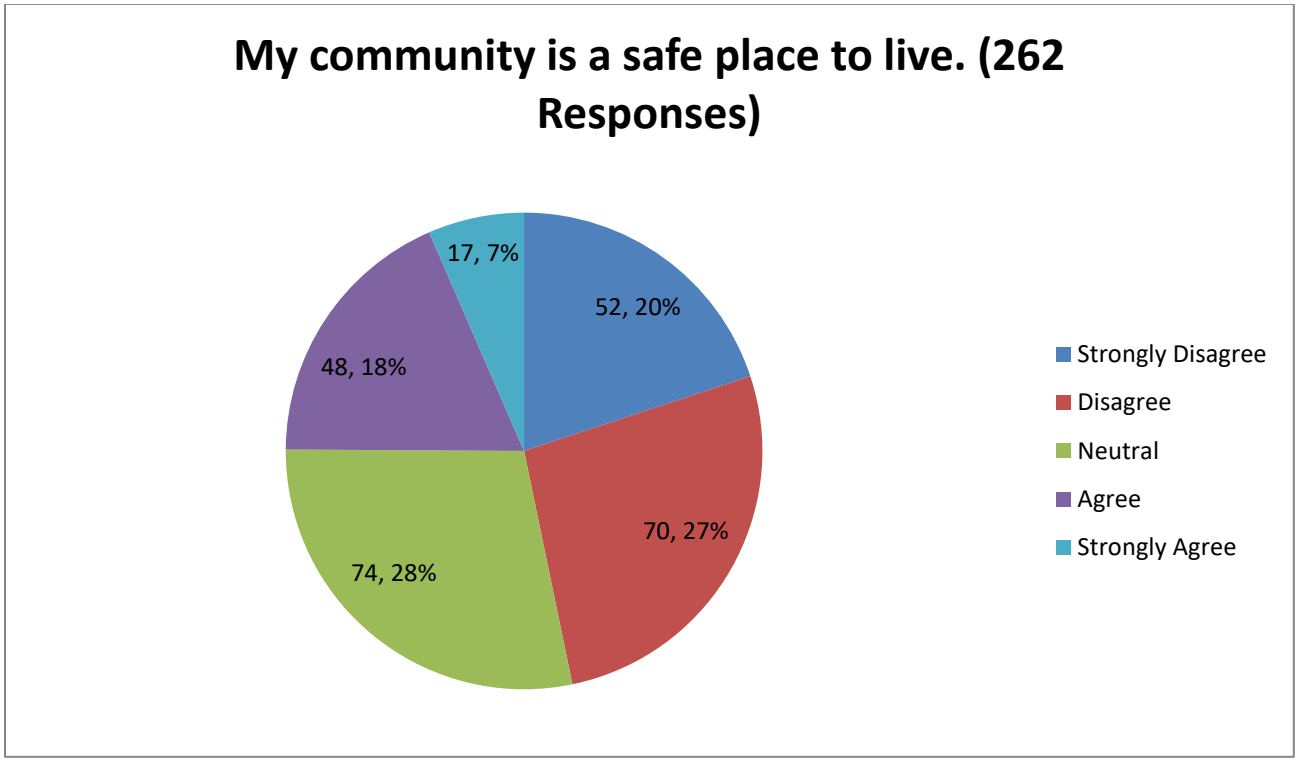

My community is STRONG in providing [good education]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
14
56
101
54
27
0
20
40
60
80
100
120
Responses


My community is STRONG in providing [transportation services]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
31
70
93
40
20
0
10
20
30
40
50
60
70
80
90
100
Responses

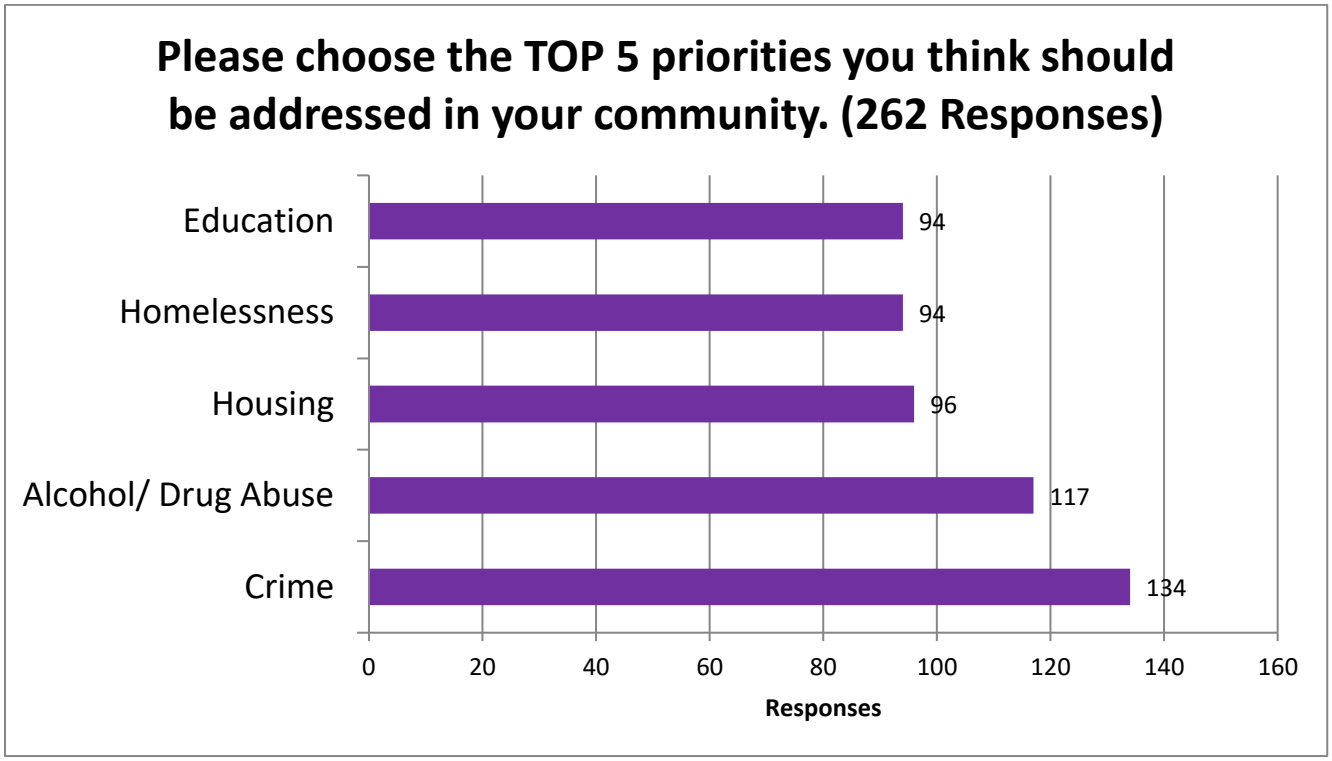

My community is STRONG in providing [child care options]
Strongly Agree
12
Agree
36
Neutral
134
Disagree
43
Strongly Disagree
27
0
20
40
60
80
100
120
140
160
Responses


My community is STRONG in providing [jobs with fair wages]
Strongly Agree
12
Agree
28
Neutral
101
Disagree
65
Strongly Disagree
46
0
20
40
60
80
100
120
Responses

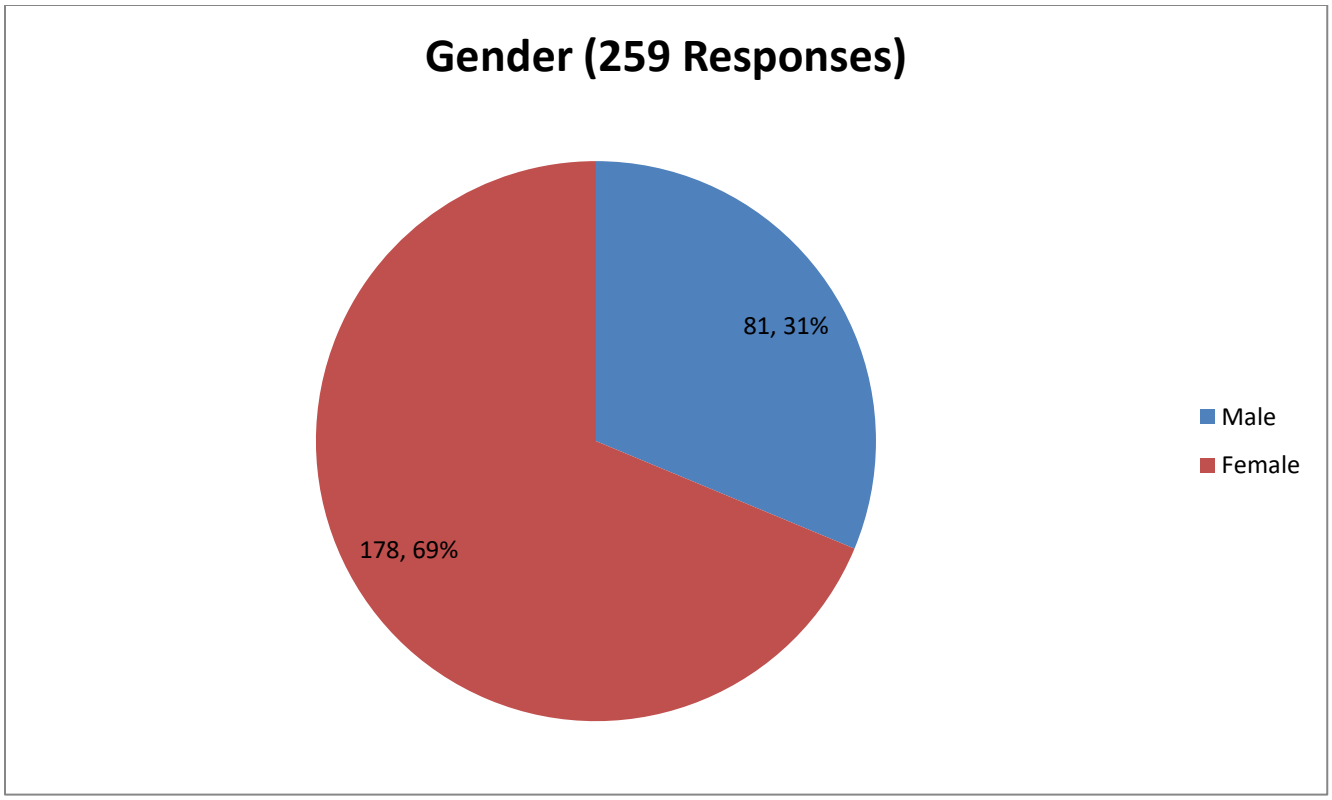
10.


My community is a safe place to live. (262 Responses)
17, 7%
52, 20%
48, 18%
70, 27%
74, 28%
Strongly Disagree
Disagree
Neutral
Agree
Strongly Agree

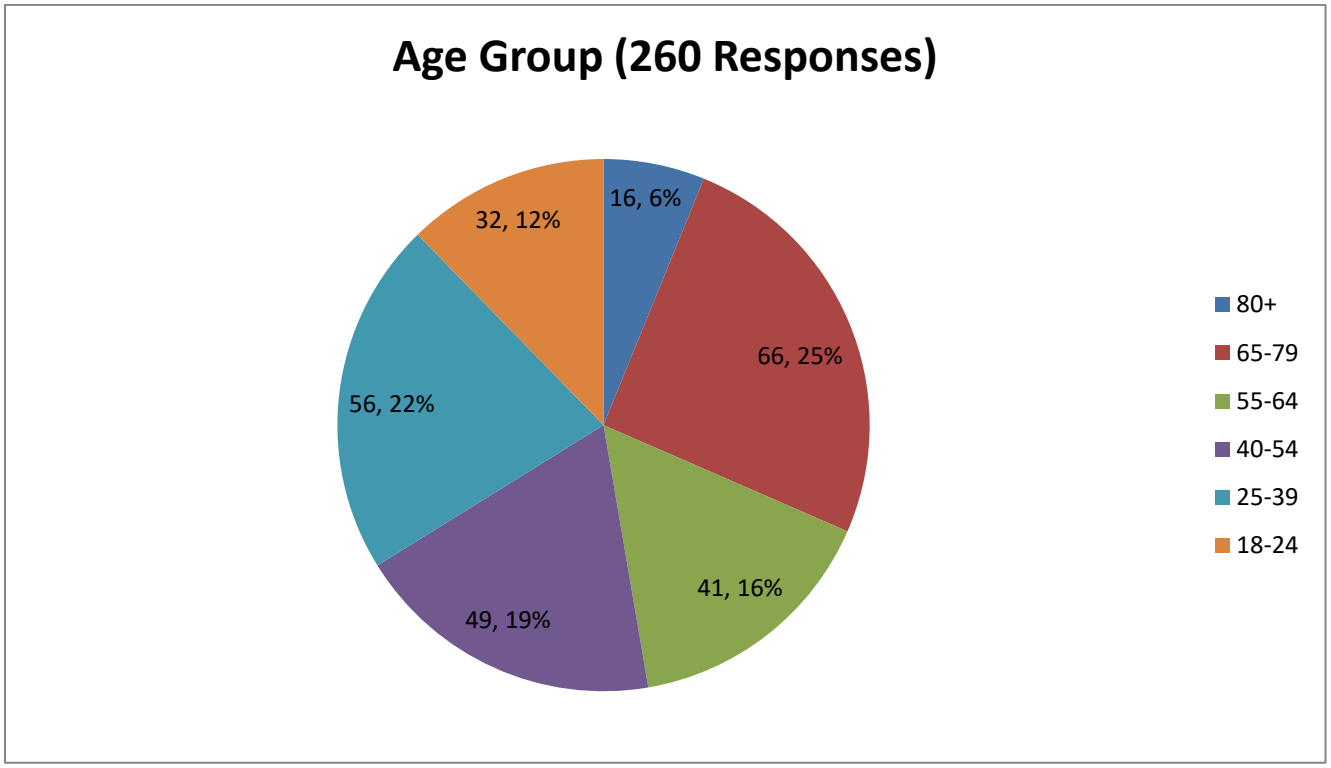
12.


Please choose the TOP 5 priorities you think should be addressed in your community. (262 Responses)
Education
94
Homelessness
94
Housing
96
Alcohol/ Drug Abuse
117
Crime
134
0
20
40
60
80
100
120
140
160
Responses

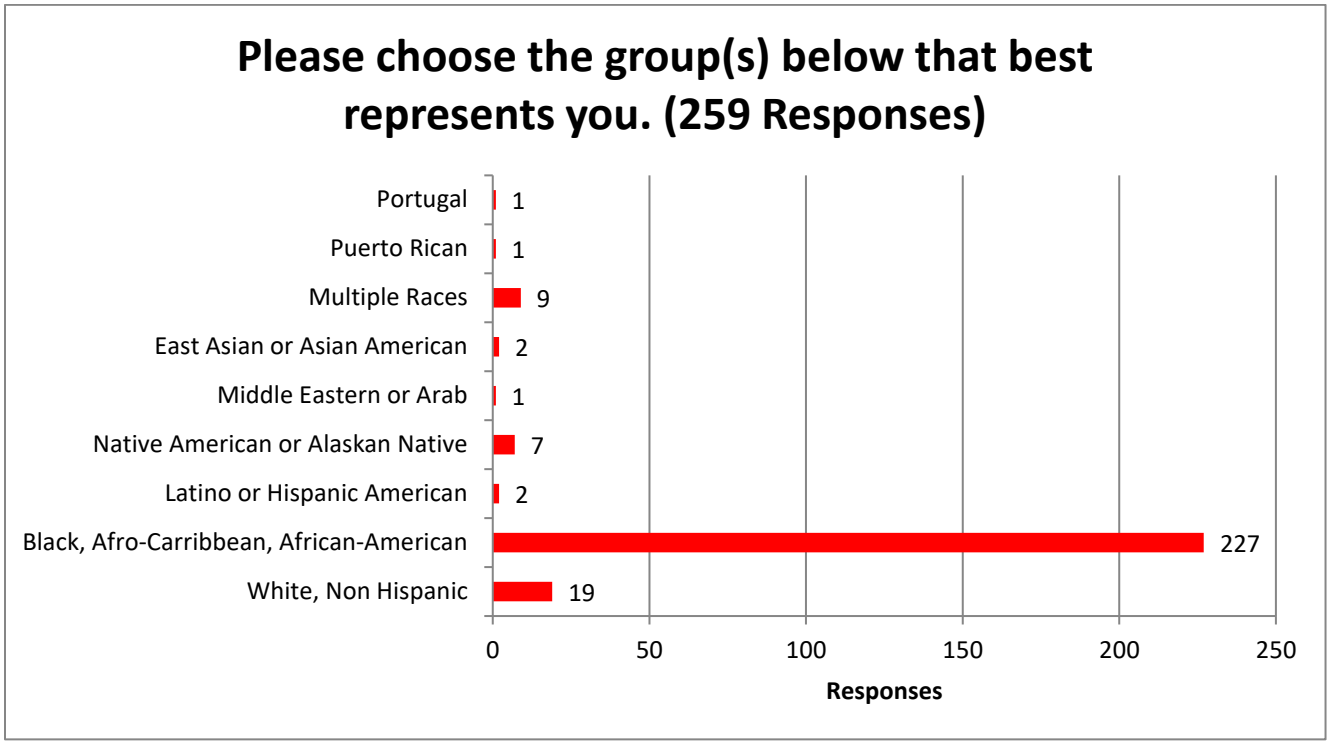
15.


Gender (259 Responses)
81, 31%
178, 69%
Male
Female

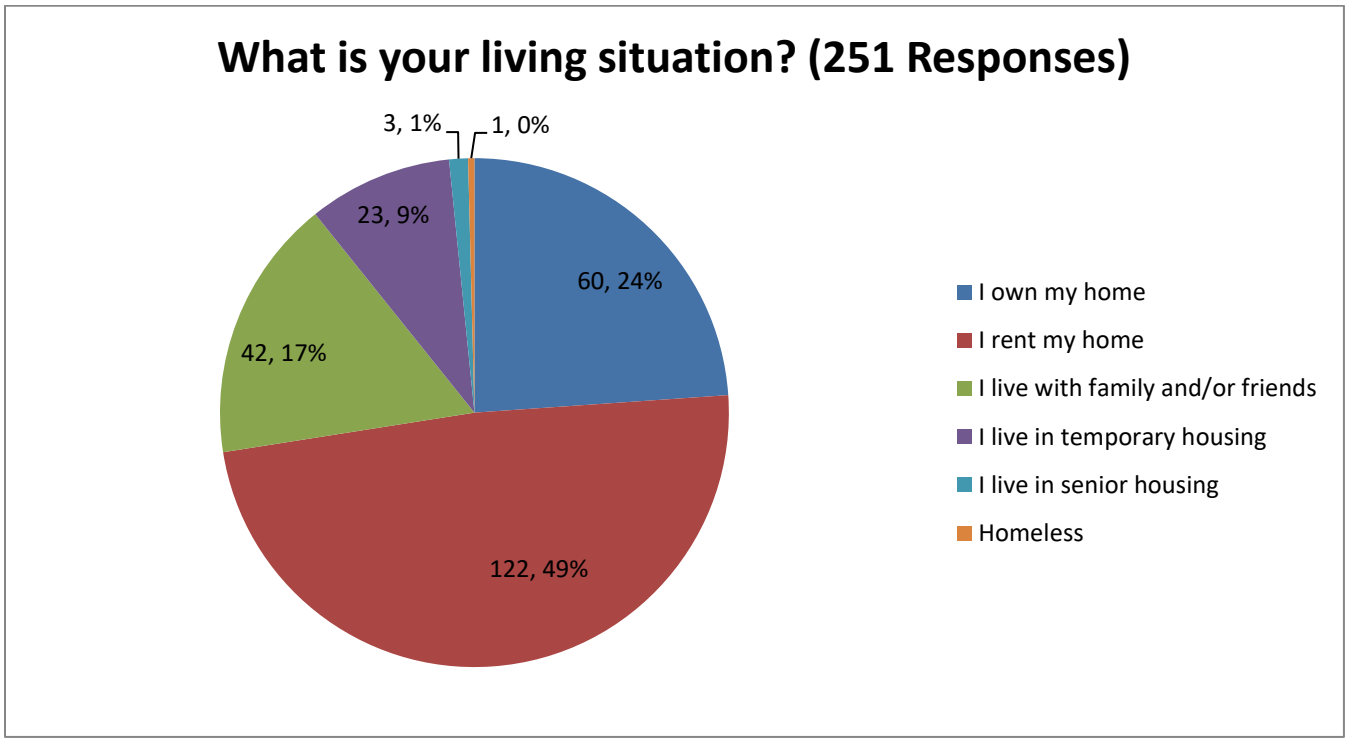
16.


Age Group (260 Responses)
16, 6%
66, 25%
41, 16%
49, 19%
56, 22%
32, 12%
80+
65-79
55-64
40-54
25-39
18-24

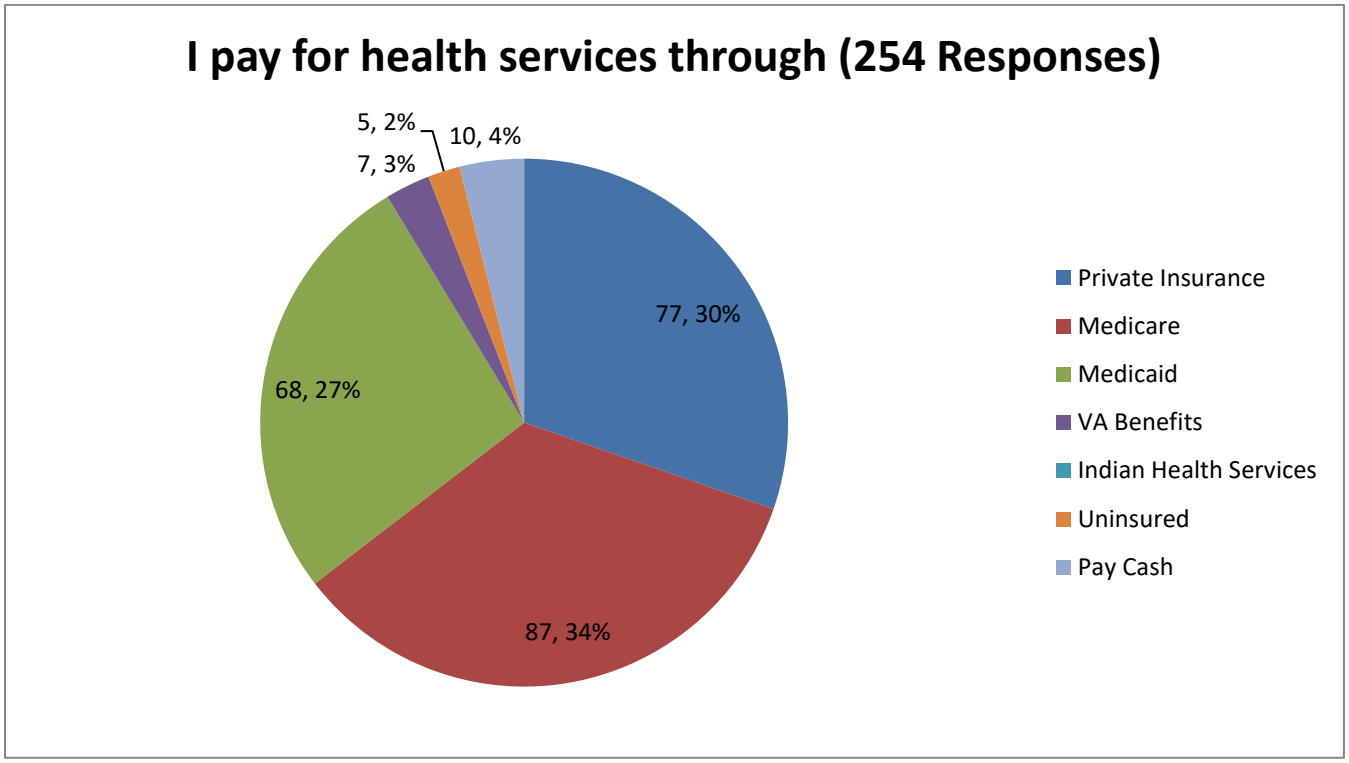
17.


Please choose the group(s) below that best represents you. (259 Responses)
Portugal
Puerto Rican
Multiple Races
East Asian or Asian American
Middle Eastern or Arab
Native American or Alaskan Native
Latino or Hispanic American
Black, Afro-Carribbean, African-American
White, Non Hispanic
1
1
9
2
1
7
2
227
19
0
50
100
150
200
250
Responses

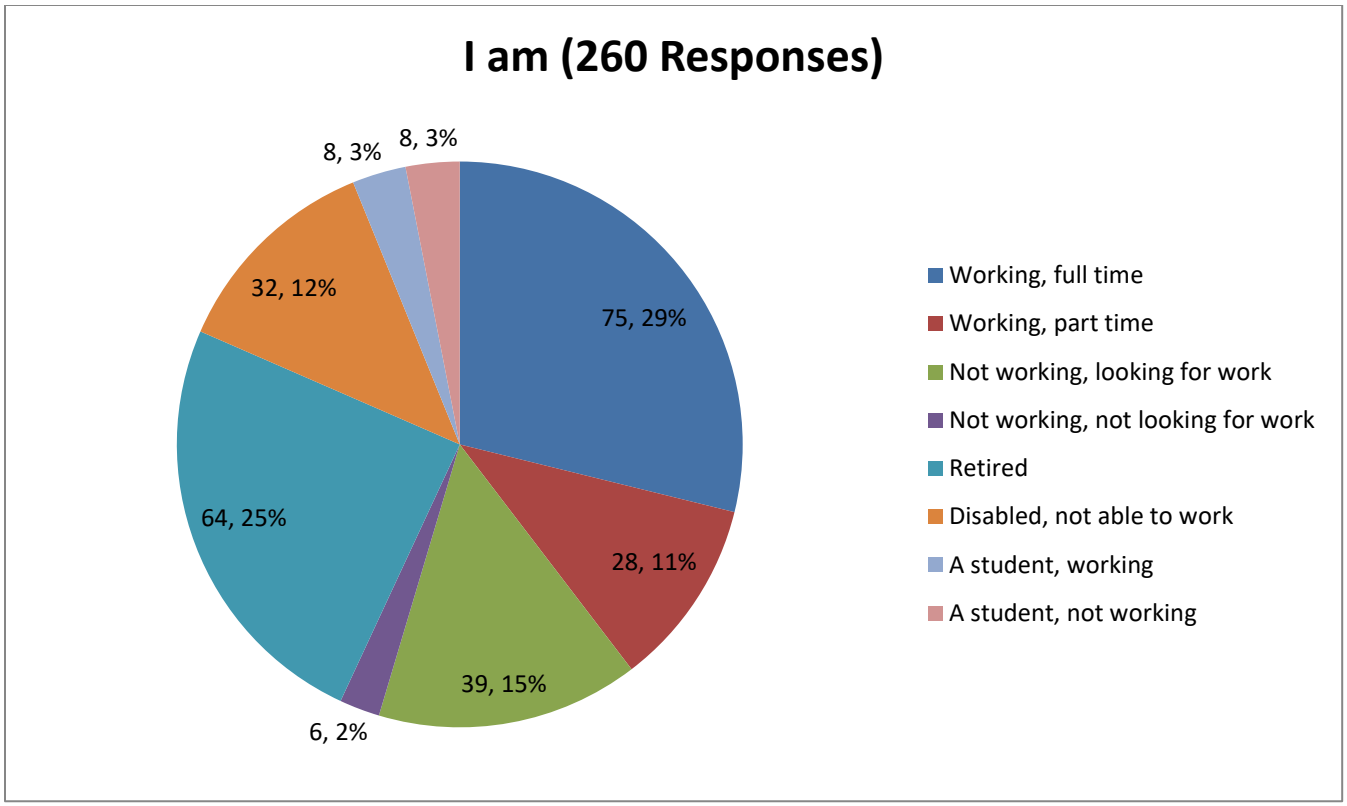
18.


What is your living situation? (251 Responses)
3, 1%
1, 0%
23, 9%
60, 24%
42, 17%
122, 49%
I own my home
I rent my home
I live with family and/or friends
I live in temporary housing
I live in senior housing
Homeless

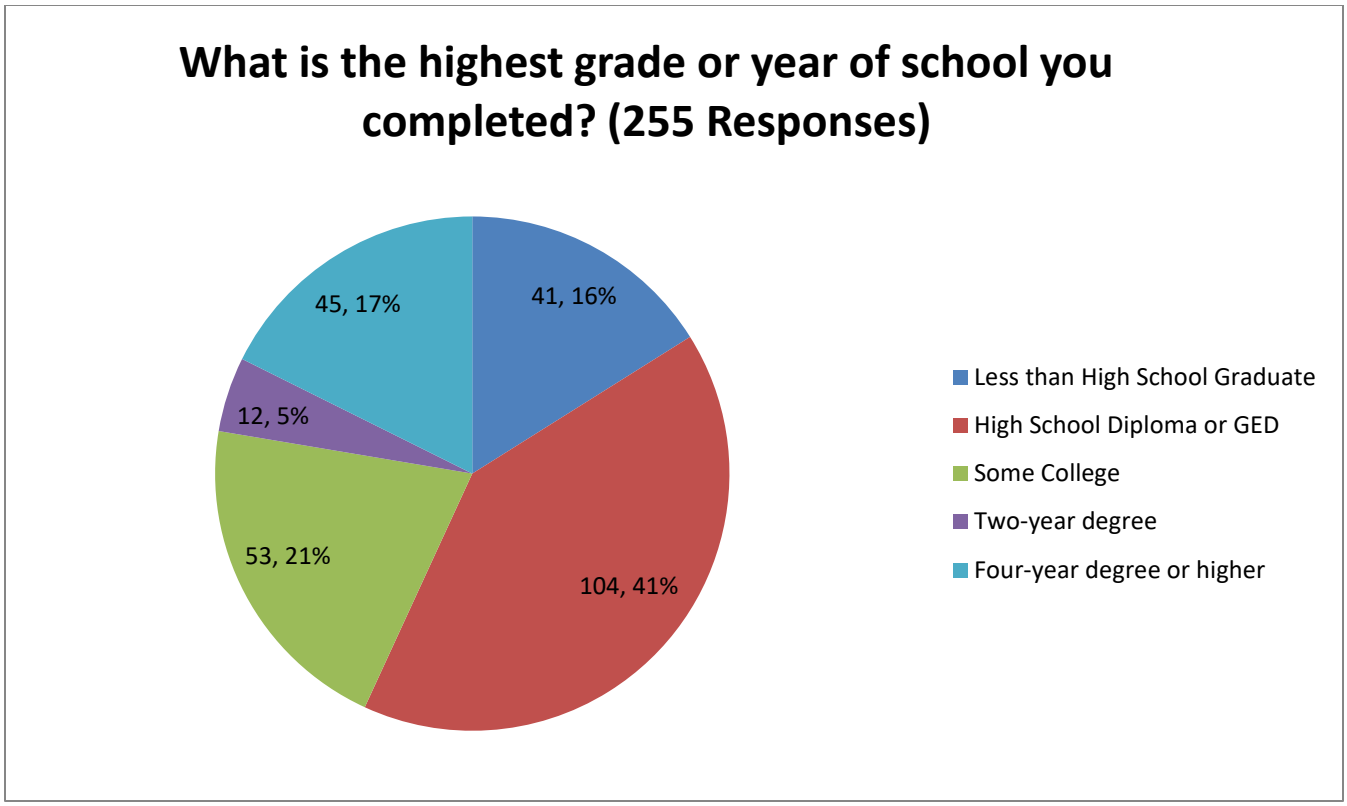
21.


I pay for health services through (254 Responses)
5, 2%
10, 4%
7, 3%
77, 30%
68, 27%
87, 34%
Private Insurance
Medicare
Medicaid
VA Benefits
Indian Health Services
Uninsured
Pay Cash

22.


I am (260 Responses)
75, 29%
28, 11%
39, 15%
6, 2%
64, 25%
32, 12%
8, 3%
8, 3%
Working, full time
Working, part time
Not working, looking for work
Not working, not looking for work
Retired
Disabled, not able to work
A student, working
A student, not working

23.


What is the highest grade or year of school you completed? (255 Responses)
41, 16%
104, 41%
53, 21%
12, 5%
45, 17%
Less than High School Graduate
High School Diploma or GED
Some College
Two-year degree
Four-year degree or higher

Grace Medical Center CHNA Implementation Plan

Health

Prioritized Need - Behavioral Health/Substance Abuse/Opioids	
Goal – Reduce fatalities among residents of West Baltimore who accidentally overdose.	
Actions:	1. Provide Overdose Prevention Education and Training to 100% of all patients enrolled in Grace Medical Center operated OTP's. 2. Provide naloxone kits to enrollees within two business days after completing an overdose prevention training document.
Anticipated Impact:	Prevention of overdose fatalities among enrollees in OTP programs as well as the southwest Baltimore community in general.
Metrics Used to determine Progress:	# Naloxone Kits distributed #Total Enrollment in all OTP's.
Resources (Staff and/or Budget):	Existing OTP staff to provide overdose prevention education and training to all OTP enrollees. Naloxone kits procured with grant funds
Leader(s):	Tara Buchanan, RN Heather Young, FNP

Prioritized Need – Behavioral Health/Substance Abuse/Opioids	
Goal – Improve the health status of residents of southwest Baltimore by increasing the number of SBIRT Interventions and Overdose Survivor's Outreach Program (OSOP) referrals by 10% over FY 19 totals for individuals who screen positive during their ED visits.	
Actions:	1. Provide SBIRT Interventions and OSOP referrals in the Emergency Department and on the Observation unit at Grace Medical Center for individuals with a positive SBIRT screening. 2. Conduct follow-up telephone surveys to validate treatment referrals
Anticipated Impact:	Reduce ED visits for individuals diagnosed with identified Substance Use Disorders. Increase the number of Individuals who accept referrals to Substance Abuse Treatment.
Metrics Used to determine Progress:	# SBIRT/ OSOP referrals who kept referral appointments # SBIRT/ OSOP referrals
Resources (Staff and/or Budget):	Existing SBIRT Peer Recovery staff/ budget

Leader:	Dr. Nicole Wagner

Health

Prioritized Need – Access to Care Providers (Primary, Pediatric, Specialty)	
Goals: 1) Improve and expand access to Primary Care, Preventive Services, and Specialty Care 2) Improve the health of the community by increasing the number of people connected to a primary care medical home and increasing annual primary care visits	
Actions:	1. Increase capacity of services by reconstructing a new area to house Primary Care, and expanded Specialty Services including Ophthalmology, OB/GYN, and Pediatrics 2. Establish a Pediatric Clinic within our current Family Practice and protocols for referral 3. Establish OB/GYN Clinic 4. Establish Eye Clinic 5. Develop communications to the community in which we increase awareness of services and how to access 6. Ongoing referral coordination provided by Referral Coordinator in collaboration with Providers, and ED/Observation and Ambulatory Care Management teams. 7. Provide patient outreach by use of patient portal, letters, or phone calls to patients not seen in the practice within six months to schedule appointments 8. Referrals made from Community Programs and activities which identify patients without a medical home and/or patients at risk for chronic conditions 9. Conduct focused events (men's health, and women's health) and refer community members for utilization of services as needed 10. Community awareness and education provided to promote the importance of establishing a medical home, receiving preventive screenings and routine well visits 11. Transitions of Care activities from both ED/Observation Care - Transitions team and Ambulatory Care Management team to connect patients with Primary Care and Specialty Services to include appointment assistance, referrals, care coordination, and follow up with patients 12. Continue to assist patients with obtaining medical insurance via onsite vendor. Care Management teams identify and refer patients without insurance to the onsite vendor for assistance.
Anticipated Impact:	Overall improved access to Primary Care, Preventive Services, and Specialty Care.

Metrics Used to determine Progress:	1. Increased Primary Care and Specialty Care volumes 2. Decreased inappropriate ED utilization 3. Improved preventive screening rates i.e. CRC, Breast Cancer 4. % of patients with post discharge appointment within 7 days 5. Number of people referred to care from Community Programs
Resources (Staff and/or Budget):	1. Ambulatory Department 2. CHW Department 3. Care Management Team
Leader:	Dr. Sheikh and Michelle Berkley-Brown

Health

Prioritized Need – Chronic Conditions	
Goal – Improve the health status of southwest Baltimore residents by engaging the community in screenings and educational events that promote healthier lifestyles and better self-management of health and chronic conditions Goal – Improve management of Chronic Conditions by early identification of patients at risk, provision of care, and management of those with chronic conditions	
Actions:	1. Health Education programs, Community Screenings, and Chronic Disease Management programs will be conducted in the community, independent senior buildings, and faith-based organizations to promote healthier lifestyle and self-management of chronic illness. These programs include: Healthy Living Series, Chronic Disease Self-Management Program, Freedom from Smoking, Health and Housing Program, and Faith Community Partnership 2. Provision of blood pressure devices and education for patients to monitor blood pressure at home and communicate readings with provider. 3. Diabetic education provided by DM educator to diabetic patients in both ambulatory and observation care setting. 4. Provide educational programs to youth in public schools about proper nutrition, diet and exercise and the interplay with health and wellness. 5. Care Transitions team completes high risk assessment on all admissions to ED and Observation level of care; and team ensures a primary care appointment is obtained prior to discharge. This effort includes connecting to Community Care Management 6. Enrollment into Community Care Management programs for specific disease state education and management

	7. Care Transitions team will complete home visits to high risk community members with chronic conditions to ensure medication reconciliation, medication compliance, and follow up appointment compliance. 8. Care Transitions will assist with nutritional support through Meals on Wheels
Anticipated Impact:	Decreased morbidity and mortality from chronic conditions such as Diabetes, HTN, heart disease, and COPD.
Metrics Used to determine Progress:	1. Decreased readmission rate. 2. Decreased primary care no show rates. 3. Increased number of patients connected to primary care. 4. Decreased inappropriate ED utilization 5. Increased number of people reached through health fairs, educational workshops and events
Resources (Staff and/or Budget):	1. Community Health & Wellness team 2. Care Transitions Team 3. Ambulatory Care Management team 4. Ambulatory Providers
Leader:	Karen Jarrell, Michelle Berkley-Brown, and Rhonda Williams

Social and Environmental

Prioritized Need – Community Engagement [and Development]	
Goal - To address key health and socio-economic challenges in West Baltimore through community-based initiatives.	
Actions:	• In partnership with Population Health and Baltimore Child Abuse Center (BCAC); offer two health education-based workshops and/or events each year to the West Baltimore community. • Build partnerships with two workforce development organizations and conduct two outreach events per year to connect area residents to employment opportunities. • Test two new non-technological strategies to reduce information gaps and improve communication to both community members and medical personnel on hospital services, programs, and initiatives as well as community-based resources. • Promote quality, healthy food access in West Baltimore through an initiative, e.g. food education, food market or organizational partnership. • Expand LifeBridge Health *Live Near Your Work* program in the West Baltimore service area.
Anticipated Impact:	• Increase access to health education, child abuse prevention, violence prevention, and other outreach opportunities to West Baltimore residents.

	• Increase opportunities for skills training, workforce development and employment for West Baltimore residents. • Decrease communication barriers while increasing access to health resources within the community. • Enhance community and hospital stability, through neighborhood revitalization efforts. • Expand access to healthy food options and resources to west Baltimore residents
Metrics Used to determine Progress:	Reach: • # of people attending events • # of classes/workshops/events offered • # of communication strategies initiated • # of partnerships initiated Outcomes: • # of people completing post event surveys • % of participants completing classes/workshops • # of communication strategies implemented • # of partnerships cultivated and maintained
Resources (Staff and/or Budget):	• Dedicated HSCRC/Community Benefit funding • Foundation Board Members • Additional Partnerships as Needed
Leader:	Sommer/Merritt

Social and Environmental

Prioritized Need – Crime and Trauma	
Goal - To address existing trauma and to prevent future trauma caused by violence within the west Baltimore community (zip codes 21223, 21217, 21216 – in descending order)	
Actions:	1. Provide Violence Intervention & Prevention Awareness training for all GMC staff on all forms of violence & abuse 2. Assess need for onsite violence responders & community violence interrupters (i.e. establish a Safe Streets site) to ensure that patients who have been victims of gun violence, stabbings, domestic violence, elder abuse, and other forms of violence have the support needed while at Grace Medical and within the community 3. Provide Case Management, including individualized needs assessments, tailored case planning, and community-based client advocacy, for survivors of violence related trauma 4. Provide trauma-responsive mental health services for survivors of violence related trauma 5. Provide school-based violence prevention services, including academic enrichment opportunities, life skills training, and

<table>
<tr><td></td><td>student support groups through an evidence-based violence prevention curriculum</td></tr>
<tr><td>Anticipated Impact:</td><td>1. 100% of staff trained in violence-related risk and protective factors and other challenging dynamics within 12 months
2. Increase safety planning and continuity of community care with survivors of violence by 50% within 12 months
3. Increase school attendance rates for program participants by 40% within 24 months
4. Decrease arrests of program participants by 30% within 24 months
5. Decrease CPS referrals of program participants by 30% within 24 months
6. Increase community resource connections of program participants by 80% within 12 months
7. Increase access to mental health services for survivors of violence by 25% within 18 months</td></tr>
<tr><td>Metrics Used to determine Progress:</td><td>1. Number of staff trained in Violence Intervention and Prevention dynamics compared to total number of staff
2. Number of patients connected to hospital and community-based violence response compared to number of patients presenting with violence-related injuries
3. Client-reported school attendance rates; verified by school records
4. Client-reported arrests; verified by arrest records
5. Client-reported CPS referrals; verified by CPS records
6. Client-reported community resource connections made
7. Number of mental health clients compared to need assessed within community</td></tr>
<tr><td>Resources (Staff and/or Budget):</td><td><table>
<tr><td>Manager of Case Management Team (35%)</td><td></td></tr>
<tr><td>School-based Coordinator (100%)</td><td></td></tr>
<tr><td>Case Manager (100%)</td><td></td></tr>
<tr><td>Hospital-based Violence Responder (100%)</td><td></td></tr>
<tr><td>Trauma Therapist (100%)</td><td></td></tr>
<tr><td>Fringe (22%)</td><td></td></tr>
<tr><td>Total Cost</td><td>$ 295,240</td></tr>
</table></td></tr>
<tr><td>Leader:</td><td>Adam Rosenberg</td></tr>
</table>

Access

Prioritized Need – Transportation	
Goal – Provide transportation to community residents for clinic appointments and dialysis treatments	
Actions:	1) Further develop request system for rides to Primary Care and Specialty Care clinic appointments 2) Continue to provide transportation to dialysis patients to facilitate treatments 3) Assess fleet needs to accommodate additional riders who need transportation to physician appointments or outpatient dialysis 4) Assess community needs for transportation of family members to visit loved ones at Sinai, Northwest and Levindale hospitals.
Anticipated Impact:	Improved access by community for medical services at Grace Medical Center; Increased availability for hemodialysis services to the community; increased efficiency and effective use of Grace clinics
Metrics Used to determine Progress:	Patient ride volumes and reduced missed appointments
Resources (Staff and/or Budget):	4 drivers, 3 fourteen passenger buses
Leader:	Stephen Winstead/John Knapp

LIFEBRIDGE HEALTH

CARE BRAVELY

Header Information

Participating Organization's: Sinai Hospital, Northwest Hospital, Carroll Hospital, Levindale Hebrew Geriatric Center and Hospital, Grace Medical Center
Policy Category: Finance
Subject: Hospital Financial Assistance
Department Responsible for Review: Revenue Cycle Division
Policy Owner: Senior Vice President and Chief Revenue Officer

I. POLICY

A. Purpose. The purposes of this Policy are to (a) set forth eligibility criteria for receiving Financial Assistance; (b) outline circumstances and criteria under which each hospital will provide free or discounted care for Eligible Services to eligible patients who are Uninsured, Underinsured, patients ineligible for public or government assistance or who are otherwise unable to pay for Eligible Services, (c) set forth the basis and methods of calculation for charging any discounted amounts to such patients, and (d) state the measures to widely publicize this Policy within the communities to be served by the hospital. LifeBridge Health expects that patients will comply fully with the terms of this Policy in the determination of their eligibility for, and any receipt of, Financial Assistance and discounts. LifeBridge Health further expects its patients to apply for Medicaid and other governmental program assistance when appropriate, and to pursue any payments from third parties who may be liable to pay for the patient's care as the result of personal injury or similar claims. LifeBridge Health also encourage individuals to obtain health insurance to the extent such individuals are financially able to do so.

B. Scope. This policy applies to LifeBridge Health State of Maryland regulated hospital affiliates specifically Carroll Hospital, Grace Medical Center, Levindale Hebrew Geriatric Center and Hospital, Northwest Hospital and Sinai Hospital (collectively known for this policy as "LifeBridge Health")

C. Policy. It is the policy of LifeBridge Health to provide medically necessary health care services to all patient's without regard to the patient's ability of pay or Protected Class as defined in MD Code, Health-General §19-214.1, at each applicable hospital location (as defined below). Each hospital also provides, without discrimination, care for Emergency Medical Conditions (as defined below) to individuals without regard to such individual's eligibility for Financial Assistance, as more specifically set forth in LifeBridge Health's separate Emergency Medical Treatment & Labor Act (EMTALA) Policy, a copy of which can be obtained free of charge from any one of the sources or locations listed in Section III. K. of this Policy.

D. Adoption of Policy. The Board of Directors of LifeBridge Health and each of its applicable tax-exempt affiliates that provides medically necessary hospital services, has adopted the following policies and procedures for the provision of Financial Assistance.

E. Frequency of Review. This policy is to be reviewed and approved every two years.

II. DEFINITIONS

For purposes of this Policy, the terms below shall be defined as follows:

A. **"AGB"** means the amounts generally billed as defined by IRS Section 501(r)(5) for hospital emergency and other Medically Necessary care to individuals who have insurance covering that care, and calculated in accordance to the State of Maryland Health Services Cost Review Commission (HSCRC).

B. **"Application"** has the meaning set forth in Section III. B. below which shall comply with the HSCRC uniform financial assistance application requirements.

C. **"Assets"** means assets and resources (and the values thereof) of an individual, that would be taken into account and valued in accordance with the Code of Maryland Regulations in determining eligibility specifically excluding such individual's (a) primary personal residence not to exceed an assessed value of $150,000, (b) retirement assets or plans as qualified or nonqualified by the Internal Revenue Service including one or more retirement plans which shall include, without limitation, an individual retirement account (traditional or Roth), profit-sharing plan, defined benefit pension plan, 401(k) plan, 403(b) plan, nonqualified deferred compensation plan, money purchase pension plan, or other retirement plan equivalent to any of the foregoing, (c) one motor vehicle owned by the patient or any family member used for necessary transportation needed, (d) prepaid education assets or plans as defined by the State of Maryland or Internal Revenue Service which include, without limitation, Education Savings Account or 529 plans, (e) any assets expressly excluded in determining eligibility for a Federal or State financial or medical assistance program or plan which include, but not limited to, the Federal Supplemental Nutrition Assistance Program (SNAP), the Maryland Medical Assistance Program, State Energy Assistance Program, or Supplemental Food Program for Women, Infants, and Children, (f) burial space or plot, funds or prepaid burial contracts, and (g) household goods and personal effects.

D. **"CMO"** means Chief Medical Officer at a LifeBridge Health hospital or Chief Physician Executive.

E. **"Eligible Services"** means the services (and any related products) provided by a LifeBridge Health hospital that are eligible for Financial Assistance under this Policy, which shall include: (1) emergency medical services provided in an emergency room setting, (2) non-elective medical services provided in response to life-threatening circumstances that are other than emergency medical services in an emergency room setting, and (3) Medically Necessary Services as defined in this policy.

F. **"Emergency Medical Conditions"** has the same meaning as such term is defined in section 1867 of the Social Security Act, as amended (42 U.S.C. 1395dd) and as stated:

> "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious

jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions: (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child."

G. **"Family Member"** means a member of a group of two (2) or more individuals who reside together and who are related by birth, marriage, or adoption, including, without limitation, any individual claimed as a dependent by any such individual on his or her federal income tax return.

H. **"Family Income"** means the gross income of an individual and all of his or her Family Members, including, without limitation, compensation for services (wages, salaries, commissions, etc.), interest, dividends, royalties, capital gains, annuities, pension, retirement income, Social Security, public or government assistance, rents, alimony, child support, business income, income from estates or trusts, survivor benefits, scholarships or other educational assistance, annuity payments, payments under or from a reverse mortgage, fees, income from life insurance or endowment contracts, and any other gross income or remuneration, from whatever source derived, all on a pre-tax basis.

I. **"Federal Poverty Guidelines"** means poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services in effect at the time of such determination.

J. **"Financial Assistance"** means any financial assistance in the form of free or discounted care granted to an eligible individual pursuant to this Policy.

K. **"Financial Hardship"** means an Uninsured or Underinsured patient of a LifeBridge Health hospital who (1) after payment by all third-party payers, is financially obligated to a LifeBridge Health hospital for an amount in excess of twenty-five percent (25%) of such patient's gross annual income and (2) has Assets that total value of which is less than the amount of "Assets", as amended from time to time.

L. **"Hospital Cost Review Commission (HSCRC)"** means an independent agency of the State of Maryland with broad regulatory authority to establish rates to promote cost containment, access to care, financial stability and accountability; including guidelines that govern hospital financial assistance.

M. **"Hospital"** means a facility (whether operated directly or through a joint venture arrangement) that is required by the State of Maryland to be licensed, registered, or similarly recognized as a

hospital. "Hospital" means collectively, more than one Hospital Facility. As it relates to this Policy, applicable locations include:

- Carroll Hospital,
- Grace Medical Center
- Levindale Hebrew Geriatric Center and Hospital
- Northwest Hospital,
- Sinai Hospital

N. **"Medically Necessary"** shall have the same meaning as such term is defined for Medicare (services or its reasonable and necessary for the diagnosis or treatment of illness or injury), or for disputed or less clear cases referred to the CMO or designee to render a decision.

O. **"Policy"** means this "Financial Assistance Policy" of a LifeBridge Health hospital, as amended from time to time.

P. **"Protected Class"** shall comply with the Code of Maryland Regulation specifically representing race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, disability, citizenship status, or any other class, ethnicity or designation not otherwise specified.

Q. **"Provider"** means a LifeBridge Health hospital employed physician, advanced clinical practitioner or licensed professional recognized and granted authority by the State of Maryland to provide health care services.

R. **"Uninsured"** means a patient of a LifeBridge Health hospital who has no level of insurance, third party assistance, medical savings account, or claims against one or more third parties covered by insurance, to pay or assist with such individual's payment obligations for the provision of Eligible Services.

S. **"Underinsured"** means a patient of LifeBridge Health hospital who has some level of insurance, third party assistance, medical savings account, or claims against one or more third parties covered by insurance, to pay or assist with such individual's payment obligations for provision of Eligible Services, but who nevertheless remains obligated to pay out-of-pocket expenses for the provision of Eligible Services that exceed such individual's financial abilities.

III. GUIDELINES

A. Eligibility. Upon a determination of financial need and eligibility in accordance with this Policy, a LifeBridge Health hospital will provide Financial Assistance for Eligible Services to or for Uninsured patients, Underinsured patients, patients who are ineligible for public or government assistance, or who are otherwise unable to pay for Eligible Services. Financial Assistance

pursuant to this Policy shall be based on a determination of financial need for each individual, regardless of race, sex, age, disability, national origin or religion, or other Protected Class.

B. Application for Financial Assistance. Except as otherwise provided in this Policy, a LifeBridge Health authorized representative will review all information requested and set forth in an application for Financial Assistance (a copy of which can be obtained free of charge from any one of the sources or locations listed in Section III. K. below of this Policy), an in any and all documentation therein requested and provided (the application and such documentation, collectively, an "Application"), as well as any one or more items of the following information, in determining whether an individual will be eligible for and receive Financial Assistance:

1. Publicly available data that provides information about an individual's ability to pay (e.g. credit reports, scores, or ratings; Federal Poverty Guidelines, relevant published federal or state guidelines, bankruptcy filings or orders);
2. Insurance eligibility for public or private health insurance including qualification for other public programs that may cover health care costs;
3. Information relating to such individual's participation or enrollment in, or receipt of benefits from or as part of, (a) any state or federal assistance program enrollment (e.g., Supplementary Security Income, Medicaid, Food Stamps/SNAP, Women, Infants, and Children (WIC) programs, AFDC, Children's Health Insurance Program (CHIP), low-income housing, disability benefits, unemployment compensation, subsidized school lunch, or (b) any free clinic, indigent health access programs, or Federally Qualified Health Center (FQHC).
4. Information substantiating the total gross Family Income and assets owned or held by the individual and liabilities or other obligations of the individual;
5. Information substantiating that such individual is or has been homeless, disabled, declared mentally incompetent or otherwise incapacitated, so as to adversely affect such individual's financial ability to pay; and/or
6. Information substantiating that such individual has sought or is seeking benefits from all other available funding sources for which the individual is eligible, including insurance, Medicaid or other state or federal programs.

It is preferred, but not required, that an individual request Financial Assistance prior to Eligible Services being provided. Any Application may be submitted prior to, upon receipt of Eligible Services, or during the billing and collection process. The information that an individual requesting Financial Assistance has provided will be re-evaluated, verified, and required to be updated at each subsequent time Eligible Services are provided that is more than twelve (12) months after the time such information was previously provided. If such information does change or additional information is discovered relevant to the patient's eligibility for Financial Assistance, it is the patient's responsibility to notify Customer Service at (800)788-6995. Applications will be made available, free of charge, at any hospital Patient Access or Customer Service. Requests for Financial Assistance will be processed promptly, and the hospital will determine eligibility within two (2) business days for probable determination or 14 (fourteen) days for final determination after receipt of a completed Application, submission of all required

information, and make all reasonable efforts to provide written notification to the patient or applicant of its determination within thirty (30) days. Such notification may be in the form of a billing statement which shows the amount of Financial Assistance applied to the patient's account(s), and if the patient is granted 100% Financial Assistance or denied, written notice will be sent in the form of a letter delivered to the patient's or guarantor's mailing address on file.

A LifeBridge Health hospital may deny or reject any Application and/or may reverse any previously provided discounts or Financial Assistance, if it determines in good faith, that information previously provided was intentionally false, incomplete or misleading. Moreover, a LifeBridge Health hospital may, at its sole discretion, pursue any and all legal remedies or actions, including criminal charges, against any person who knowingly misrepresented their financial condition including, without limitation, the amount or value of Family Income and/or Assets.

C. Appeals and Complaints. Patients or Guarantors with applications denied for Financial Assistance covered under this Policy may appeal such decisions or file a complaint.
   1. Appeals must be in writing and describe the basis of reconsideration, including any supporting documentation. Appeals must be submitted to Customer Service within fourteen (14) calendar days of the application decision or otherwise the decision shall be upheld and considered final. Customer Service will make every effort to notify Patients or Guarantors of the appeal decision within thirty (30) calendar days.
   2. Complaints regarding this Policy can be received by mail, email or phone. All complaints are to be reported to LifeBridge Health Compliance Department for monitoring and reporting. Customer Service will respond to each complaint, contact the individual who filed the complaint and notify the LifeBridge Health Compliance Department of the complaint's outcome.

      Patients or Guarantors may also file a complaint with Maryland Health Education and Advocacy Unit using the following contact information:

      Office of the Attorney General
      Health Education and Advocacy Unit
      200 St. Paul Place, 16th Floor
      Baltimore, MD 21202
      Phone: (410)528-1840
      Fax: (410)576-6571
      Email: HEAU@oag.state.md.us

D. Presumptive Financial Assistance. In some cases or circumstances a patient or applicant may appear eligible for Financial Assistance, but either has not provided all requested information or otherwise non-responsive to the application process. In such cases or circumstances, an authorized representative of a LifeBridge Health hospital may complete the Application on the patient's behalf and research evidence of eligibility for Financial Assistance from available

outside sources to determine the patient's estimated income and potential discount amounts or may utilize other sources of information to make an assessment of financial need. As a result of such information, the patient may be eligible for discounts up to 100% of the amounts owed for Eligible Services. In such circumstances, a patient is presumed eligible to receive Financial Assistance for Eligible Services if the patient meets one or more of the following criteria:

1. Eligible for the Maryland Medical Assistance program or Maryland Children's Health Program and:
    i. Lives in a household with children enrolled in the free and reduced-cost meal program;
    ii. Receives benefits through the federal Supplemental Nutrition Assistance Program;
    iii. Receives benefits through the State's Energy Assistance Program;
    iv. Receives benefits through the federal Special Supplemental Food Program for Women, Infants, and Children; or
    v. Receives benefits from any other social service program as determined by the Maryland Department of Health and Mental Hygiene (MD DHMH) and the State of Maryland HSCRC.
2. Residence in low income or subsidized housing;
3. Unfavorable credit history, based on the patient's credit report (high risk, low medical score, delinquent accounts);
4. Utilization of third-party predictive modeling based on public record databases and calibrated historical approvals statistically matched to this Policy. Such technology will be deployed prior to bad debt assignment in an effort to screen all patients for financial assistance prior to collection agency placement or pursuing any extraordinary collection actions.
5. Homeless or received care from a homeless shelter, free clinic;
6. Mentally incompetent as declared by a court or licensed professional; or
7. Deceased with no known estate.

E. Eligibility Criteria and Amounts Charged to Patients. Patients who are determined to be eligible, shall receive Financial Assistance in accordance with such individual's financial need, as determined by referring to the Federal Poverty Guidelines as published annually in the Federal Register.

1. Notwithstanding anything in this Policy to the contrary, no patient who is eligible to receive Financial Assistance for Eligible Services will be charged more than allowed by the State of Maryland HSCRC pricing or AGB for emergency or other Medically Necessary care.
2. The basis for determining and calculating the amounts billed an Uninsured or Underinsured patient who is eligible for Financial Assistance is as follows:
    i. Any Uninsured or Underinsured patient eligible for Financial Assistance will first receive the Financial Assistance discount for either 100% of billed charges or a reduced billed amount for those with Family income above 300% of the Federal Poverty Guidelines.

ii. Uninsured or Underinsured patients eligible for Financial Assistance whose yearly Family Income is equal to or less than 300% of the Federal Poverty Guidelines and whose total Assets do not exceed amounts allowed will receive a discount of 100% of their remaining account balance.

iii. Any Uninsured with Family Income above 300%, but less than 500% of the Federal Poverty Guidelines may qualify for a Financial Hardship discount. To qualify total Assets must be less than allowed provided total outstanding medical expenses minus co-payments, coinsurance and deductibles exceed 25% of annual Family Income. The amount of the Financial Hardship discount is any amount that exceeds 25% of annual Family Income. Thus, remaining balance owed excluding co-payments, coinsurance and deductibles if applicable after discount does not exceed 25% of Family Income.

F. Excluded Services. The following healthcare services are not eligible for Financial Assistance under this Policy:

1. Purchases from retail operations, including gift shops, retail pharmacy, durable medical equipment, cafeteria purchases;
2. Services provided by non-LifeBridge Health entities or professional services from physicians or advanced practice providers during hospital visits;
3. Elective procedures or treatments that are not Medically Necessary including cosmetic surgery, bariatric surgery, venous ablation.
4. Services provided at Levindale Nursing, Rehabilitation and Adult Day Care locations and any amounts deemed by Medicaid as patient liability.
5. Existing or pre-established programs to assist patients with defined coverage of services similar to Best Beginnings for undocumented women needing prenatal care or Access Carroll for free clinic care to uninsured and underinsured patient populations in Carroll County.

G. Communication of Information about the Policy to Patients and the Public. LifeBridge Health hospitals will take measures to inform and notify patients and visitors and the residents of the community at large served by the hospital, of this Policy in a manner that, at a minimum, will notify the listener and reader that the hospital offers Financial Assistance and informs individuals about how and where to obtain more information about this Policy. Such measures will include the following:

1. Clearly and conspicuously post signage to advise patients and visitors of Financial Assistance availability including Emergency Department, admission areas and billing departments
2. Make this Policy, the Application, and a plain language summary of this Policy widely available on its website www.lifebrigehealth.org.
3. Make paper copies of this Policy, the Application, and a plain language summary of this Policy available upon request, without charge, in public locations in each hospital including Emergency Department, admission areas, billing department and by mail or e-

mail. Furthermore, Patient Access and Customer Service representatives will notify and inform individuals upon admission or discharge of Financial Assistance and offer a paper copy of a plain language summary of the Financial Assistance Policy.

4. List all Providers, as referenced as Addendum I, whether employed or not employed by the hospital, covered by this Policy and will make widely available on its website www.lifebridgehealth.org.
5. Referral of patients for Financial Assistance may be made by any member of LifeBridge Health staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors.
6. A request for Financial Assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws and limitations.
7. Any and all written or printed information concerning this Policy, including the Application, will be made available in each of the languages spoken by the lesser of 1,000 individuals or 5% of the community served by the hospital or the population likely to be encountered or affected by the hospital. The hospital will take reasonable efforts to ensure that information about this Policy and its availability is clearly communicated to patients who are not proficient in reading and writing and/or who speak languages other than those for which information about this Policy are printed or published.

H. Document Retention Procedures. The hospital will maintain documentation in accordance with retention policies sufficient to identify each patient determined to be eligible for Financial Assistance including the patient's Application, any information obtained or considered in determining such patient's eligibility for Financial Assistance (including information about such patient's income and assets), the method used to verify patient's income, the amount owed by the patient, the method and calculation of any Financial Assistance for which such patient was eligible and in fact received, and the person who approved the determination of such patient's eligibility for Financial Assistance.

I. Relationship to Billing and Collections Policy. For any patient who fails to timely pay all or any portion of amount(s) owed, the hospital will follow guidelines set forth in its separate Billing and Collections Policy; provided that, the hospital will not commence or institute any extraordinary collection actions (including garnishments, liens, foreclosures, levies, attachments or seizures of assets, commencing civil or criminal actions, sales of debts to third parties, reporting adverse information to credit reporting agencies or credit bureaus) against any patient for failure to timely pay all of any portion of patient's account, without first, making reasonable efforts to determine whether the patient is eligible for Financial Assistance. Reasonable efforts are set forth in the separate Billing and Collections Policy, including those relating to patient communications and required actions, time periods, and notices of complete or incomplete Application for Financial Assistance. A copy of the Billing and Collection Policy may be obtained free of charge from any one of the sources or locations listed in Section III.K. below.

J. No Effect on Other Policies; Policy Subject to Applicable Law. This Policy shall not alter or modify other policies regarding efforts to obtain payment from third party payers, transfers or emergency care. This Policy and the provision of any Financial Assistance will be subject to all applicable federal, state, and local law.

K. Sources of and Locations for Information. Copies of this Policy, the Application, the Billing and Collections Policy, and the EMTALA Policy, may be obtained from or at any one or more of the following sources or locations:

1. Any Customer Service, Patient Access, or Patient Registration areas;
2. Emergency Department, admission areas or billing department;
3. By calling Customer Service at (800)788-6995; and
4. LifeBridge Health's website at www.lifebridgehealth.org.

From:	Rhonda Williams
To:	Hilltop HCB Help Account
Cc:	Michelle Berkley-Brown; Sharon McClernan
Subject:	Re: Clarification Required - Grace Medical Center FY 21 Community Benefit Narrative
Date:	Wednesday, June 8, 2022 10:38:36 AM
Attachments:	image001.png Outlook-w0g5qywc.png

Report This Email

Good morning,
Pediatrics was selected in error. Please disregard.

Rhonda L. Williams, MSN, RN
Program Manager

GRACE MEDICAL CENTER
A LifeBridge Health Center
CARE BRAVELY

2000 West Baltimore Street |Rm. 3112| Baltimore, MD 21223
410-362-3804 office | 443-879-9467 mobile
rwilliams1@lifebridgehealth.org

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Wednesday, June 8, 2022 10:35 AM
To: Rhonda Williams <rwilliams1@lifebridgehealth.org>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Michelle Berkley-Brown <mberkley-brown@lifebridgehealth.org>; Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - Grace Medical Center FY 21 Community Benefit Narrative

Thank you for your response. We have one additional item to clear up. On the supplementary survey, you selected "Yes" for Pediatrics under physician subsidies but did not select a subsidy type from the drop-down menu. Please indicate which type of subsidy is provided for Pediatrics:

- Non-resident house staff and hospitalists
- Coverage of emergency department call
- Physician recruitment to meet community need
- Physician provision of financial assistance

From: Rhonda Williams <rwilliams1@lifebridgehealth.org>

Sent: Wednesday, June 8, 2022 10:24 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Michelle Berkley-Brown <mberkley-brown@lifebridgehealth.org>; Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: Clarification Required - Grace Medical Center FY 21 Community Benefit Narrative

Good morning,
Please see the responses below regarding the narrative submitted where you requested further clarification:

"For Questions 44 and 46 on pages 5-7 of the attached, for several positions at your hospital, selections were made for the ways that they assisted with either the CHNA process or community benefit activities throughout the year, but the option "N/A – Position or Department does not exist" was also selected in this section. Please clarify the status of each of these entities, listed below:"

- Clinical Leadership (System Level) -N/A should not be checked.
- Population Health Staff (Facility Level) -N/A should not be selected but should be: Selecting health needs that will be targeted and selecting initiatives that will be supported.
- Population Health Staff (System Level) -N/A should not be selected.

Please let me know if additional clarification is needed.
Thank you,

Rhonda L. Williams, MSN, RN
Program Manager

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CARE BRAVELY

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410-362-3804 office | 443-879-9467 mobile
rwilliams1@lifebridgehealth.org

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

To track health disparities in the communities it serves, Grace Medical Center collects patient-level information about race, gender, zip code, Area Deprivation Index, and social determinants of health. To reduce health disparities in the communities it serves, the facility prioritizes outreach to neighborhoods with higher economic and social disparities in its service area. To help address traditional barriers to health care access among these communities, the facility brings health care resources to where people live through regular Mobile Health Clinic events in priority neighborhoods--including events focused on chronic disease management, pediatric wellness, and COVID-19 vaccinations. The facility also conducts regular health clinics in nearby senior buildings. To further its reach and better capture residents in most need of services, the hospital regularly partners with trusted neighborhood-based entities, including churches, barbershops and community associations and centers.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [x] Regional Partnership Catalyst Grant Program
- [x] The Medicare Advantage Partnership Grant Program
- [x] The COVID-19 Long-Term Care Partnership Grant
- [x] The COVID-19 Community Vaccination Program
- [x] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

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

Ololaryngology	○	○	
Pathology	○	○	
Pediatrics	◉	○	
Physical Medicine & Rehabilitation	○	○	
Plastic Surgery	○	○	
Preventive Medicine	○	○	
Psychiatry	○	○	
Radiology	○	○	
Surgery	○	○	
Urology	○	○	
Other. (Describe)	○	○	

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

Non-Resident House Staff and Hospitalists-This subsidy is necessary to ensure that any patient requiring anesthesia, behavioral health, radiology and general medicine can have the access they need including 24 hour coverage. Grace Medical Center provides coverage through contracted physicians, house staff or hospitalists and allocates significant resources to sustain these services. Coverage of Emergency Department Call-To help ease the effects of uncompensated care on physicians and address the gap in care for our patients, Grace Medical Center contracts with various specialists to ensure 24/7 coverage in the ED.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

Q1. Thank you. To edit your answers, please use the "back" button below. To submit your answers, please use the "forward" button below.

Location Data

Location: (39.3407, -76.6753)

Source: GeoIP Estimation