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	Is this information correct? No	If no, please provide the correct information here:
The proper name of your hospital is: Saint Agnes Hospital	○	◉	Saint Agnes Healthcare, Inc
Your hospital's ID is: 210011	◉	○	
Your hospital is part of the hospital system called Ascension	◉	○	
The primary Narrative contacts at your hospital are Cynthia Mullinix & Olivia Farrow	◉	○	
The primary Narrative contact email addresses at your hospital are cmullini@ascension.org, olivia.farrow@ascension.org	◉	○	
The primary Financial contact at your hospital is UNKNOWN	○	◉	Mitch Lomax
The primary Financial email at your hospital is mlomax@ascension.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
- [x] 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
- [x] Life expectancy
- [ ] Crude death rate
- [x] Other

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

Prevalence of diabetes in the community. Readmission rates.

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
- [x] Anne Arundel County
- [x] Baltimore City
- [x] 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.

- [ ] 20701
- [ ] 20711
- [ ] 20714
- [ ] 20724
- [ ] 20733
- [ ] 20736
- [ ] 20751
- [ ] 20754
- [ ] 20755
- [ ] 20758
- [ ] 20764
- [ ] 20765
- [ ] 20776
- [ ] 20778
- [ ] 20779
- [ ] 20794
- [ ] 21012
- [ ] 21032
- [ ] 21035
- [ ] 21037
- [ ] 21054
- [ ] 21056
- [ ] 21060
- [ ] 21061
- [ ] 21062
- [ ] 21076
- [ ] 21077
- [ ] 21090
- [ ] 21106
- [ ] 21108
- [ ] 21113
- [ ] 21114
- [ ] 21122
- [ ] 21123
- [ ] 21140
- [ ] 21144
- [ ] 21146
- [x] 21225
- [x] 21226
- [ ] 21240
- [ ] 21401
- [ ] 21402
- [ ] 21403
- [ ] 21404
- [ ] 21405
- [ ] 21409
- [ ] 21411
- [ ] 21412

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

- [ ] 21201
- [ ] 21202
- [ ] 21203
- [ ] 21205
- [ ] 21206
- [x] 21207
- [ ] 21208
- [ ] 21209
- [ ] 21210
- [ ] 21211
- [ ] 21212
- [ ] 21213
- [ ] 21214
- [x] 21215
- [x] 21216
- [x] 21217
- [ ] 21218
- [ ] 21222
- [x] 21223
- [ ] 21224
- [x] 21225
- [x] 21226
- [x] 21227
- [x] 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.

- [ ] 21013
- [ ] 21020
- [ ] 21092
- [ ] 21093
- [ ] 21156
- [ ] 21161
- [x] 21225
- [x] 21227

- [ ] 21022
- [ ] 21023
- [ ] 21027
- [ ] 21030
- [ ] 21031
- [ ] 21043
- [ ] 21051
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- [ ] 21071
- [ ] 21074
- [ ] 21082
- [ ] 21085
- [ ] 21087
- [ ] 21094
- [ ] 21102
- [ ] 21104
- [ ] 21105
- [ ] 21111
- [ ] 21117
- [ ] 21120
- [ ] 21128
- [ ] 21131
- [ ] 21133
- [ ] 21136
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- [ ] 21155
- [ ] 21162
- [ ] 21163
- [ ] 21204
- [ ] 21206
- [x] 21207
- [ ] 21208
- [ ] 21209
- [ ] 21210
- [ ] 21212
- [x] 21215
- [ ] 21219
- [ ] 21220
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- [x] 21228
- [x] 21229
- [ ] 21234
- [ ] 21235
- [ ] 21236
- [ ] 21237
- [ ] 21239
- [ ] 21241
- [ ] 21244
- [ ] 21250
- [ ] 21252
- [ ] 21282
- [ ] 21284
- [ ] 21285
- [ ] 21286

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?

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

  Closely aligns with Total Cost of Care patient attribution as determined in the Medicare Performance Adjustor methodology

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

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

- [ ] Other. Please describe.

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

https://ascension.org/Our-Mission/Mission-Vision-Values

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

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

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

- (●) Yes
- ( ) No

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

This question was not displayed to the respondent.

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

6/30/2021

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

https://healthcare.ascension.org/-/media/healthcare/compliance-documents/maryland/2021-ascension-saint-agnes-chna-report.pdf

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

2021 Ascension Saint Agnes CHNA Report (2).pdf
4.9MB
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)	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐	
	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 (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:
Senior Executives (CEO, CFO, VP, etc.) (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:
Senior Executives (CEO, CFO, VP, etc.) (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:
Board of Directors or Board Committee (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:
Board of Directors or Board Committee (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:
Clinical Leadership (facility level)	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	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 (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)	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐	
Nurse(s)	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐	
Social Workers	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐	
Hospital Advisory Board	☐	☐	☐	☐	☐	☑	☑	☐	☐	☐	
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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)	☐	☐	☑	☑	☑	☐	☑	☑	☑	☐	
CB/ Community Health/ Population Health Director (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
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)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	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:
Physician(s)	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	
	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:
Nurse(s)	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	

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

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other State Agencies -- Please list the agencies here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Govt. Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	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:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	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:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.

09/20/2001

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

https://healthcare.ascension.org/-/media/healthcare/compliance-documents/maryland/2022-2024-ascension-saint-agnes-implementation-strategy.pdf

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

2022-2024-ascension-saint-agnes-implementation-strategy.pdf
93.3KB
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.

- [x] Health Conditions - Addiction
- [ ] Health Conditions - Arthritis
- [ ] Health Conditions - Blood Disorders
- [ ] Health Conditions - Cancer
- [ ] Health Conditions - Chronic Kidney Disease
- [ ] Health Conditions - Chronic Pain
- [ ] Health Conditions - Dementias
- [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 Behaviors - Drug and Alcohol Use
- [ ] Health Behaviors - Emergency Preparedness
- [ ] Health Behaviors - Family Planning
- [ ] Health Behaviors - Health Communication
- [ ] Health Behaviors - Injury Prevention
- [x] Health Behaviors - Nutrition and Healthy Eating
- [ ] Health Behaviors - Physical Activity
- [ ] Health Behaviors - Preventive Care
- [ ] Health Behaviors - Safe Food Handling
- [ ] Health Behaviors - Sleep
- [ ] Health Behaviors - Tobacco Use
- [x] Health Behaviors - Vaccination
- [x] Health Behaviors - Violence Prevention
- [ ] Populations - Adolescents
- [ ] Populations - Children
- [ ] Populations - Infants
- [ ] Populations – LGBT
- [ ] Populations - Women
- [ ] Populations - Workforce
- [ ] Settings and Systems - Community
- [ ] Settings and Systems - Environmental Health
- [ ] Settings and Systems - Global Health
- [ ] Settings and Systems - Health Care
- [ ] Settings and Systems - Health Insurance
- [ ] Settings and Systems - Health IT
- [ ] Settings and Systems - Health Policy
- [ ] Settings and Systems - Hospital and Emergency Services
- [ ] Settings and Systems - Housing and Homes
- [ ] Settings and Systems - Public Health Infrastructure
- [ ] Settings and Systems - Schools
- [x] Settings and Systems - Transportation
- [ ] Settings and Systems - Workplace
- [ ] Social Determinants of Health - Economic Stability
- [ ] Social Determinants of Health - Education Access and Quality

☐ Health Conditions - Respiratory Disease	☐ Populations - Men	☑ Social Determinants of Health - Health Care Access and Quality
☐ Health Conditions - Sensory or Communication Disorders	☑ Populations - Older Adults	☐ Social Determinants of Health - Neighborhood and Built Environment
☐ Health Conditions - Sexually Transmitted Infections	☐ Populations - Parents or Caregivers	☐ Social Determinants of Health - Social and Community Context
☐ Health Behaviors - Child and Adolescent Development	☐ Populations - People with Disabilities	☐ 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	Peer Recovery Program ED and Inpatient	Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based approach to identifying patients who use alcohol and other drugs at risky levels. The goal of SBIRT, implemented by Peer Recovery Coaches, is to reduce and prevent related health consequences, disease, accidents and injuries.	81% of patients were screened, yielding at 13% positive screen rate. Of those 59% received a Brief Intervention and 3% accepted a referral to treatment. Of those referred, 89% were linked to treatment.	# postive screens, # brief intervetions, # referred to treatment, # linked to treatment
Initiative B	Peer Recovery Program OB/GYN	Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based approach to identifying OB/GYN patients who use alcohol and other drugs at risky levels. The goal of SBIRT is to reduce and prevent related health consequences, disease, accidents and injuries.	New Initiative started in June 2021. 27% of patients screened, yielding a 38% positive screen rate.	# postive screens, # brief interventions, # referred to treatment, # linked to treatment
Initiative C				
Initiative D				
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 Prevention Program	Health eduation and support individuals in lifestyle changes in order to delay or prevent the onset of Type 2 Diabetes.	Of 245 participants, 102 participants lost 2% or more of their body weight upon completion of 6 months in the program. 50 participants met goal of 150 minutes of brisk physical activity each week upon completion of 12 months in the program.	Number of participants enrolled; weekly weights and minutes of exercise were self reported by the participants.
Initiative B	Diabetes Innovation Tank	Decrease A1c greater than 8 for African American MDPCP eligible patients	Recruited and enrolled 60 individuals to participate in (3) targeted DM initiatives aimed at reducing A1cs in the MDPCP attributed African American patient population within our AMG practices. 50% achieved a decrease in A1c to 8 or below.	Pre/post A1c measurements in enrolled patient population.
Initiative C				
Initiative D				
Initiative E				
Initiative F				
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	Diabetes Prevention Program	Health education and support individuals in lifestyle changes in order to delay or prevent the onset of Type 2 Diabetes and its co-morbidities of heart disease and stroke	Of 245 participants, 102 participants lost 2% or more of their body weight upon completion of 6 months in the program. 50 participants met goal of 150 minutes of brisk physical activity each week upon completion of 12 months in the program.	Measure participant weight and survey participants on their physical activity.
Initiative B				
Initiative C				
Initiative D				
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	AMG Integrated BH Program	Provide short-term, solution focused counseling to our patients in an effort to support positive behavior change, to decrease stress, and to support continued engagement with their Provider and Care Team.	Outcome tracking began in 7/2021	eCW system to track number referred, number enrolled, number attended 5+ visits
Initiative B				
Initiative C				
Initiative D				
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.

This question was not displayed to the respondent.

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.

	Health Behaviors - Nutrition and Healthy Eating Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Diabetes Prevention Program	Health education and support individuals in lifestyle changes in order to delay or prevent the onset of Type 2 Diabetes by providing nutrition education.	Of 245 participants, 102 participants lost 2% or more of their body weight upon completion of 6 months in the program. 50 participants met goal of 150 minutes of brisk physical activity each week upon completion of 12 months in the program.	Number of participants enrolled, weekly weights were self reported by the participants.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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.

This question was not displayed to the respondent.

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	Community Vaccine Clinics	Provide COVID - 19 vaccine and Flu vaccine in community settings to improve access to care.	26,103 vaccines administered.	Number of persons vaccinated.
Initiative B				
Initiative C				
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	Safe Streets Hospital Responder Program	Address the social needs of victims of violence who present to the E.D. and prevent further violence in the community. Intended outcome is to engage and enroll over 125 patients who receive additional community social services.	Program began in the last quarter of FY'21. No outcomes as of June 30th due to staff onboarding and training.	Number of E.D. patients enrolled in program and linked to community resources.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
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.

	Populations - Older Adults Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Trusted Ride Chaperone Program	Assist older adult patients and adults with disabilities who need extra support during transportation to and from medical appointments. Reduces missed and cancelled appointments to improve health outcomes.	1,890 Chaperone appointments conducted.	Number of Chaperone rides completed.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				

Initiative J				
All Other Initiatives				

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.

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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	Trusted Ride Chaperone Program	Assist older adult patients and adults with disabilities who need extra support during transportation to and from medical appointments. Reduces missed and cancelled appointments to improve health outcomes.	1,890 Chaperone appointments conducted.	Number of Chaperone rides completed.
Initiative B	LYFT Ride Services - AMG	Provide access to LYFT transportation for AMG PCP appointments for those patients without access, or reliable access, to transportation. Ensures safe transport of patients to medical appointments and then a return trip home. Reduces missed and cancelled appointments resulting in improved health outcomes.	Provided 3,996 Lyft rides to Primary Care/ Specialist / Appointments	Number of patients receiving rides
Initiative C	LYFT Ride Services -Inpatient	Provide access to LYFT for those patients upon in-patient hospital discharge, and discharge from hospital-based services, without access, or reliable access, to transportation. Ensures safe transport home resulting in improved health outcomes as the patient begins their convalescence.	Provided 12,720 Lyft rides to/from hospital services	Number of patients receiving rides
Initiative D				
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.

This question was not displayed to the respondent.

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	MDPCP DM Care Management	MDPCP is a voluntary program open to all qualifying Maryland primary care providers that provides funding and support for the delivery of advanced primary care throughout the state. The MDPCP supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization.	5 % attributed MDPCP patient population enrolled in Episodic /Longitudinal Care Management to address chronic and complex medical conditions including BH and SUD. 942 MDPCP Enrollments	eCW report
Initiative B	My Brother's Keeper Clinic	Provide primary care and other health services in the community to severely underserved community members with poor social determinants of health and high rates of unmanaged chronic disease	142 unique individuals served by expanding health services in the community	ECW registration
Initiative C	RME PCP Connection Initiative	Targeted Care Coord Intervention to connect patients to PCP	Linked 166 patients without a PCP to PCP f/u within 7 days post discharge from RME to reduce unnecessary ED utilization	eCW report
Initiative D	Commit to Health AMG	Commit to Health is a voluntary program open to all qualifying AMG patients by referral. The Commit to Health Program supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization.	536 CHP patients enrollments in the CHP program	eCW report
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.

This question was not displayed to the respondent.

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 - Nutrition and Healthy Eating, Health Behaviors - Vaccination, Health Behaviors - Violence Prevention, Populations - Older Adults, Settings and Systems - Transportation, Social Determinants of Health - Health Care Access and Quality
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.

Ascension Saint Agnes has taken great strides to identify health disparities in the community through health data readily available through CRISP and Electronic Medical Records. A special focus is to address the profound deleterious impact of Diabetes in the African American/Black community which measures at significantly higher rates than White residents in Baltimore City. The Diabetes Prevention Program has been bolstered to provide health education and prevention strategies to community members in the heart of ASA's community benefit service area. ASA has also worked to bring healthcare directly to the community in underserved neighborhoods through the work of primary care provided at a community resource center and COVID and Flu vaccine clinics in community sites where low vaccination rates exist for African Americans and Latino populations compared to the rates for White residents in the City.

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:

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

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

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
- [ ] 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.

Prepared by the finance staff and reviewed by the CFO.

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

- ( ) Yes
- (●) No

Q65. Please explain:

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

- ( ) Yes
- (●) No

Q67. Please explain:

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.

Diabetes is a key report on the Chief Executive's dashboard.

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
- [ ] 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.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	( )	(•)	
Anesthesiology	( )	(•)	
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	(•)	( )	Non-resident house staff and hospitalists
Oncology-Cancer	( )	(•)	
Ophthamology	( )	(•)	
Orthopedics	( )	(•)	
Otololaryngology	( )	(•)	
Pathology	( )	(•)	
Pediatrics	( )	(•)	
Physical Medicine & Rehabilitation	( )	(•)	
Plastic Surgery	( )	(•)	
Preventive Medicine	( )	(•)	
Psychiatry	(•)	( )	Non-resident house staff and hospitalists
Radiology	(•)	( )	Non-resident house staff and hospitalists
Surgery	( )	(•)	
Urology	( )	(•)	
Other, (Describe) Intensivists and Hospitalists	(•)	( )	Non-resident house staff and hospitalists

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.

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

Itemized List of PhysicianType_CBR2021.docx
13.2KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q140. Section VI - Financial Assistance Policy (FAP)

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

Ascension Saint Agnes Financial Assistance Policy_2021.pdf
215.8KB
application/pdf

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

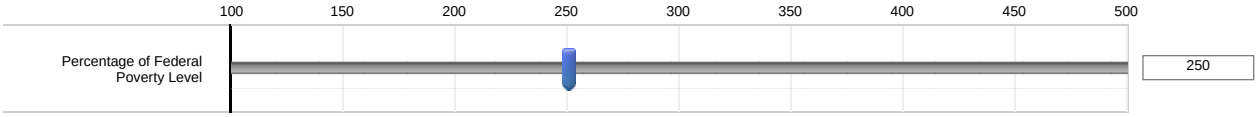
https://healthcare.ascension.org/locations/maryland/mdbal/baltimore-ascension-saint-agnes-health-center/financial-assistance#:~:text=Financial%20assistance%20is%20generally%20determined,for%20which%20you%20are%20responsible.

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:

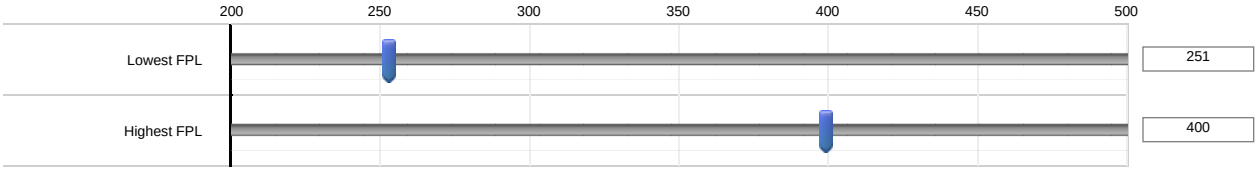
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



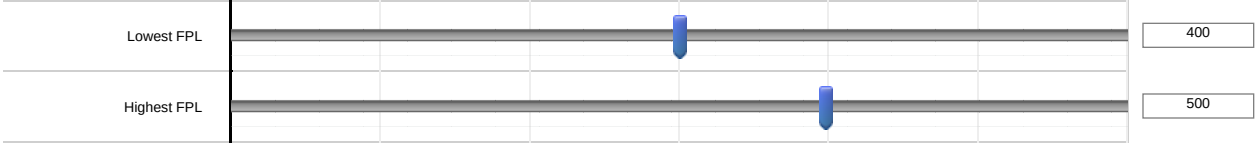
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

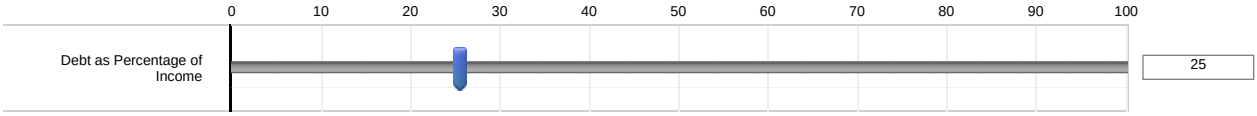


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health 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)
- [ ] Other (Describe)

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: (39.284194946289, -76.691802978516)

Source: GeoIP Estimation

Ascension Saint Agnes Hospital

FY 21 Community Health Needs Assessment

Table of Contents

Summary

The three Community Health Need Priorities to be addressed by Ascension Saint Agnes (ASA) for the FY 2021 through FY 2024 cycle are:

- **Address mental health/substance use disorder;**
- **Prevent diabetes and improve health; and**
- **Build person-centered healthy neighborhoods to address social determinants of health.**

These priorities were defined with robust community input.

Introduction

Background

ASA is dedicated to the art of healing. We have a long history of providing exceptional holistic care to a diverse population of over 400,500 residents of the southwest segment of the Baltimore metropolitan area. We are a fully accredited, full-service 251 bed teaching hospital with residency programs in medical and surgical specialties. ASA offers emergency services and a wide variety of inpatient and outpatient services in addition to institutes and community-based offices including Saint Agnes Medical Group and Seton Imaging. Built on a strong foundation of excellent medical care and compassion, ASA and the physicians who practice here are committed to providing the best care for our patients for many years to come.

Maryland increasingly recognizes the many factors influencing health beyond traditional health care, and ASA is leading the way by creating new opportunities to be as relevant to our community when they are well as when they are sick. ASA is committed to achieving measurable improvements in health and the social determinants of health. ASA annually provides approximately $45 million in charitable giving and community benefit.

Since 2018, the ASA Health Institute has partnered with the community to keep individuals at their best health. The ASA Health Institute continually evolves to implement new initiatives, with a focus on community engagement, care management, chronic disease management, and behavioral health. ASA operates a robust Diabetes Prevention Program (DPP), and recently secured $5 million in new funding to support DPP. In 2020, ASA in partnership with Catholic Charities established a primary care clinic at My Brother's Keeper. Efforts to improve health outcomes and reduce health disparities traditionally sought to build care coordination services into clinical practice. The My Brother's Keeper clinic inverts that approach, by building clinical services into a trusted community anchor. To address patients' transportation needs, in 2020

ASA developed a new transportation model, building a network of volunteer chaperones to accompany older adults and adults with disabilities to and from medical appointments. Another ASA initiative is Food Rx, which addresses systemic inequities in access to healthy food and improves nutrition for chronically and medically complex patients.

ASA submits the Fiscal Year (FY) 2021 Community Health Needs Assessment (CHNA) amidst the ongoing COVID-19 pandemic. The effect of COVID-19 on the U.S. healthcare system and economy is unprecedented. Motivated by our mission, we've taken every precaution to keep our communities safe while caring for those who need us most.

Our Mission and Vision

Saint Agnes Hospital was founded in 1862 by the Daughters of Charity to meet the health needs of the poor. As a Catholic health care ministry and member of Ascension Health, ASA is dedicated to the art of healing to sustain and improve the lives of the individuals and communities we serve. Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving our entire community, with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words. Figure 1 shows ASA's core values.

Figure 1: ASA Core Values

Our community outreach programs continue to expand our mission. ASA has launched community initiatives to fight diabetes, cardiovascular disease, and obesity, improve access to primary care, and address social determinants of health such as access to nutritious food and transportation. Through expanding outreach and community integration services our dedicated team strives to enhance the social and physical environments that promote good health for all.

We envision a strong, vibrant Catholic health ministry in the United States which will lead to the transformation of healthcare. We will ensure service that is committed to health and well-being for our communities and that responds to the needs of individuals throughout the life cycle. We will expand the role of laity, in both leadership and sponsorship, to ensure a Catholic health ministry in the future.

CHNA Purpose and Scope

The ASA CHNA process is about improving health—the health of individuals, families, and communities. The objective of the assessment is to evaluate the health status of the people residing in the communities surrounding our hospital, to highlight the geographic regions and populations within the service area that have greater health needs, and to determine how ASA can best respond to health need priorities. In accordance with IRS requirements and Affordable Care Act, hospital facilities with a tax-exempt status are mandated to complete this assessment every three years, with the input of representatives from the community as well as local health jurisdictions. Hospital services and health improvement programs are to be linked to the needs identified in the assessment process. Improvements in community health are to be demonstrated through measurable outcomes, as impacted by hospital services and programs.

The assessment process involved both quantitative and qualitative components. See Figure 2. ASA engaged the participation of the public through a structured online survey and a series of focus groups. We presented findings to several groups of external stakeholders to solicit feedback from leaders among the communities we serve. Internal stakeholders representing clinical care, population health, care management, and pastoral care also provided input.

Figure 2: Community Health Needs Assessment Process

In the prior CHNA cycle, ASA adopted the following three priorities for FY 2018 through FY 2021:

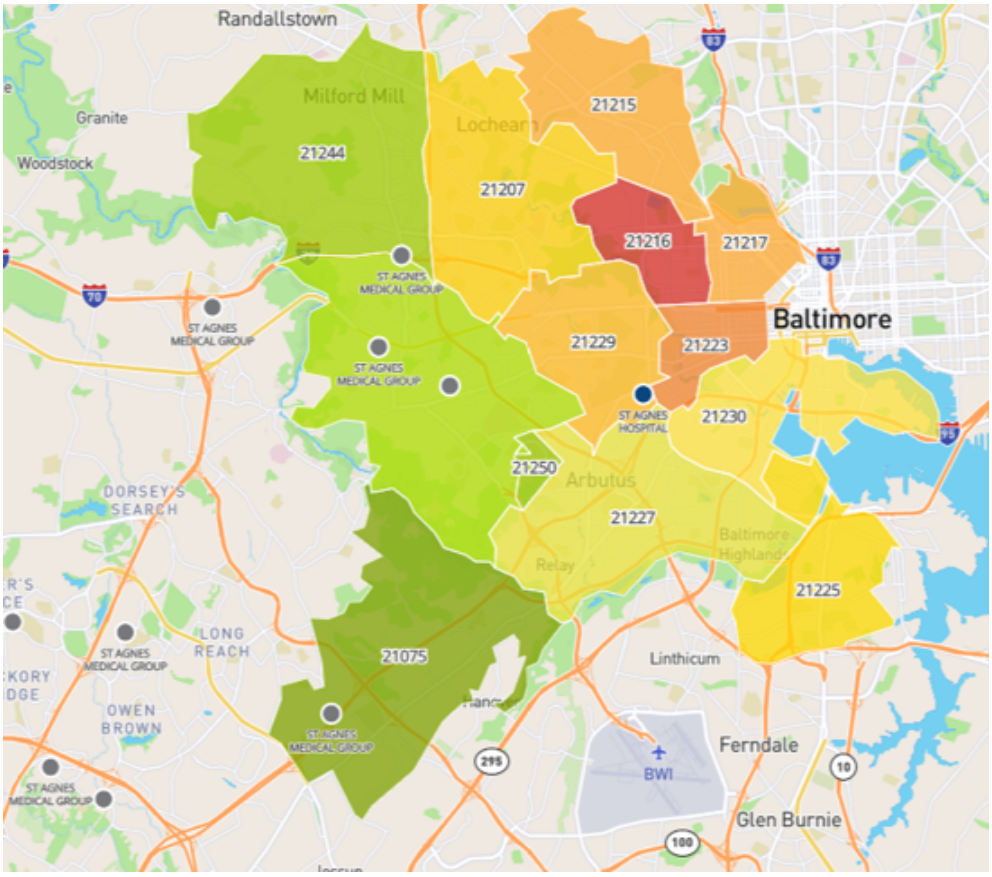
- Address mental health/substance abuse (shared priority with all Baltimore City hospitals);
- Reduce obesity and impact of chronic diseases; and
- Create person-centered healthy neighborhoods to address social determinants of health.

For FY 2021, ASA again conducted our CHNA collaboratively with other Baltimore City Hospitals. This facilitates the establishment of shared health need priorities as well as strategies to collectively address identified health needs. As the healthcare industry transitions to value-based based care across the continuum, a shared understanding and knowledge of community needs has become a more important aspect of the CHNA.

Community Benefit Service Area

The community benefit service area is comprised of the zip codes that account for 70% of ASA hospital discharges. The ASA service area changed between FY 2018 and FY 2021. The zip code 21226 Curtis Bay is no longer included; in FY 2018 it was the furthest south community in the ASA service area. New zip codes in FY 2021 include 21075 Elkridge, representing a southwestward expansion into Howard County, and 21244 Windsor Mill and 21250 Baltimore/UMBC. These represent a westward shift into Baltimore County. The ASA FY 2021 community benefit service area is shown in Figure 3. Within the service area, ASA has defined different communities. The communities are groupings of zip codes in with similar demographic characteristics and geographic boundaries. Details about each of the individual communities are in Appendix 1.

Figure 3: Ascension Saint Agnes Service Area by Zip Code



The needs of the ASA service area are highly variable from community to community. ASA focuses upon the needs where we can have the greatest impact on community health. This guides the allocation of resources and development of new healthcare programs.

Addressing the COVID-19 Pandemic

It is important to acknowledge the context of the COVID-19 pandemic as a backdrop to the FY 2021 CHNA. The social, economic, and health effects of COVID-19 have reverberated through our community. Given the requirement to eliminate non-emergency services for a period of months, hospital revenues plummeted. At the same time, hospitals faced increased costs for protective personal equipment (PPE), testing, ventilators, and infrastructure to implement telemedicine. ASA has taken steps to support our patients, health care partners, associates, and the community at large.

Patient Support

In addition to serving COVID-19 patients through the emergency department and on an inpatient basis, ASA focused on the provision of testing. We established a 24/7 COVID-19 hotline, where our nurses and care teams could guide patients with the most up-to-date screening information and best options for care and testing. We launched the availability of drive-by COVID-19 tests for qualified patients.

We took measures to address patients' hesitancy to seek medical care due to fear of COVID-19 exposure by rapidly expanding telemedicine services and enabling patients to access care

without leaving home. To date we've provided over 32,000 telemedicine visits. We also have provided prescription delivery to medically fragile patients.

Additional steps helped ensure the safety of our patients. This included the provision of remote monitoring tools and access to care team support for the daily status monitoring for COVID-19 positive patients and persons under investigation for COVID-19. Tracphones were provided for patients without phone access to facilitate remote management. We also provided shuttle rides home, and hoteling for COVID-19 patients in need of isolation from their households.

We provided a remote monitoring program for COVID positive patients identified as high risk of hospitalization by the ED or their PCP. These patients were provided with a pulse oxygen monitor, application for their phone, and care management support. Patients were asked to respond to questions on the mobile application three times per day describing signs and symptoms. Patients with specific responses triggered follow up by a nurse or physician. Patients who did not respond were contacted by the care management team, and if they were not able to connect with them, the local 911 was called and a wellness check was requested. Patients reported high satisfaction with this program.

Skilled Nursing Facility Support

Nationwide, skilled nursing facilities (SNFs) have been heavily impacted by COVID-19. ASA supported our post-acute network through the provision of PPE, testing supplies and staff for testing, weekly technical assistance and coordination calls, Medical Director support calls, and COVID-19 prevention messaging supplies. ASA contracted home health agencies and SNFs to serve underinsured patients with home health services, skilled nursing days, and home oxygen services.

Community Support

ASA implemented the following actions to mitigate vulnerabilities and disparities exacerbated by the COVID-19 crisis:

- Distributed over 42,000 pounds of produce to key community partners including churches, urban farming group, family homeless shelter, and a day resource center.
- Distributed over 27,000 pounds of produce to medically fragile patients.
- Distributed COVID-19 prevention messaging posters throughout the community.
- Provided 250 hygiene kits for seniors and families with infants distributed door-to-door and through community partners.

Vaccine Distribution

ASA has led the way in distributing COVID-19 vaccinations to our community, with a special focus on reaching vulnerable populations. We continue to coordinate with local health departments and other hospitals and health care providers to deliver vaccinations. By leveraging our well-established relationships with community partners, we are gaining insight into how best to target areas with extremely low vaccination rates. These partners are known and trusted in their communities and serve as the base of vaccine distribution operations. Our efforts include the following:

- Community-based vaccine clinics convened with our partners in underserved areas;

- A mobile vaccine team that brings vaccines to communities in need and homebound individuals to overcome transportation barriers; and
- Broad community educational efforts as well as in-person outreach by community health workers.

Associate Support

During the COVID-19 crisis, our ASA doctors, nurses, respiratory therapists, and other members of our care teams worked long shifts to meet patients' needs. Like other families across the country, our front-line healthcare workers had to balance the demands of work with the closure of their children's schools and childcare centers. National news of healthcare workers falling ill and even dying from COVID-19 was widespread prior to vaccine availability. Our front-line staff faced the daily potential risk of COVID-19 infection for themselves, and potential risk of transmission of the virus to their families—adding to physical and mental stress. In recognition of this, ASA provided support to our associates through financial assistance to address basic needs, $25,000 in meals to associates, organization and delivery of donated meals for our hospital teams, shuttle service and Lyft gift cards for associates, and peer support counseling.

Primary and Secondary Data Research and Analysis

Community Survey Overview

A consumer survey sought to gain a quantitative assessment to establish broad public input from the community. The survey was conducted in October 2020 in collaboration with other Baltimore City Hospitals. Due to COVID-19 restrictions, the survey was fielded solely electronically. The survey questions are included as Appendix 2. Like the prior CHNA cycle, the survey asked respondents to rate the community's three most important health problems, social/environmental problems, and barriers to accessing healthcare. The survey asked respondents about their mental health, given the prioritization of that issue. Respondents were provided an opportunity to state ideas and suggestions for improving the health of their community. In 2020, the survey also asked respondents about their concerns and needs related to the COVID-19 pandemic.

Through the collaboration among Baltimore City Hospitals, there were 3,170 respondents across Baltimore City with over 100 zip codes represented. As in the past, respondents are predominately female (63%) and African American (61%). Approximately half of respondents are age 50 or older (52%) and half are ages 18 through 49 (48%). Respondents who reside in zip codes within ASA's service area (referred to as ASA respondents throughout this report) accounted for 1,202 responses (38% of total responses). Their demographics are similar, but with a higher proportion of respondents who are African American (74%).

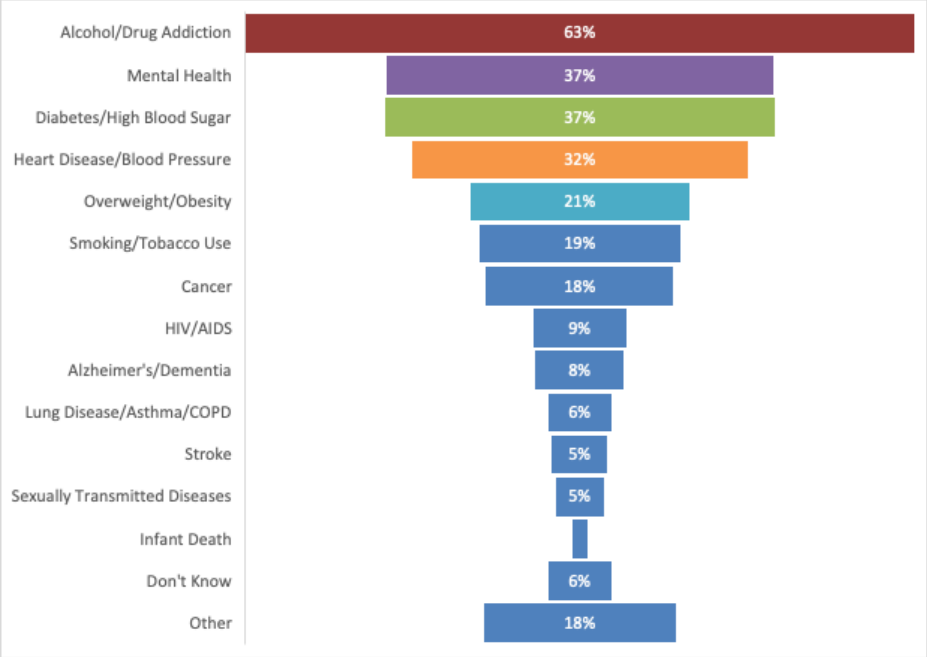
Community Survey – Top Health Concerns

Survey respondents identified the three most important health concerns facing their community from a list of health issues, including behavioral health problems such as

alcohol/drug abuse or tobacco use, mental health issues; chronic health conditions such as diabetes, hypertension, and overweight; and major diseases such as cancer, HIV, and Alzheimer's.

Results are shown in Figure 4. Among respondents residing in the ASA service area, the most named health concern was alcohol/drug addiction (named by 63%). This was followed by diabetes/high blood sugar and mental health (including depression and anxiety)—each were named by 37%). The next most named concern was heart disease/blood pressure (named by 32%).

Figure 4: Top Three Health Problems
Identified by Survey Respondents Residing in ASA Service Area



City-wide responses were similar, with alcohol/drug addiction named by 63%, followed by mental health (depression/anxiety) named by 36%, and diabetes/high blood sugar and heart disease/blood pressure each named by 34% of respondents City-wide. Overweight/obesity was

named by 21% of ASA respondents and 22% of respondents City-wide. Among those who responded “other,” the most common issue was chronic pain/arthritis, followed by violence (which is one of the choices for the question on social/environmental concerns).

Respondents were asked how many days during the past month their mental health not good. Among the 21% of ASA respondents who indicated they had days when their mental health was not good, the average number of days was approximately 11.

The top health concerns cited by ASA respondents—alcohol/drug addiction, diabetes/high blood sugar, and metal health—varied only slightly when segmented by different parameters. Figure 5 below shows the responses by neighborhood area, sex, race/ethnicity, and age. Male respondents ranked heart disease/blood pressure over mental health. Hispanic/Latino respondents and respondents under age 50 ranked heart disease/blood pressure over diabetes/ high blood sugar.

Figure 5: Top Health Problems by Area, Sex, Race/Ethnicity, and Age

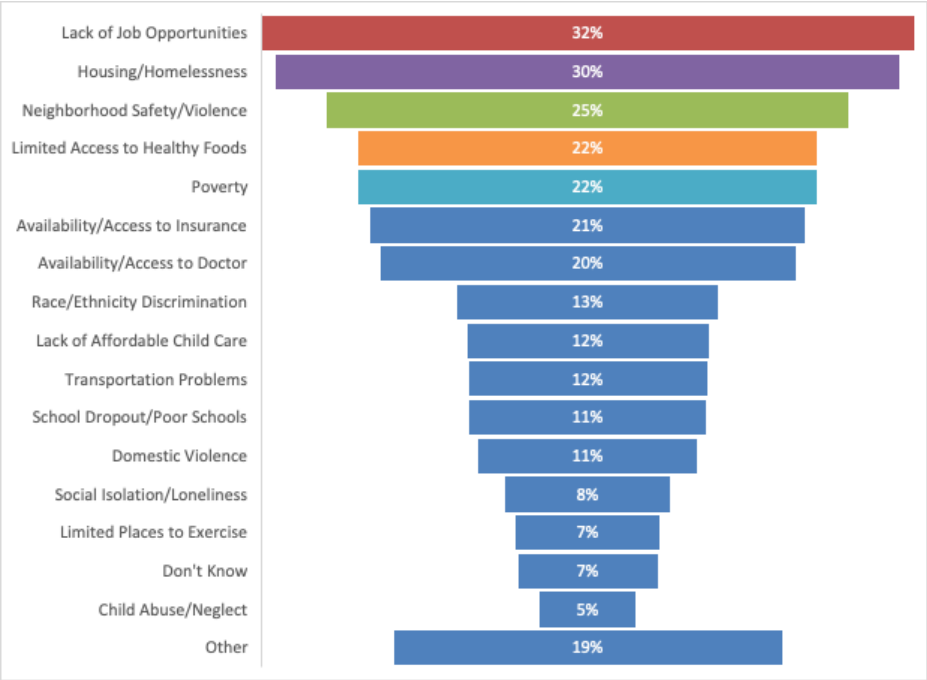
Most Important Health Problems	Total	Area		Sex		Race/Ethnicity				Age	
		City 91%	County 9%	Male 32%	Female 68%	African American 73%	White 18%	Multi/ Other 9%	Hispanic 4%	18-49 44%	50+ Years 56%
Alcohol/Drug Addiction	**63%**	**65%**	**46%**	**64%**	**63%**	**65%**	**62%**	**56%**	**53%**	**69%**	**59%**
Diabetes/High Blood Sugar	**37%**	**37%**	**39%**	**35%**	**38%**	**39%**	**30%**	**36%**	28%	29%	**43%**
Mental Health	**37%**	**37%**	**36%**	32%	**39%**	**38%**	**35%**	**36%**	**40%**	**41%**	**34%**
Heart Disease/ Blood Pressure	32%	32%	33%	**35%**	30%	33%	29%	**36%**	**40%**	**30%**	**34%**
Overweight/ Obesity	21%	20%	28%	18%	23%	20%	22%	30%	30%	23%	20%
Smoking/ Tobacco Use	19%	20%	12%	22%	18%	21%	11%	18%	6%	14%	22%
Cancer	18%	18%	21%	18%	19%	17%	22%	18%	15%	18%	18%
HIV/AIDS	9%	10%	2%	11%	8%	9%	7%	13%	19%	12%	7%
Alzheimer's/ Dementia	8%	8%	11%	6%	9%	8%	15%	4%	4%	7%	10%
Lung Disease/ Asthma/COPD	6%	6%	2%	6%	6%	6%	9%	4%	9%	5%	7%
Stroke	5%	5%	9%	6%	5%	6%	1%	8%	4%	4%	7%
Sexually Transmitted Diseases	5%	5%	0%	5%	5%	5%	3%	5%	4%	6%	4%
Infant Death	1%	2%	2%	1%	1%	2%	1%	1%	0%	2%	1%

Community Survey – Top Social/Environmental Concerns

The next portion of the survey asked about the three most important social or environmental problems affecting the health of respondents' communities, from a list of 15 issues. The results

are shown in Figure 6. Among ASA respondents, the top three most named issues were lack of job opportunities (32%), housing/homelessness (30%), and neighborhood safety/violence (25%). This is consistent with City-wide responses: housing/homelessness (32%), lack of job opportunities (30%), and neighborhood safety/violence (25%).

Figure 6: Top Three Social/Environmental Problems Identified by Electronic Survey Respondents Residing in ASA Service Area



Among those who responded "other," the most common issue was addiction/substance use, which is one of the choices for the question on health concerns. This was followed by food insecurity, which is related to but not the same as the choice limited access to healthy foods. Figure 7 shows how responses by neighborhood area, sex, race/ethnicity, and age.

Figure 7: Top Social/Environmental Problems by Area, Sex, Race/Ethnicity, and Age

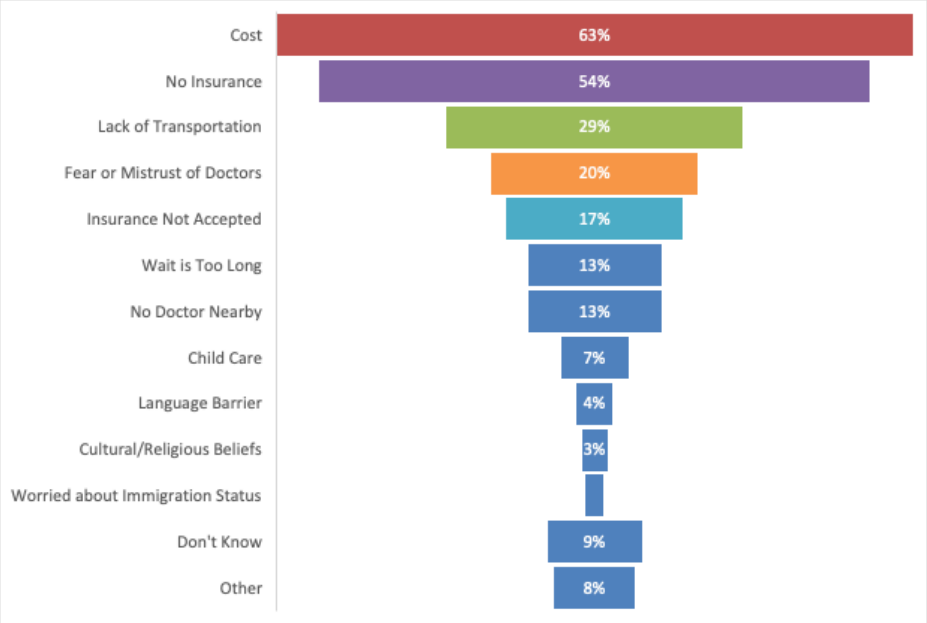
Most Important Social Problems	Total	Area		Sex		Race/Ethnicity				Age	
		City 91%	County 9%	Male 32%	Female 68%	African American 73%	White 18%	Multi/ Other 9%	Hispanic 4%	18-49 44%	50+ Years 56%
Lack of Job Opportunities	**32%**	**32%**	**30%**	**37%**	**29%**	**35%**	**23%**	25%	21%	**33%**	**30%**
Housing/ Homelessness	**30%**	**31%**	19%	**29%**	**30%**	**28%**	**35%**	**36%**	**38%**	**32%**	**29%**
Neighborhood Safety/Violence	**25%**	**26%**	**21%**	20%	**28%**	**26%**	19%	**28%**	**34%**	**25%**	**26%**
Limited Access to Healthy Foods	22%	22%	**22%**	21%	23%	22%	**23%**	23%	28%	19%	24%
Poverty	22%	23%	18%	**25%**	21%	22%	19%	**30%**	**40%**	**25%**	20%
Availability/ Access to Insurance	21%	21%	19%	21%	21%	20%	**23%**	24%	21%	24%	18%
Availability/ Access to Doctor's Office	20%	21%	16%	23%	18%	21%	18%	17%	28%	23%	18%
Race/ Ethnicity Discrimination	13%	12%	19%	11%	13%	11%	17%	17%	26%	15%	11%
Lack of Affordable Child Care	12%	12%	14%	10%	12%	10%	16%	16%	13%	16%	8%
Transportation Problems	12%	11%	13%	11%	12%	13%	10%	8%	0%	8%	14%
School Dropout/ Poor Schools	11%	12%	5%	11%	12%	13%	7%	9%	9%	12%	11%
Domestic Violence	11%	11%	8%	12%	10%	11%	10%	12%	9%	14%	8%
Social Isolation/ Loneliness	8%	8%	10%	6%	9%	8%	10%	5%	6%	5%	11%
Limited Places to Exercise	7%	6%	16%	5%	8%	7%	5%	8%	9%	4%	10%
Child Abuse/Neglect	5%	5%	3%	4%	5%	5%	3%	9%	9%	7%	3%

County residents and white respondents ranked limited access to healthy foods among their top three concerns. Male respondents, Hispanics/Latinos, multiracial, and younger respondents ranked poverty among their top three concerns.

Community Survey – Top Barriers to Accessing Healthcare

Survey respondents next chose from a list of 12 factors to identify the top three barriers to community members' healthcare access. Results are shown in Figure 8. Among ASA respondents, the most common reason cited was the cost of care (63%), followed by lack of insurance (54%). While most ASA respondents—86%—indicated that they have health insurance, their insured rate was lower than that of City-wide respondents (91%). Lack of transportation was also cited as a barrier (29%). Other reasons included fear or mistrust of doctors (20%) and insurance not being accepted (17%). The City-wide responses were similar, although insurance not being accepted was a more common response that fear or mistrust of doctors.

Figure 8: Top Barriers to Accessing Health Care
Identified by Electronic Survey Respondents Residing in ASA Service Area



Among those who responded "other," the most common issue was concern about job loss due to time taken off, followed by worry or discomfort about sharing their concerns with a doctor.

Figure 9 shows how results vary by neighborhood area and race/ethnicity. County residents and Hispanic/Latino respondents included fear or mistrust of doctors among their top three concerns.

Figure 9: Top Barriers to Accessing Health Care by Area, Sex, Race/Ethnicity, and Age

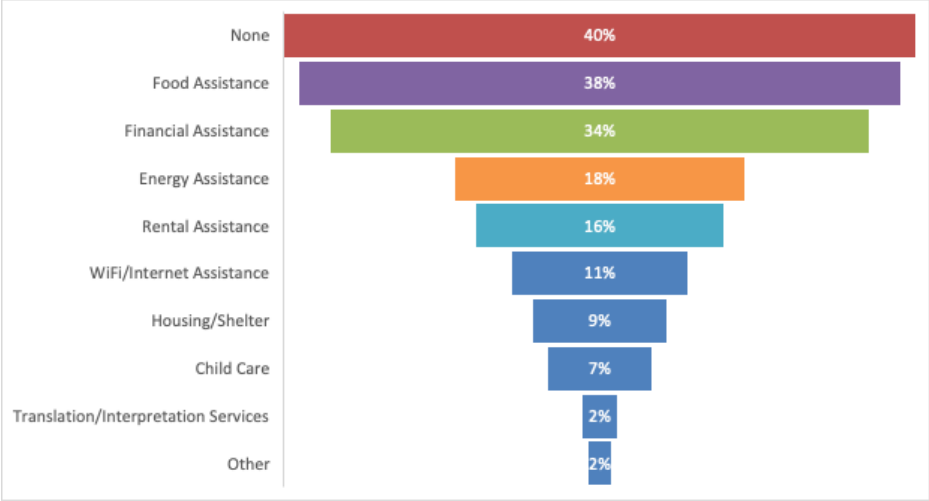
Barriers to Accessing Health Care	Total	Area		Sex		Race/Ethnicity				Age	
		City 91%	County 9%	Male 32%	Female 68%	African American 73%	White 18%	Multi/ Other 9%	Hispanic 4%	18-49 44%	50+ Years 56%
Cost - Too Expensive/ Can't Pay	**63%**	**63%**	**61%**	**55%**	**66%**	**62%**	**65%**	**65%**	**77%**	**67%**	**59%**
Lack of Insurance	**54%**	**55%**	**47%**	**52%**	**55%**	**55%**	**48%**	**48%**	**51%**	**57%**	**52%**
Lack of Transportation	**29%**	**30%**	24%	**28%**	**30%**	**30%**	**28%**	**28%**	15%	**29%**	**30%**
Fear or Mistrust of Doctors	20%	20%	**25%**	19%	21%	21%	18%	18%	**26%**	22%	19%
Insurance Not Accepted	17%	17%	19%	15%	19%	17%	18%	18%	19%	18%	18%
Wait is Too Long	13%	13%	13%	14%	13%	14%	11%	11%	19%	13%	13%
No Doctor Nearby	13%	14%	5%	16%	12%	13%	14%	14%	15%	13%	13%
Lack of Child Care	7%	6%	10%	7%	6%	7%	7%	7%	11%	10%	4%
Language Barrier	4%	4%	5%	4%	4%	3%	6%	6%	9%	5%	3%
Cultural/ Religious Beliefs	3%	3%	4%	2%	3%	3%	1%	1%	6%	2%	3%
Worried About Immigration Status	2%	2%	3%	2%	2%	2%	1%	1%	2%	2%	2%

Community Survey – COVID-19 Needs

The health needs survey included a new section of questions specific to COVID-19. Approximately 8% of ASA respondents indicated that they or a member of their household had been diagnosed with COVID-19. However, the social and economic effects of COVID-19 have been felt much more widely. Among ASA respondents, as a result of COVID-19, 38% have needed food assistance, 34% have needed financial assistance, and 18% have needed energy assistance. Approximately 40% indicated they needed no assistance due to COVID-19. The level of need among ASA respondents was somewhat higher than City-wide respondents (49% indicated no needed assistance). For both ASA and City-wide respondents, the greatest concern

related to COVID-19 was household members becoming infected, followed by financial hardship.

Figure 10: Top Needs Resulting from COVID-19 Pandemic
Identified by Electronic Survey Respondents Residing in ASA Service Area



Key Findings from the Community Survey

Since the FY 16 CHNA, substance use disorder and mental health concerns have continued their predominance as major community health concerns. Similarly, the top three social or environmental problems remain unchanged from the FY 18 CHNA survey results: lack of job opportunities, housing/homelessness, and neighborhood safety/violence. This indicates that ASA's FY 18 CHNA priority of creating person-centered health neighborhoods to address the social determinants of health remains relevant. The top barriers to accessing healthcare identified in this CNHA are also consistent with the FY 18 CHNA: cost of care, lack of insurance, and lack of transportation. The ASA Community Council has prioritized transportation as a foundational social determinant of health. It is also notable that one out of five respondents identified fear or mistrust of doctors as a major barrier to accessing health care.

While the health risks of COVID-19 are waning as vaccination becomes more widespread, the social and economic effects of the pandemic are longer lasting. Due to the pandemic, 60% of ASA respondents have required support to meet basic needs.

Focus Groups

To further understand community needs, qualitative input was gained from facilitated focus groups conducted by the Baltimore City hospital collaborative. Seventeen focus groups were held with leaders and members of community organizations, neighborhood associations, and faith-based organizations. Participants were recruited to understand the needs of vulnerable populations. Four of the groups focused on needs among older adults, three of the groups focused on needs among Baltimore's Latino/Hispanic community, and other groups focused on the needs of individuals with disabilities, individuals with prior justice system involvement, members of the LGBTQ community, individuals who have experienced homelessness, and individuals with a history of substance use disorder, among others.

Focus group members discussed the most serious health issues facing their communities. There were several health issues identified by multiple focus groups. These included needs related to mental health and substance use disorder; COVID-19 and the isolation resulting from the pandemic; and chronic diseases such as diabetes, heart disease, and chronic obstructive pulmonary disease (COPD). Additional health issues identified by at least one focus group included obesity, access to preventive care and family planning, cancer, vision impairment, and sexually transmitted infections.

There was overlap between what focus group members identified as the most serious health issues, and what they identified as the significant environmental or social factors affecting quality of life in their communities. Two major categories of social determinants of health were repeated across multiple focus groups: access to healthy food, and transportation—not just to access health care but also to access food and other needed resources. More generally, the affordability of basic needs, unemployment, and poverty were discussed, with particular emphasis on the effect of poverty on mental health. Among older adults, technology—the lack of access to it and the lack of knowledge of how to navigate it—was a significant issue. It was noted that the "digital divide" has been exacerbated by the COVID-19 pandemic. Other factors affecting quality of life were related to the physical environment. This included the need for safe housing, free from mold, pests, and trash; the need for safe, well-lit spaces to walk, exercise, and recreate; and the physical accessibility of streets, transportation, and hospital campuses, especially for older adults and individuals with disabilities. Another major topic identified was crime and violence, including violence and domestic violence.

Lastly, across multiple focus groups, the effects of systemic racism and discrimination were discussed as a key barrier to accessing health care. Focus group members described mistrust of the medical community due to historical experiences, exacerbated by the underrepresentation of people of color in health care professions. Focus group members perceived a lack of respect or sensitivity on the part of providers, or stigma assigned when not adhering to health care advise, for example to lose weight. Individuals experiencing a lifetime of poverty were described as living in survival mode, oriented away from preventive care. Moreover, some cultural preferences focus more on holistic practices instead of seeking out solutions from the health care establishment. Mistrust leads to a fear of revealing information to health care providers, particularly among undocumented immigrants.

The affordability of health care was also named as a key barrier to access. Dental services in particular were mentioned by older adults, and the time and cost to acquire or repair adaptive equipment was mentioned by individuals with disabilities. The complexity of navigating the health care system, the loss of historical providers due to insurance network requirements, and a general lack of awareness of resources were all barriers. Lastly, fear of exposure to COVID-19 acted as a deterrent to seeking out health care.

Focus group members offered suggestions for how hospital systems could help improve community health and quality of life. Communication between hospital systems and community organizations and businesses can help increase awareness of community needs and the resources available to meet them. A particular need was identified to address the stigma surrounding mental health. In addition to electronic communication, focus group members stated the need for information to be shared in print, and in other formats such as radio or television advertisements to reach community members with low literacy. Resources are needed in Spanish as well as English.

Two-way communication was suggested as a means of addressing the barrier presented by mistrust of the health care system due to racism. Ongoing conversations are needed to understand the needs of and advocate for lower income community members. Sensitivity training for health care workers can help foster more collaborative relationships among providers and patients. More representation of people of color in health care can also help.

Focus group members described strategies to help community members navigate the health care system. Roles such as advocates, community health workers, and case managers are needed to provide outreach, education, and follow-up for community members on the health resources available, how to access them, and understanding the management of health conditions. One idea was to hold regular resource fairs for health care staff, so they become aware of the resources available to patients and community members. There were multiple suggestions for how to reach community members where they are, for example by out-stationing mobile clinics, visiting nurses, and navigators to sites such as libraries, churches, and senior centers. A nurse call line was also mentioned as a valuable resource.

Other suggestions included incentives, such as free produce and healthy meals, to help engage community members in these efforts. Hospital systems could provide meeting space for community members to come together to address needs, or provide other resources for capacity-building. Hospital systems could also have a role in providing transportation to services.

In addition to the Baltimore City hospital collaborative focus groups, ASA conducted eight additional online focus groups with community leaders, local public health experts, and community members. These focus groups provided insight on key social determinants of health. The need for childcare and transportation were most often mentioned. Telehealth was viewed as a potential solution, but many community members lack reliable technology and connectivity. Provision of transportation or mobile clinics were additional solutions named.

Other issues include neighborhood safety, in particular to facilitate exercise and socialization, as well as concerns about the cost of accessing health care. The need for language interpretation and health literacy/health education was also mentioned. Outreach information on patient-specific due dates for health screenings would be valuable, although this can be challenging for populations that are transient. The focus groups noted that all social determinant of health needs have been exacerbated by the COVID-19 pandemic.

Key Findings from Focus Groups

The focus group discussions reinforced the results of the consumer survey. Mental health and substance use disorder are priority issues; they are exacerbated by both poverty and the economic effects and social isolation resulting from the COVID-19 pandemic. The need for transportation and access to healthy food were repeated themes. In addition, systemic racism, discrimination, and mistrust of the medical community create barriers to accessing health care.

Conduent Healthy Communities Institute Analysis

To gain further insight on the community ASA serves, Conduent Healthy Communities Institute was engaged to provide community health indicator data for Baltimore City and Baltimore County. Conduent provided Socio-Need Index Scores, Health and Quality of Life Topic Scores, and Indicator Scores for Baltimore City and Baltimore County.

SocioNeed Index Scores

Conduent develops SocioNeed Index Scores by incorporating measures of six different social and economic determinants of health associated with poor health outcomes. These six indicators include income, poverty, unemployment, occupation, education, and language. The indicators are standardized and averaged to create one composite index value for each zip code. Zip codes with higher values are estimated to have higher socio-economic need, which is correlated with poorer health. Figure 11 shows SocioNeed Index Scores for ASA zip codes, comparing FY 2021 results to FY 2018.

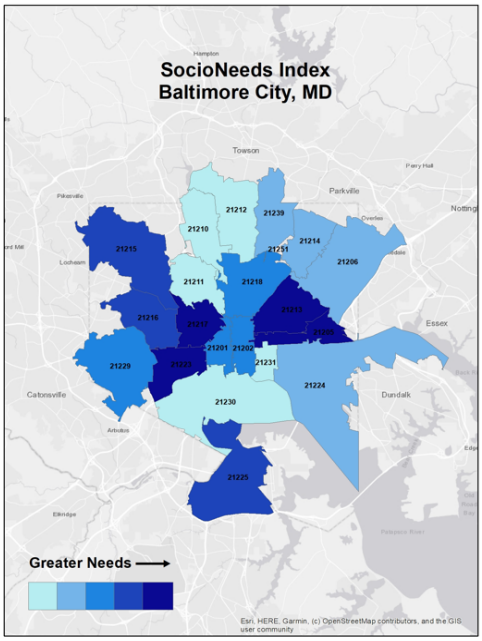
Figure 11: SocioNeed Index Scores for ASA Zip Codes

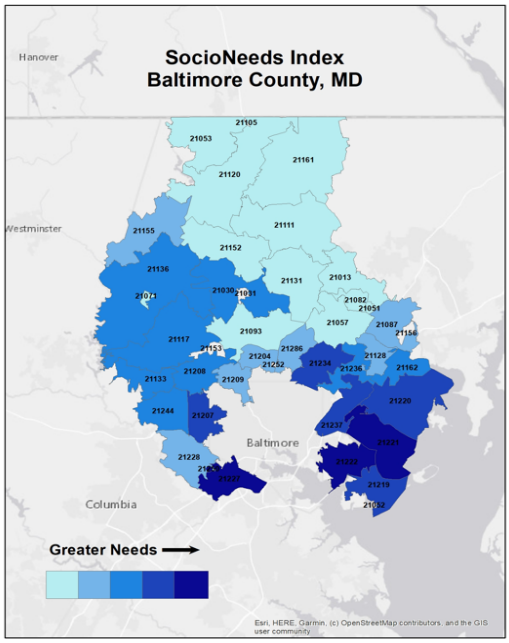
Zip Code	Community	2021 Score	2018 Score
21223	**South Baltimore City**	**97.9**	97.5
21250	Baltimore - UMBC	94.7	n/a
21217	West Baltimore City	93.7	94.9
21216	**West Baltimore City**	**90.9**	87.6
21225	Brooklyn – Linthicum	89.4	91.1
21215	West Baltimore City	85.8	87.1
21229	Southwest Baltimore City	74.7	79.6
21227	**Arbutus - Halethorpe**	**58.6**	54.7
21207	Gwynn Oak – Woodlawn	47.7	51.3
21244	Windsor Mill	24.4	n/a
21230	South Baltimore City	24.2	31.5
21228	Catonsville	11.5	11.5
21075	Elkridge	9.5	n/a

Approximately half of communities in the ASA service have SocioNeed Index Scores in the eighties and nineties, indicating a high level of need. While most communities' scores have improved or remained stable since FY 2018, there are three communities indicated in Figure 11 in bold that have experienced worsening scores—South Baltimore City 21223, West Baltimore

City 21216, and Arbutus—Halethorpe 21227. The wide range of need among zip codes is also notable, from a low score of 9.5 for Elkridge to a high score of 97.9 for South Baltimore City. Figure 12 shows the Scores mapped for Baltimore City and Baltimore County.

Figure 12: FY 2021 Baltimore City and Baltimore County Maps of SocioNeeds Index Scores





Indicator Scores and Health and Quality of Life Topic Scores

The Conduent Healthy Communities Institute provided Health and Quality of Life Topic Scores and Indicator Scores. This data scoring process involves several stages. Conduent collects data from over 25 secondary data sources, incorporating over 200 demographic, social, economic, and health indicators. Indicators are collected at the county level, to result in county-level scores.

For each indicator, a county is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0 through 3, where 0 indicates the best outcome and 3 the worst. Figures 13 and 14 below show Baltimore City and Baltimore County indicator scores that are 2.50 or higher, indicating high levels of unmet need. Baltimore City has 25 indicators meeting this threshold; these include indicators related to cancer, chronic disease, mental health, substance use disorder, and injuries. Baltimore County has seven indicators meeting this threshold; these include indicators related to mental health, substance use disorder, and cancer.

Source: Conduent Healthy Communities Institute 2021

Figure 13: Baltimore City Indicators with Scores of 2.50 and Above

Score	Indicator
2.83	Lung and Bronchus Cancer Incidence Rate
2.83	Chronic Kidney Disease: Medicare Population
2.83	Death Rate due to Drug Poisoning
2.83	Depression: Medicare Population
2.78	Cervical Cancer Incidence Rate
2.75	Age-Adjusted Death Rate due to Unintentional Injuries
2.75	Age-Adjusted Death Rate due to Drug Use
2.67	Alzheimer's Disease or Dementia: Medicare Population
2.61	Frequent Mental Distress
2.61	Diabetes: Medicare Population
2.61	Homeownership
2.61	People 65+ Living Below Poverty Level
2.61	Students Eligible for the Free Lunch Program
2.61	Asthma: Medicare Population
2.58	Chlamydia Incidence Rate
2.58	Age-Adjusted Death Rate due to Diabetes
2.56	Age-Adjusted Death Rate due to Prostate Cancer
2.53	Age-Adjusted Death Rate due to Stroke
2.53	High Blood Pressure Prevalence
2.53	Preterm Births
2.50	Child Food Insecurity Rate
2.50	Food Insecurity Rate
2.50	Persons with Disability Living in Poverty (5-year)
2.50	Hypertension: Medicare Population
2.50	Pedestrian Injuries

Figure 14: Baltimore County Indicators with Scores of 2.50 and Above

Score	Indicator
2.83	Depression: Medicare Population
2.83	Death Rate due to Drug Poisoning
2.67	Breast Cancer Incidence Rate
2.61	Cancer: Medicare Population
2.58	Age-Adjusted Death Rate due to Drug Use
2.50	Age-Adjusted Death Rate due to Falls
2.50	Liquor Store Density

Conduent categorizes indicators into topic areas and gives each topic area a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic. Figure 15 below shows the Health and Quality of Life Topic Scores for Baltimore County and Baltimore City. Prevention and Safety was the highest-ranked topic for both jurisdictions. Scores were higher for Baltimore City relative to Baltimore County, indicating more unmet need in Baltimore City.

Figure 15: Health and Quality of Life Topic Scores for Baltimore County and Baltimore City

Baltimore County

Health and Quality of Life Topics	Score
Prevention & Safety	2.11
Other Chronic Diseases	2.09
Older Adults & Aging	1.83
Public Safety	1.81
Substance Abuse	1.75
Mental Health & Mental Disorders	1.73
Transportation	1.72
Heart Disease & Stroke	1.71
Women's Health	1.70
Maternal, Fetal & Infant Health	1.68
Cancer	1.66
Environmental & Occupational Health	1.55
Diabetes	1.48
Respiratory Diseases	1.47
Oral Health	1.47
Children's Health	1.42
Immunizations & Infectious Diseases	1.40
Exercise, Nutrition, & Weight	1.39
Environment	1.38
Education	1.36
Access to Health Services	1.27
Social Environment	1.22
Teen & Adolescent Health	1.22

Baltimore City

Health and Quality of Life Topics	Score
Prevention & Safety	2.55
Diabetes	2.39
Maternal, Fetal & Infant Health	2.16
Economy	2.12
Cancer	2.03
Older Adults & Aging	2.00
Environmental & Occupational Health	1.97
Education	1.97
Mental Health & Mental Disorders	1.95
Social Environment	1.90
Respiratory Diseases	1.87
Women's Health	1.86
Heart Disease & Stroke	1.85
Public Safety	1.84
Substance Abuse	1.80
Children's Health	1.78
Teen & Adolescent Health	1.77
Immunizations & Infectious Diseases	1.76
Oral Health	1.62
Other Chronic Diseases	1.57
Environment	1.55
Exercise, Nutrition, & Weight	1.47
Transportation	1.27
Access to Health Services	1.25

Source: Conduent Healthy Communities Institute 2021

Key Findings from the Conduent Healthy Communities Institute Analysis

For many communities within the ASA service area, there is an extremely high level of unmet health and social determinant of health needs. Key health issues include mental health and substance use disorder, cancer, and chronic disease. Unmet needs exist in both Baltimore City and Baltimore County. However, Baltimore City experiences a more extreme level of need for a broader range of issues. Also, in Baltimore City, maternal and infant health is a more prevalent issue while in Baltimore County, issues related to aging are more prevalent.

Hospital Utilization Data

As part of the FY 2021 CHNA, ASA analyzed hospital utilization data. “Prevention Quality Indicators” or “PQIs” are nationally recognized measures that examine hospital utilization to help assess access to health care in the community. The ASA PQI rate (15.05) is very similar to the Statewide rate (14.45).[1] This indicates that relative to the rest of the State, patients of ASA do not disproportionately face barriers to accessing care in the community. ASA’s most common PQIs—measures that indicate a potential issue with access in the community—are heart failure,

[1] CY 2019 Risk Adjusted Rate: IP/OBS24+.

COPD or asthma in older adults, and diabetes (combined categories of short- and long-term complications).

Prevention Quality Indicators are also available specifically for the pediatric population. These are referred to as "PDIs." For the pediatric population, ASA's PDI rate is higher than the Statewide rate (2.07 versus 0.91).[2] The main category driving ASA's PDI rate is asthma.

Baltimore City Health Department Maps

The Baltimore City Health Department compiled maps to provide input to the CHNA. Figure 16 shows the all-cause mortality rate per 10,000 in Baltimore City over time. The map on the left includes data for the years 2014 through 2018. The map on the right shows data for the years 2011 through 2015. The all-cause mortality rate has increased between these two time periods.

Figure 16: Baltimore City All-Cause Mortality Rate

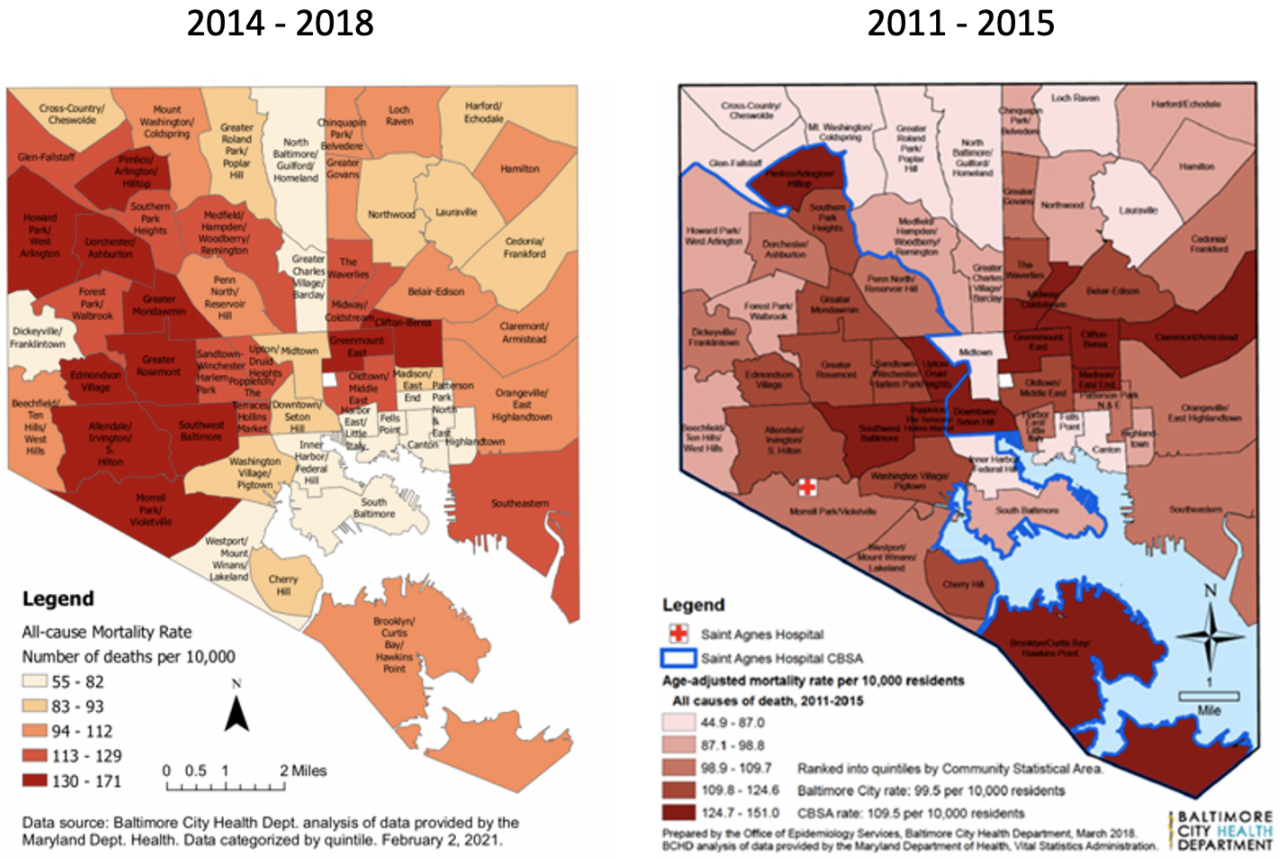
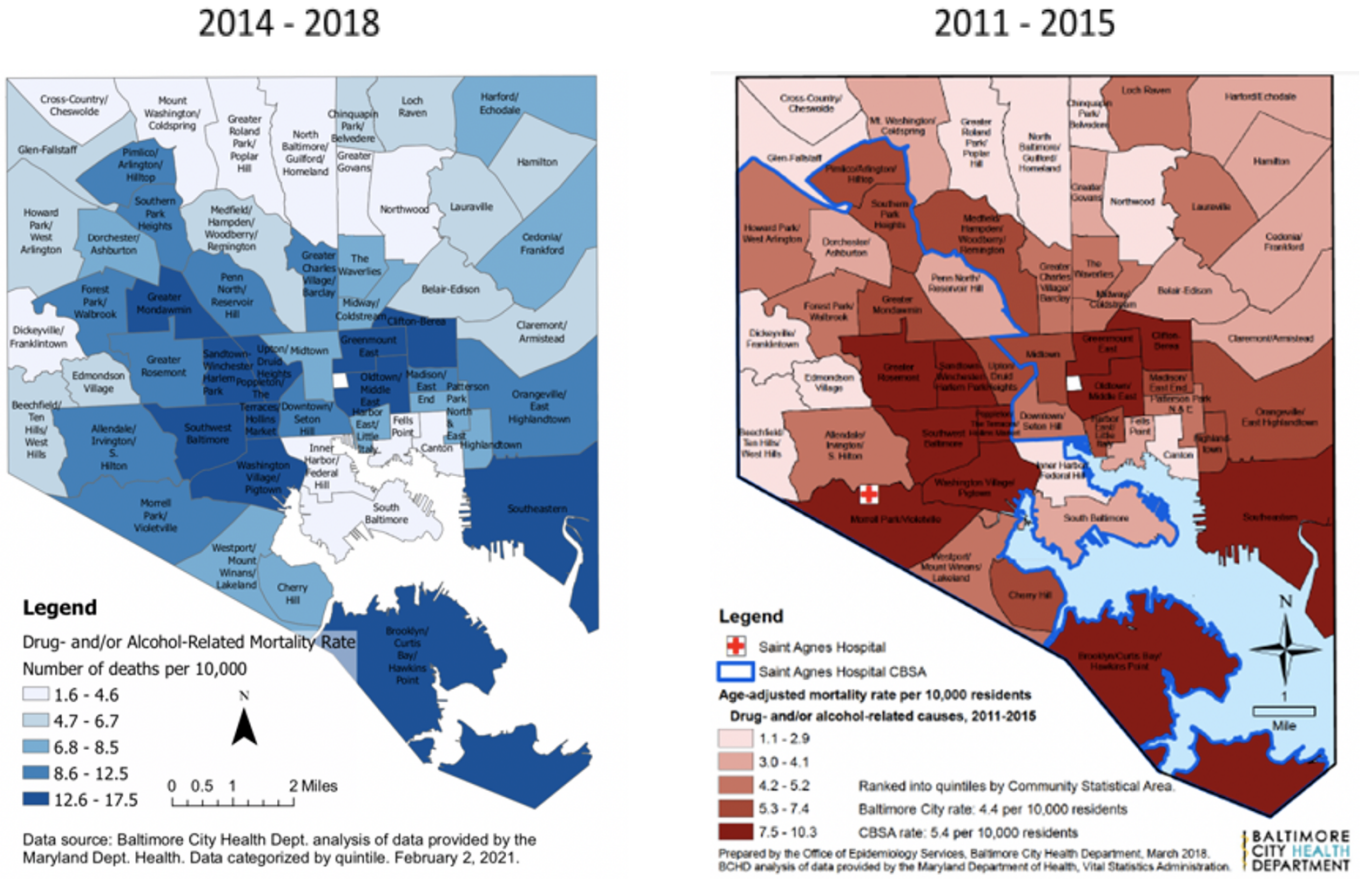


Figure 17 shows the drug- and/or alcohol-related mortality rate per 10,000 in Baltimore City over time. The map on the left includes data for the years 2014 through 2018. The map on the

[2] CY 2019 Risk Adjusted Rate IP/OBS24+

right shows data for the years 2011 through 2015. The drug- and/or alcohol-related mortality rate has increased between these two time periods.

Figure 17: Baltimore City Drug- and/or Alcohol-Related Mortality Rate



Conclusion of Primary and Secondary Data Research and Analysis

ASA sought a number of inputs to the CHNA to acquire meaningful community input. Through the survey, focus groups, Conduent analysis, hospital utilization data and information from the Baltimore City Health Department, was able to highlight the greatest unmet needs of the communities we serve. There was a high degree of correlation among the primary and secondary data findings. There was also consistency with the FY 2018 CHNA. Among the most significant health and social determinant of health needs are:

- Substance use disorder;
- Mental health;
- Chronic disease, including diabetes and heart disease;
- Economic opportunity;
- Affordable housing and safe neighborhoods;
- Affordable health care; and

- Transportation.

Stakeholder Input

ASA took multiple steps to gain stakeholder input on the findings of the primary and secondary data research and analysis. The findings were presented to three separate community groups, with the following questions posed:

- What about the findings resonates with you?
- What topics do you think are missing?
- What surprises you about the findings?
- What do you view as the major conclusions of the qualitative and quantitative analyses?

Additionally, stakeholders were asked questions and offered response choices similar to what was included in the community survey:

- What are the top health needs affecting the health of the community you serve?
- What are the top reasons people in the community you serve do not get health care?
- What are the top social/environmental concerns affecting the community you serve?

ASA Community Council

ASA renewed its commitment to community partnerships through the convening of its Community Council in August 2018. The Council's 25 members include a broad array of health care providers—including those with special knowledge of or expertise in public health, non-profit organizations, and other organizations devoted to addressing social determinants of health. The Community Council provides on ongoing forum for discussing the planning, implementation, and monitoring of ASA initiatives.

The qualitative and quantitative findings were presented to the Community Council to gain members' feedback on unmet needs in the ASA service area, and to directly hear from community members regarding allocation of community benefit resources.

Community Council members agreed that the findings of the primary and secondary data research and analysis accurately reflected the needs of the community. Discussion among the members largely focused on the significant effect of the COVID-19 pandemic on exacerbating existing needs. For example, members discussed the significance of substance use disorder and mental health, stating that the isolation resulting from the pandemic is having a major worsening effect. At the same time, fear of exposure to COVID-19 resulted in individuals with critical health needs delaying their care.

In terms of social/environmental concerns, members discussed the prevalence of job loss and inability of families to afford basic needs as a result of COVID-19. Other social determinants identified include housing/homelessness, lack of transportation, safety and violence, and the

significant digital divide. The school closures resulting from COVID-19 were highlighted as a major concern, as children are unable to engage in remote learning and are lost to the school system. Similarly, other community based organizations have but unable to engage and support their target populations throughout the pandemic. The economic and socially isolating footprint of COVID-19 is significant, with long term effects.

Members discussed a number of barriers to accessing healthcare, including affordability and lack of insurance, particularly for immigrants. The complexity of navigating the healthcare system can be significant, and even more so when there are language barriers. Members recognized the fear and mistrust of the healthcare system described by survey respondents and focus group participants. This acts as a barrier to COVID-19 vaccine uptake. As healthcare providers pivot to telehealth, some community members will be left behind due to a lack of access to technology and connectivity. The Community Council saw elevation of the role of community health workers as a strategy for overcoming barriers to healthcare and achieving long term health goals.

Community Associations

The qualitative and quantitative findings were presented to two separate Violetville associations to gain members' feedback on unmet needs and seek input on the allocation of community benefit resources. At these meetings, community association members agreed that the major issues from primary and secondary research were an accurate reflection of health and social needs and barriers to care.

One of the community associations primarily discussed mental health and substance use disorder as huge issues faced by the community. It is especially difficult to navigate the healthcare system for individuals who are dually diagnosed with a mental health condition and substance use disorder. Significant service gaps and fragmentation exist for this population, and there is a lack of support for patients and their families. Repeated failed attempts to navigate the system make it difficult to re-initiate with existing resources. Peer mentoring was described as valuable because it is a way to offer hope.

The other community association noted that based on the findings, many of the same needs extend across Baltimore City and Baltimore County; these challenges are not unique to the City. The group also discussed the need to identify solutions to overcome fear and mistrust of the healthcare system. They noted the implications this has for uptake of COVID-19 vaccines.

Conclusion of Stakeholder Input

Stakeholders overwhelmingly agreed with the findings with the primary and secondary research. They went on to emphasize how COVID-19 exacerbates the top health and social concerns:

- Worsening mental health and substance use;

- Difficult for community based organizations to engage clients;
- Digital divide is severe;
- Many more families require help with basic needs; and
- Fear and mistrust create barriers to vaccination.

Community Health Need Priorities

We presented research findings and stakeholder input to the ASA Board of Directors Mission Committee and the ASA Executive Team. We then engaged both groups to translate the top concerns into priorities for the ASA FY 2021 Community Health Needs Assessment. ASA's three Community Health Need Priorities approved by the Executive Team for the FY 2019 through FY 2021 cycle are:

- **Address mental health and substance use disorder;**
- **Prevent diabetes and improve health outcomes for individuals with diabetes; and**
- **Build person-centered healthy neighborhoods to address social determinants of health.**

ASA leadership believes in the importance of maintaining continuity with FY 2018 priorities,

Many of the needs identified in the FY 2016 and FY 2018 CHNAs remain significant. Given the scale and complexity of addressing these issues, ASA leadership believes in the importance of maintaining continuity around the priorities. Thus, there is continued focus on addressing mental health and substance use disorder. In addition, building person-centered healthy neighborhoods to address social determinants of health continues to reflect ASA's existing efforts and is aligned with our Catholic health mission of serving our community with a special focus on those who are poor or vulnerable. ASA leadership reoriented the FY 2018 priority to reduce obesity and the impact of chronic disease to focus on diabetes. This is consistent with State of Maryland health priorities. The ASA priorities continue to closely align with local, state and national priorities as found in Healthy Baltimore 2020, State of Maryland State Health Improvement Plan (SHIP) Vision Areas and Healthy People 2020. See Appendix 3.

Documenting and Communicating Results

The completion of this Community Health Needs Assessment marks a milestone in community involvement and participation, with input from the public, community leaders and health experts, and ASA administration. This report will be posted on the ASA website following ASA Board approval. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

Planning for Action and Monitoring Progress

Using both primary and secondary research and stakeholder input—including those with special knowledge of or expertise in public health—the next step is to develop an implementation plan for the three identified priorities. The ASA Executive Leadership Team, Health Institute and Mission Integration will oversee the development of implementation strategies. The strategies will be shared with stakeholders for feedback and presented to the ASA Board by November 2021.

Appendix 1: Community Profiles

Arbutus (Zip Code 21227):
Arbutus is an older suburban community, located south of Caton and Wilkens Avenues, and has a population of 34,139. The traditionally blue collar community is part of the Baltimore County Health Jurisdiction. Saint Agnes Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Baltimore/UMBC (Zip Code 21250):
The 21250 zip code is home to the University of Maryland, Baltimore County (UMBC) campus, adjacent to Catonsville. UMBC enrolls approximately 13,500 students, one quarter of whom live on campus. On-campus health resources include University Health Services, which provides diagnosis and treatment of acute illnesses and injuries, treatment and monitoring of chronic illnesses, immunizations, preventative care, routine gynecological care, allergy shots, laboratory testing, and limited pharmacy services. The UMBC Counseling Center provides short-term individual and group counseling, and psychiatric services for students engaged in counseling.

Brooklyn-Linthicum (Zip Code 21225):
Brooklyn-Linthicum is an older urban/suburban community, located southeast of Caton and Wilkens Avenues, and has a population of 33,550. The industrial and blue collar community has seen an increase in the uninsured population and is part of both the Baltimore City and Baltimore County Health Jurisdictions. Harbor Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Catonsville (Zip Code 21228):
Catonsville is an older suburban community, located west of Caton and Wilkens Avenues, and has a population of 49,758, with a growing proportion of seniors. The traditionally white collar community is part of the Baltimore County Health Jurisdiction. ASA is the primary hospital provider best positioned to address the specific health needs of this community.

Elkridge (Zip Code 21075):
Elkridge is an older suburban community with historical and recreational areas. It located in Howard County, adjacent to Anne Arundel and Baltimore counties. Elkridge has a population of approximately 16,000, with higher incomes than other portions of the ASA service area. The median household income is approximately $66,000, and less than 3% of the population us under the poverty line. The population is over 80% white.

South Baltimore City (Zip Code 21223, 21230):
South Baltimore City is an older urban community, located east/southeast of Caton and Wilkens Avenues, and has a population of 59,923. The urban community is projected to experience population declines. South Baltimore City is part of the Baltimore City Health Jurisdiction. Baltimore Washington Medical Center and MedStar Harbor Hospital are the primary hospitals provider best positioned to address the specific health needs of this community.

Southwest Baltimore City (Zip Code 21229):
Southwest Baltimore City is an older urban community, located at Caton and Wilkens Avenues, and has a population of 44,537. Similar to other urban areas, Southwest Baltimore is projected to experience population declines. Southwest Baltimore City is part of the Baltimore City Health Jurisdiction. Saint Agnes Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

West Baltimore City (Zip Code 21215, 21216, 21217):
West Baltimore City is an older urban community, located north of Caton and Wilkens Avenues, and has a population of 123,222. Similar to other urban areas, West Baltimore is projected to experience population declines. West Baltimore City is part of the Baltimore City Health Jurisdiction. Sinai Hospital, University of Maryland and Bon Secours Hospital are the primary hospital providers best positioned to address the specific health needs of this community.

Windsor Mill (Zip Code 21244):
Windsor Mill is a suburban community in Baltimore County, near Woodlawn. It has a population of approximately 34,000. Approximately 77% of the population is under 55 years of age. Median household income is $44,000.

Woodlawn (Zip Code 21207):
Woodlawn is a suburban community, located northwest of Caton and Wilkens Avenues, and has a population of 47,456, with a growing proportion of seniors. Woodlawn is part of the Baltimore County Health Jurisdiction. Northwest Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Appendix 2: Community Survey Questions

Question	Response Options
What is your zip code? (Please write 5-digit Zip code)	Open-Ended Response
What is your gender? (Please check one)	Female
	Male
	Transgender
	Other (please specify)
What is your age group? (Please check one)	18-29
	30-39
	40-49
	50-64
	65-74
	75+
Which one of the following is your race? (Please check all that apply)	Black or African American
	White or Caucasian
	Asian
	Native Hawaiian or Other Pacific Islander
	American Indian or Alaska Native
	Don't Know
	Prefer Not to Answer
	Other /More than one race (please specify)
Are you Hispanic or Latino/a? (Please check one)	Yes
	No
	Don't Know
	Prefer Not to Answer
Do you have health insurance?	Yes
	No
On how many days during the past 30 days was your mental health not good? (Mental health includes stress, depression, and problems with emotions)	Zero Days
	Don't Know
	Prefer Not to Answer
	(Please specify how many days here)
What are the three most important health problems that affect the health of your community? Please check only three.	Alcohol/Drug Addiction
	Mental Health (Depression/Anxiety)
	Diabetes/High Blood Sugar
	HIV/AIDS
	Lung Disease/Asthma/COPD
	Smoking/Tobacco Use
	Sexually Transmitted Diseases
	Alzheimer's/Dementia
	Cancer
	Heart Disease/Blood Pressure
	Infant Death
	Stroke
	Overweight/Obesity
	Don't Know or Prefer Not to Answer
	Other (please specify)

Continued on next page.

Question	Response Options
What are the three most important social/environmental problems that affect the health of your community? Please check only three.	Availability/Access to Doctor's Office
	Availability/Access to Insurance
	Domestic Violence
	Limited Access to Healthy Foods
	School Dropout/Poor Schools
	Lack of Job Opportunities
	Race/Ethnicity Discrimination
	Social Isolation/Loneliness
	Child Abuse/Neglect
	Lack of Affordable Child Care
	Housing/Homelessness
	Neighborhood Safety/Violence
	Poverty
	Limited Places to Exercise
	Transportation Problems
	Don't Know or Prefer Not to Answer
	Other (please specify)
What are the three most important reasons people in your community do not get health care? Please check only three.	Cost - Too Expensive/Can't Pay
	No Insurance
	Lack of Transportation
	Language Barrier
	Worried about Immigration Status
	Fear or Mistrust of Doctors
	Wait is Too Long
	No Doctor Nearby
	Insurance Not Accepted
	Cultural/Religious Beliefs
	Child Care
	Wait is Too Long
	Don't Know or Prefer Not to Answer
	Other (please specify)
Which of the following apply to you?	I have been diagnosed with the Coronavirus (COVID-19)
	A household member has been diagnosed with the Coronavirus
	A family member outside my household has been diagnosed with the Coronavirus
	A friend or someone I know outside my family has been diagnosed with the Coronavirus
	I don't know anyone personally who has been diagnosed with the Coronavirus
	Prefer not to say
As a result of COVID-19, have you needed any of the following? (Check all that apply)	Financial Assistance
	Food Assistance
	Rental Assistance
	Translation/Interpretation Services
	Energy Assistance
	WiFi/Internet Assistance
	Housing/Shelter
	Child Care
	None
	Other (please specify)
When it comes to COVID-19, what are you most concerned about right now? (Rank the following options in order of importance. 1 = Most important to 4 = Least important)	Members of my household becoming infected
	The health of my community as the pandemic continues
	The emotional health of my household
	Financial hardship
What ideas or suggestions do you have to improve the health in your community?	Open-Ended Response

Appendix 3: Alignment Among ASA, National, State, and City Priorities

ASA Community Health Needs Assessment Priorities	National Healthy People 2030 Goals	Maryland State Health Improvement Process[3]	Healthy Baltimore 2020[4]
Address Mental Health and Substance Abuse	● Improve mental health ● Reduce misuse of drugs and alcohol ● Reduce drug and alcohol addiction	● ED visits related to mental health conditions ● Suicide rate ● ED visits for addiction-related concerns ● Drug-induced death rate	● Close the male-female gap in students reporting periods of feeling sad/hopeless ● Close the gap, by ZIP code, in substance use-related ER visits ● Close the gap in overdose deaths between Baltimore and Maryland
Prevent Diabetes and Improve Health Outcomes for Individuals with Diabetes	● Reduce the burden of diabetes and improve quality of life for all people who have, or at risk for, diabetes	● ED visits due to diabetes ● Adults who are not overweight or obese ● Adolescents who have obesity ● Increase physical activity	● Close the Black-White gap in adult obesity ● Close the gap in food insecurity between Baltimore and Maryland
Build Person-Centered Healthy Neighborhoods to Address Social Determinants of Health	● Create neighborhoods and environments that promote health and safety ● Help people earn steady incomes that allow them to meet their health needs ● Increase educational opportunities and help children and adolescents do well in school ● Increase access to comprehensive, high-quality healthcare services ● Increase social and community support	● Life expectancy ● Affordable housing ● High school graduation rate ● Pedestrian injury rate on public roads ● Persons with usual source of primary care ● Uninsured ED visits	● Close the Black-White gap in life expectancy ● Close the Black-White gap in chronic high school absences ● Close the gap in youth homicides between Baltimore and Maryland

[3] https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx
[4] https://health.baltimorecity.gov/sites/default/files/HB2020%20-%20April%202017.pdf

Ascension Saint Agnes Implementation Strategy

Fiscal Years 2022 through 2024

Overview

The Ascension Saint Agnes community health needs assessment (ASA CHNA) process is about improving health—the health of individuals, families, and communities. The CHNA evaluates the health status of the people residing in our surrounding communities to identify the greatest health needs and to determine how ASA can best respond to them. In addition to analyzing public health and hospital utilization data, ASA engaged the public through a structured online survey and a series of focus groups. We presented findings to several groups of external stakeholders to solicit feedback from leaders among the communities we serve. Internal stakeholders representing clinical care, population health, care management, and pastoral care also provided input. ASA continues to collaborate with other Baltimore City Hospitals to establish shared health priorities and collectively address health needs.

Priority Needs to be Addressed

The three community health need priorities to be addressed by ASA for the FY 2022 through FY 2024 cycle are as follows:

- **Address mental health and substance use disorder;**
- **Prevent diabetes and improve health outcomes for individuals with diabetes; and**
- **Build person-centered healthy neighborhoods to address social determinants of health.**

Implementation Strategy

Below is an implementation strategy for each of the three prioritized needs, including the resources, proposed actions, and anticipated outcomes.

Prioritized Need 1: Address mental health and substance use disorder

GOAL: Provide access to hospital and community resources that help meet the mental health and substance use disorder needs of community members.

Action Plan

STRATEGY: Build a path toward a comprehensive continuum of care for mental health needs and substance use disorder by strengthening programs in various hospital divisions with SBIRT and buprenorphine induction. Create and strengthen community programming with the Health Institute and community partners.

BACKGROUND:

- Mental health needs and substance use disorder have been greatly exacerbated by the COVID-19 pandemic. ASA faces a continued need to address mental health and substance use disorder needs of individuals presenting to the ED. Efforts must continue to increase connections to resources and treatment for individuals experiencing substance use disorder.
- Addressing mental health and substance use disorder needs is a shared priority among all Baltimore City hospitals. ASA is participating in the Greater Baltimore Regional Integrated Crisis System (GBRICS) to reduce unnecessary ED use and police interaction for people in behavioral health crisis.

RESOURCES:

- ASA Hospital
- ASA Health Institute
- Community Partners (hospital partners, GBRICS Council, Mosaic, Baltimore City Health Department, Trauma Partners)

ACTIONS:

- Provide SBIRT to ASA patients during inpatient stays, in the ED, and through primary care and OB/GYN practices.
- Increase access to medication assisted treatment for patients with opioid use disorder treated in the ED and inpatient settings.
- Increase mental health visits in the Ascension Medical Group and Health Institute programs.
- Conduct naloxone training on campus and throughout the community.
- Provide trauma-informed care trainings for ASA staff.

ANTICIPATED OUTCOMES:

- Increase by 10% the proportion of patients with opioid dependency who have naloxone prescriptions filled upon discharge.
- Increase to 25% the proportion of patients enrolled with the Ascension Medical Group behavioral health Hope Counseling Program who remain connected to care for three visits.
- ASA staff and the larger community will be better able to meet individuals' mental health and substance use disorder needs.

Prioritized Need 2: Prevent diabetes and improve health outcomes for individuals with diabetes

GOAL: Reduce the burden of diabetes and improve quality of life for individuals who have, or are at risk for, diabetes.

Action Plan

STRATEGY: Provide increased outreach, education, and medical intervention, on campus and in the community, to individuals who face physical and mental effects of diabetes or prediabetes and who seek a change in health status.

BACKGROUND:

- The ASA service area is significantly impacted by diabetes. Communities surrounding ASA have rates of diabetes two times the state average.
- The target population is patients experiencing health problems related to diabetes or prediabetes, with particular emphasis on vulnerable populations who lack access to primary care, care management, and education.
- The State of Maryland has prioritized diabetes prevention and management.

RESOURCES:

- ASA Hospital
- ASA Health Institute
- Saint Agnes Medical Group
- Additional community partners (Maryland Department of Health, Baltimore City Health Department, Associated Catholic Charities of America/My Brother's Keeper, Food Project, Central Baptist Church, Baltimore Medical System, Partnership for a Healthier America, Meals on Wheels of Central Maryland, Moveable Feast, Hungry Harvest, and other partners within the faith-based community)

ACTIONS:

- Expand Food Rx to meet the nutritional needs of more patients with diabetes or prediabetes.
- Expand the ASA Diabetes Prevention Program (DPP).
- Develop an ASA care pathway for diabetes care management.
- Increase care management services for primary care patients with diabetes.
- Continue to offer the Diabetes in Pregnancy program to provide nutrition therapy, health education, and monitoring for pregnant women with or at risk for diabetes.

ANTICIPATED OUTCOMES:

- Reduce diabetes composite PQI[1] by 2.5% by CY 2023 and by 5% by CY 2025, equating to a total reduction of 52 patient admissions.
- Expand Diabetes Self-Management Education (DSME) to provide 2,884 unique individuals at least one DSME visit by year-end CY 2023.
- Expand DPP to enroll 351 unique individuals who have attended at least one session by year-end CY 2023.
- DPP 5% weight loss goal: 316 unique individuals (from cohorts starting CYs 2021 - 2024) by year-end CY 2025.
- Proportion of patients with uncontrolled diabetes, defined as A1C levels greater than 8%: ≤ 22% for all patients, and ≤ 24% for African American patients.
- Among mothers participating in the Diabetes in Pregnancy program, ≤ 9% of newborns born large for gestational age.

Prioritized Need 3: Build person-centered healthy neighborhoods to address social determinants of health.

GOAL: Improve quality of life by improving access to health care resources and resources to address the social determinants of health.

Action Plan

STRATEGY: Collaborate with community agencies to provide access to health programs and resources that address social determinants and improve health outcomes.

BACKGROUND:

- The target population is high-utilizing patients with the greatest need and fewest resources. The focus will be on individuals who lack connection to community programs, particularly in West Baltimore.

RESOURCES:

- ASA Hospital
- ASA Health Institute
- Saint Agnes Medical Group
- Additional community partners (Baltimore Medical Systems, Inc., West Baltimore Collaborative, Health Care Access Maryland)

ACTIONS:

- Establish violence prevention programming for patients suffering from violent injuries.

[1] "Prevention Quality Indicators" or "PQIs" are nationally recognized measures that examine hospital utilization to help assess access to health care in the community. PQI 93 is a composite measure that Includes admissions for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, and diabetes with lower-extremity amputation.

- Provide health services in the community to help meet local neighborhood needs.
- Grow the volunteer chaperoned ride program to reduce transportation barriers to accessing healthcare.
- Expand access to technology infrastructure for individuals to access telehealth.
- Identify a partner to provide affordable housing on ASA-owned property.
- Connect patients to community resources that address social determinants of health.

ANTICIPATED OUTCOMES:

- Among individuals receiving annual wellness visits, 80% will be screened for social determinant of health needs.
- Implement core elements of violence prevention programming by the end of FY 2022, providing initial intervention to 100 patients.
- For patients served by the chaperoned ride program, decrease the missed or canceled appointment rate by 35% compared to the period prior to chaperoned ride participation.
- Support the post-acute and social determinant needs among ASA patients by applying to operate a Program of All-Inclusive Care for the Elderly (PAC) site and expanding care management services.
- By the end of FY 2022, expand health services provided in the community.
- Decrease the Prevention Quality Indicator Rate to the Statewide rate.

Needs Addressed through Referral Relationships

The ASA CHNA identified some needs not specifically addressed above. These include the following:

- Economic opportunity;
- Affordable housing and safe neighborhoods; and
- Affordable health care.

ASA focused its three prioritized needs on areas that fall within the core competency of the hospital and health system. ASA will rely on referral relationships with other organizations that have the core competencies to address areas such as housing and economic opportunity. For example, the ASA Implementation Strategy includes identifying a partner to provide affordable housing on ASA-owned property.

ASA's existing initiatives to screen for social determinants of health and refer individuals to available community resources will continue to address the above areas. As described in the outcomes for Prioritized Need 3, ASA will continue to screen patients for social determinant of health needs and refer them to available community services.

Many of ASA's prior initiatives have focused on overweight/obesity, heart disease, and blood pressure. ASA is reorienting its focus to diabetes to be consistent with State of Maryland health priorities. However, within our diabetes initiatives we will still address these other chronic health conditions.

Itemized List of PhysicianType/Specialty Subsidized	Subsidy Type	DIRECT COST($)	INDIRECT COST($)	HSCRC GRANTS/RATE SUPPORT	OTHER OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT
Physician ED OnCall	Coverage of Emergency Department Call	$1,911,360.00				$1,911,360.00
Hospital Based Phys Coverage	Non-Resident House Staff and Hospitalists	$11,716,355.00			$5,141,875.00	$6,574,480.00
Hospitalists	Non-Resident House Staff and Hospitalists	$11,461,060.00			$6,266,133.00	$5,194,927.00

Origination:	*2/1/2005*
Effective:	*12/1/2021*
Last Approved:	*12/1/2021*
Last Revised:	*12/1/2021*
Next Review:	*11/30/2024*
Owner:	*Laura Hesselbein: Dir-Accounting*
Area:	*Finance*
References:	*SYS FI 05*

Ascension Saint Agnes Financial Assistance Policy

POLICY/PRINCIPLES

It is the policy of the organizations listed below this paragraph (each one being the "Organization") to ensure a socially just practice for providing emergency and other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization. This policy applies to each of the following Organizations within Ascension Saint Agnes:

Ascension Saint Agnes Hospital, Ascension Medical Group, Seton Imaging, Lab Outreach, Integrated Specialist Group, Radiologists Professional Services, Anesthesia Professional Services

1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.
2. This policy applies to all emergency and other medically necessary care provided by the Organization, including employed physician services and behavioral health. This policy does not apply to charges for care that is not emergency and other medically necessary care.
3. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

SCOPE

This policy applies to all entities of Ascension Saint Agnes.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- "**Amount Generally Billed**" or "**AGB**" means, with respect to emergency and other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- "**Community**" means patients residing in the following zip codes consistent with the Organization's Community Health Needs Assessment(CHNA): Arbutus 21227, Brooklyn/Linthicum,21225, Catonsville 21250, 21228, Curtis Bay 21226, Gwynn Oak 21207, South Baltimore City 21223,21230, Southwest Baltimore City 21229, West Baltimore City 21215,21216,21217. A Patient will also be deemed to be a member of the Organization's Community if the emergency and medically necessary care the Patient requires is continuity of

emergency and medically necessary care received at another Ascension Health facility where the Patient has qualified for financial assistance for such emergency and medically necessary care.

- "**Emergency care**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonable by expected to result in either:
    a. 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, or
    b. Serious impairment to bodily functions, or
    c. Serious dysfunction of any bodily organ or part.
- "**Medically necessary care**" means care that is (1) appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a Patient's condition; (2) the most appropriate supply or level of service for the Patient's condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient's family, physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. For future scheduled care to be "medically necessary care", the care and the timing of care must be approved by the Organization's Chief Medical Officer (or designee). The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at the Organization's discretion, by the admitting physician, referring physician, and/or Chief Medical Officer or other reviewing physician (depending on the type of care being recommended). In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- "**Organization**" means Ascension Saint Agnes.
- "**Patient**" means those persons who receive emergency and other medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

Financial assistance described in this section is limited to Patients that live in the Community:

1. Subject to the other provisions of this Financial Assistance Policy, Patients with income less than or equal to 250% of the Federal Poverty Level income ("FPL"), will be eligible for 100% charity care on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any, if such Patient determined to be eligible pursuant to presumptive scoring (described in Paragraph 7 below) or submits a financial assistance application (an "FAP Application") on or prior to the 240th day after the Patient's first bill and the FAP Application is approved by the Organization[1]. Patient will be eligible for up to 100% financial assistance if Patient submits the FAP Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account, unless a refund is prescribed under Maryland Law and Section 3(b) of the Organization's Billing and Collections Policy.[2] A Patient eligible for this category of financial assistance will not be charged more than the charges minus the hospital mark-up or the calculated AGB charges, whichever is less.
2. Subject to the other provisions of this Financial Assistance Policy, Patients with incomes above 250% of the FPL but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any, if such Patient submits a FAP Application on or prior to the 240th day after the Patient's first bill and the Application is approved by the Organization[3]. Patient will be eligible for the sliding scale discount financial assistance if Patient submits the FAP Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the charges minus the hospital mark-up or the calculated AGB

charges, whichever is less. The sliding scale discount is as follows:

FINANCIAL ASSISTANCE SCALE
As of July 1, 2021

For Hospital Facility Services Only (Regulated)

Household	Charity Care				Financial Assistance Program					
Size	**100%**	**to 200%**	**to 225%**	**to 250%**	**to 275%**	**to 300%**	**to 325%**	**to 350%**	**to 375%**	**to 400%**
1	$12,880	$25,760	$28,980	$32,200	$35,420	$38,640	$41,860	$45,080	$48,300	$51,520
2	$17,420	$34,840	$39,200	$43,550	$47,910	$52,260	$56,620	$60,970	$65,330	$69,680
3	$21,960	$43,920	$49,410	$54,900	$60,390	$65,880	$71,370	$76,860	$82,350	$87,840
4	$26,500	$53,000	$59,630	$66,250	$72,880	$79,500	$86,130	$92,750	$99,380	$106,000
Saint Agnes Discount	100%	100%	100%	100%	75%	50%	25%	15%	12%	11.5%

For Professional Services (Deregulated)*

Household	Charity Care				Financial Assistance Program					
Size	**100%**	**to 200%**	**to 225%**	**to 250%**	**to 275%**	**to 300%**	**to 325%**	**to 350%**	**to 375%**	**to 400%**
1	$12,880	$25,760	$28,980	$32,200	$35,420	$38,640	$41,860	$45,080	$48,300	$51,520
2	$17,420	$34,840	$39,200	$43,550	$47,910	$52,260	$56,620	$60,970	$65,330	$69,680
3	$21,960	$43,920	$49,410	$54,900	$60,390	$65,880	$71,370	$76,860	$82,350	$87,840
4	$26,500	$53,000	$59,630	$66,250	$72,880	$79,500	$86,130	$92,750	$99,380	$106,000
Saint Agnes Discount	100%	100%	100%	100%	90%	80%	70%	60%	55%	50.7%

**Includes the following services:*
Seton Imaging
Lab Outreach
Seton Medical Group
Ascension Medical Group
Saint Agnes Medical Group
Integrated Specialist Group
Radiologists Professional Services
Anesthesia Professional Services

3. Subject to the other provisions of this Financial Assistance Policy, a Patient with i) income greater than 400% of the FPL but not exceeding 500% of the FPL and ii) medical debt, which includes medical debt to Ascension and any other health care provider, for emergency and other medically necessary care, that is incurred by the Patient over a twelve (12) month period that is equal to or greater than 25% of such Patient's household's gross income; will be eligible for financial assistance as set forth in this paragraph. The level of financial assistance provided is the same as is granted to a patient with income at 400% of the FPL under Paragraph 2

above, if such Patient submits a FAP Application on or prior to the 240th day after the Patient's first discharge bill and the FAP Application is approved by the Organization. Patient will be eligible for such financial assistance if the Patient submits the FAP Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the charges minus the hospital mark-up or the calculated AGB charges, whichever is less.

4. Subject to the other provisions of this Financial Assistance Policy, a Patient with income greater than 500% of the FPL may be eligible for financial assistance under a "Means Test" for some discount of Patient's charges for services from the Organization based on a Patient's total medical debt. A Patient will be eligible for financial assistance pursuant to the Means Test if the Patient has excessive total medical debt, which includes medical debt to Ascension and any other health care provider, for emergency and other medically necessary care, that is equal to or greater than such Patient's household's gross income. The level of financial assistance provided pursuant to the Means Test is the same as is granted to a patient with income at 400% of the FPL under Paragraph 2 above, if such Patient submits a FAP Application on or prior to the 240th day after the Patient's first discharge bill and the FAP Application is approved by the Organization. Patient will be eligible for the means test discount financial assistance if such Patient submits the FAP Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the charges minus the hospital mark-up or the calculated AGB charges, whichever is less.
5. A patient will be eligible for a payment plan if Patient's income is between 200% and 500% of the FPL and Patient requests assistance by submitting a FAP Application.
6. The determination of a Patient's income shall include consideration of the household size of the Patient, which consists of the Patient and the following individuals: (1) a spouse (regardless of whether the patient and spouse expect to file a joint federal or State tax return); (2) biological, adopted, or step children; and (3) anyone for whom Patient claims a personal exemption in federal or State tax returns. If the Patient is a child, the household size shall consist of the child and the following individuals; (1) biological parents, adopted parents, or stepparents or guardians, (2) biological siblings, adopted siblings, or stepsiblings; and (3) anyone for whom the Patient's parents or guardians claim a personal exemption in a federal or State tax return.
7. A Patient may not be eligible for the financial assistance described in Paragraphs 1 through 4 above if such Patient is deemed to have sufficient assets to pay pursuant to an "Asset Test[4]". The Asset Test involves a substantive assessment of a Patient's ability to pay based on the categories of assets measured in the FAP Application. A Patient with such assets that exceed 250% of such Patient's FPL amount may not be eligible for financial assistance.
8. Eligibility for financial assistance may be determined at any point in the revenue cycle, provided that patient shall remain eligible for at least a twelve (12) month period beginning on date when care was first received, and may include the use of presumptive scoring for a Patient with a sufficient unpaid balance within the first 240 days after the Patient's first discharge bill to determine eligibility for 100% charity care notwithstanding Patient's failure to complete an FAP Application. If Patient is granted 100% charity care without submitting a completed FAP Application and via presumptive scoring only, the amount of financial assistance for which Patient is eligible is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A determination of eligibility based on presumptive scoring only applies to the episode of care for which the presumptive scoring is conducted.
9. For a Patient that participates in certain insurance plans that deem the Organization to be "out-ofnetwork", the Organization may reduce or deny the financial assistance that would otherwise be available to Patient based upon a review of Patient's insurance information and other pertinent facts and circumstances.

10. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social service programs are deemed eligible for charity care, provided that the patient submits proof or enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days:
    a. Households with children in the free or reduced lunch program;
    b. Supplemental Nutritional Assistance Program (SNAP);
    c. Low-income household energy assistance Program;
    d. Women, Infants and Children (WIC);
    e. Other means-tested social services program deemed eligible for hospital free care by the Department of Health and Mental Hygiene and the HSCRC.
11. The Patient may appeal any denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. The process for Patients and families to appeal the Organization's decisions regarding eligibility for financial assistance is as follows:
    a. Patients will be notified of ineligibility of financial assistance through the hospital's financial assistance denial letter. Patients or families may appeal decisions regarding eligibility for financial assistance by contacting: Patient Financial Services in writing at 900 Caton Ave., Baltimore, Md. 21229.
    b. All appeals will be considered by the Organization's financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal.

Other Assistance for Patients Not Eligible for Financial Assistance (applicable to non-hospital services only)

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by the Organization.

1. Uninsured Patients receiving services at Seton Imaging, Lab Outreach or Professional Services who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.

Limitations on Charges for Patients Eligible for Financial Assistance

a. Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained on the Organization's website or by contacting Patient Financial Services in writing/in person at 900 S. Caton Ave., Baltimore, MD 21229.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available on the Organization's website or by calling Patient Financial Assistance at 1-667234-2140. FAP applications are also available at various Registrations Locations throughout the hospital. The Organization will require the uninsured to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process, if the patient refuses to assign insurance proceeds or the right to be paid directly by an insurance company that may be obligated to pay for the care provided, or if the patient refuses to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). The Organization may consider a FAP Application completed less than six months prior to any eligibility determination date in making a determination about eligibility for a current episode of care. The Organization will not consider a FAP Application completed more than six months prior to any eligibility determination date.

The Organization shall provide information in writing to the Patient or his/her representative, legal guardian or family, as applicable, regarding the availability of installment payment plans. The Organization shall provide this information before the Patient is discharged, with the hospital bill, on request, and in each written communication to the Patient regarding collection of hospital debt. For at least 180 days after issuing the initial Patient bill, Organization may not report adverse information about Patient to a consumer reporting agency or commence a civil action for nonpayment.

Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained on the Organization's website or by contacting Patient Financial Services at 1-667-234-2140.

Interpretation

This policy, together with all applicable procedures, is intended to comply with and shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY

As of December 1, 2021

The list below specifies which providers of emergency and other medically necessary care delivered in the hospital facility are covered by the Financial Assistance Policy (FAP). ***Please note that any care that is not emergency and other medically necessary care is not covered by the FAP for any providers.***

Providers covered by FAP	Providers not covered by FAP
Seton Medical Group Ascension Medical Group	ABBAS,ALI MD
	ABDELAZIM,SUZANNE A D.O.

Providers covered by FAP	Providers not covered by FAP
Integrated Specialist Group Saint Agnes Medical Group Vituity CEP America	ABDUR-RAHMAN,NAJLA MD
	ABERNATHY,THOMAS MD
	ADAMS,SCOTT MD
	AFZAL,MUHAMMAD MD
	AHLUWALIA,GURDEEP S MD
	AHMED,AZRA MD
	AHUJA,NAVNEET K MD
	AKHTAR,YASMIN DO
	ALBUERNE,MARCELINO D MD
	ALEX,BIJU K MD
	ALI,LIAQAT MD
	ALLEN,DANISHA MD
	ALONSO,ADOLFO M MD
	AMERI,MARIAM MD
	AMIN,SHAHRIAR MD
	ANANDAKRISHNAN,RAVI K MD
	ANDRADE,JORGE R MD
	ANSARI,MOHSIN MD
	ANTHONY,JAMES D MD
	APGAR,LESLIE MD
	APOSTOLIDES,GEORGE Y MD
	APOSTOLO,PAUL M MD
	ARCHER,CORRIS E MD
	ARSHAD,RAJA R MD
	ASHLEY JR,WILLIAM W MD
	AWAN,HASAN A MD
	AWAN,MATEEN A MD
	AZIE,JULIET C MD
	AZIZ,SHAHID MD
	BAJAJ,BHAVANDEEP MD
	BAJAJ,HARJIT S MD
	BANEGURA,ALLEN T MD
	BARBOUR,WALID K MD
	BARNES,BENJAMIN T MD
	BASKARAN,DEEPAK MD
	BASKARAN,SAMBANDAM MD

Providers covered by FAP	Providers not covered by FAP
	BASSI,ASHWANI K MD
	BASTACKY,DAVID C DMD
	BECK,CLAUDIA MD
	BEHRENS,MARY T MD
	BELTRAN,JUAN A MD
	BENVENUTO,VICTOR MD
	BERGER,LESLY MD
	BERKENBLIT,SCOTT I MD
	BERNIER,MEGHAN M.D.
	BEZIRDJIAN,LAWRENCE C MD
	BHARGAVA,NALINI MD
	BHASIN,SUSHMA MD
	BHATNAGAR,RISHI MD
	BHATTI,NASIR I MD
	BIRCHESS,DAMIAN E MD
	BLAM,OREN G MD
	BLANK,MICHAEL DDS
	BODDETI,ANURADHA MD
	BORDON,JOSE M MD
	BOYKIN,DIANE MD
	BRANDAO,ROBERTO A DPM
	BRITT,CHRISTOPHER J MD
	BROOKLAND,ROBERT K M.D.
	BROUILLET, JR.,GEORGE H MD
	BROWN,JACQUELINE A MD
	BURROWS,WHITNEY MD
	CAHILL,EDWARD H MD
	CALLAHAN,CHARLES W DO
	CALLENDER,MARC MD
	CAO,QI MD
	CARPENTER,MYLA MD
	CARTER,MIHAELA M.D.
	CERCONE,KRISTEN MD
	CHAIKEN,MARC L MD
	CHANG,HENRY MD
	CHANG,JOSEPH J M.D.

Providers covered by FAP	Providers not covered by FAP
	CHATTERJEE,CHANDANA MD
	CHEIKH,EYAD MD
	CHEN,WENGEN MD
	CHEN,YIBO N MD
	CHEUNG,AMY M MD
	CHINSKY,JEFFREY M MD
	CHOUDHRY,SHABBIR A MD
	CLASQUIN,MARGOT E MD
	CLONMELL,DIANE J LCPC
	COCA-SOLIZ,VLADIMIR MD
	COHEN,BERNARD MD
	COHEN,GORDON MD
	COLANDREA,JEAN MD
	COMMERFORD,CHRISTINE MD
	COSENTINO,ENZO MD
	CRESS,JANE M NP
	CROWLEY,HELENA M MD
	DANG,KOMAL K MD
	DA SILVA,MONICA L MD
	DAVALOS,JULIO MD
	DEBORJA,LILIA L MD
	DEJARNETTE,JUDITH MD
	DE JESUS-ACOSTA,ANA MARIA CRIS
	DESAI,KIRTIKANT I MD
	DESAI,SHAUN C MD
	DIAZ-MONTES,TERESA P MD
	DICKSTEIN,RIAN MD
	DIDOLKAR,MUKUND S MD
	DILSIZIAN,VASKEN MD
	DOHERTY,BRENDAN MD
	DOVE,JOSEPH DPM
	DROSSNER,MICHAEL N MD
	DUA,VINEET MD
	DUBOIS,BENJAMIN MD
	DUNNE,MEAGAN MD
	DUONG,BICH T MD

Providers covered by FAP	Providers not covered by FAP
	DUSON,SIRA M MD
	DZIUBA,SYLWESTER MD
	EGERTON,WALTER E MD
	EISENMAN,DAVID J MD
	EMERSON,CAROL MD
	ENELOW,THOMAS MD
	ENGELBERT,PATRICK R MD
	ENGLUM,BRIAN R MD
	ERAS,JENNIFER L MD
	FALCAO,KEITH D MD
	FATTERPAKER,ANIL MD
	FELTON,PATRICK M. DPM
	FERNANDEZ,RODOLFO E MD
	FILDERMAN,PETER S MD
	FLOYD,DEBORA M LCPC
	FOLGUERAS,ALBERT J MD
	FRAZIER,JAMES MD
	FRAZIER,TIMOTHY S MD
	FRIEDBERG,JOSEPH S MD
	FUGOSO,VALERIANO P MD
	GABLE,NICOLE J MD
	GALITA,OLIVER C MD
	GANGALAM,AJAY B M.D.
	GARCIA,LORI MD
	GARCIA,PABLO MD
	GARG,PRADEEP MD
	GEORGIA,JEFFREY MD
	GERSH,STEVEN DPM
	GERSTENBLITH,DANIEL DPM
	GIARDINA,VITO N DPM
	GITLITZ,DAVID B MD
	GIUSTO,LAURA MD
	GLASER,STEPHEN R MD
	GOBRIAL,EVEIT E MD
	GOLDFARB,ROBERT A MD
	GOLDMAN,MICHAEL H MD

Providers covered by FAP	Providers not covered by FAP
	GOMA,MONIQUE L MD
	GORMLEY,PAUL E MD
	GRAHAM, JR.,CHARLES R MD
	GREEN-SU,FRANCES M MD
	GROCHMAL,JAY C MD
	GROSSO,NICHOLAS MD
	GRUNEBERG,SHERRI L MD
	GUARDIANI,ELIZABETH A MD
	GURETZKY,TARA MD
	HABIB,FADI M.D.
	HAJJ,SAMAR J MD
	HAMMOND,SHARICE MD
	HANSEN,CHRISTIAN H MD
	HAROUN,RAYMOND I MD
	HATTEN,KYLE M MD
	HAYWARD,GERALD MD
	HEBERT,ANDREA M MD
	HECTOR,ROGER M.D.
	HENNESSY,ROBERT G MD
	HENRY,GAVIN MD
	HERTZANO,RONNA MD
	HESSAN,HOWARD S MD
	HEYMAN,MEYER R MD
	HICKEN,WILLIAM J MD
	HILL,TERRI MD
	HOCHULI,STEPHAN U MD
	HOFERT,SHEILA MD
	HORMOZI,DARAB MD
	HUANG,LIGUANG M.D.
	HUDES,RICHARD MD
	HUNDLEY,JEAN C MD
	HUNT,NICOLE A MD
	IM,DWIGHT D MD
	IMIRU,ABEBE MD
	ISAIAH,AMAL MD
	IWEALA,UCHECHI A MD

Providers covered by FAP	Providers not covered by FAP
	JACKSON,PRUDENCE MD
	JACOB,ASHOK C MD
	JACOBS,MARIANNE B DO
	JANZ,BRIAN A MD
	JOHNSON,GLEN E MD
	JULKA,SURJIT S MD
	JUSTICZ,NATALIE S MD
	KAHL,LAUREN MD
	KALLMEYER,GABRIELLE A
	FNP KALRA,KAVITA B MD
	KANTER,MITCHEL A MD
	KANTER,WILLIAM R MD
	KEATING,SHAUGHN T MD
	KHAN,JAVEED MD
	KHAN,RAO A MD
	KHULPATEEA,BEMAN R MD
	KHURANA,ARUNA Y MD
	KIM,CHRISTOPHER MD
	KIM,LISA MD
	KIM,SOON JA MD
	KIRONJI,ANTONY G MD
	KLEBANOW,KENNETH M MD
	KLEINMAN,BENJAMIN DPM
	KNAISH,KINAN MD
	KOLI,EMMANUEL N MD
	KOPACK,ANGELA M MD
	KUMAR,RAMESH MD
	KUPPUSAMY,TAMIL S MD
	LAFFERMAN,JEFFREY MD
	LALA,PADMA M MD
	LAL,BRAJESH K M.D.
	LANCELOTTA,CHARLES J MD
	LANDIS,JEFFREY T MD
	LANDRUM,B. MARK MD
	LANDRUM,DIANNE J MD
	LANDSMAN,JENNIFER MD

Providers covered by FAP	Providers not covered by FAP
	LANE,ANNE D MD
	LANGER,KENNETH F MD
	LANTZ,JENNIFER MS, CCC/A
	LEBLANC,DIANA M.D.
	LEE,CHEE H MD
	LEE,DANA M MD
	LENING,CHRISTOPHER B MD
	LEVIN,BRIAN M MD
	LEVY,DAVID MD
	LIANG,DANNY MD
	LIM,JOSHUA J MD
	LIN,ANNIE Z MD
	LIPTON,MARC DPM
	LI,ROBIN Z MD
	LIU,JIA MD
	LONG,ADRIAN E MD
	LOTLIKAR,JEFFREY P MD
	LOWDER,GERARD M MD
	LUMPKINS,KIMBERLY M. M.D.
	MACIEJEWSKI,SHARON PT
	MADDEN,JOSHUA S MD
	MAKONNEN,ZELALEM MD
	MALLALIEU,JARED DO
	MALONEY,PATRICK MD
	MAMO,GEORGE J MD
	MANDIR,ALLEN S MD
	MATSUNAGA,MARK T MD
	MAUNG,CHO C MD
	MAUNG,TIN O MD
	MAYO,LINDA D OTS
	MCCARUS,DAVID MD
	MCCARVILLE,PATRICK B MD
	MCCORMACK,SHARON J MD
	MEDWIN,IRINA MD
	MEININGER,GLENN R MD
	MIDDLETON,JEFFREY G MD

Providers covered by FAP	Providers not covered by FAP
	MILLER,KAREN J MD
	MILLER,PAUL R MD
	MINAHAN,ROBERT E M.D., JR
	MITCHERLING,JOHN J DDS
	MITCHERLING,WILLIAM W DDS
	MOORE,JAMES T MD
	MOORE,ROBERT F M.D.
	MORGAN,ATHOL W MD
	MOUSSAIDE,GHITA MD
	MUMTAZ,M. ANWAR MD
	MURPHY,ANNE MD
	MURTHY,KALPANA MD
	MYDLARZ,WOJCIECH MD
	NAKAZAWA,HIROSHI MD
	NALLU,ANITHA M.D.
	NARAYEN,GEETANJALI MD
	NARAYEN,VIJAY MD
	NEUNER,GEOFFREY MD
	NEUZIL,DANIEL F MD
	NGUYEN,HUONG MD
	NUCKOLS,JOSEPH MD
	O'BRIEN,CAITLIN MD
	O'CONNOR,MEGHAN P MD
	ODUYEBO,TITILOPE M.D.
	OLLAYOS,CURTIS MD
	OTTO,DAVID I MD
	OTTO,JAMES MD
	OWENS,KERRY MD
	OWUSU-ANTWI,KOFI MD
	OWUSU-SAKYI,JOSEPHINE MD
	PAIVANAS,BRITTANY M MD
	PARIKH,JYOTIN MD
	PARK,CHARLES MD
	PASS,CAROLYN J MD
	PASUMARTHY,ANITA MD
	PATAKI,ANDREW M MD

Providers covered by FAP	Providers not covered by FAP
	PATEL,ANOOP MD
	PATEL,JANKI MD
	PATEL,KRUTI N MD
	PEREZ,DANIEL DPM
	PERVAIZ,KHURRAM MD
	PETERS,MATTHEW N MD
	PETIT,LISA MD
	PIEPRZAK,MARY A MD
	PIROUZ,BABAK MD
	POLSKY,MORRIS B MD
	POMERANTZ,RICHARD M MD
	POON,THAW MD
	POULTON,SCOTT C MD
	PRESTI,MICHAEL S DPM
	PULLMANN,RUDOLF MD
	PURDY,ANGEL MD
	QURESHI,JAZIBETH A MD
	RAIKAR,RAJESH V MD
	RAJA,GEETHA MD
	RANKIN,ROBERT MD
	RAVEKES,WILLIAM MD
	RAVENDHRAN,NATARAJAN MD
	REDDY,ANURADHA MD
	REED,ANN MD
	REHMAN,MALIK A MD
	REILLY,CHRISTINE MD
	REINER,BARRY J MD
	REMY,KENNETH MD
	REYAL,FARHANA S MD
	RIAZ,AWAIS MD
	RICHARDSON,LEONARD A MD
	ROBERTSON,KAISER MD
	ROSEN,DANIEL C MD
	ROTH,JOHN DPM
	RUSSELL,JONATHON O MD
	RYU,HYUNG MD

Providers covered by FAP	Providers not covered by FAP
	SABOURY SICHANI,BABAK MD
	SAIEDY,SAMER MD
	SAINI,ANJALI MD
	SAINI,RUMNEET K MD
	SALAS,LOUIS MD
	SALAZAR,ANDRES E MD
	SALENGER,RAWN V MD
	SALIM,MUBADDA MD
	SALVO,EUGENE C MD
	SANDERSON,SEAN O M.D.
	SANDHU,RUPINDER MD
	SANGHAVI,MILAN MD
	SANTOS,MARIA L MD
	SARDANA,NEERAJ MD
	SAVAGE,ANGELA Y DPM
	SCHNEE,CHARLES MD
	SCHNEYER,MARK MD
	SEIBEL,JEFFREY L MD
	SHAH,BANSARI H M.D.
	SHAIKH,NAOMI N MD
	SHAPIRO,BRUCE K
	SHEEHAN,CHARLES E M.D.
	SHORTS,ALISON MSCCC-SLP
	SHUSTER,JERI MD
	SIEGEL,ELIOT L MD
	SILBER,GLENN MD
	SILBER,MOLLY H MD
	SILHAN,LEANN MD
	SILVERSTEIN,SCOTT MD
	SIMLOTE,KAPIL MD
	SIMMONS,SHELTON MD
	SIMO,ARMEL MD
	SINGH,GURTEJ MD
	SINNO,FADY MD
	SKLAR,GEOFFREY MD
	SMENTKOWSKI,KATHERINE E MD

Providers covered by FAP	Providers not covered by FAP
	SMITH,BRANDON M MD
	SMITH,RACHELLE MD
	SMITH,WARREN J MD
	SNOW,GRACE E MD
	SOILEAU-BURKE,MONIQUE J MD
	SOLOMON,MISSALE MD
	SOMERVILLE,JUSTIN C MD
	SPEVAK,PHILIP J MD
	STEINER-LARSEN,VICTORIA E MD
	STERN,MELVIN S MD
	STEWART,SHELBY J MD
	STRAUCH,ERIC MD
	SUNDEL,ERIC M.D.
	SURMAK,ANDREW J MD
	SWANTON,EDWARD MD
	SWETT,JEFFREY T DO
	SYDNEY,SAM V MD
	TANSINDA,JAMES MD
	TAYLOR,AISHA K MD
	TAYLOR,RODNEY J MD
	THOMAS,RADCLIFFE MD
	THOMPSON III,WILLIAM R MD
	TOLLEY,MATTHEW DPM
	TUCHMAN,DAVID N MD
	TURAKHIA,BIPIN K MD
	TURNER,GAURI J M.D.
	TUUR-SAUNDERS,SYLVANA MD
	TWIGG,AARON MD
	UCUZIAN,ARECK A MD
	UDOCHI,NJIDEKA MD
	VAKHARIA,KALPESH T MD
	VALLECILLO,JORGE MD
	VAN DEN BROEK,JEFFREY W DO
	VASANTHAKUMAR,MUTHUKRISHNAN MD
	VOIGT,ROGER W MD
	VON WALDNER,CHRISTINA A LCPC

Providers covered by FAP	Providers not covered by FAP
	WALLACE,MICHAEL MD
	WALTROUS,JUSTIN D MD
	WARDEN,MARJORIE K MD
	WARD,FRANCISCO A DO
	WHIPPS,RANDOLPH G MD
	WHITE,PATRICK W MD
	WICKRAMARATNE,KANTHI MD
	WILLIAMS,SAMUEL R MD
	WINAKUR,SHANNON MD
	WOLF,JEFFREY S MD
	WOLLNEY,DANA E MD
	WONG,MATTHEW H MD
	WORMSER,BENJAMIN K MD
	XIE,KE MD
	YI,MING MD
	YIM,KENNETH MD
	YU,WARREN D. M.D.
	ZADE,RALPH MD
	ZAIM,BULENT R MD
	ZHANG,LINDY MD
	ZHAO,JUN MD
	ZHU,WEIMIN MD
	ZUNIGA,LUIS M MD

AMOUNT GENERALLY BILLED CALCULATION

Ascension Saint Agnes calculates two AGB percentages – one for hospital facility charges and one for professional fees – both using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with IRS Reg. Sec. 1.501(r)-5(b)(3), 1.501(r)-5(b)(3)(ii)(B) and 1.501(r)-5(b)(3)(iii). The details of those calculations and AGB percentages are described below.

The AGB percentages for Ascension Saint Agnes are as follows:

AGB for hospital facility charges: 93.1%
AGB for physicians' professional fees: 50.7%

These AGB percentages are calculated by dividing the sum of the amounts of all of the hospital facility's claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility (separately for facility charges and professional services) by the sum of the associated gross charges for those claims. The only claims that are utilized for purposes of determining the AGB are those that were allowed by a health insurer during the

12-month period prior to the AGB calculation (rather than those claims that relate to care provided during the prior 12 months).

*Notwithstanding the foregoing AGB calculation, Saint Agnes Health Care has chosen to apply a lower AGB percentage for hospital facility charges as follows:
AGB: 88.55%

Ascension Saint Agnes

Ascension Saint Agnes Hospital, Ascension Medical Group, Seton Imaging, Lab Outreach, Integrated Specialist Group, Radiologists Professional Services, Anesthesia Professional Services

Summary of Financial Assistance Policy

Ascension Saint Agnes, including the health ministries listed above, have a commitment to and respect for each person's dignity with a special concern for those who struggle with barriers to access healthcare services.
Ascension Saint Agnes has an equal commitment to manage its healthcare resources as a service to the entire community. In furtherance of these principles, Ascension Saint Agnes provides financial assistance for certain individuals who receive emergency or other medically necessary care from Ascension Saint Agnes. This summary provides a brief overview of Ascension Saint Agnes's Financial Assistance Policy.

Who Is Eligible?
You may be able to get financial assistance if you live in Arbutus 21227, Brooklyn/Linthicum,21225, Catonsville 21250,21228, Curtis Bay 21226, Gwynn Oak 21207, South Baltimore City 21223,21230, Southwest Baltimore City 21229, West Baltimore City 21215,21216,21217. Financial assistance is generally determined by your total household income as compared to the Federal Poverty Level. If your income is less than or equal to 250% of the Federal Poverty Level, you may receive a 100% charity care write-off on the portion of the charges for which you are responsible. If your income is above 250% of the Federal Poverty Level but does not exceed 500% of the Federal Poverty Level, you may receive discounted rates on a sliding scale or a based on a means test. If you have medical debt for emergency and medically necessary care that exceeds your income, you may be eligible for a discount. If you have assets in excess of 250% of your Federal Poverty Level income amount you may not qualify for financial assistance. Patients who are eligible for financial assistance will not be charged more than the charges minus the hospital mark-up or the amounts generally billed to patients with insurance coverage, whichever is less.

Written Estimate.
Patients shall have the right to request and receive a written estimate of the total charges for hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided for professional services by the hospital.

What Services Are Covered?
The Financial Assistance Policy applies to emergency and other medically necessary care. Physician charges are not included in the hospital bill and will be billed separately. These terms are defined in the Financial Assistance Policy. All other care is not covered by the Financial Assistance Policy.

How Can I Apply?
To apply for financial assistance, you typically will complete a written application and provide supporting documentation, as described in the Financial Assistance Policy and the Financial Assistance Policy application. For an application, please contact 667-234-2140.

How Can I Get Help with an Application?
For help with a Financial Assistance Policy application, you may contact Patient Financial Services at

667-2342140, the Maryland Medical Assistance at 1-855-642-8572 or internet www.dhr.state.md.us, or your local Department of Social Services by phone 1-800-332-6347; TTY: 1-800-925-4434.

How Can I Get More Information?
Copies of the Financial Assistance Policy and Financial Assistance Policy application form are available at https://healthcare.ascension.org/Locations/Maryland/MDBAL/Baltimore-Saint-Agnes-Hospital and at 900 S. Caton Avenue, Baltimore, MD 21229, Patient Financial Services Department. Free copies of the Financial Assistance Policy and Financial Assistance Application also can be obtained by mail by contacting the Patient Financial Services Department at 667-234-2140.

What If I Am Not Eligible?
If you do not qualify for financial assistance under the Financial Assistance Policy, you may qualify for other types of assistance. For more information, please contact Patient Financial Services Department, 900 S. Caton Avenue, Baltimore, MD 21229 or by telephone at 667-234-2140.

Payment Plans
Ascension Saint Agnes Hospital offers payment plans to help you pay your medical bills. For more information, please contact the Customer Service Department at 667-234-2175.

Acknowledgment
I have received the above plain language summary of the Ascension Saint Agnes Financial Assistance Policy and understand my rights under the Policy.

Please Initial: [Initials will be collected on the general consent form].

Translations of the Financial Assistance Policy, the Financial Assistance Application and instructions, and this plain language summary are available in the following languages on our website and upon request:

Arabic
Burmese
Chinese (Simplified)
Chinese (Traditional)
English
French
Gujarati
Italian
Korean
Russian
Spanish
Tagalog
Urdu
Vietnamese

[1] Pursuant to Maryland Code Section 19-214.1(b)(2)(i), Patients income shall be calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided.
[2] Pursuant to Maryland Code Section 19-214.2(c)(1-3), if Organization discovers that Patient was eligible for free care on a specific date of service (using Organization's eligibility standards applicable on that date of service) and that specific date is within a two (2) year period of discovery, the patient shall be refunded amounts the Organization received from Patient or Patient's guarantor exceeding twenty-five dollars. If Organization documents a lack of cooperation from the patient or guarantor in providing information needed to determine Patient's eligibility for free care, the two (2) year period may be reduced to thirty (30) days from the

date of initial request for Patient's information. If the Patient is enrolled in a means-tested government health plan that requires Patient to pay out-of-pocket healthcare expenses, then Patient shall not be refunded any amount that may result in patient losing financial eligibility for such health plan coverage.

[3] Pursuant to Maryland Code Section 19-214.1(b)(2)(ii), Patient income shall be calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided.

[4] Pursuant to COMAR .26 (A-2)(8) and Maryland Statutes Section 19-213-1(b)(8)(ii), the following assets that are convertible to cash shall be excluded from the Asset Test: (1) the first $10,000 of monetary assets; (2) a "Safe harbor" equity of $150,000 in a primary residence; (3) retirement assets to which the IRS has granted preferential tax treatment as a retirement account, including, but not limited to, deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans; (4) one motor vehicle used for the transportation needs of the patient or any family member of the patient; (5) any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and (6) prepaid higher education funds in a Maryland 529 Program account. The monetary assets excluded from the determination of eligibility under this Financial Assistance Policy shall be adjusted annually for inflation in accordance with the Consumer Price Index.

Attachments

Letter of Support

From: Hilltop HCB Help Account
To: Hilltop HCB Help Account; "cmullini@ascension.org"; Olivia Farrow
Subject: Clarification Required - Saint Agnes FY 21 Community Benefit Narrative
Date: Thursday, May 19, 2022 4:38:05 PM
Attachments: St Agnes Hospital_HCBNarrative_FY2021_20220228.pdf

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Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for Saint Agnes Healthcare, Inc. In reviewing the narrative, we encountered an item that requires clarification:

- Your response to Question 218 on page 22 indicated gaps in the availability of OB/GYN, psychiatry, radiology, and intensivist physician types. However, these physician types were not included in the itemized physician subsidies tab in your hospital's community benefit financial report. Please clarify this discrepancy.

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