Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

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

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

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

- [ ] Other. Please describe.

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

https://www.lifebridgehealth.org/main/about

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)

6/30/2020

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

https://www.lifebridgehealth.org/main/community-health

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

GraceCHNA 2020.pdf
2.2MB
application/pdf

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (●) Yes
- ( ) No

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

4/29/2021

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

https://www.lifebridgehealth.org/main/community-health

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

Grace Implement Plan 2020.pdf
172.5KB
application/pdf

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

This question was not displayed to the respondent.

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

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

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

- (●) Yes
- ( ) No

Q58.
Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q59. Why were these needs unaddressed?

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q63. Section III - CB Administration

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

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

Q65. Please describe the third party audit process used.

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q67. Please describe the community benefit narrative audit process.

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

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

- (●) Yes
- ( ) No

Q69. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q71. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

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

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

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

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

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

  Regular diabetes management classes promoted and provided to community members each month (telephonically and in-person) including on topics to reduce BMI like healthy eating and exercise.

- [x] Opioid Use Disorder - Improve overdose mortality

  SBIRT Program: Peer recovery coaches in Emergency Departments connect Substance Use Disorder (SUD) patients with treatment and community resources. The Grace Medical Center Emergency Department refers SUD patients who are ready to get clean into New Hope. New Hope provides individuals with counseling and helps with employment.

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

- [x]

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

Providers assist families to get them access to asthma management resources, inhalers and regular preventive care to prevent future asthma-related ED visits.

- [ ] None of the Above

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

Q77. Section IV - Physician Gaps & Subsidies

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

- ( ) No
- (•) Yes

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q82. Section VI - Financial Assistance Policy (FAP)

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

LBH Hospital Information Sheet 220302_ENGLISH.pdf
184.8KB
application/pdf

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

https://www.lifebridgehealth.org/main/financial-assistance

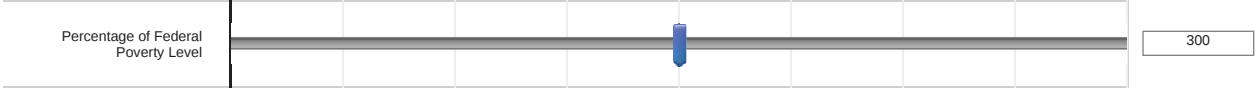
Q85. Has your FAP changed within the last year? If so, please describe the change.

- (•) No, the FAP has not changed.
- ( ) Yes, the FAP has changed. Please describe:

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

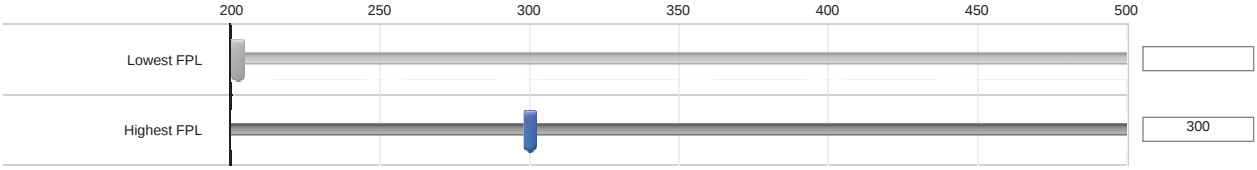
Please select the percentage of FPL below which your hospital's FAP offers free care.

100 150 200 250 300 350 400 450 500



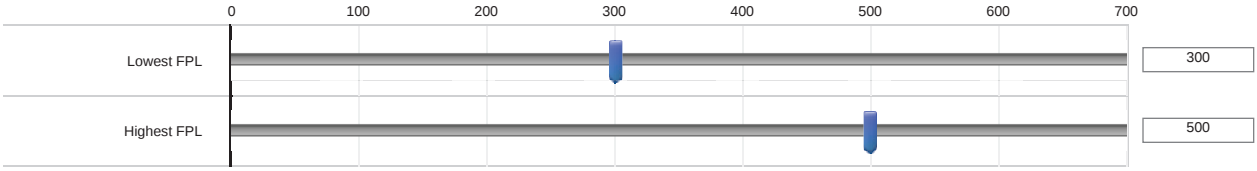
Q87. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

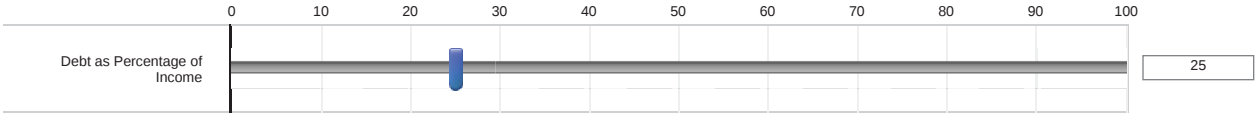


Q88. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health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

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



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



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

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

Q91. Summary & Report Submission

Q92.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (38.2539, -85.76)

Source: GeoIP Estimation

LifeBridge Health

Grace Medical Center

Community Health Needs Assessment

2021

Executive Summary

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

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

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

2019 Community Health Needs Assessment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Participants highlighted the following themes as top health concerns:

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

The leading social and environmental barriers referenced were:

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

The top reasons for not accessing healthcare services included:

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

Increased barriers as a result of COVID-19 include:

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

Suggestions made to improve health or healthcare systems were:

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

West Baltimore Priority Health Needs

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

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

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

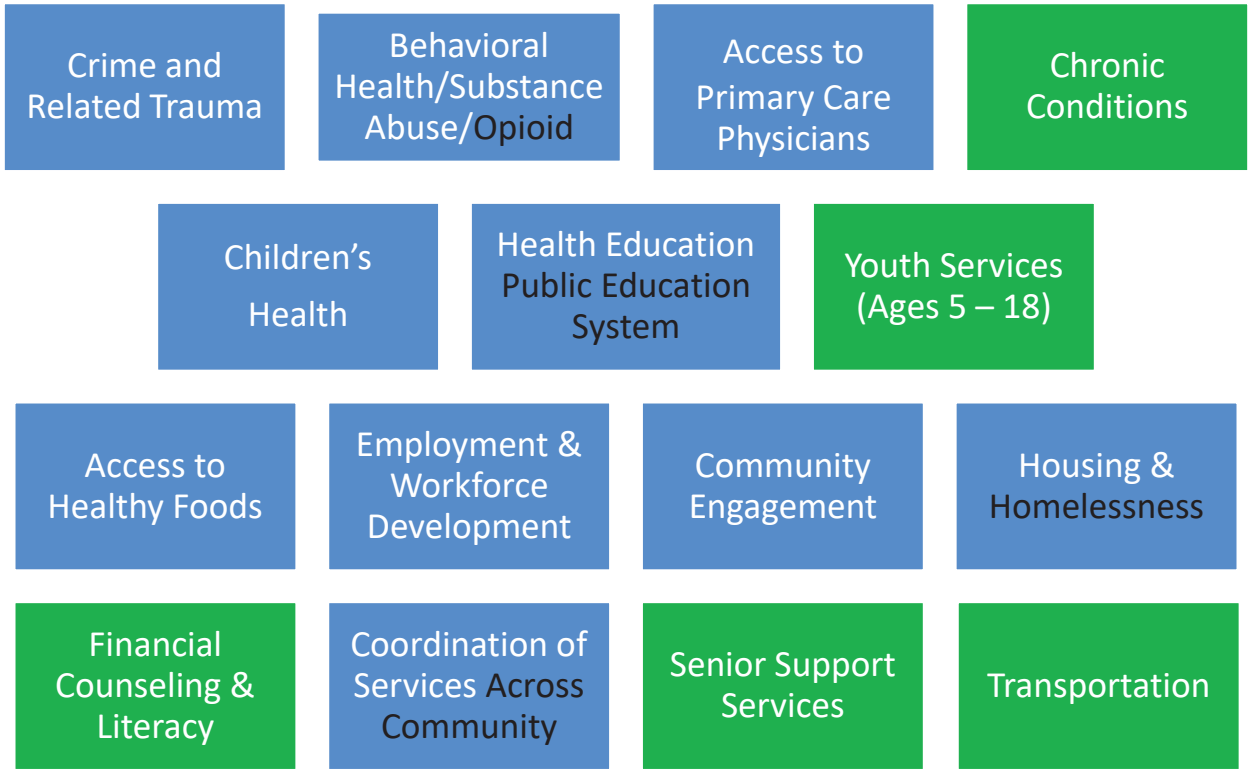


Figure 1 – Identified Needs of Community Served

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

The following criteria were used to prioritize the community needs:

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

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

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

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

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

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

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

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

Grace Medical Center CHNA Implementation Plan

Health

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

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

Leader:	Dr. Nicole Wagner

Health

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

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

Health

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

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

Social and Environmental

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

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

Social and Environmental

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

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

Access

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

2019 Community Health Needs Assessment

1 Purpose of the CHNA Report

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

1.1 Federal CHNA Requirement

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

The IRS describes a CHNA as:

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

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

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

1.2 Comments on FY2016 CHNA Report and Implementation Plan

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

2 Impact of Implementation Plan (2016 – 2019)

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

Healthy People

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Healthy Economy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Healthy Environment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mission

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

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

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

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

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

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

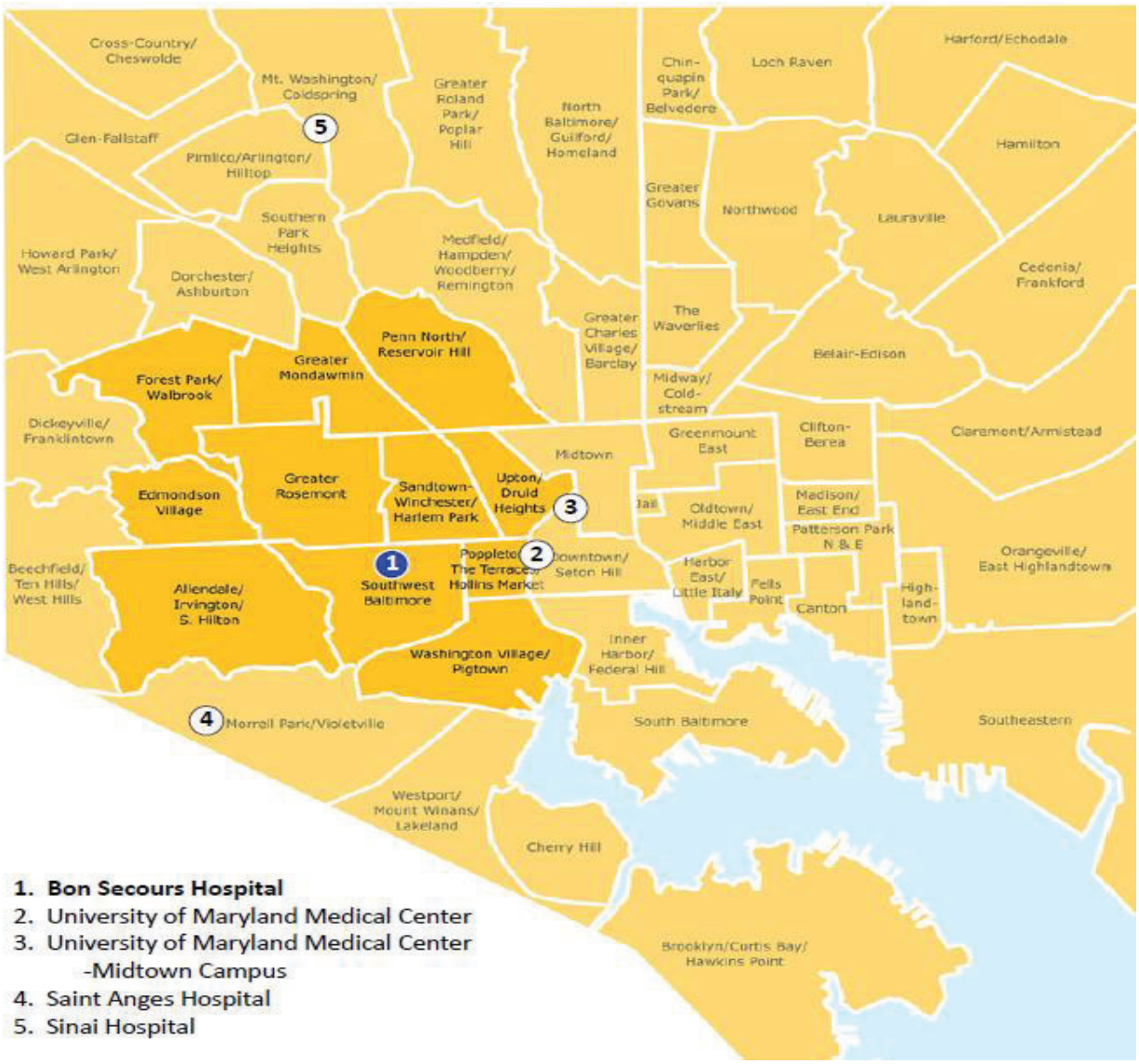
- **Unity Properties** is the housing and community development subsidiary, providing safe and affordable housing to low-income families, seniors and people with disabilities. Together, their supportive programs integrate with Bon Secours' health care services to make positive changes in individuals'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

3.1 Description of the Community Served

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

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

Figure 2 - Bon Secours Primary Service Area



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

Service Area Demographics

Population

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

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

Table 1 – Service Area Population

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

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

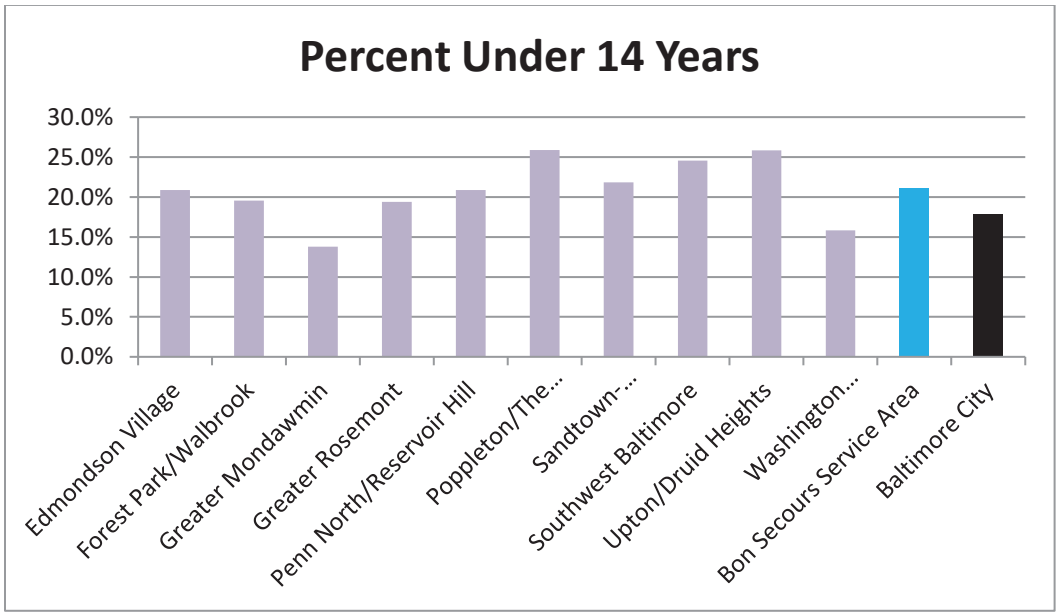
The service area is similar to Baltimore City in regards to gender with females constituting 53.5% and males 46.5% of the population. City-wide, males are 47% of the population.

Age

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

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

Figure 3 – Population Under Age 14



Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute

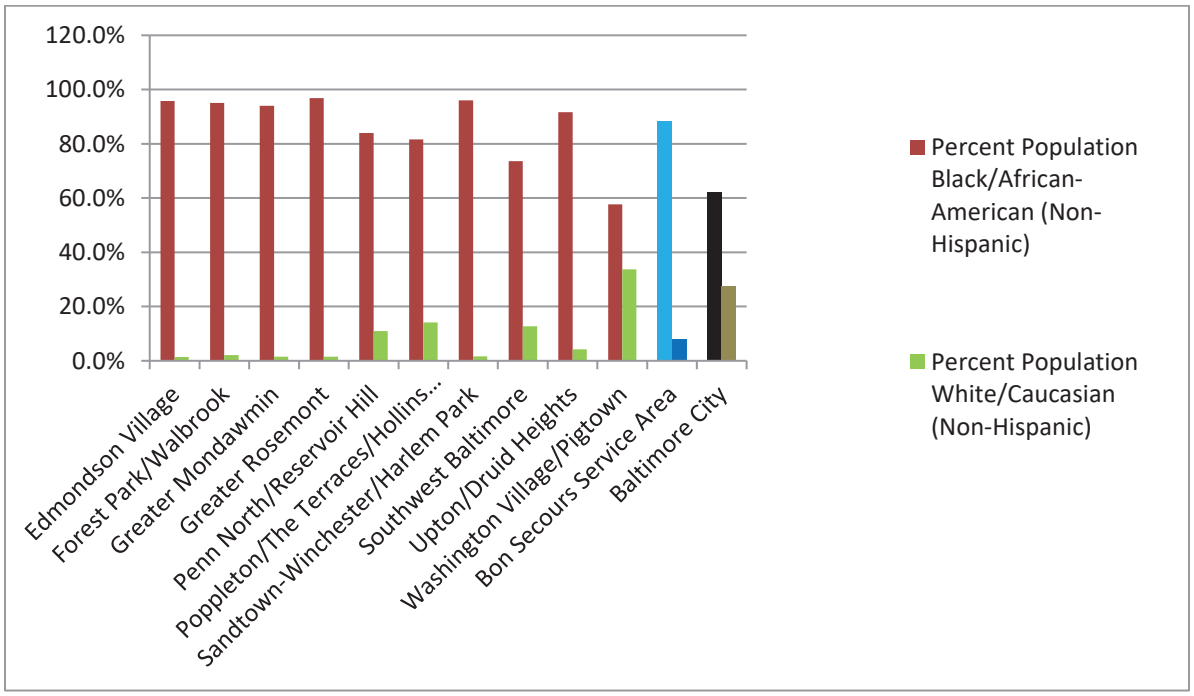
In addition, there are significant differences with regard to race/ethnicity, income, and access to insurance (Income will be discussed within the Socio-Economic section). Overall, the service area is a substantially African American, of lower income, and either uninsured or publicly insured.

Race/Ethnicity

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

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

Figure 4 – Race/Ethnicity by CSA and Baltimore City

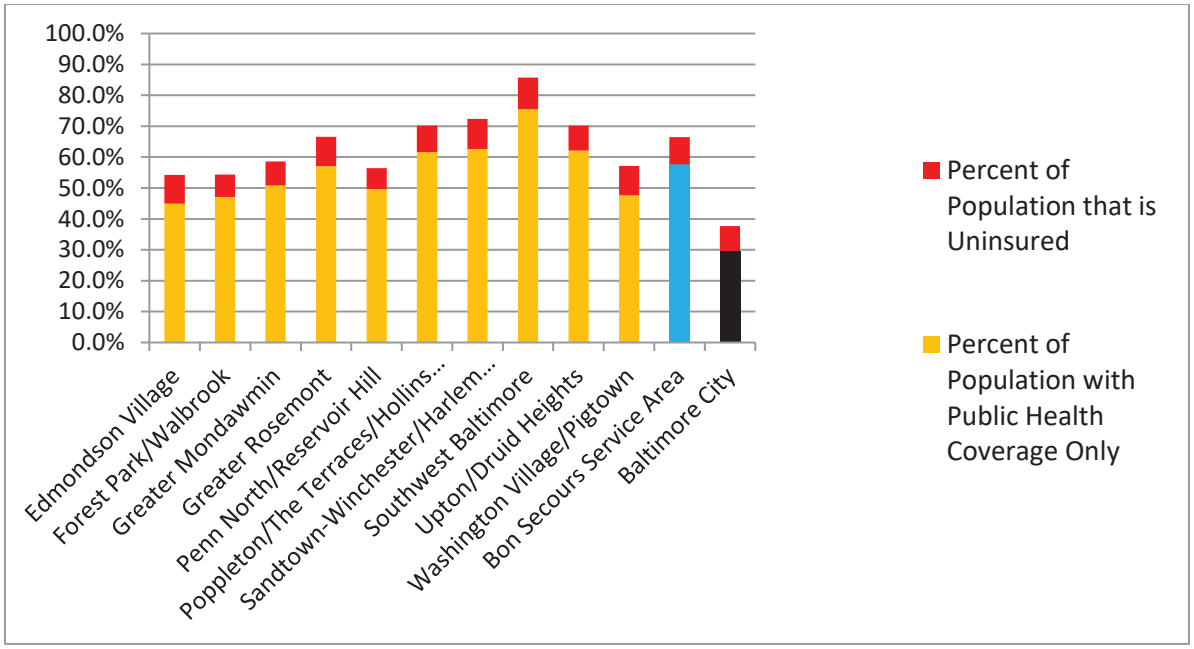


Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Access to Insurance

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

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



Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute

4 CHNA Approach and Methodology

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

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

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

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

Figure 6 - CHNA Requirement and Data Collection Methodology

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

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

5 Qualitative Findings

Stakeholder Interviews

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Focus Groups

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

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

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

The following issues/needs were recommended as significant Priorities:

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

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

Survey

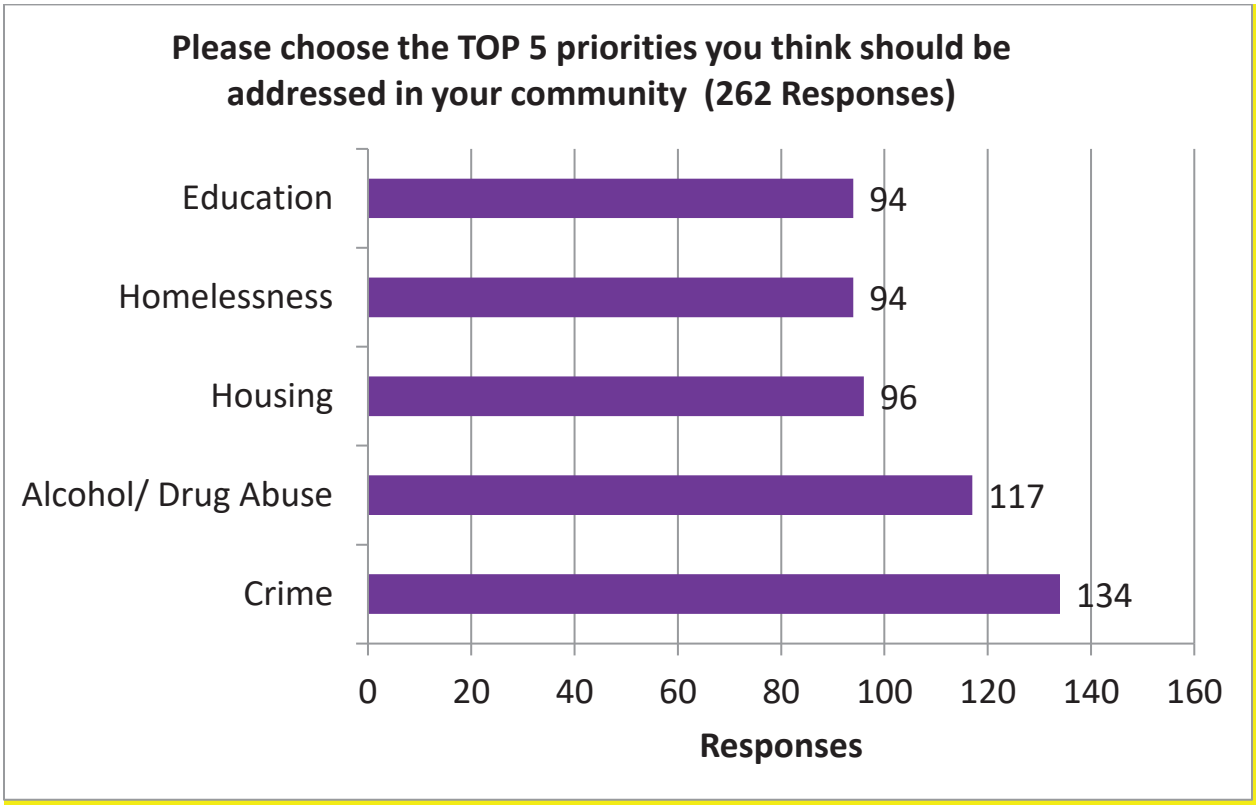
A web-based and hardcopy survey instrument used in 2016 to collect information from West Baltimore residents regarding their health and social needs was distributed again in 2019. The survey consisted of twenty-seven questions (both open and closed ended) covering the following categories: My Community,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

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

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

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

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



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

6 Secondary Data Analysis

Data Source

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

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

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

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

6.1 Health Outcomes

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

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

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

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

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

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

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

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

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

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

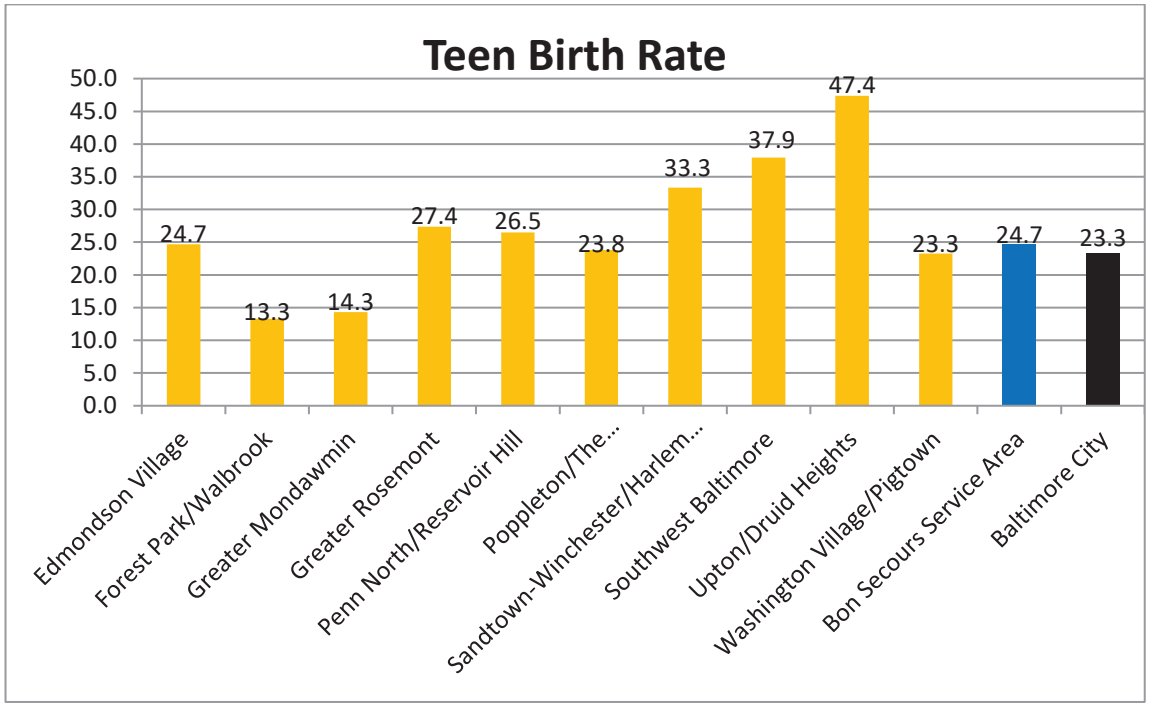
Table 5 – Infant Mortality Rate per 1,000 Live Births by CSA, Bon Secours Service Area and Baltimore City

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

Morbidity

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

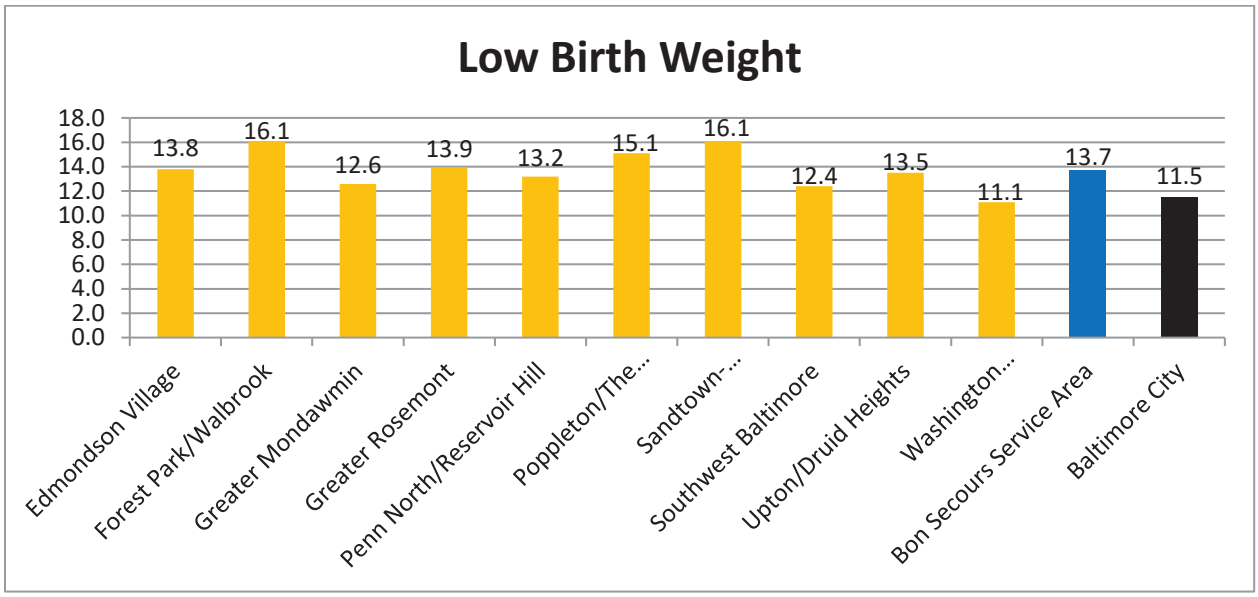
Figure 8 – Teen Births per 1,000 by CSA, Bon Secours Service Area, and Baltimore City



Source – Baltimore City Health Department

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

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



6.2 Social and Economic Factors

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

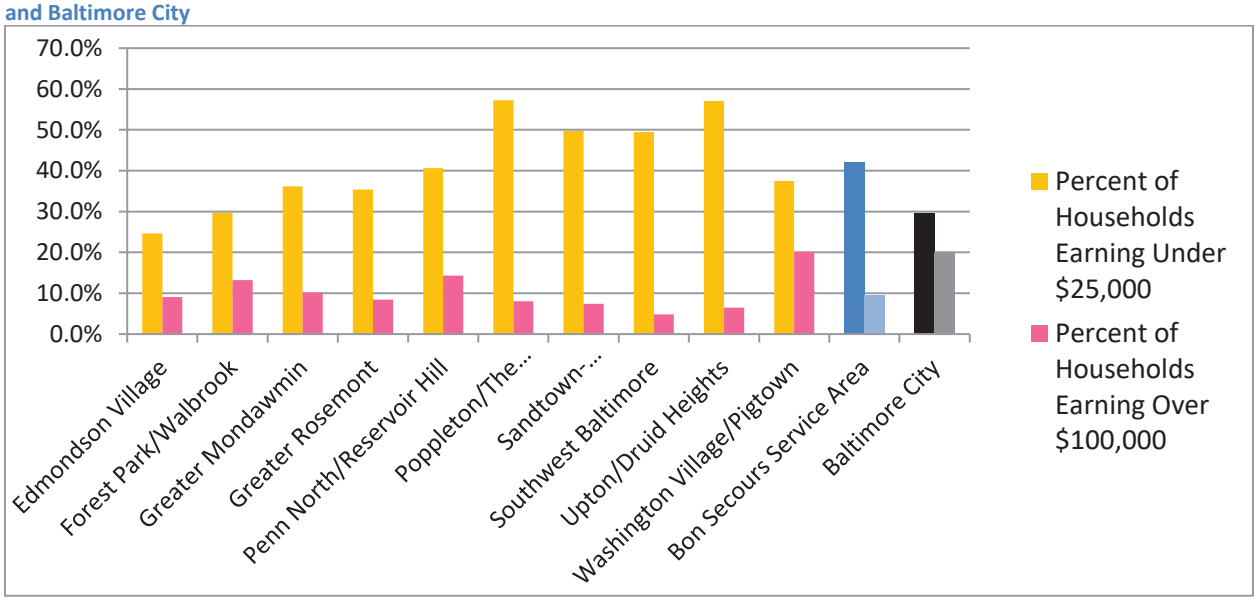
Inequalities exist among income, employment, education, and wealth gaps. The service area experiences more frequent crime and violence, and fewer affordable housing options than the City of Baltimore experiences as a whole. The deep poverty experienced by these residents has created conditions that undermine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

Household Income/Poverty/Unemployment

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

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

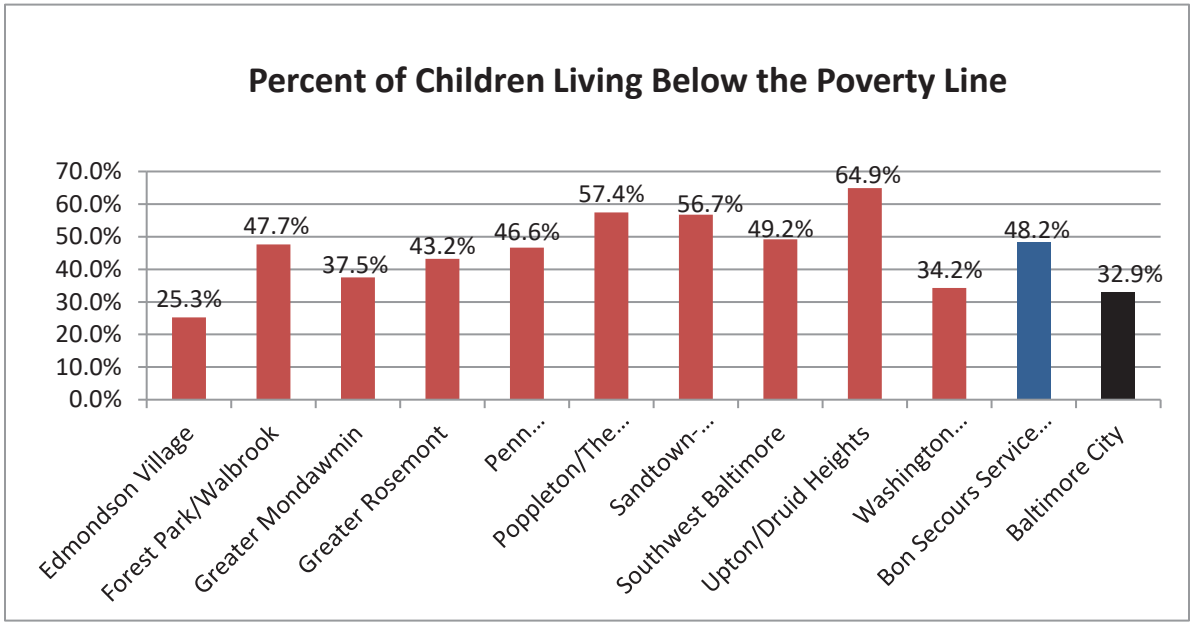
Figure 10 – Percentage of Households Earning less than $25,000 or greater than $100,000 by CSA, Bon Secours Service Area, and Baltimore City



Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

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

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



Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

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

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

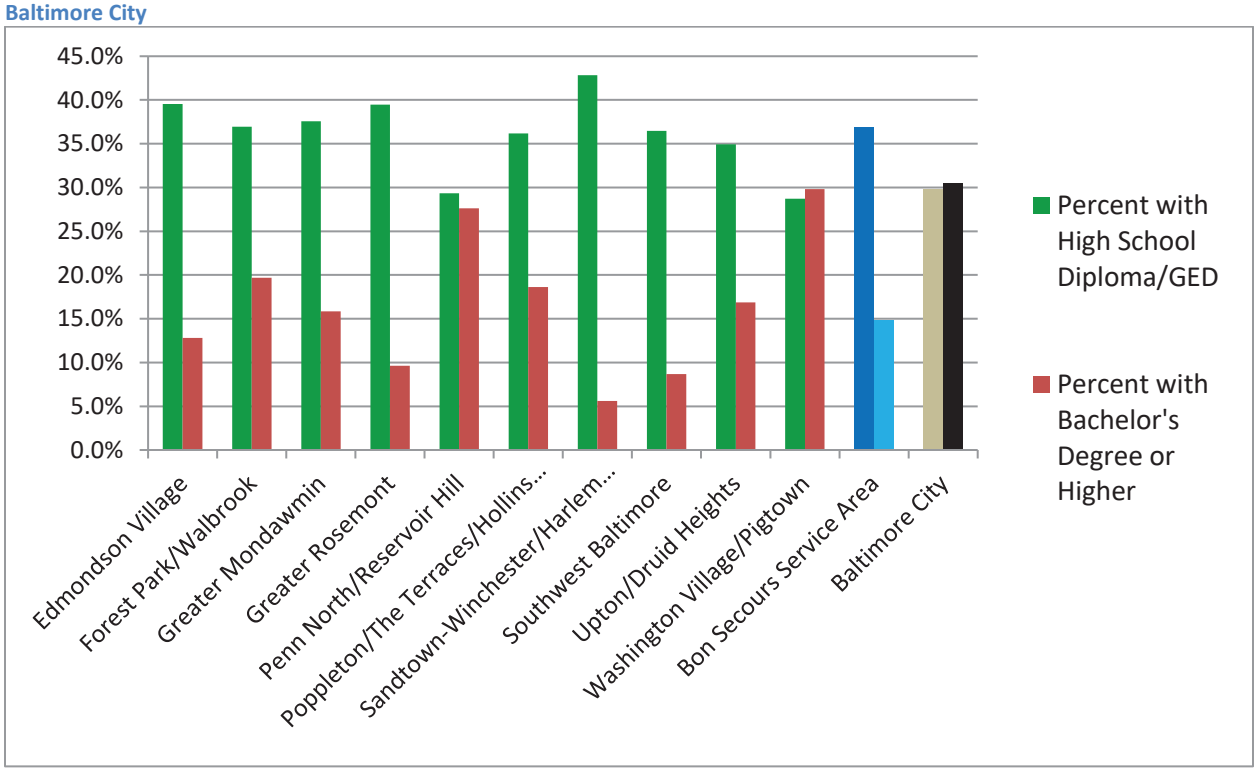
Community Statistical Area (CSA)	Unemployment rate, %
Edmondson Village	12.5%
Forest Park/Walbrook	11.4%
Greater Mondawmin	12.6%
Greater Rosemont	15.6%
Penn North/Reservoir Hill	12.0%
Poppleton/The Terraces/Hollins Market	16.1%
Sandtown-Winchester/Harlem Park	14.9%
Southwest Baltimore	15.1%
Upton/Druid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

Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Education Attainment

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

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

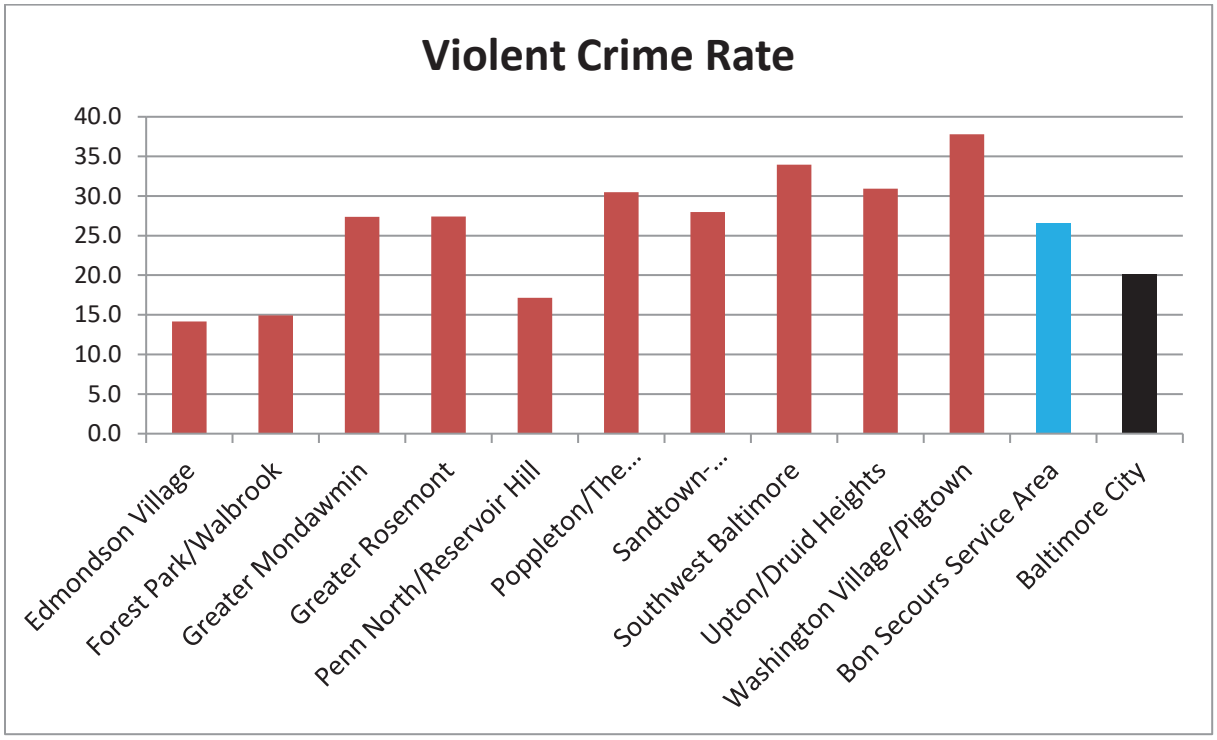


Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Violent Crime

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

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

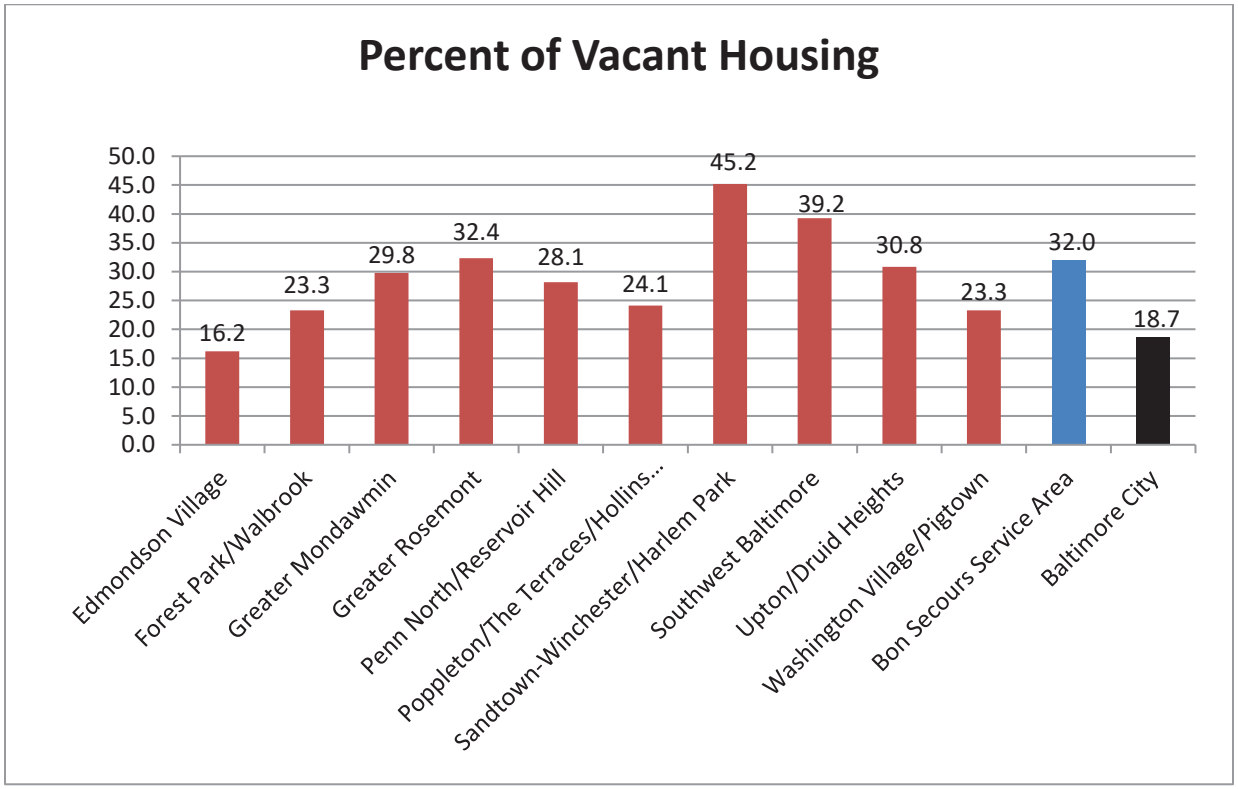


Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Housing Vacancy

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

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



Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

2-1-1 Calls

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

Hardship Index

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

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

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

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

7 West Baltimore Priority Health Needs

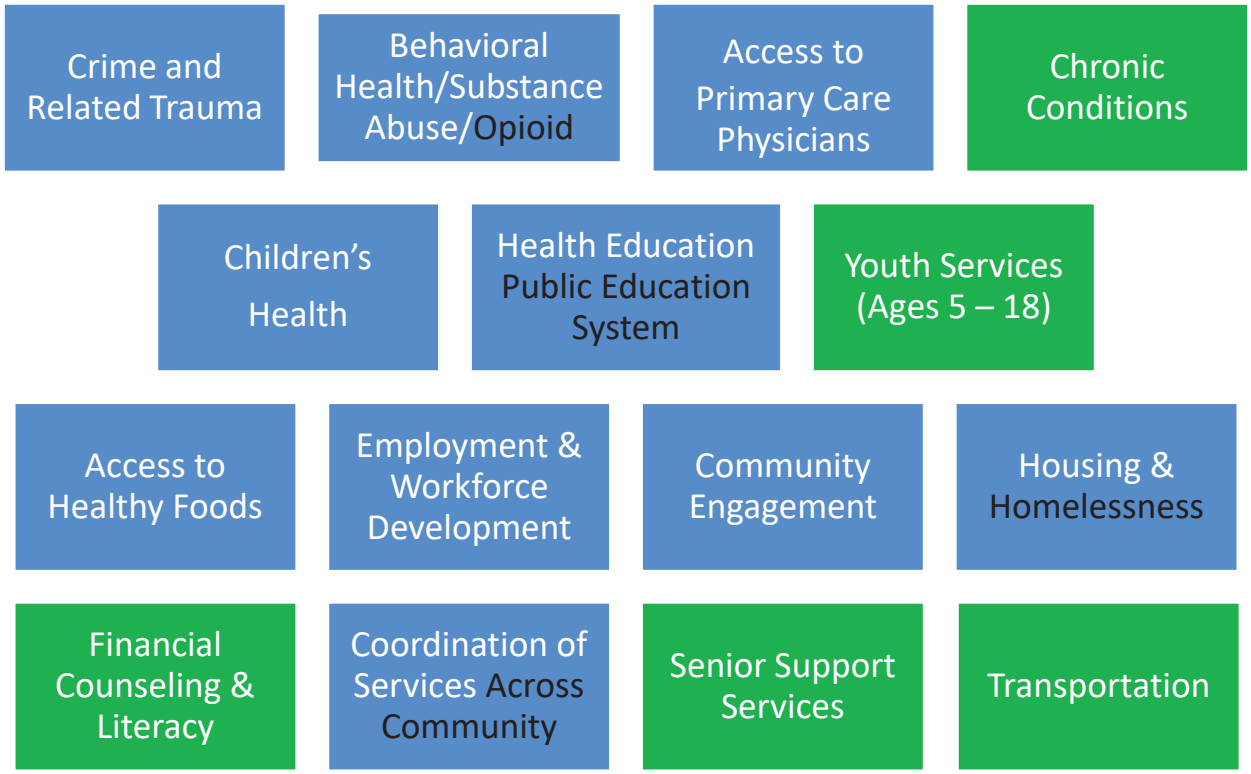
In 2016, Bon Secours Hospital identified the following health needs in the community:

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

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

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

Figure 15 – Identified Needs of Community Served



7.1 Prioritization Process and Criteria Used to Prioritize Needs

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

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

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

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

7.2 Priorities for 2019 - 2021

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

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

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

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

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

8 Resources Available Within the Community Served to Meet Identified Needs

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

Bon Secours New Hope Treatment Center

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

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

Bon Secours Family Support Center

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

Bon Secours Housing (Unity Properties)

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

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

Other community resources include:

PUBLIC HEALTH DEPARTMENTS

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

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

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

COMMUNITY HOSPITALS AND ACADEMIC MEDICAL CENTERS

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

SAFETY NET PROVIDERS

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

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

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

ACADEMIC AND WORKFORCE TRAINING RESOURCES

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

APPENDICES

Appendix 1 – Bon Secours CHNA Team

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

Appendix 2 – Community Advisory Board Members

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

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

Appendix 3 – Stakeholder Interview Questions

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

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

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

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

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

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

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

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

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

Appendix 4 – Stakeholders Interview List

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

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

Appendix 5 - Focus Group Notes

Substance Abuse & Mental Health Stakeholders - March 13, 2019

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

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

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

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

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

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

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

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

(Facilitator) "Magic Wand" Wish-list

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

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

(Facilitator) What needs to happen at the Macro Level

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

Community Focus Groups – April 5 and April 10, 2019

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

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

Healthy People

Feedback:

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

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

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

<u>Questions raised:</u>

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

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

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

Healthy Economy

Feedback:

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

What Else (Unmet Needs):

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

Healthy Environment

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

What Else (Unmet Needs):

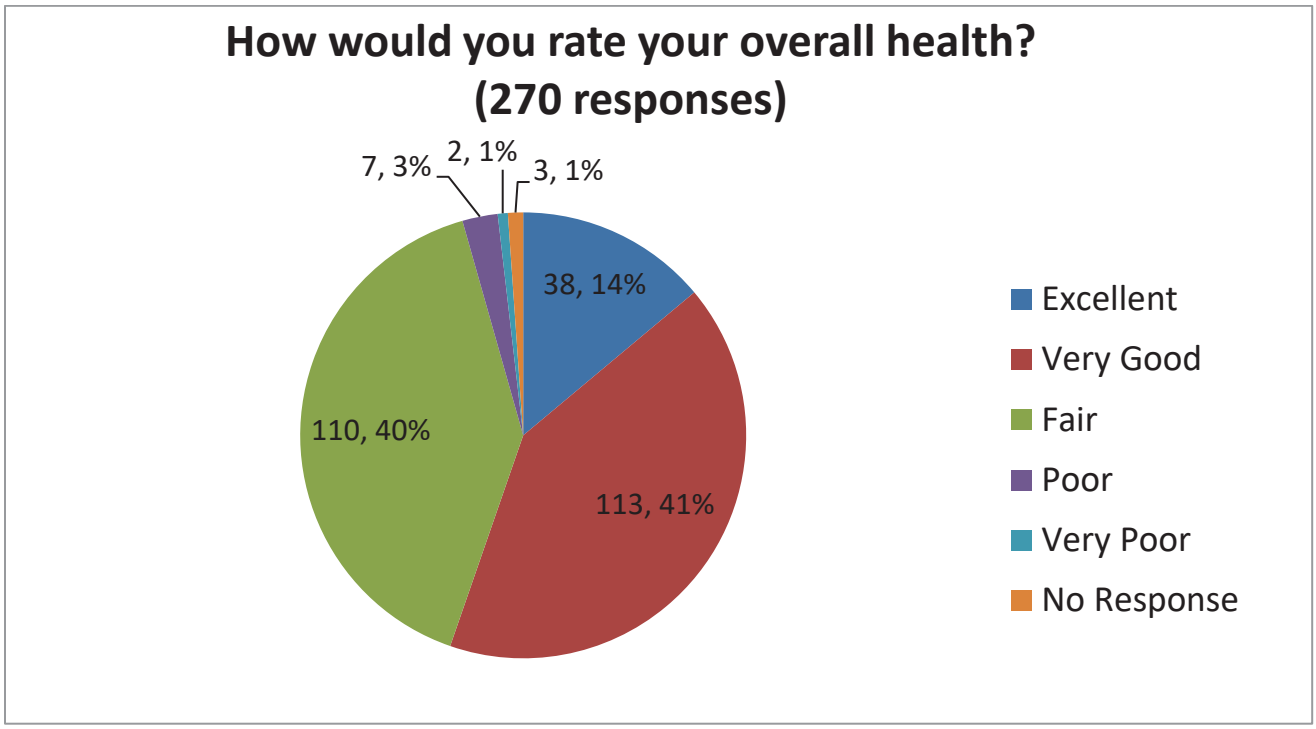
- Help to address Community cleanliness, work to end “dumping” on lots
- Expand environmental awareness
    - Climate change, storm water issues
- Work through Partnerships across community
- How to get kids to get involved in parks, both the clean-up and opportunities to play

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

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

Appendix 6 – CHNA Survey Results

1.



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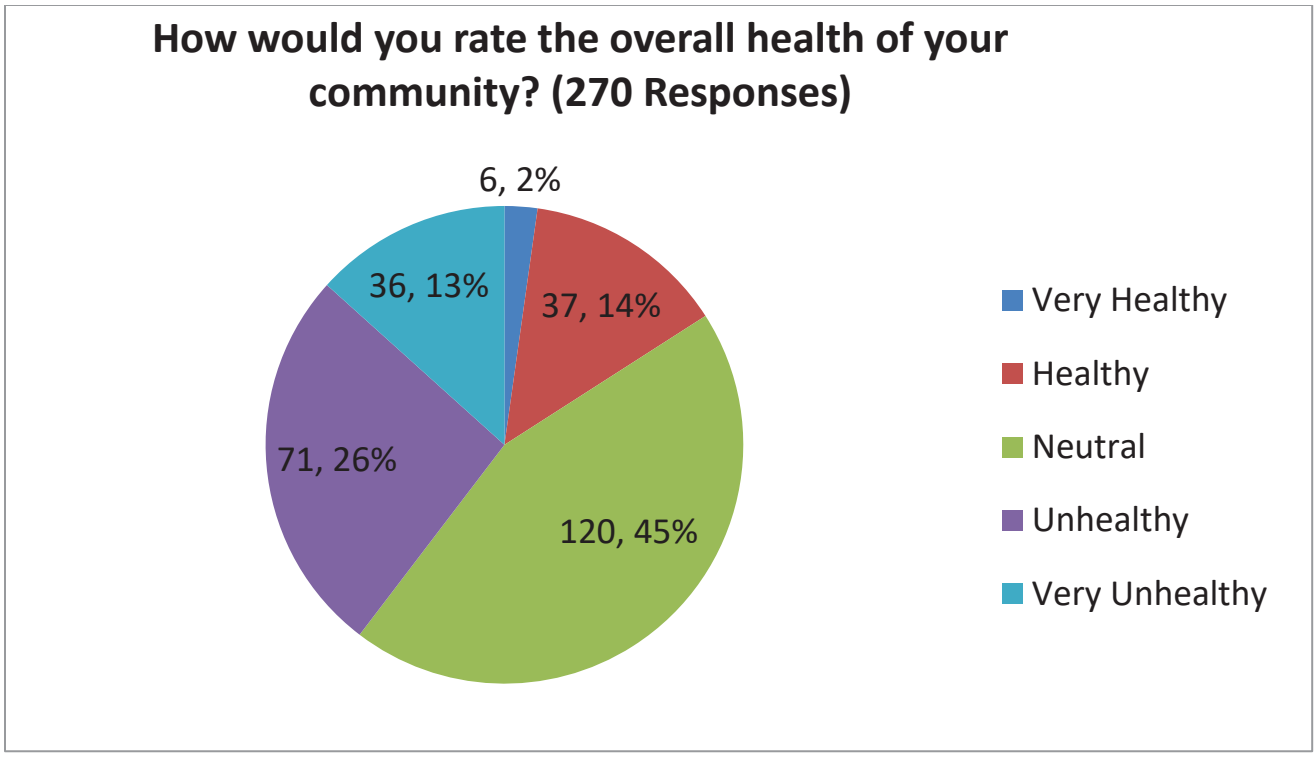
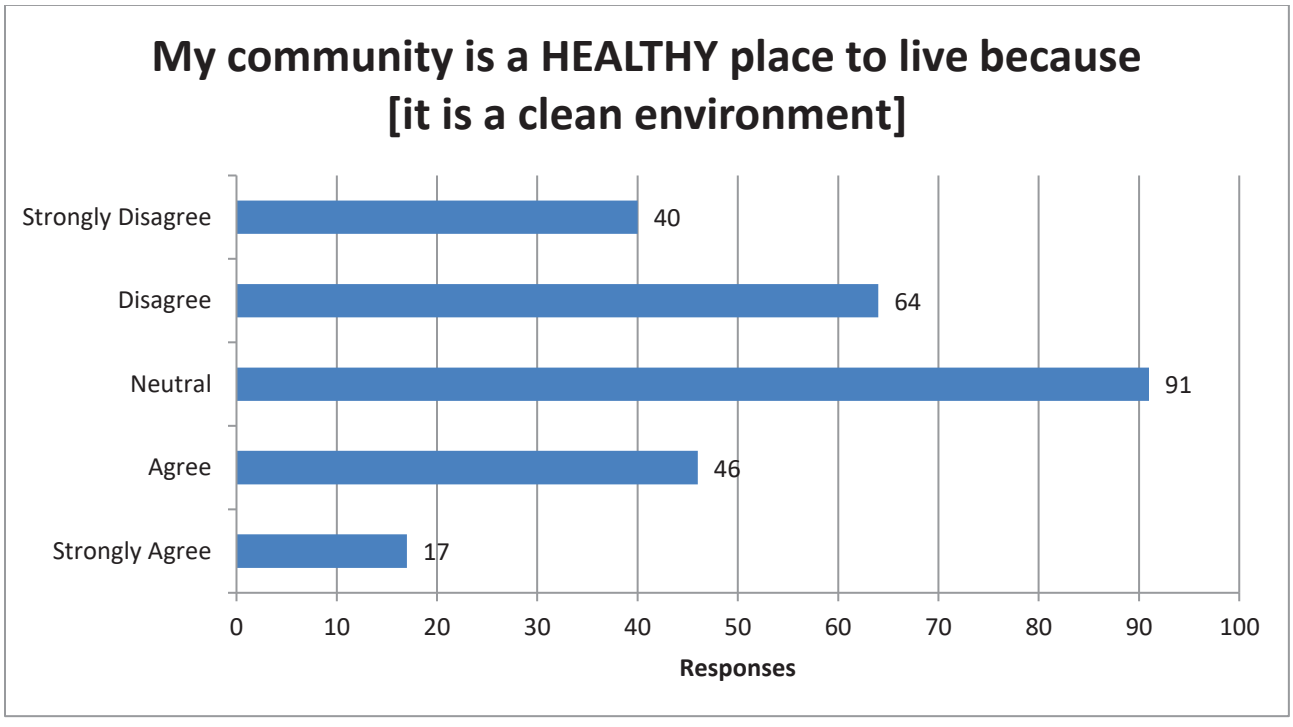
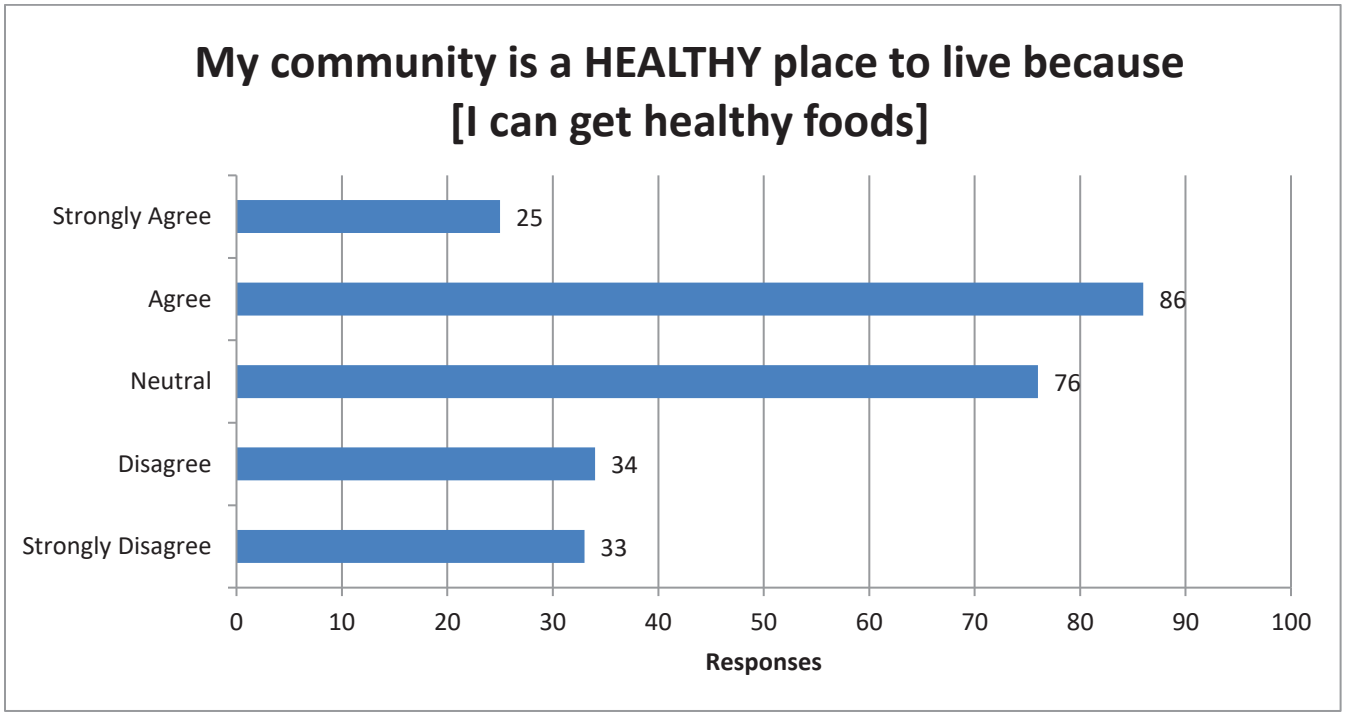
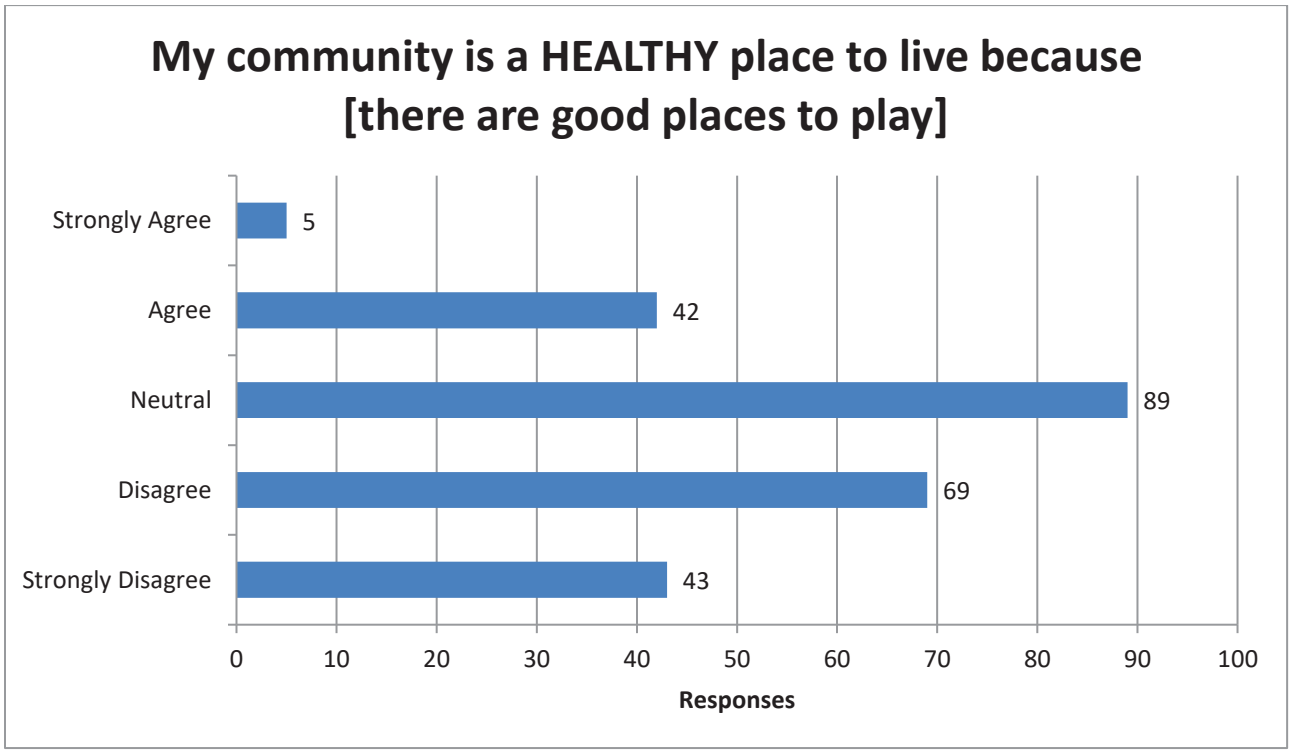

How would you rate the overall health of your community? (270 Responses)
6, 2%
37, 14%
120, 45%
71, 26%
36, 13%
Very Healthy
Healthy
Neutral
Unhealthy
Very Unhealthy

5.


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


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


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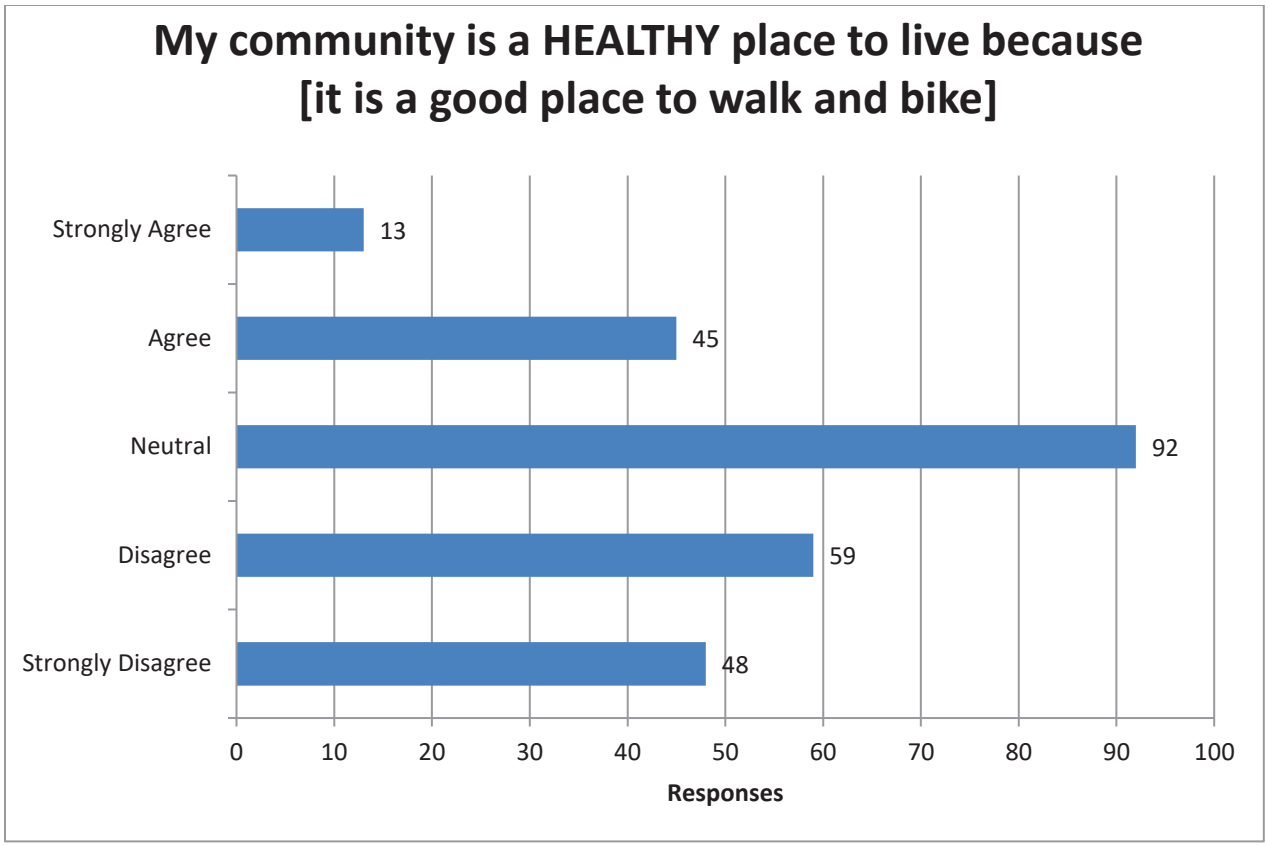
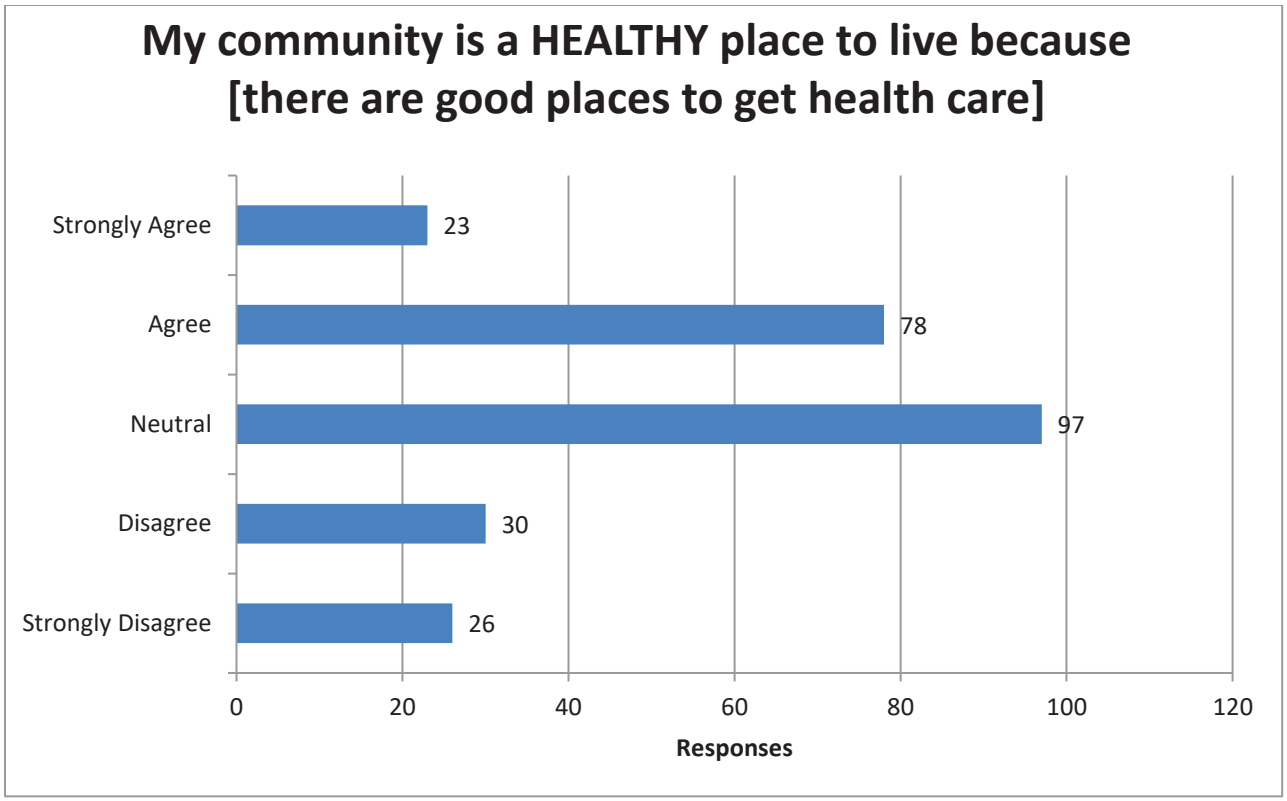
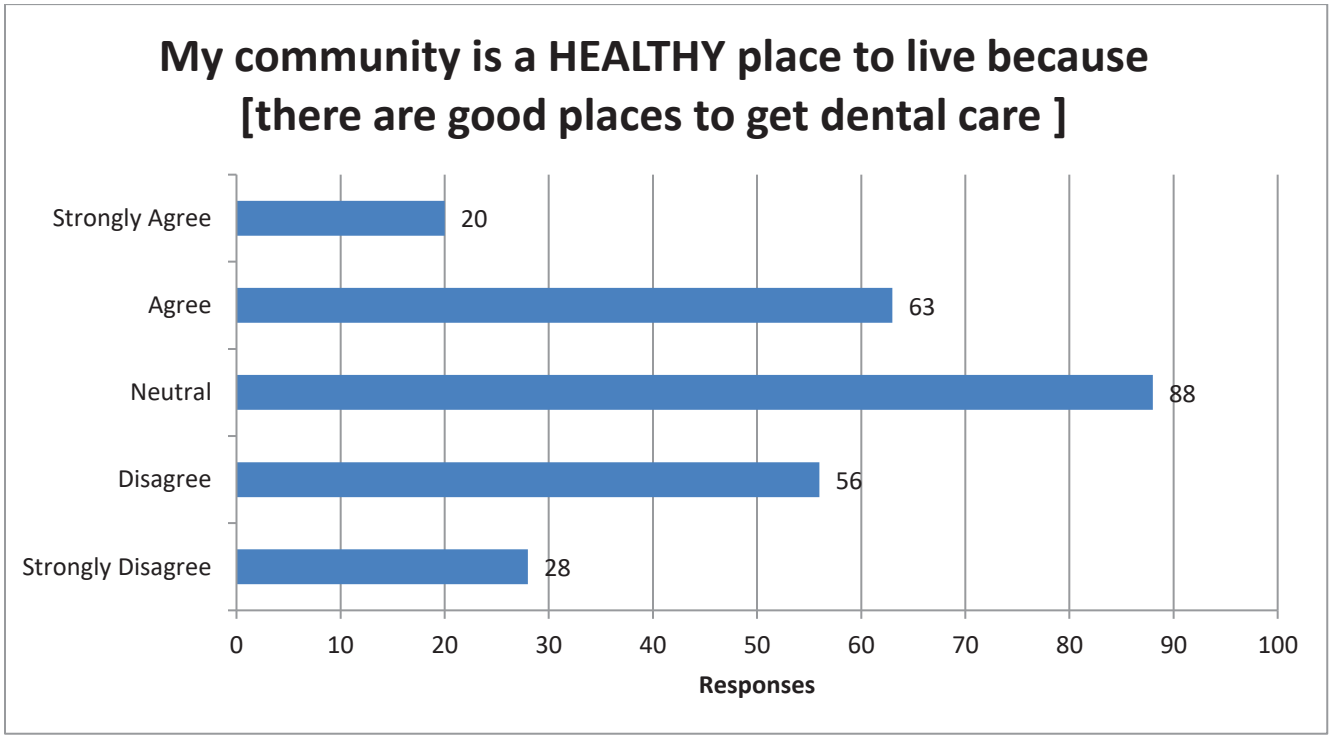
40
50
60
70
80
90
100
Responses


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


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


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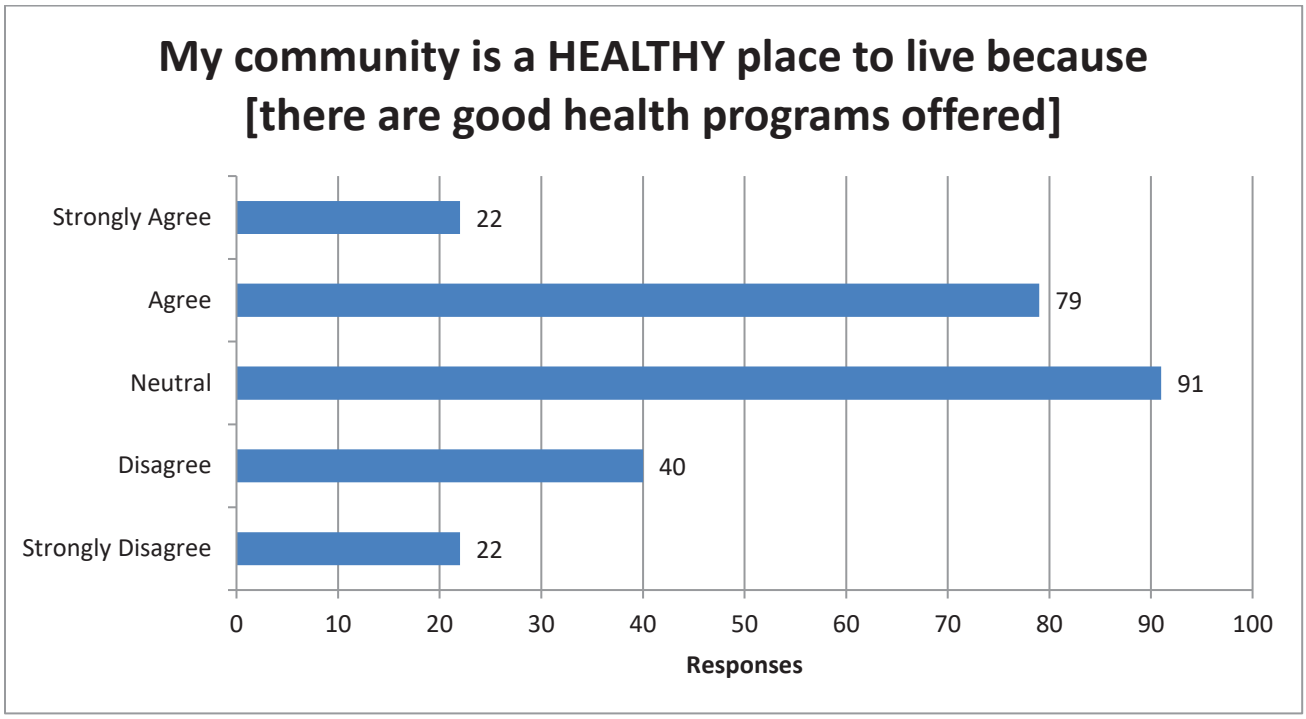
Responses


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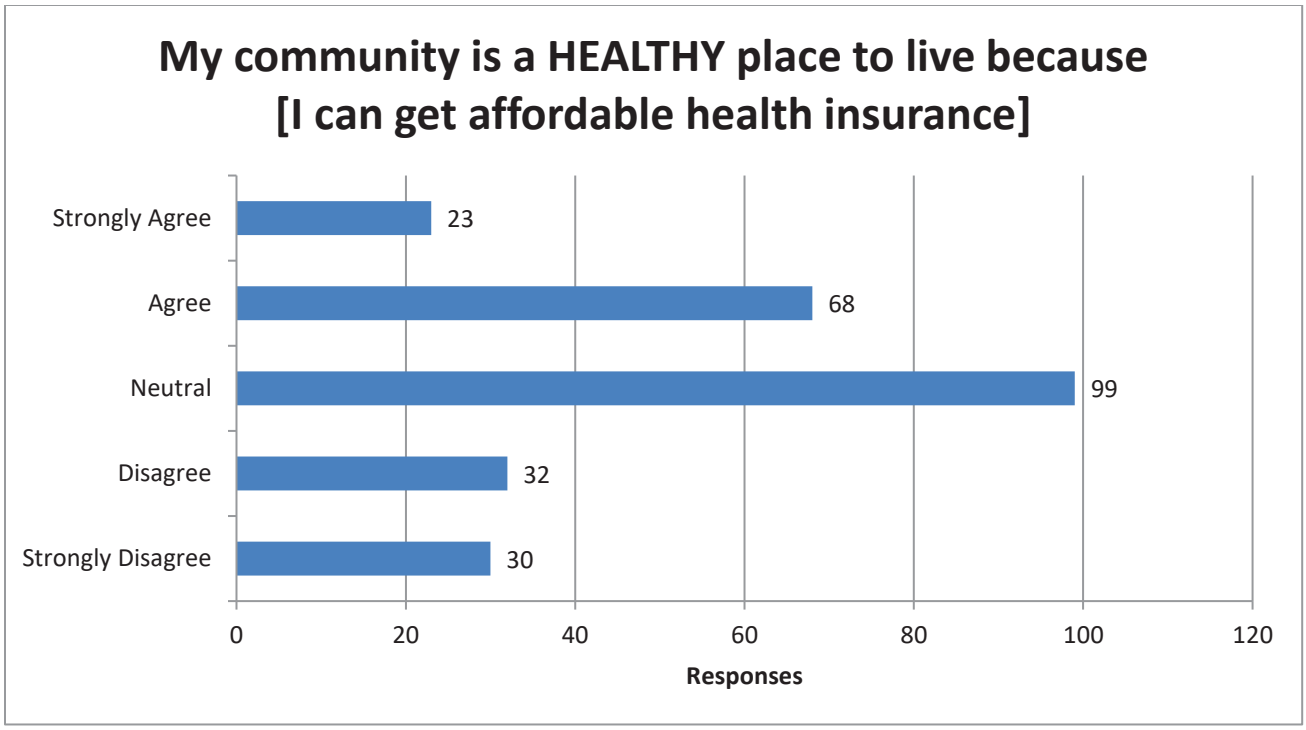
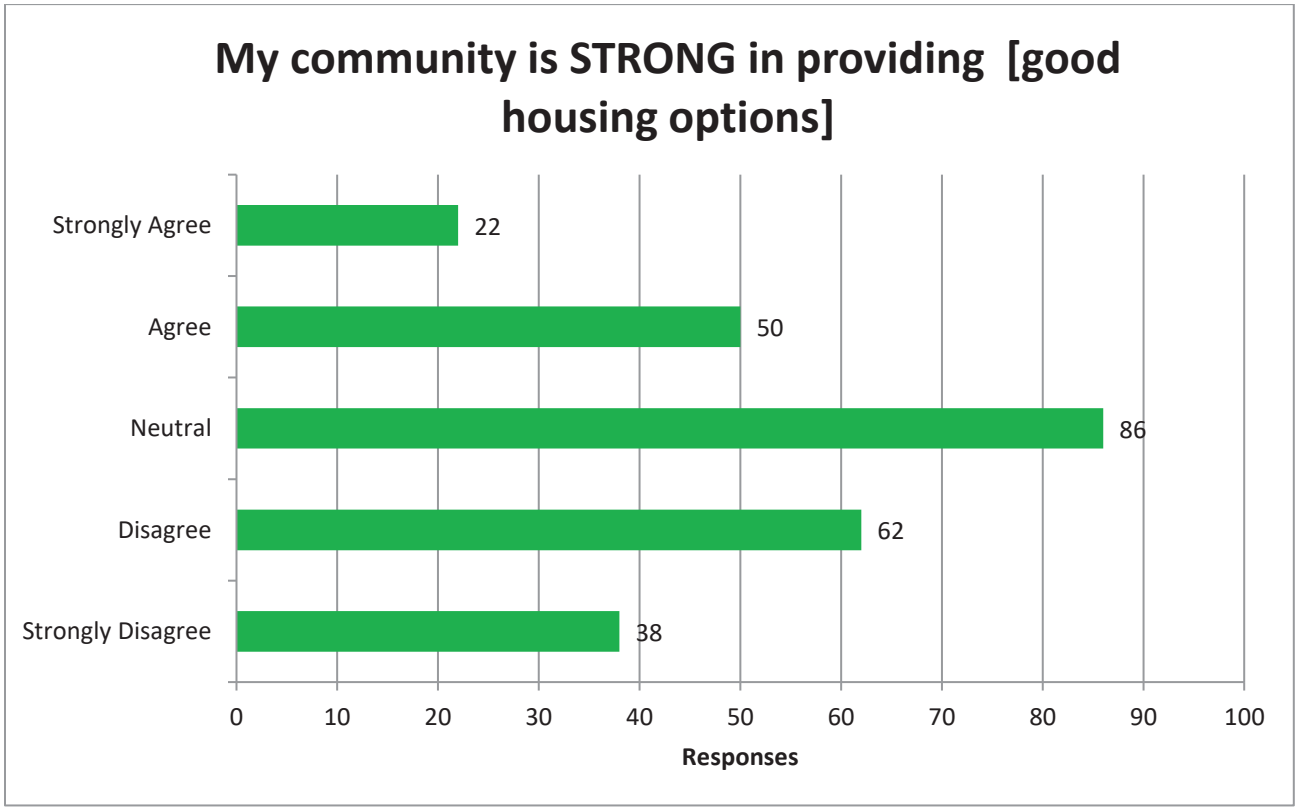
Responses


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

6.


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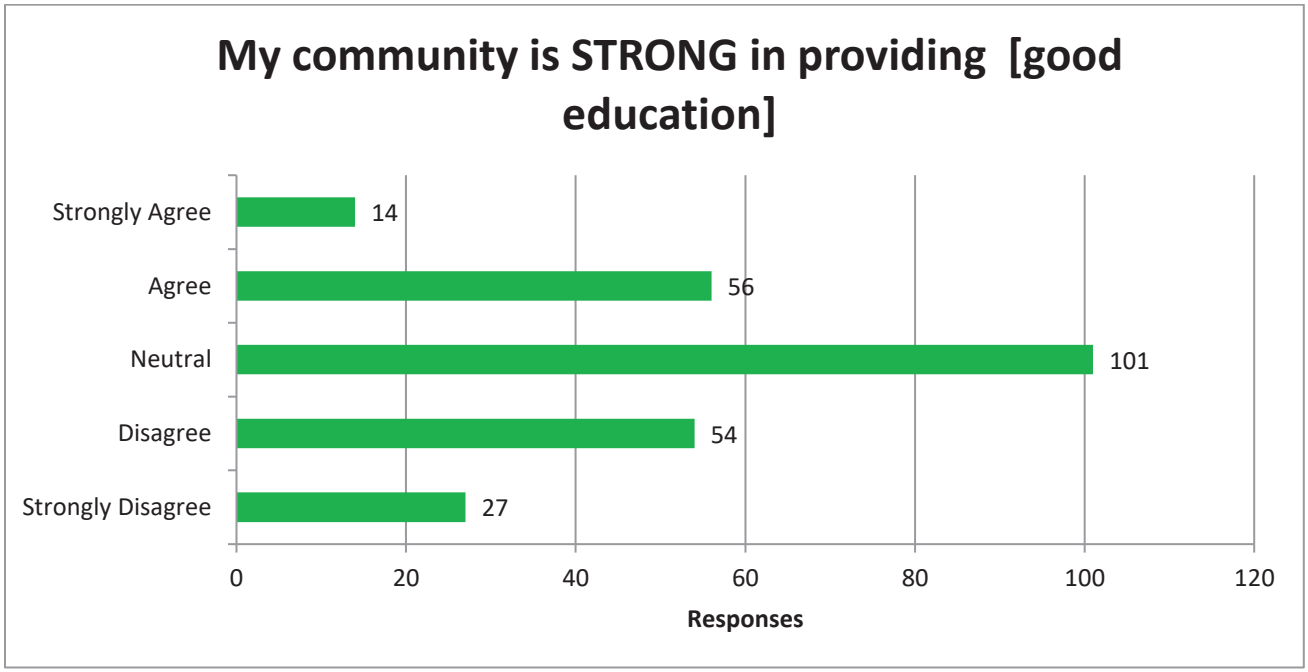
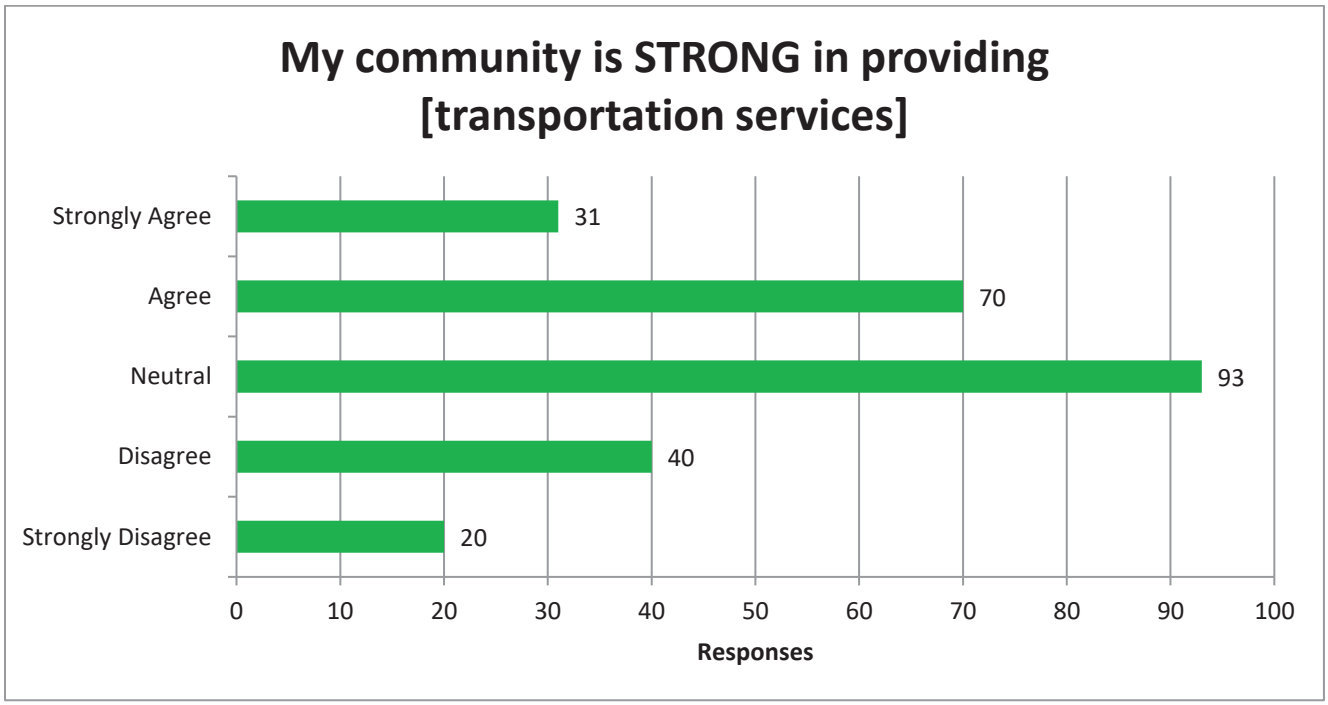
30
40
50
60
70
80
90
100
Responses


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


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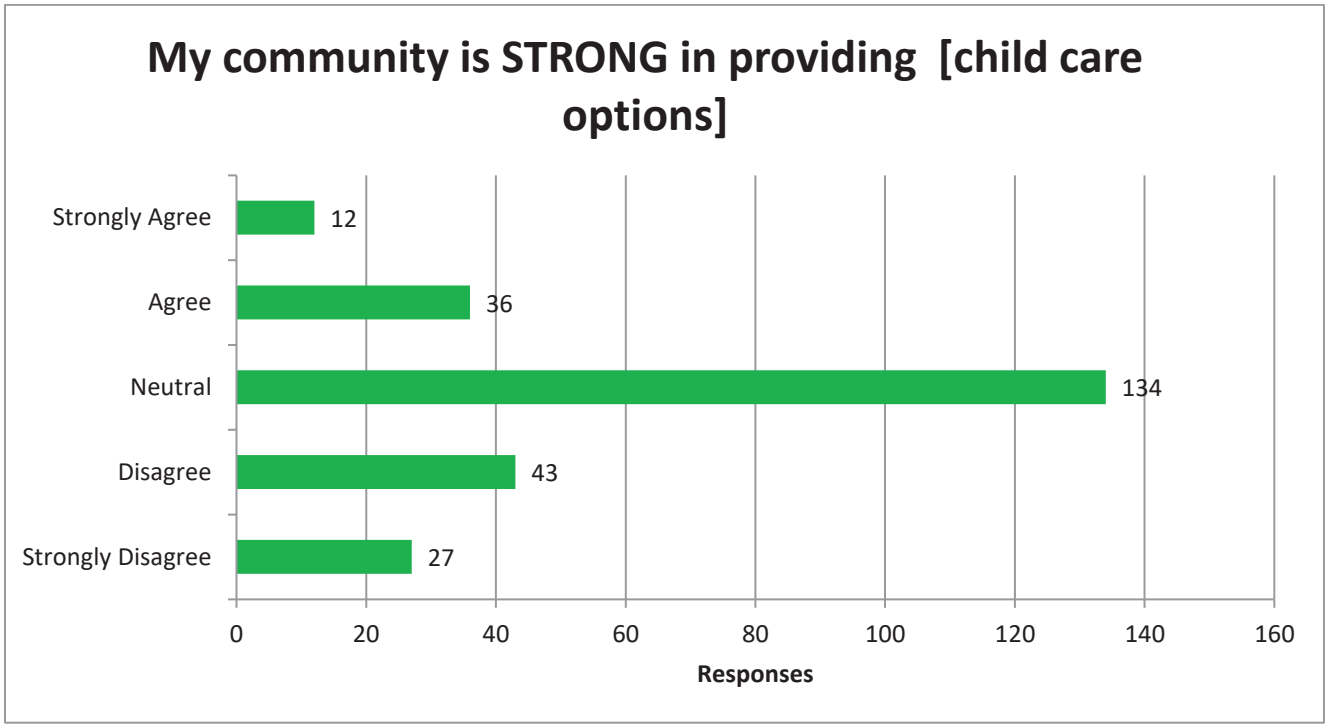
100
Responses


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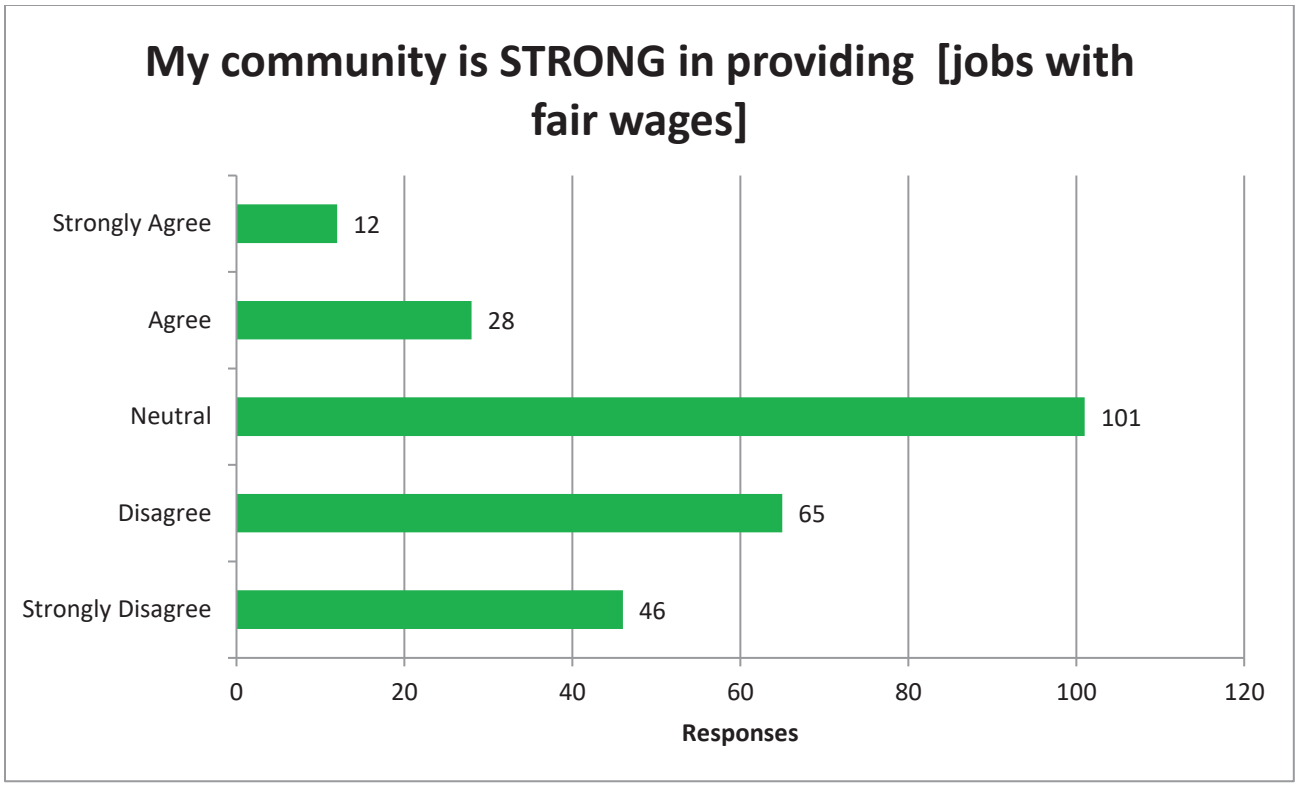
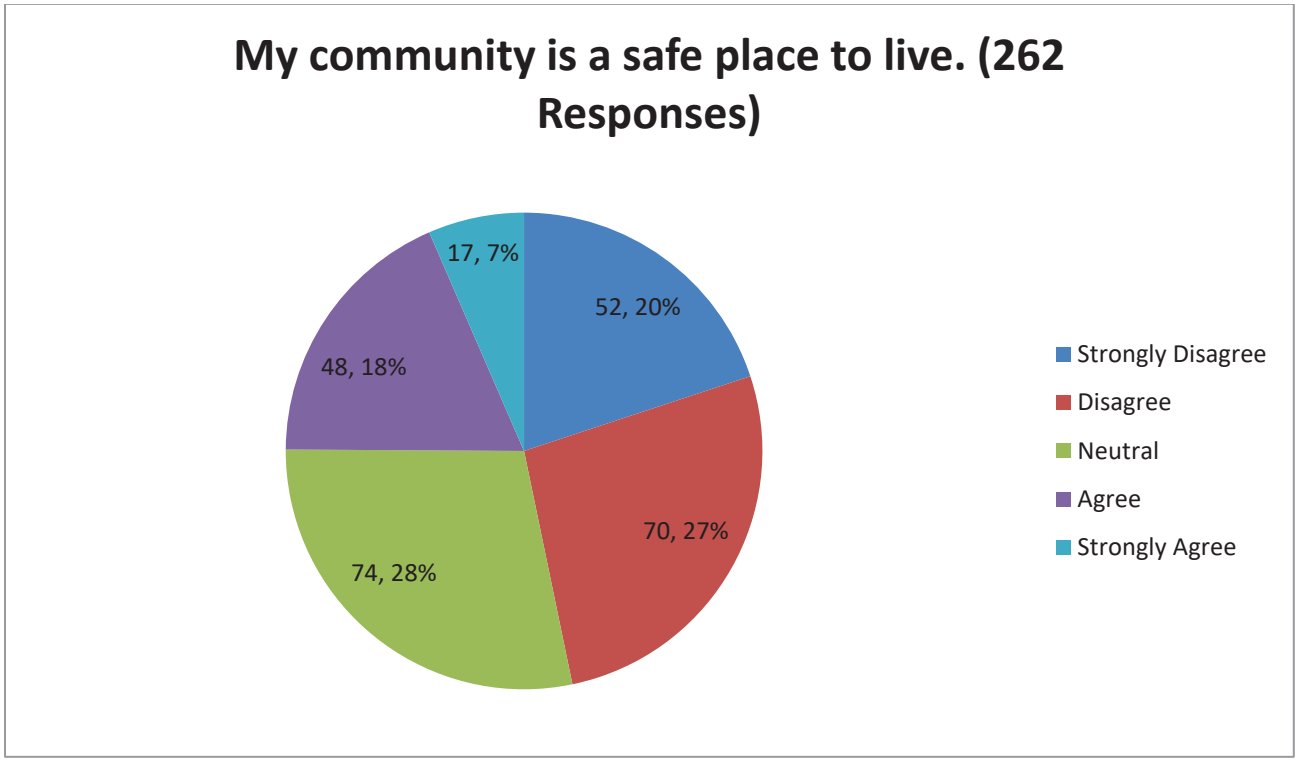
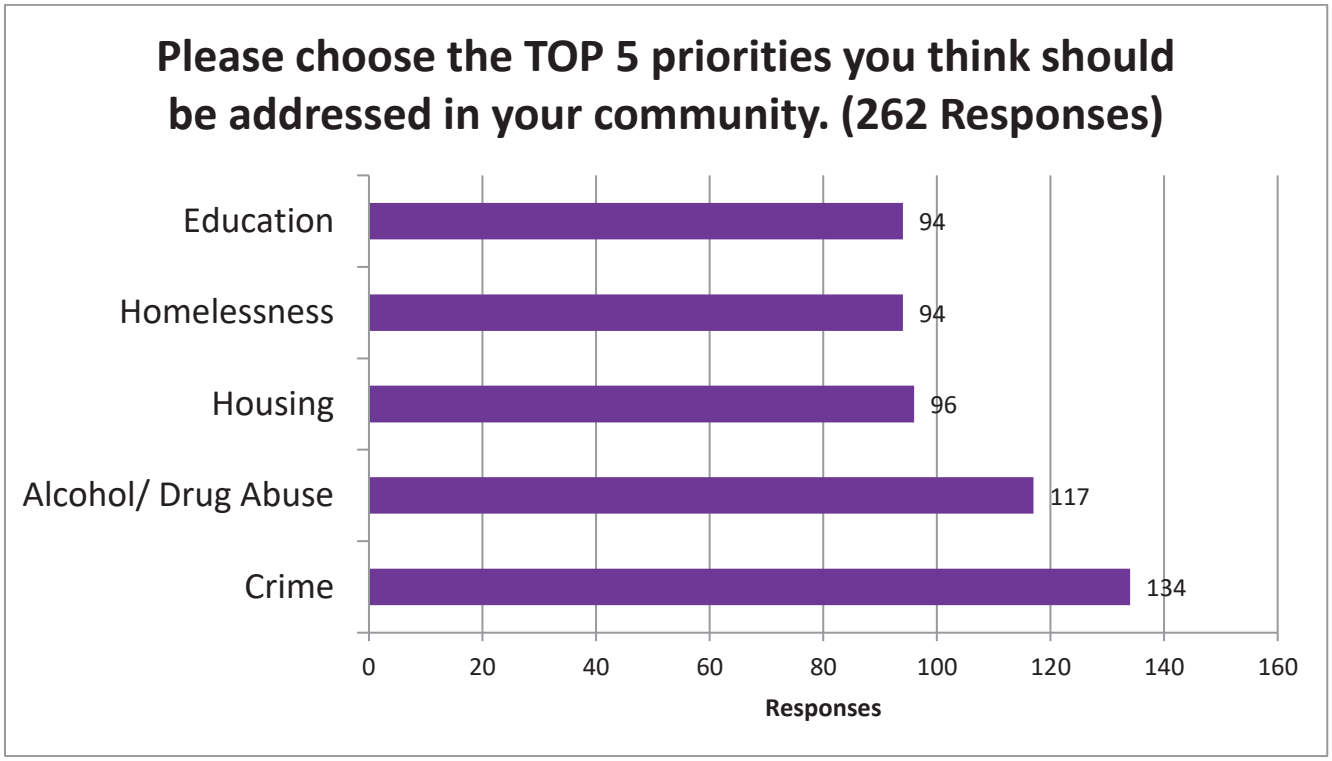
Disagree
43
Strongly Disagree
27
0
20
40
60
80
100
120
140
160
Responses


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

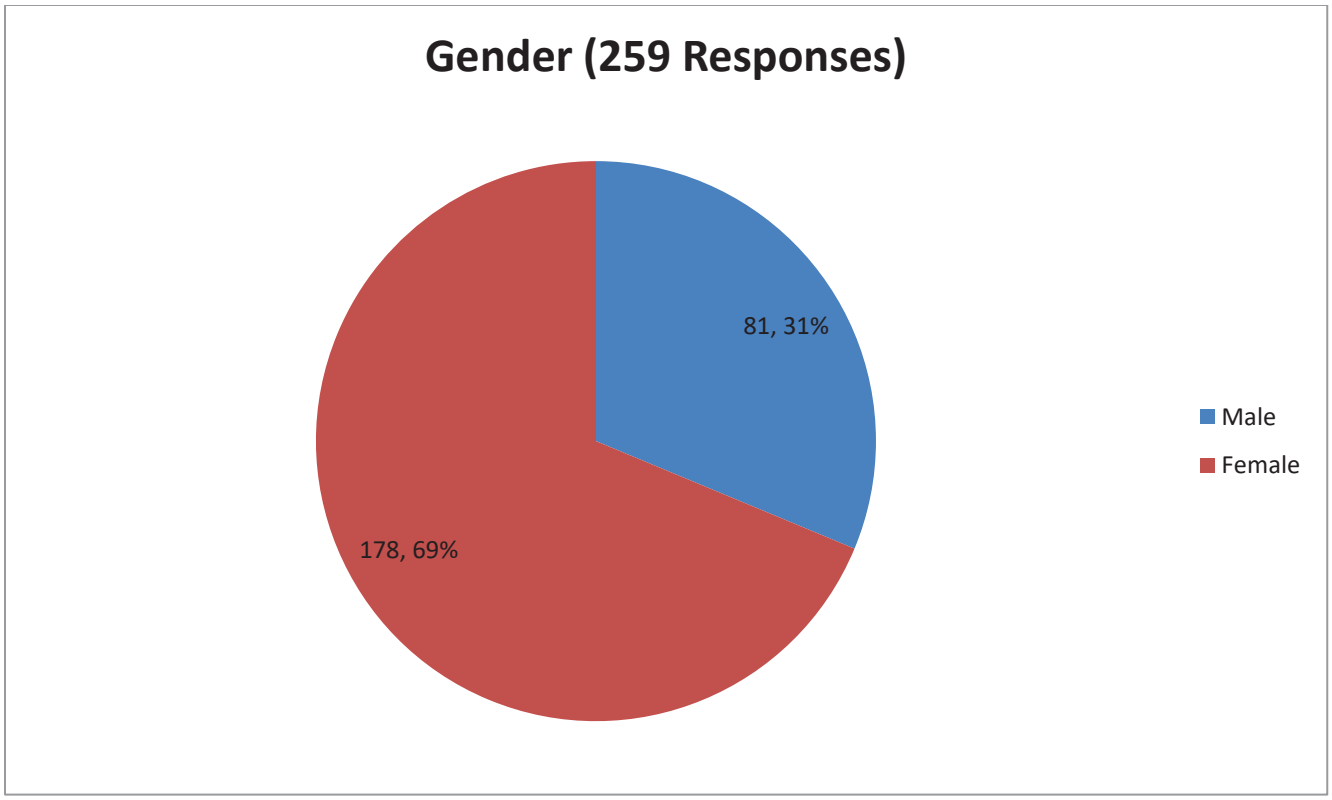
10.


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

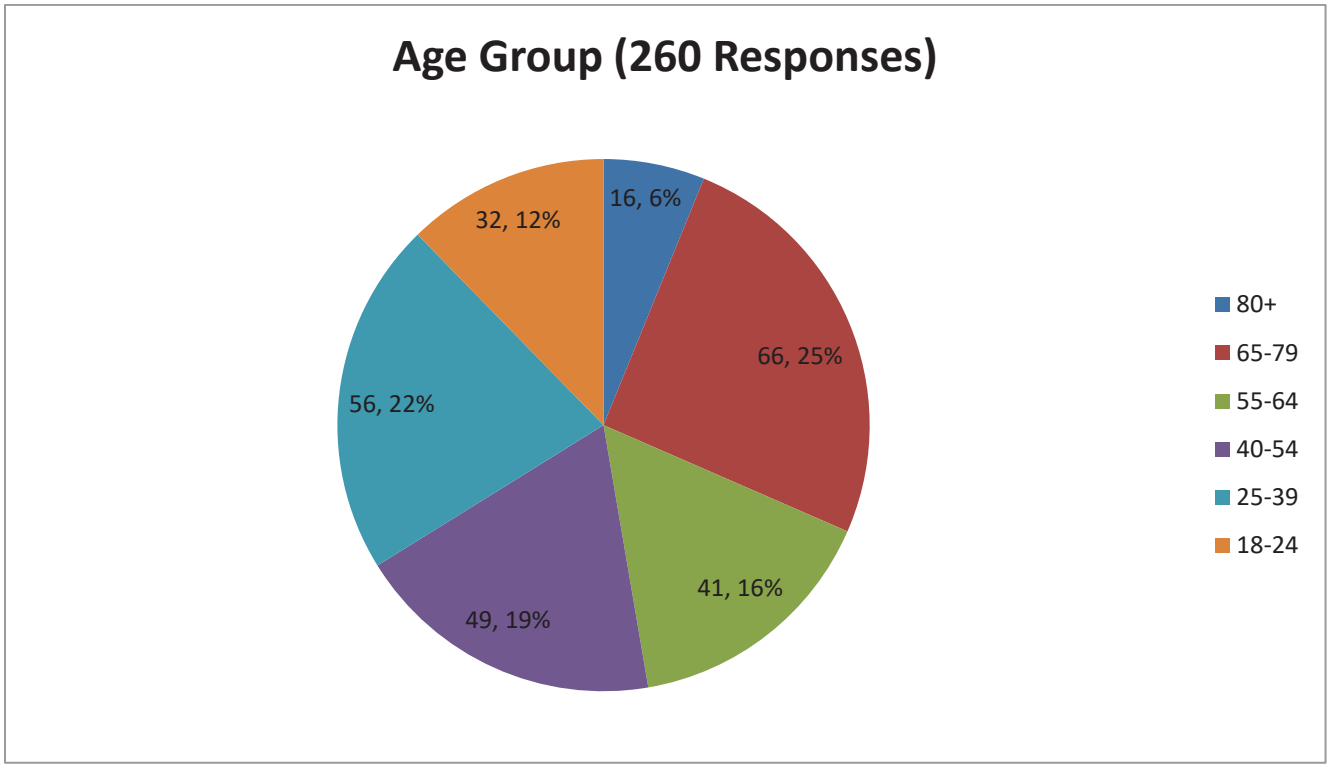
12.


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

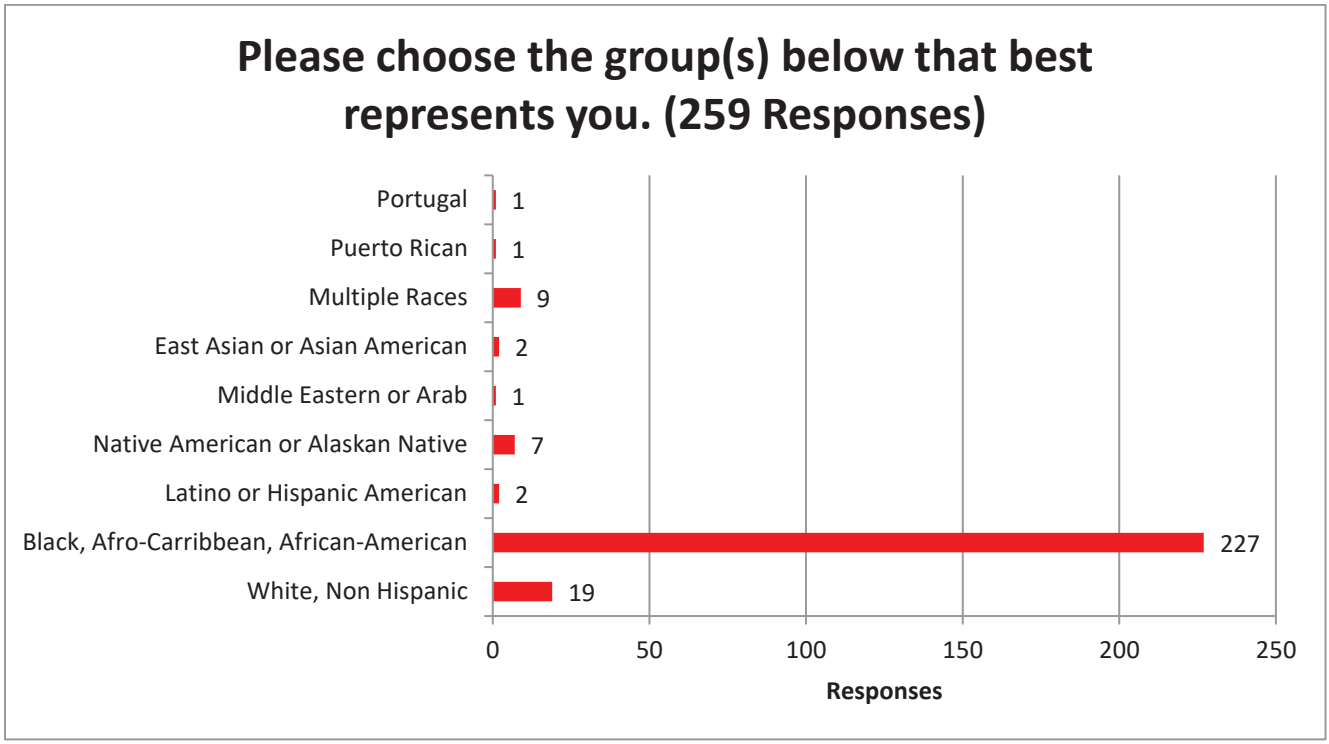
15.


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

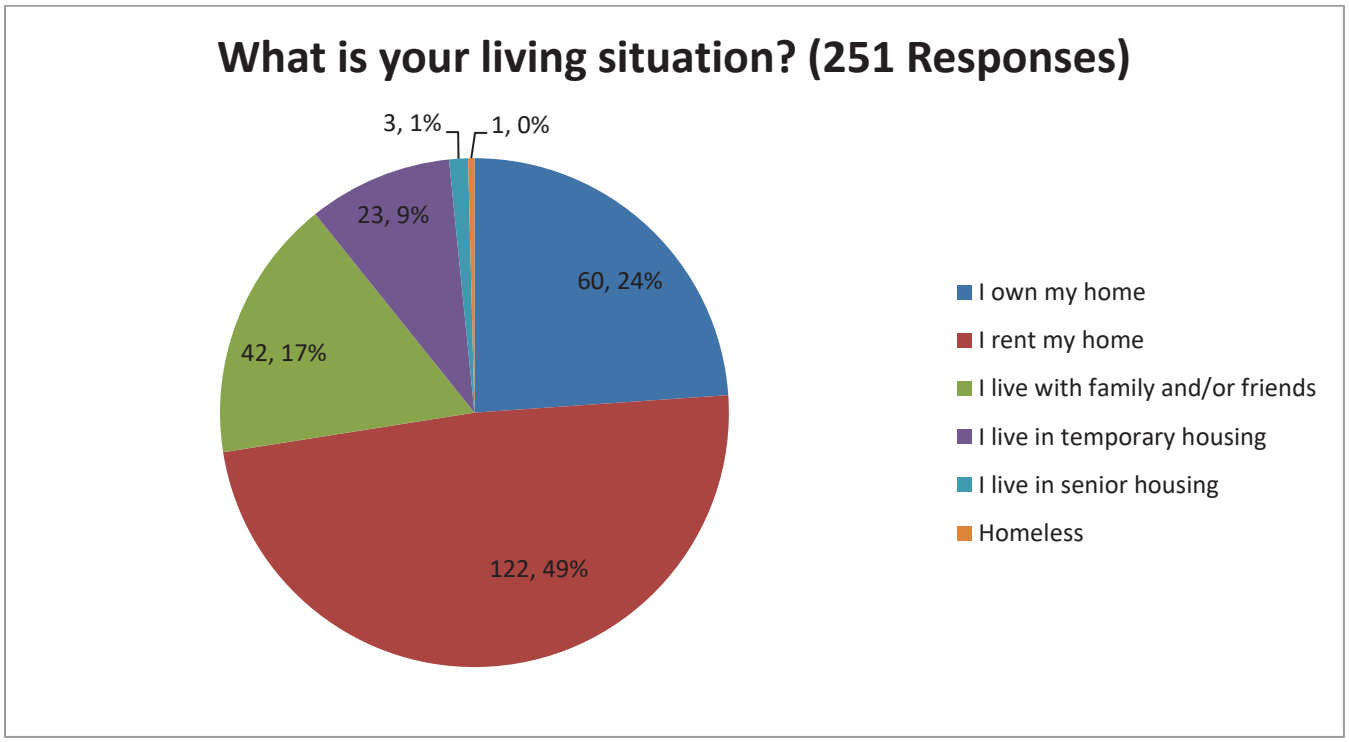
16.


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

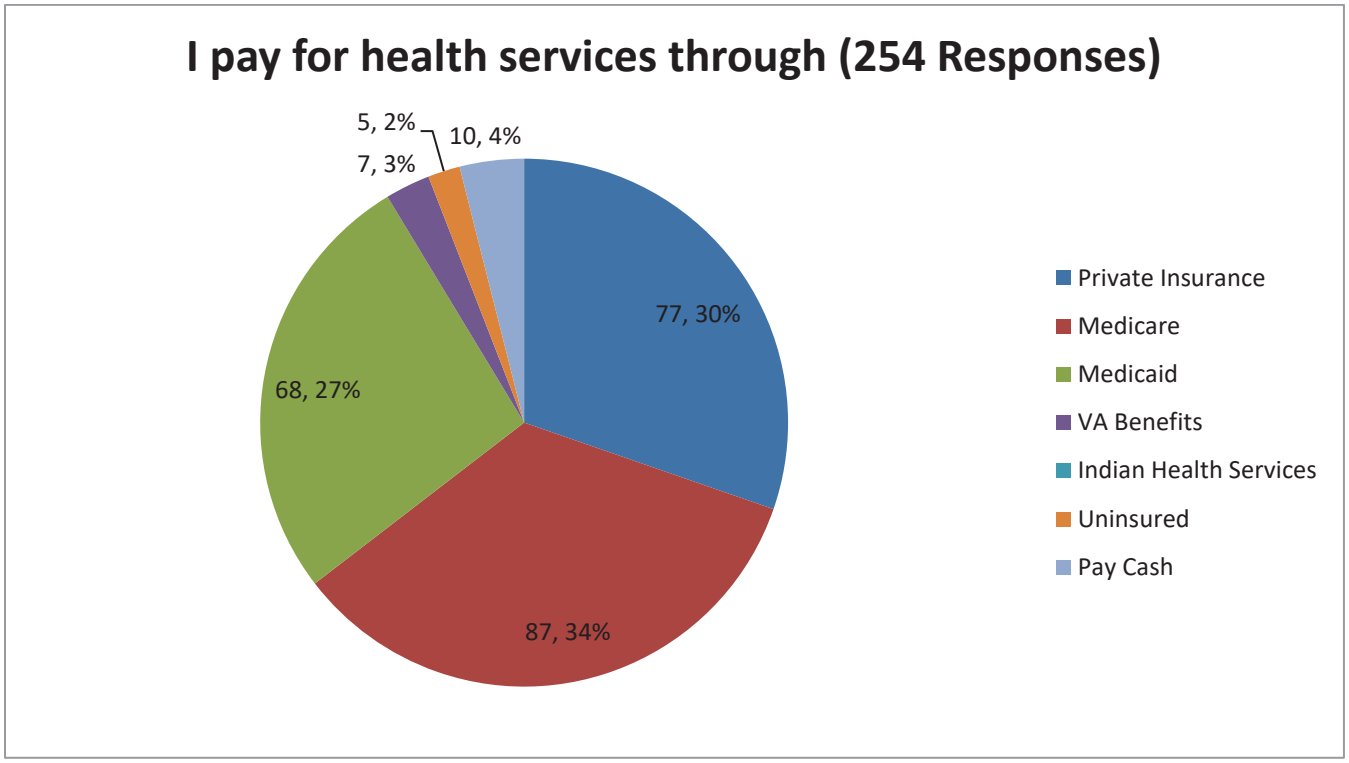
17.


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

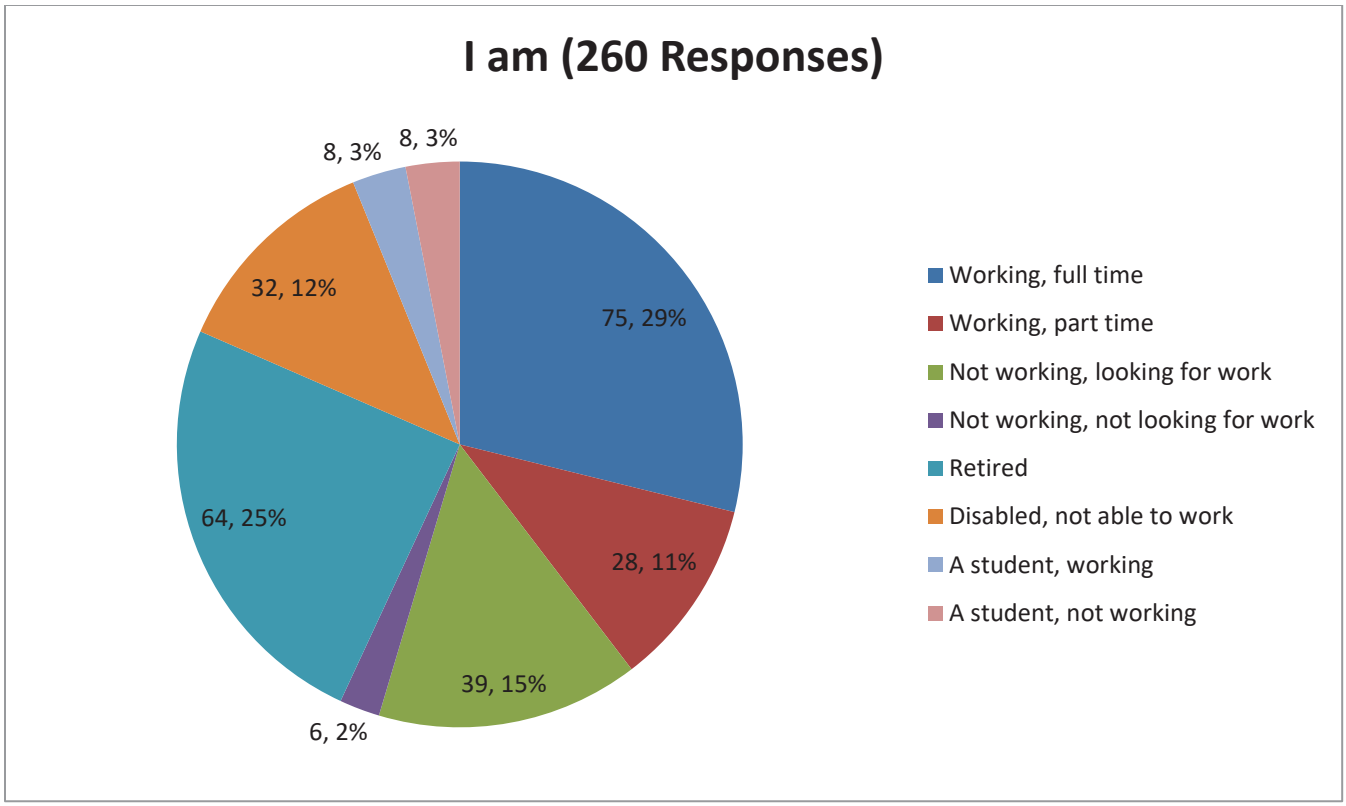
18.


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

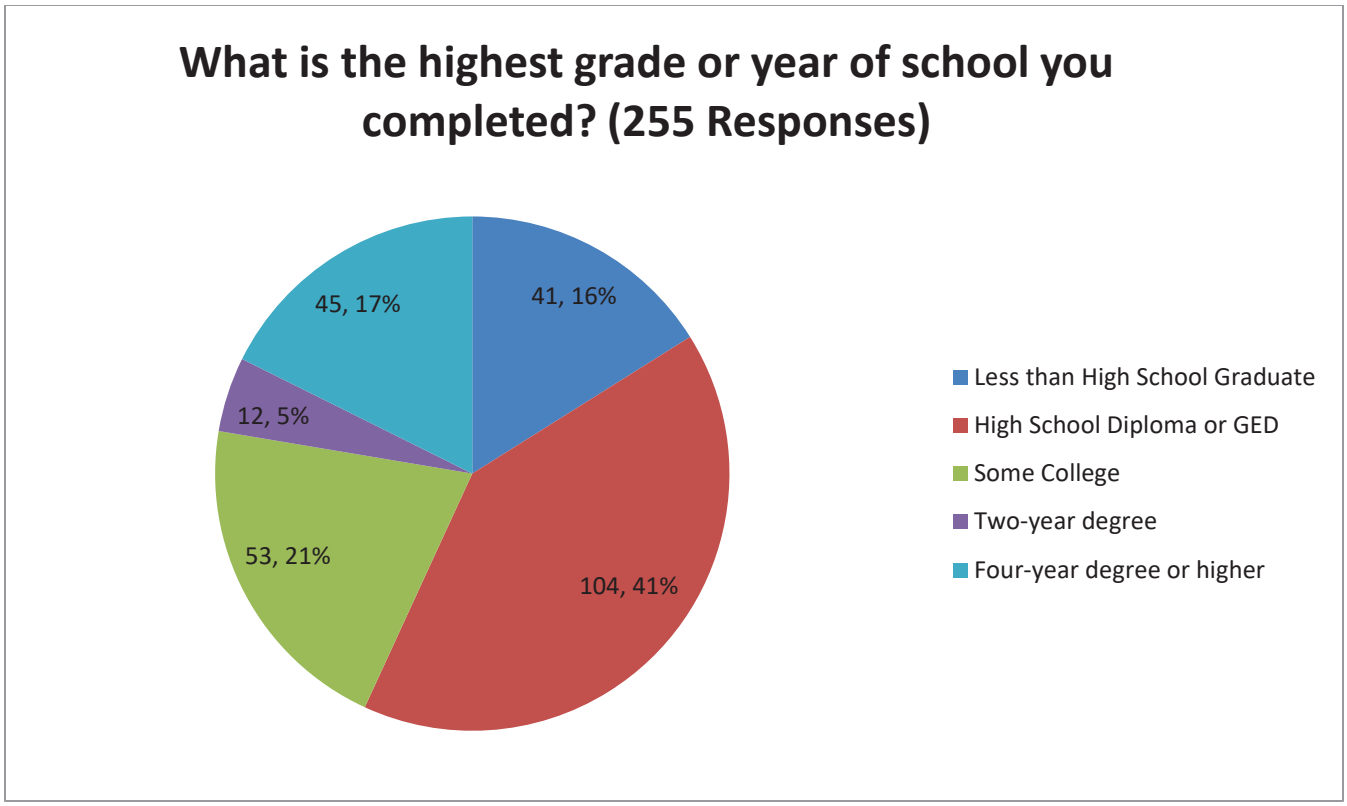
21.


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

22.


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

23.


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

Grace Medical Center CHNA Implementation Plan

Health

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

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

Leader:	Dr. Nicole Wagner

Health

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

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

Health

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

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

Social and Environmental

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

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

Social and Environmental

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

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

Access

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

LIFEBRIDGE HEALTH
CARE BRAVELY

FINANCIAL ASSISTANCE:

You may qualify for full or partial Financial Assistance from LifeBridge Health. To qualify for full assistance, you must show proof of income up to 300% of the federal poverty guidelines; income between 301% - 500% may qualify you for Financial Hardship Reduced Cost Care, limiting your liability to 25% of your gross annual income. Eligibility is calculated based on the number of people in the household and extends to any immediate family member living in the household. You may also qualify for presumptive eligibility if you are a beneficiary/recipient of a means-tested Federal, State or Local social service program. Financial Assistance covers uninsured and under-insured patients. Approvals are granted for twelve months. Patients are encouraged to re-apply for continued eligibility. An individual eligible for Financial Assistance cannot be charged more than the amounts generally billed (AGB) for emergency or other medically necessary care.

Where to Find Information - To obtain a Financial Assistance application and cover letter: 1) ask any member of Registration 2) visit our Customer Service Representatives in the main lobby of the Hospital 3) call Customer Service at (800) 788-6995 (Monday - Friday 7:30 AM – 5:00 PM) 4) visit www.lifebridgehealth.org

How to Apply - Complete the Financial Assistance application available online or at any registration area and return the application and required documentation to Customer Service at the Hospital or by mail to: LifeBridge Health, Inc., Financial Assistance Representative, 2401 West Belvedere Avenue, Baltimore, Maryland 21215.

Payment Plans – Interest free monthly payment plans are available without application and no service charges to those who are uninsured. Monthly payment plan amounts must not exceed 5% of an individual monthly adjusted gross income and are available with no credit screening after a quick and easy paperless enrollment. Visit www.lifebridgehealth.org or call Customer Service for more information. Governing Law: This agreement/payment plan is made pursuant and subject to Subtitle 10 of Title 12 of the Commercial Law Article of the Annotated Code of Maryland.

Maryland Medical Assistance (Medicaid) – For information, call the Department of Health and Mental Hygiene (DHMH) Recipient Relations Hotline at (800) 492-5231 or your local Department of Social Services at (800) 332-6347 or on the web at www.dhr.state.md.us. LifeBridge Health Patient Representatives can also assist you with the Maryland Medical Assistance application process.

Patient's Rights and Responsibilities – You have the right to receive information about hospital and physician charges and ask for an estimate of hospital charges before care is provided, as long as your care is not impeded. Patients admitted to the hospital will receive a Uniform Summary Statement within thirty days of discharge. You have the right to receive an itemized statement and explanation of charges. You are responsible to provide correct insurance information, pay your hospital bill timely and contact the hospital if you are unable to pay. Failure to pay or make satisfactory payment arrangements may result in your account being referred to a collection agency.

ADDITIONAL IMPORTANT INFORMATION:

Physician charges to hospital inpatients and outpatients are generally not included in the hospital bill and are billed separately.

LifeBridge Health, Inc. is permitted to bill outpatients a fee, commonly referred to as a "facility fee," for their use of hospital facilities, clinics, supplies, and equipment and non-physician services, including but not limited to the services of non-physician clinicians, in addition to physician fees billed for professional services provided in the hospital.

Patients 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 and billed for by LifeBridge Health, Inc.

Patients and their authorized representatives have the right to file a complaint with the Health Services Cost Review Commission (HSCRC) or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office (HEAU) against a hospital for an alleged violation of Maryland law regarding financial assistance and debt collection (MD Code, Health-General Article, §§19-214.1 & 19-214.2). The HEAU is located at 200 Saint Paul Place, Baltimore, Maryland 21202-2021 and can be contacted as follows: phone (410-528-1840 or 1-877-261-8807); email (heau@oag.state.md.us); fax (410-

576-6571); or website (www.marylandattorneygeneral.gov/pages/cpd/heau/default.aspx). Complaints can be sent to the HSCRC by email at hscrc.patient-complaints@maryland.gov. The HSCRC can also be contacted at 410-764-2605 or 1-888-287-3229 and found online at hscrc.maryland.gov/Pages/default.aspx.

I have been made aware of the LifeBridge Health Inc., Hospital Financial Assistance Policy: _____ (Patient's or Representative's Initials)

_____ (Date) _____ (Relationship to patient if representative initialed above)

From:	Julie A. Sessa
To:	Hilltop HCB Help Account; David Baker
Cc:	Stephanie Resetar; Sharon McClernan
Subject:	RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives
Date:	Thursday, May 25, 2023 3:03:24 PM
Attachments:	image001.png image002.png Updated 052523 - Northwest FY 2022 Community Benefit Financial Report Template.xlsx Updated 052523 Carroll FY 2022 Community Benefit Financial Report Template.xlsx Updated 052523 Sinai FY 2022 Community Benefit Financial Report Template.xlsx

Report This Email

Good afternoon-

The supplemental surveys for Northwest, Carroll and Sinai Hospitals have been updated. We have also further updated the Physician Subsidy tab on the data reports to make sure the two are aligned.

Please let us know if you have any questions.

Julie

Julie Sessa
CFO
LifeBridge Health Partners
410.601.7238 office
410.469.5518 fax
jsessa@lifebridgehealth.org

LIFEBRIDGE HEALTH PARTNERS

CARE BRAVELY

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Thursday, May 18, 2023 1:17 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; David Baker <Dbaker@lifebridgehealth.org>
Cc: Julie A. Sessa <JSessa@lifebridgehealth.org>; Stephanie Resetar <Sresetar@lifebridgehealth.org>; Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Thank you very much for the responses submitted yesterday; we had a couple more questions. The following table represents the remaining items from LifeBridge Health hospitals' supplemental survey responses for which we need clarification (the discrepancies are listed in red).

Specialty Selected on Suppl. Survey	Suppl. Survey Subsidy Type	Specialty Listed on Financials	Financials Subsidy Type
Carroll Hospital Center			
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Med Surg*	Non-Resident House Staff and Hospitalists
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Critical Care*	Non-Resident House Staff and Hospitalists
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Physician Recruitment*	Physician Recruitment to Meet Community Need
Internal Medicine	Non-resident house staff and hospitalists	[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]
Northwest Hospital Center, Inc.			
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Orthopedics*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Surgery*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Neurology*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Opthalmology*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Hospitalists*	Physician Provision of Financial Assistance
Internal Medicine	Non-resident house staff and hospitalists (different on suppl. survey vs. financials)	*Internal Medicine*	Physician Provision of Financial Assistance (different on suppl. survey vs. financials)
Sinai Hospital of Baltimore, Inc.			
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Hospitalists*	Non-Resident House Staff and Hospitalists
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Rehabilitation Medicine*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Neurology*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Cardiology*	Non-Resident House Staff and Hospitalists
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Orthopedics*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Oncology*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Surgery*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Opthamalogy*	Physician Provision of Financial Assistance
[corresponding specialty	[corresponding specialty	*OB/GYN*	Physician Provision of Financial Assistance

unclear / not present]	unclear / not present]		
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Psychiatry*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*NICU Coverage*	Non-Resident House Staff and Hospitalists
Internal Medicine	Non-resident house staff and hospitalists (different on suppl. survey vs. financials)	*Internal Medicine*	Physician Provision of Financial Assistance (different on suppl. survey vs. financials)

Additionally, please find the requested links to the LifeBridge Health hospitals' supplemental surveys below, with our apologies for the delay in getting them to you.

Carroll Hospital Center:
https://umbc.co1.qualtrics.com/jfe/form/SV_9XryoB7vuQA7NJk?Q_CHL=gl&Q_DL=EMD_eafzoAPzeWz6GAQ_9XryoB7vuQA7NJk_CGC_YdyYBV7aLB1sJeP&_g_=g

Northwest Hospital Center, Inc.:
https://umbc.co1.qualtrics.com/jfe/form/SV_aYn6n81gUDDAiay?Q_CHL=gl&Q_DL=EMD_bIeuBhK4J9V38NR_aYn6n81gUDDAiay_CGC_YdyYBV7aLB1sJeP&_g_=g

Sinai Hospital of Baltimore, Inc.:
https://umbc.co1.qualtrics.com/jfe/form/SV_1TXaRWWAfSXiUCi?Q_CHL=gl&Q_DL=EMD_zAgCnplH5llBPq5_1TXaRWWAfSXiUCi_CGC_YdyYBV7aLB1sJeP&_g_=g

---

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Wednesday, April 19, 2023 8:59 AM
To: David Baker <Dbaker@lifebridgehealth.org>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Julie A. Sessa <JSessa@lifebridgehealth.org>; Stephanie Resetar <Sresetar@lifebridgehealth.org>; Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Thanks for your patience. We've just sent a clarification request regarding the financials for the LifeBridge hospitals, which should give you an opportunity to clarify some of the specialties involved.

For any specialties not captured in your response to the financials clarification request, please respond to this email explaining which subsidies reported on each respective hospital's narrative response correspond to the financials entries we asked about below. For subsidies without a category that corresponds directly, please feel free to answer by saying so, and we'll update our record of your narrative responses accordingly. In the future, please use the "Other" category on the narrative survey to capture any subsidies listed on the hospital's financials not described by the other specialty options on the narrative survey.

From: David Baker <Dbaker@lifebridgehealth.org>
Sent: Monday, April 17, 2023 1:22 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Julie A. Sessa <JSessa@lifebridgehealth.org>; Stephanie Resetar <Sresetar@lifebridgehealth.org>; Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: Re: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Hello,
Can you please clarify how best we can provide you with this information? We're a bit stumped trying to reconcile the categories in the financial reports with those in the supplemental surveys as the available options are different for each.

For example, for Carroll Hospital, there is no option in the supplemental survey to select the financial report categories of "Med Surg," "Critical Care," and "Physician Recruitment." Should we somehow be using the supplemental survey's "Other" section for this?

Also, can you please re-send us the supplemental survey links for the 3 hospitals listed below?

Thanks,
Dave

David R. Baker, DrPH, MBA
Executive Director, Population Health

LifeBridge Health
dbaker@lifebridgehealth.org
Assistant: Cheryl Ebaugh, chebaugh@lifebridgehealth.org

LIFEBRIDGE HEALTH
CARE BRAVELY

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Monday, April 10, 2023 9:55 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; David Baker <Dbaker@lifebridgehealth.org>
Cc: Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Good morning. When reviewing the supplemental survey responses for the Lifebridge Health hospitals, we encountered several discrepancies between the physician subsidies indicated on the supplemental surveys and their respective corresponding financial reports (the physician subsidies should align between the two reports). Please clarify the following:

Carroll Hospital Center

- The following entries were only present on the financial sheet, or it was unclear which subsidy indicated on the narrative survey corresponds to the program/specialty in question:
    - *Med Surg*
    - *Critical Care*

- *Physician Recruitment* – the subsidy type indicated for this specialty is "Physician Recruitment to Meet Community Need," which does not match the subsidy type indicated for any of the specialties on the supplemental survey response.

- The specialty *Internal Medicine* was only selected on the supplemental survey response, or it was unclear which subsidy indicated on the financial sheet corresponds to this specialty.

Northwest Hospital Center, Inc.

- The item *Physician Charity Care* was only indicated on the financial sheet, or it was unclear which subsidy selected on the supplemental survey corresponds to this specialty.

Sinai Hospital of Baltimore, Inc.

- The item *Physician Charity Care* was only indicated on the financial sheet, or it was unclear which subsidy selected on the supplemental survey corresponds to this specialty.

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Friday, March 24, 2023 11:08 AM
To: David Baker <Dbaker@lifebridgehealth.org>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Thank you for providing additional clarification. We will review your message along with the supplemental surveys that were submitted yesterday and will reach back out if we have any further questions.

From: David Baker <Dbaker@lifebridgehealth.org>
Sent: Friday, March 24, 2023 9:37 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: Re: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Please see our additional clarifications below.
Best regards,
Dave

David R. Baker, DrPH, MBA
Executive Director, Population Health

LifeBridge Health
dbaker@lifebridgehealth.org
Assistant: Cheryl Ebaugh, chebaugh@lifebridgehealth.org

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>

Sent: Thursday, March 23, 2023 12:56 PM
To: David Baker <Dbaker@lifebridgehealth.org>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Thank you for your response. Could you please provide further clarification on the following items?

- Regarding your clarification of the response given for Question 61, please confirm whether your intended meaning was that each of the following hospitals reported rate support for all of the rate support categories selected.
    - Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore
    - Northwest Hospital Center
    - Sinai Hospital of Baltimore

  Clarification for Question 61:
  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 below or indicate if there were none.

    - Regional Partnership Catalyst Grant Program
        - Diabetes: Sinai Hospital only
        - Behavioral Health: Sinai, Carroll, and Northwest Hospitals
    - The Medicare Advantage Partnership Grant Program
    - The COVID-19 Long-Term Care Partnership Grant
        - Sinai Hospital only
    - The COVID-19 Community Vaccination Program
        - Sinai Hospital only
    - The Population Health Workforce Support for Disadvantaged Areas Program
    - Other (describe)

  Clarification for Question 44 for Levindale:

- To clarify the responses to Question 44 on the narrative for Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, for each of the following positions, please indicate whether the intended response was (a) “N/A – Person or Organization was not involved” or (b) “N/A – Position or Department does not exist.”

    - CB/ Community Health/Population Health Director (facility level)

        i. N/A – Person or Organization was not involved
        ii. N/A – Position or Department does not exist
    - Population Health Staff (facility level)
        i. N/A – Person or Organization was not involved
        ii. N/A – Position or Department does not exist
    - Community Benefit staff (facility level)
        i. N/A – Person or Organization was not involved
        ii. N/A – Position or Department does not exist
    - Community Benefit staff (system level)
        i. N/A – Person or Organization was not involved
        ii. N/A – Position or Department does not exist
    - Hospital Advisory Board
        i. N/A – Person or Organization was not involved
        ii. N/A – Position or Department does not exist

Additionally, we look forward to receiving your responses to the supplemental surveys.

From: David Baker <Dbaker@lifebridgehealth.org>
Sent: Thursday, March 23, 2023 11:46 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: Fw: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Hello,
Following up on your request, please see below our responses to follow-up questions in **blue** or **highlighted in yellow.** I will submit the supplemental reports for the facilities by the end of the day today.

Thank you,
Dave

David R. Baker, DrPH, MBA
Executive Director, Population Health

LifeBridge Health
dbaker@lifebridgehealth.org
Assistant: Cheryl Ebaugh, chebaugh@lifebridgehealth.org

LIFEBRIDGE HEALTH
CARE BRAVELY

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Tuesday, March 7, 2023 3:56 PM
To: Sharon McClernan <smcclernan@lifebridgehealth.org>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>

Subject: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Thank you for submitting the FY 2022 Hospital Community Benefit Narrative reports for Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Northwest Hospital Center, Sinai Hospital of Baltimore, and Grace Medical Center. In reviewing the narrative, we encountered several items that require clarification:

All Lifebridge Hospitals Except for Grace Medical Center

- Question 60 was left blank. Please describe your hospital's efforts to track and reduce health disparities in the community it serves.

  Our hospitals screen inpatients for social determinant of health (SDOH) needs and to assess health disparities. Our system-wide Population Health Department uses community-level mapping tools (e.g., the Area Deprivation Index) as well as CRISP and hospital-level data to identify specific neigborhoods facing inequities to target its outreach and support. LifeBridge proactively brings health screening, chronic disease education, health insurance sign-up, and referrals to health care providers to underserved communities surrounding our hospitals through community-based health events and mobile clinic outreach to reduce disparities. LifeBridge organizes and supports partnerships with community organizations (e.g., senior centers, public libraries, faith-based organizations, healthy food delivery programs, barber shops/salons, senior buildings, local Ys) to deliver these services and improve our ability to enhance community members' access to preventive screening, health care, and health-supporting resources.

- Question 61 was left blank. 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 below or indicate if there were none.
  - Regional Partnership Catalyst Grant Program
  - The Medicare Advantage Partnership Grant Program
  - The COVID-19 Long-Term Care Partnership Grant
  - The COVID-19 Community Vaccination Program
  - The Population Health Workforce Support for Disadvantaged Areas Program
  - Other (describe)

Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore

- For Question 44 on pages 6-8 and Question 46 on pages 8-10 both options "N/A – Person or Organization was not involved" and "N/A – Position or Department does not exist" were selected for the internal partner categories listed below. Please clarify which option you

meant to select.

- CB/ Community Health/Population Health Director (facility level)
- Population Health Staff (facility level)
- Community Benefit staff (facility level)
- Community Benefit staff (system level)
- Hospital Advisory Board

- For Question 48 on pages 10-12, the level of community engagement was selected for four stakeholder categories, but none of the recommended practices were selected. Please clarify which recommended practices should be selected for the following stakeholder groups:
  - Local Health Improvement Coalition

    Baltimore City Health Department helped collect and analyze data.

  - Maryland Department of Health

    Maryland Department of Health helped collect and analyze data.

  - School - K-12

    Pimlico Elementary and Middle Schools helped document and communicate results.

  - Other

    American Heart Association, American Diabetes Association helped implement improvement plans.

- Your community benefit narrative report appears to have experienced an error by not displaying the follow up questions regarding physician subsidies: questions 79 through 81 on page 16 of the attached. Please use this link to complete a supplemental report with only these questions: https://umbc.co1.qualtrics.com/jfe/form/SV_9XryoB7vuQA7NJk?Q_CHL=gl&Q_DL=EMD_Q5msih4UfQ4Z0IO_9XryoB7vuQA7NJk_MLRP_3dtAvJIlbgV2gFE&_g_=g

Northwest Hospital Center

- For Question 48 on page 11 of the attached, the level of community engagement was selected for Maryland Department of Health and Faith-Based Organizations but none of the recommended practices were selected. Please clarify which recommended practices listed below should be selected for these two stakeholder groups:
  - Identify & engage stakeholders -- Faith-Based Organizations
  - Define the community to be assessed
  - Collect and analyze the data -- Maryland Dept of Health

Select priority community health issues
    - Document and communicate results -- Faith-Based Organizations
    - Plan implementation strategies
    - Implement improvement plans
    - Evaluate progress
- The response to Question 73 on page 15 is unclear. Please provide more detail on how community benefit planning and investments were included in your hospital's internal strategic plan.

  The top community needs identified through our hospital's CHNA were used by our hospital senior leaders to prioritize them within the year's strategic planning.

- Your community benefit narrative report appears to have experienced an error by not displaying the follow up questions regarding physician subsidies: questions 79 through 81 on page 16 of the attached. Please use this link to complete a supplemental report with only these questions: https://umbc.co1.qualtrics.com/jfe/form/SV_aYn6n81gUDDAiay?Q_CHL=gl&Q_DL=EbfMGBSrXW166mt_aYn6n81gUDDAiay_MLRP_0SM4usoj365lEGy

Sinai Hospital of Baltimore

- Question 6 on page 1 was left blank. Please describe the community health statistics that your hospital uses in its community benefit efforts.

  Sinai Hospital uses:

  - Data powered by the Healthy Communities Institute and can be found at https://healthycarroll.org/lifebridge/

  - The Robert Wood Johnson Foundation's County Health Rankings and Roadmaps (https://www.countyhealthrankings.org/)

  - The Baltimore Neighborhood Indicators Alliance (https://bniajfi.org/)

  - Maryland Department of Health's Vital Statistics and Reports (https://health.maryland.gov/vsa/Pages/reports.aspx)

  - The Robert Wood Johnson Foundation's City Health Dashboard (https://www.cityhealthdashboard.com/md/baltimore/city-overview?metric=37&dataRange=city)

  - The University of Wisconsin School of Medicine and Public Health's Neighborhood Atlas/Area Deprivation Index Map (https://www.neighborhoodatlas.medicine.wisc.edu/)

- For Question 48 on pages 11-12 of the attached, the level of community engagement was selected for the following stakeholder categories: Local Health Improvement Coalition,

Maryland Department of Health, Schools-K-12 and Other. However, none of the recommended practices were selected. Please clarify which recommended practices listed below should be selected for these four stakeholder groups:

- Identify & engage stakeholders
- Define the community to be assessed
- Collect and analyze the data -- Maryland Dept of Health
- Select priority community health issues -- LHIC
- Document and communicate results -- Schools K-12
- Plan implementation strategies -- Other (American Heart Association, American Diabetes Association)
- Implement improvement plans
- Evaluate progress

- The response to Question 73 on page 15 is unclear. Please provide more detail on how community benefit planning and investments were included in your hospital's internal strategic plan.

  The top community needs identified through our hospital's CHNA were used by our hospital senior leaders to prioritize them within the year's strategic planning.

- Your community benefit narrative report appears to have experienced an error by not displaying the follow up questions regarding physician subsidies: questions 79 through 81 on page 16 of the attached. Please use this link to complete a supplemental report with only these questions: https://umbc.co1.qualtrics.com/jfe/form/SV_1TXaRWWAfSXiUCi?Q_CHL=gl&Q_DL=GKJnNyYJFz9UjKz_1TXaRWWAfSXiUCi_MLRP_0SM4usoj365lEGy

Grace Medical Center

- Your community benefit narrative report appears to have experienced an error by not displaying the follow up questions regarding physician subsidies: questions 79 through 81 on page 14 of the attached. Please use this link to complete a supplemental report with only these questions: https://umbc.co1.qualtrics.com/jfe/form/SV_cMZBRrFewsWFmNU?Q_CHL=gl&Q_DL=YAKyf0FyUpkqnKy_cMZBRrFewsWFmNU_MLRP_3dtAvJIlbgV2gFE

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

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Q77. Section IV - Physician Gaps & Subsidies

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

- ○ No
- ◉ Yes

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

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	○	◉	
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	○	◉	
Oncology-Cancer	○	◉	
Ophthalmology	○	◉	
Orthopedics	○	◉	
Otolaryngology	○	◉	
Pathology	○	◉	
Pediatrics	○	◉	
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	○	◉	
Psychiatry	○	◉	
Radiology	○	◉	
Surgery	○	◉	

Urology	○	◉	
Other, (Describe)	○	◉	

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

Emergency Medicine – Coverage of emergency department call: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care.

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

Q91. Summary & Report Submission

Q92.

Attention Hospital Staff! IMPORTANT!

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

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

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

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