

**Mercy Medical Center  
Community Benefit Narrative  
FY 2014**

**Reporting Requirements**

**I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:**

1. Please list the following information in Table I below. For the purposes of this section, “primary services area” means the Maryland postal ZIP code areas from which the first 60 percent of a hospital’s patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
225	15,224  And 2,566  Observation  cases	21202,21217, 21213,21215, 21218,21216, 21206,21223, 21224,21230, 21229,21201, 21207,21222, 21205,21225, 21234,21231	University of Maryland, Bon Secours, Sinai, St. Agnes, Johns Hopkins, Johns Hopkins Bayview, Union Memorial, Maryland General, Harbor	Baltimore City: 54.5%  Baltimore County: 25.2%  All other counties: 20.3%	Baltimore City: 60.8%  Baltimore County: 31.9%  All other counties: 7.3%

2. For purposes of reporting on your community benefit activities, please provide the following information:
  - a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital’s Community Benefit Service Area – “CBSA”. This service area may differ from your primary service area on page

1.) This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

### **DEFINING THE COMMUNITY SERVED BY MERCY**

In prior years, Mercy's community benefit outreach was focused on a large geographic area within Baltimore City. Mercy's primary service area historically covered 17 zip codes in which 60% of all inpatient admissions originated. 15 of these 17 zip codes were previously selected as Mercy's Community Benefit Service Area ("CBSA") based on the prevalence and concentration of emergency room visits. While appropriate and well intentioned, the use of zip codes as the basis for Mercy's CBSA has proved cumbersome for the following reasons:

- Zip codes are by nature large. Mercy's previous CBSA covered almost 70 square miles within the City—the total land area in Baltimore is 81 square miles. Other peer hospitals have designated a much smaller CBSA footprint that tends to focus on the immediate neighborhood(s) in which they reside.
- A concentration of emergency room visits (or any other variable) may only exist in a small portion of a zip code. Yet the entire zip code was being added into our CBSA.
- Accessible, timely, and high quality community health profiles have already been created by the Baltimore City Health Department. But these community health profiles are organized by much smaller Community Statistical Areas (CSAs), not zip codes.
- Finally, zip codes are faceless, impersonal designations that do not carry the same connection and impact as a specifically named community. Mercy's Community Benefits Committee believes that we should focus attention on our neighbors in "Midtown" or "Mt. Vernon", and not "21202".

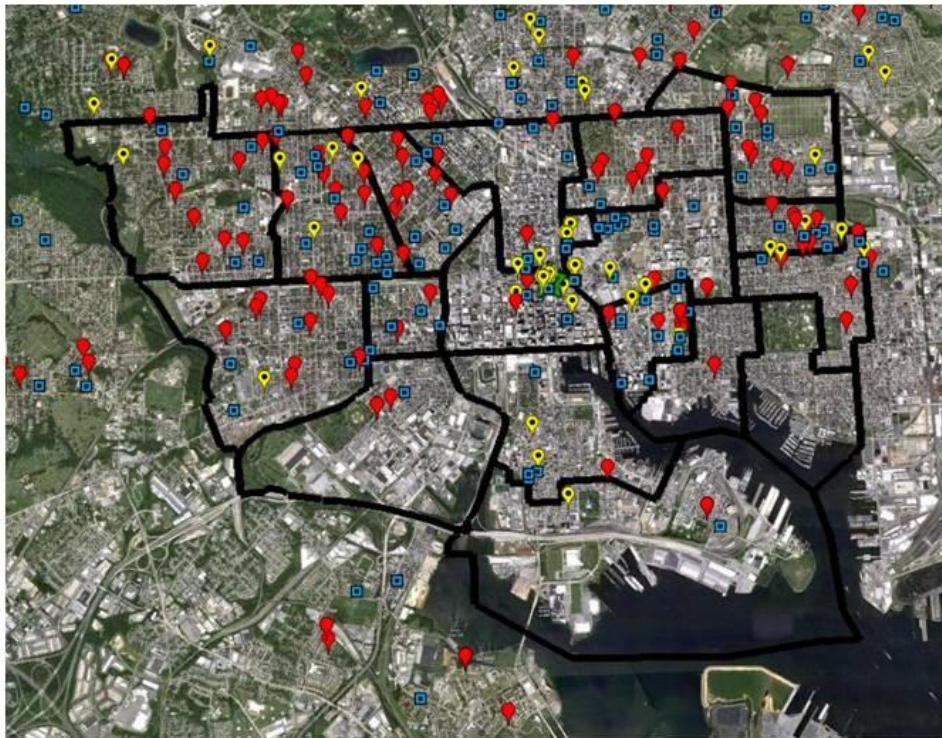
During a series of meetings, Mercy's Community Benefits Committee discussed the socioeconomic and health parameters that should help define Mercy's "community" for purposes of this CHNA. The Sisters of Mercy were originally founded in Dublin, Ireland to care for homeless, abused and neglected women and children. **This timeless legacy influenced the Committee to focus attention on certain target populations, such as infants, women, and the impoverished.** With a strong desire to be data-driven and mission focused, the Committee identified three relevant factors to help shape the community in which Mercy will focus its limited financial resources as part of the CHNA process:

- Low birth weight babies born at Mercy
- Repeat emergency room visitors (10+ visits in one year)
- Charity care recipients

These data points were compiled and plotted by CSA to identify any concentrations or obvious areas in need of intervention. While these target populations are found throughout Baltimore City and into the surrounding Counties, the map below highlights the disproportionate share of low birth weight babies, repeat emergency department visitors, and charity care recipients in the downtown core. As a result of these findings, Mercy has determined that its community served for purposes of this CHNA includes the 18 CSAs that represent downtown and the communities east,

west, and south of the city center. The Committee believes that this definition of Mercy’s community, which represents a smaller geographic area than the CBSA previously utilized by Mercy, will foster greater coordination, better strategic partnerships and improved measurement of outcomes, in particular with respect to the targeted populations described above.

## First Step – Defining Our Service Area



Canton  
 Clifton-Berea  
 Downtown / Seton Hill  
 Fells Point  
 Greater Rosemont  
 Greenmount East  
 Harbor East / Little Italy  
 Inner Harbor / Fed Hill  
 Madison / East End  
 Midtown  
 Oldtown / Middle East  
 Patterson Park North & East  
 Poppleton /Terraces/Hollins  
 Market  
 Sandtown-Winchester/Harlem Park  
 South Baltimore  
 Southwest Baltimore  
 Washington Village  
 Upton / Druid Heights

- **Red Pins**— Low Birth Weight Babies by Address
- **Blue Pins**— Repeat ED Visitors by Address (10+ visits in one year)
- **Yellow Pins**— Charity Care Recipients by Address

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b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person’s current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature.

### **FINDINGS FROM ANALYSIS OF QUANTITATIVE DATA—MERCY’S COMMUNITY HEALTH PROFILE**

To obtain the quantitative data required to complete the assessment, Mercy’s Community Benefit Committee used the high quality and comprehensive Neighborhood Health Profiles completed by the Baltimore City Health Department in 2008 and 2011 (and updated in March 2012). The

Neighborhood Health Profiles present demographic, social and health outcome information at the CSA level in Baltimore City to support community-level health improvement efforts to achieve the Healthy Baltimore 2015 plan, the City's comprehensive public health agenda to improve health outcomes in Baltimore. The City plans to conduct these comprehensive Neighborhood Health Profiles every two to three years. By partnering with the Baltimore City Health Department, Mercy avoided the unnecessary expense of conducting a redundant community survey and received an extremely high quality, current, and narrowly tailored dataset. Mercy was able to leverage this existing data source to help create a single community health profile that spans across the 18 CSAs in the hospital's community. Thus, Mercy can state specifically the demographic and health status of residents living in our specific community and not rely on extrapolations from aggregate citywide data. As we develop long term implementation strategies, this ability to measure trends in specific communities should prove to be very useful. **Beyond providing a solid foundation for data analysis and ongoing programmatic accountability, this strategic partnership with the City Health Department ensures that the community health priorities of Mercy Medical Center remain aligned with the health priorities of the City and the City Health Commissioner.**

In order to put together the Neighborhood Health Profiles, the Baltimore City's Office of Epidemiology Services compiled an enormous amount of data from a variety of public and private sources such as the following:

- U.S. Census
- American Community Survey
- The Baltimore Neighborhoods Indicators Alliance—Jacob France Institute
- Baltimore City Public Schools System
- The Mayor's Office of Information Technology
- Baltimore City Housing Department
- Baltimore City Comptroller's Office
- Baltimore City Planning Department
- Baltimore City Real Property Management Database
- Baltimore City Liquor Board
- Baltimore City Health Department
- The Center for a Liveable Future
- Vital Statistics Administration at the Maryland Department of Health and Mental Hygiene
- Maryland Department of the Environment
- The National Center for Health Statistics

#### Demographic Characteristics—Race, Age & Gender

The first chart below details the demographic makeup of Mercy's community. 187,714, or 30%, of the City's 620,961 residents live within Mercy's defined community. Of note, the total population of the City in the health profile does not include incarcerated residents. Mercy's community ranges

from the Gwynns Falls to the west, Edison Highway to the east, North Avenue to the north and the South Baltimore peninsula to the south. The area of focus comprises an incredibly diverse cross section of the City. However, on the whole, the diversity of this geographic area represents an aggregate diversity; there are distinctive concentrations of racial and ethnic groups as well as wealth and poverty within the eighteen community statistical areas. Almost 67% of the residents within Mercy’s community are minorities. In 13 of the 18 CSAs, racial and ethnic minorities make up the majority of residents. In 8 of the 18 CSAs, the Black resident population exceeds 83%. White residents make up more than 75% of the population in Canton, Fells Point, Inner Harbor/Federal Hill, and South Baltimore. Hispanic/Latino residents comprise 4.4% of the population in our target area, which is slightly higher than the citywide percentage. The highest concentration of Hispanic/Latino residents in our community is located in Patterson Park North & East (21.1%) and Fells Point (15.1%). Though only 3.1% of our community’s population is Asian, the percentage of Asian residents in our target area is higher than the citywide percentage. In particular, the Asian population in Downtown/Seton Hill (16%), Fells Point (7.6%), and Washington Village/Pigtown (5.3%) are all more than double the 2.2% citywide Asian representation.

2011 Neighborhood Health Profile Summary

Mercy Health Services Proposed Community Benefit Service Area

1. Demographics

CSA	Population	Percentage of Population by Race/Ethnicity					
		Black	White	Asian	Other	Two or More	Hispanic/Latino
Canton	8,100	4.1	88.9	3.4	1.9	1.7	5.0
Clifton-Berea	9,874	96.9	1.2	0.3	0.5	1.2	1.0
Downtown/Seton Hill	6,446	37.5	41.8	16.0	1.5	3.1	4.5
Fells Point	9,039	8.0	76.7	4.6	7.3	3.3	15.1
Greater Rosemont	19,258	97.1	0.7	0.2	0.5	1.5	1.0
Greenmount East	9,262	94.3	3.6	0.3	0.7	1.1	1.2
Inner Harbor/Federal Hill	12,855	11.7	81.5	3.9	1.2	1.8	3.2
Jonestown/Oldtown*	10,841	75.7	17.7	2.7	2.1	1.8	4.3
Madison/East End	7,781	91.1	4.0	0.9	2.2	1.7	4.0
Midtown	15,685	34.3	53.4	7.6	1.4	3.3	3.8
Patterson Park North & East	14,549	38.7	44.1	2.0	11.8	3.4	21.1
Perkins/Middle East*	4,587	87.1	7.5	3.6	0.6	1.3	1.5
Poppleton/The Terraces/Hollins Market	5,086	83.5	13.2	1.0	0.9	1.4	1.7
Sandtown/Winchester/Harlem Park	14,801	96.9	1.2	0.3	0.3	1.2	0.7
South Baltimore	6,406	2.7	92.1	2.7	0.8	1.7	2.6
Southwest Baltimore	17,886	76.2	17.6	1.2	2.6	2.4	3.6
Upton/Druid Heights	9,755	94.3	3.1	0.5	0.6	1.5	1.4
Washington Village/Pigtown	5,503	49.7	40.7	5.3	1.6	2.7	3.4
Mercy Health Services Area Estimate	187,714	60.0	32.7	3.1	2.1	2.0	4.4
Baltimore City	620,961	63.6	29.7	2.4	2.2	2.1	4.2

52% of residents within Mercy’s community are female and 48% are male. Mercy’s community has slightly more male residents and slightly fewer female residents when compared to Baltimore City as a whole. With respect to the age of the population within Mercy’s community, residents in our

community tend to be younger than the City as a whole. As portrayed in the chart below, 34.7% of residents in our focus area are between the ages of 25 and 44. Only 28.8% of residents in the entire City are between 25 and 44. The age data for the community is skewed upward by the high concentrations of young adults in some of the more affluent neighborhoods near the Inner Harbor. In Canton, Downtown/Seton Hill, Fells Point, South Baltimore, and the Inner Harbor/Federal Hill, the percentage of the population between the ages of 25 and 44 exceeded 47%. Mercy's community also has fewer senior citizens when compared to the City as a whole. Only 9.8% of the community's residents are 65 and up as compared to 11.8% of the citywide population.

**2011 Neighborhood Health Profile Summary  
Mercy Health Services Proposed Community Benefit Service Area**

**1. Demographics (continued)**

CSA	Percentage of Population by Age (years)					Percentage of Population by Gender	
	Under 18	18-24	25-44	45-64	65 and up	Male	Female
Canton	7.1	10.5	53.0	18.5	10.9	49.5	50.5
Clifton-Berea	25.5	10.5	22.5	26.1	15.5	45.3	54.7
Downtown/Seton Hill	8.0	20.6	50.7	16.9	3.8	49.1	50.9
Fells Point	9.7	11.3	51.7	19.5	7.7	51.0	49.0
Greater Rosemont	26.1	11.0	22.3	27.6	12.9	45.6	54.4
Greenmount East	23.0	11.2	24.1	30.7	11.1	50.6	49.4
Inner Harbor/Federal Hill	9.5	13.3	47.2	19.4	10.6	50.8	49.2
Jonestown/Oldtown*	24.0	11.2	32.5	23.5	8.8	48.1	51.9
Madison/East End	32.8	13.1	24.9	22.6	6.6	46.1	53.9
Midtown	6.4	22.2	39.0	19.6	12.7	48.5	51.5
Patterson Park North & East	22.2	11.6	41.2	18.7	6.2	50.1	49.9
Perkins/Middle East*	26.2	12.0	25.8	23.2	12.8	42.8	57.2
Poppleton/The Terraces/Hollins Market	25.5	10.5	28.7	25.9	9.3	47.2	52.8
Sandtown-Winchester/Harlem Park	25.8	11.5	23.9	26.9	11.8	45.7	54.3
South Baltimore	10.6	10.4	51.3	19.6	8.1	50.9	49.1
Southwest Baltimore	27.1	11.0	25.3	26.6	10.0	48.6	51.4
Upton/Druid Heights	30.0	12.0	23.7	24.4	10.0	44.7	55.3
Washington Village/Pigtown	21.0	11.3	37.6	22.0	8.1	49.8	50.2
Mercy Health Services Area Estimate	20.0	12.5	34.7	22.9	9.8	48.0	52.0
Baltimore City	21.6	12.5	28.8	25.2	11.8	46.7	53.3

**Socioeconomic Characteristics**

In general, Mercy's community is poorer than the City as a whole. 40.6% of households in Mercy's community earn less than \$25,000 compared to 33.3% for the City. Adult unemployment ranges from highs of 21% in Sandtown-Winchester/Harlem Park and 20% in Clifton-Berea to a low of 2.5% in the Inner Harbor/Federal Hill community. This alarmingly high range in unemployment rates highlights the severity of the socioeconomic disparities found within Mercy's community. 11 of the 18 CSAs in Mercy's service area have unemployment rates that exceed the City's already high unemployment rate of 11%. Poverty levels within Mercy's community are also disturbingly high.

21.4% of families in Mercy's community have incomes below the federal poverty level. Again, the range within our community is striking—48.8% of families in Upton/Druid Heights earn below the poverty level; only 1.6% of families in Canton earn below the poverty level. According to the Annie E. Casey Foundation's 2012 Kids Count Report, 84% of City school children receive free and reduced price meals, which is double the statewide average of 42%. These socioeconomic characteristics strike at the heart of the real world challenges confronting any government or hospital-led efforts to improve health outcomes in Mercy's community. If 1 in 8 adults are unemployed and more than 1 in 5 families are living below the poverty level, then personal health choices and accessing health systems take a back seat to more basic day to day needs. Any effort to affect change in the community must be grounded in this fundamental reality.

### Education

The education data in Mercy's Neighborhood Health Profile reveals that children in our community are less prepared for kindergarten, score lower on key reading assessments, and are more chronically absent from school. Increased public funding for pre-K programs in the City is currently helping to address school readiness issues in Baltimore. However, the drop off in advanced or proficient reading levels between the 3<sup>rd</sup> and 8<sup>th</sup> grade is alarming (a 41% reduction in this key performance indicator occurred in the Poppleton CSA).



**2011 Neighborhood Health Profile Summary  
Mercy Health Services Proposed Community Benefit Service Area**

**3. Education**

CSA	% of Kindergarten Students "Fully Ready" to Learn	% of students reading at "proficient" or "advanced" levels		% of students missing 20 or more days of school		
		3rd Grade	8th Grade	Elementary	Middle	High
Canton	47.8	79.2	75.7	9.9	14.7	33.3
Clifton-Berea	71.0	65.0	42.8	12.7	18.6	45.4
Downtown/Seton Hill	65.5	72.5	48.1	5.6	22.2	41.9
Fells Point	74.3	78.2	52.3	6.3	19.4	31.9
Greater Rosemont	56.0	74.2	51.0	9.9	19.3	47.0
Greenmount East	43.3	72.4	44.4	14.2	21.3	45.3
Inner Harbor/Federal Hill	55.0	81.8	67.2	8.2	14.9	41.2
Jonestown/Oldtown*	57.9	72.8	52.6	13.1	21.1	50.9
Madison/East End	64.2	70.9	41.0	14.2	26.5	52.6
Midtown	59.6	75.1	56.3	13.3	13.9	46.9
Patterson Park North & East	60.1	62.1	43.6	13.4	23.7	46.3
Perkins/Middle East*	44.7	73.8	45.7	17.1	27.0	47.2
Poppleton/The Terraces/Hollins Market	76.6	84.1	43.4	11.3	26.7	49.6
Sandtown-Winchester/Harlem Park	60.1	65.6	51.6	7.3	21.5	45.8
South Baltimore	70.4	85.9	70.2	9.8	18.8	25.0
Southwest Baltimore	61.2	73.2	45.9	11.8	27.6	48.0
Upton/Druid Heights	55.1	58.8	40.6	10.9	33.5	49.0
Washington Village/Pigtown	69.3	70.9	53.0	6.5	23.8	41.3
Mercy Health Services Area Estimate	60.7	73.1	51.4	10.9	21.9	43.8
Baltimore City	65.0	77.6	58.6	10.1	16.3	39.2

Office of Epidemiology Services, Baltimore City Health Department

2011 NHP October 2012

**Physical, Built, and Social Environment**

Though often overlooked in health surveys, the Baltimore City Health Department’s health profile project compiled data on the built and social environment affecting residents in the City. These policy experts sought to identify and track environmental factors that directly contribute to the health and well-being of our community’s residents. Scholarly research like the CDC’s Adverse Childhood Experiences (ACE) study highlights the link between childhood trauma and later-life health. The CDC’s ACE study found a strong correlation between adverse childhood experiences and poor health outcomes. The ACE Study suggests that children exposed to the “toxic stress” of violence, homelessness, abuse, and neglect are at a greater risk for illness and premature death as well as a lower quality of life. Children are also greatly impacted by family dysfunction when their parents are separated, mentally ill or incarcerated. The chart below reveals that residents in Mercy’s community are disproportionately exposed to alcohol and liquor stores, juvenile arrests, domestic violence and gun violence. In addition to these adverse social conditions, the built environment presents similar challenges within our community. Data from our health



profile reveals that our community has more than twice the rate of vacant homes and lead paint violations as the rest of the City. Furthermore, an oversupply and over-reliance on carry out restaurants and corner stores for food supply also highlights the existence of food deserts within our community.

**2011 Neighborhood Health Profile Summary  
Mercy Health Services Proposed Community Benefit Service Area**

**4. Community Built and Social Environment**

CSA	Alcohol Store Density per 10,000 Residents	Tobacco Store Density per 10,000 Residents	Juvenile Arrests per 1,000 10-17 Year Olds	Domestic Violence Incidents Reported per 1,000 Res.	Non-Fatal Shootings per 10,000 Residents
Canton	4.9	23.5	179.3	18.7	2.5
Clifton-Berea	8.1	49.6	326.5	58.2	126.6
Downtown/Seton Hill	20.2	130.3	906.7	45.5	69.8
Fells Point	6.6	50.9	129.4	21.7	13.3
Greater Rosemont	7.8	36.9	182.1	56.8	95.0
Greenmount East	9.7	49.7	280.3	53.2	115.5
Inner Harbor/Federal Hill	4.7	38.1	264.7	14.5	6.2
Jonestown/Oldtown*	5.5	25.8	187.5	46.6	76.6
Madison/East End	5.1	50.1	280.2	66.2	169.6
Midtown	8.3	28.7	249.1	19.1	22.3
Patterson Park North & East	2.7	32.3	205.4	42.6	49.5
Perkins/Middle East*	6.5	50.1	337.1	59.7	117.7
Poppleton/The Terraces/Hollins Market	9.8	43.3	155.6	57.1	72.7
Sandtown-Winchester/Harlem Park	8.1	56.1	252.3	68.1	91.2
South Baltimore	3.1	18.7	102.1	15.9	1.6
Southwest Baltimore	11.2	51.4	250.0	66.3	117.4
Upton/Druid Heights	6.2	39.0	340.0	55.0	108.7
Washington Village/Pigtown	7.3	50.9	204.5	46.1	50.9
Mercy Health Services Area Estimate	7.6	45.9	268.5	45.1	72.6
Baltimore City	4.6	21.8	145.09	40.6	46.5

Community Health Indicators

- Premature Mortality and Years of Potential Life Lost (YPLL)

In the citywide health profile, the City Health Department used life expectancy estimates that reflected the mortality rates in the City from 2005 thru 2009. The estimated citywide life expectancy at birth in Baltimore was 71.8 years. Life expectancy is a significant indicator of overall health. The City Health Department used the life expectancy and

mortality rates to calculate the years of potential life lost (YPLL) throughout our community. YPLL measure the impact of premature mortality on a specific population. The City Health Department defined premature mortality as death before age 75. The Health Department then calculated the YPLL by adding together the years of life that were not lived because people died before the age of 75. Thus, infant deaths and juvenile deaths can heavily impact a community's life expectancy data and YPLL.

**The chart below reveals that more people die prematurely from all causes in Mercy's community than in the City as a whole.** The Health Department calculated that 36.2% of all deaths in the City are avertable. Avertable deaths are defined as being deaths that could have been avoided if all Baltimore communities had the same opportunities for health. Specifically, the Health Department created a baseline by calculating the death rate in the five communities with the highest income in the City. The assumption is that the death rate in the five highest-income neighborhoods can be achieved by every other community. In the chart below, a positive percentage in the column labeled "% of deaths potentially avertable" reflects the percentage of deaths that could have been avoided if a particular CSA had the same death rate as the baseline rate from the five highest-income communities. While the overall death rates in our community is higher than the city average, the data for the Downtown/Seton Hill community, Madison/East End, Poppleton, and Upton/Druid Heights merits further examination. On the most basic level, the data suggests that we have a significant problem in these areas with residents dying far earlier than residents in higher income neighborhoods. One potential factor in the Downtown/Seton Hill data point (approx 70% avertable death) could be the disproportionate concentration of homeless persons in the downtown area. During a CHNA interview of Kevin Lindamood, the President and CEO of Healthcare for the Homeless, the Mercy Community Benefit Committee learned that the average life expectancy for an individual experiencing homelessness at any point is only 47 years

2011 Neighborhood Health Profile Summary  
Mercy Health Services Proposed Community Benefit Service Area

## 7. Health Outcomes

CSA	Age-adjusted Deaths per 10,000 Residents, All Causes	Total Annual YPLL, per 10,000 Residents	% of Deaths Potentially Avertable
Canton	86.7	506.7	15.9
Clifton-Berea	141.9	2,423.5	45.8
Downtown/Seton Hill	238.2	1,511.9	69.9
Fells Point	110.6	806.9	35.0
Greater Rosemont	140.0	1,902.1	46.7
Greenmount East	144.9	2,241.6	54.1
Inner Harbor/Federal Hill	83.5	624.7	15.6
Jonestown/Oldtown*	113.2	1,431.0	42.9
Madison/East End	157.9	2,264.0	64.0
Midtown	90.6	875.0	18.2
Patterson Park North & East	133.9	1,312.8	50.4
Perkins/Middle East*	128.9	1,852.6	48.5
Poppleton/The Terraces/Hollins Market	171.7	2,366.5	64.0
Sandtown-Winchester/Harlem Park	144.5	2,323.1	50.8
South Baltimore	122.3	782.4	40.6
Southwest Baltimore	157.8	2,250.4	57.3
Upton/Druid Heights	175.8	2,494.5	63.2
Washington Village/Pigtown	145.9	1,482.8	55.3
Mercy Health Services Area Estimate	128.0	1,636.3	46.6
Baltimore City	110.8	1,377.4	36.2

Office of Epidemiology Services, Baltimore City Health Department 2011 NHP October 2012

- Top Causes of Premature Death

A significant output of Mercy’s community health profile is the identification of the top causes of premature death within our specific community. **The top four causes of premature death in our 18 priority communities are heart disease, cancer, homicides, and HIV/AIDS.** These four categories contribute greatly to the years of potential life lost in each neighborhood. These four causes also match up with the highest percentages of potential life lost in the City as a whole (see chart below). Of note, these four conditions are not necessarily the top causes of death in our community. For example, there are 5.2 strokes deaths per 10,000 residents in the City and 3.5 homicide deaths per 10,000 residents in the City. However, when calculating the years of potential life lost, the younger age of homicide victims prioritizes the impact of their premature death in our health profile.

2011 Neighborhood Health Profile Summary  
 Mercy Health Services Proposed Community Benefit Service Area

**7. Health Outcomes (continued)**

CSA	% of Years of Potential Life Lost by Cause of Deaths				
	Heart Disease	Cancer (All)	Lung Cancer	Stroke	HIV/AIDS
Canton	18.2	20.6	3.8	3.9	+
Clifton-Berea	15.1	14.7	3.4	3.1	7.8
Downtown/Seton Hill	14.8	17.4	4.0	0.0	15.3
Fells Point	12.1	15.4	3.6	3.8	+
Greater Rosemont	15.2	13.6	3.5	2.1	8.6
Greenmount East	14.3	14.7	4.7	3.1	10.7
Inner Harbor/Federal Hill	19.8	15.4	2.7	2.7	5.6
Jonestown/Oldtown*	14.0	12.4	2.8	2.8	10.4
Madison/East End	13.0	10.2	3.5	1.9	6.9
Midtown	20.0	14.0	3.9	1.9	15.7
Patterson Park North & East	12.5	16.2	4.2	2.2	7.5
Perkins/Middle East*	15.0	12.0	3.0	2.4	11.4
Poppleton/The Terraces/Hollins Market	9.9	9.6	4.1	3.4	12.5
Sandtown-Winchester/Harlem Park	14.1	13.4	3.2	2.1	7.3
South Baltimore	15.5	18.0	6.7	1.1	+
Southwest Baltimore	17.0	13.3	4.2	2.1	7.5
Upton/Druid Heights	16.8	10.6	2.8	1.7	12.8
Washington Village/Pigtown	15.8	14.8	8.2	3.9	6.3
Mercy Health Services Area Estimate	15.1	14.3	4.0	2.5	8.6
Baltimore City	15.4	14.7	4.2	2.6	7.6

+ Rate not calculated - fewer than five deaths

**2011 Neighborhood Health Profile Summary  
Mercy Health Services Proposed Community Benefit Service Area**

**7. Health Outcomes (continued)**

CSA	% of Years of Potential Life Lost by Cause of Deaths				
	Chronic Lower Respiratory Disease	Homicide	Diabetes	Septicemia	Drug-Induced Deaths
Canton	2.3	+	2.9	3.0	+
Clifton-Berea	0.9	16.3	1.1	2.5	7.7
Downtown/Seton Hill	0.8	7.7	3.7	2.3	6.7
Fells Point	1.4	8.3	1.6	1.1	15.9
Greater Rosemont	1.5	17.6	1.0	2.3	7.8
Greenmount East	1.9	12.6	2.8	3.2	8.6
Inner Harbor/Federal Hill	2.1	+	3.6	4.2	10.1
Jonestown/Oldtown*	3.0	12.9	1.5	0.6	5.7
Madison/East End	1.6	24.2	0.5	2.0	7.1
Midtown	0.6	4.5	3.2	0.5	6.8
Patterson Park North & East	0.6	13.6	1.3	1.5	9.4
Perkins/Middle East*	0.9	15.7	2.6	4.4	4.7
Poppleton/The Terraces/Hollins Market	1.6	13.0	1.2	2.9	11.1
Sandtown-Winchester/Harlem Park	1.3	16.4	1.2	2.4	9.1
South Baltimore	3.8	+	0.0	1.8	10.5
Southwest Baltimore	1.4	13.0	2.0	2.2	10.0
Upton/Druid Heights	0.8	14.6	1.9	2.9	8.4
Washington Village/Pigtown	1.6	9.7	1.4	2.6	6.2
Mercy Health Services Area Estimate	1.6	11.4	1.9	2.4	7.2
Baltimore City	1.6	12.5	2.0	2.1	7.8

+ Rate not calculated - fewer than five deaths

Office of Epidemiology Services, Baltimore City Health Department      2011 NHP      October 2012

- Maternal and Child Health Indicators

The Sisters of Mercy were originally founded in Dublin, Ireland, to care for the needs of women and children. From our founding principles to the fact that more babies are born at Mercy than at any other hospital, Mercy Medical Center is highly invested in improving maternal and child health outcomes in our community for a variety of reasons. The data below suggests that despite the hospital's strong efforts and the early success of the City's B'more for Healthy Babies campaign, much more must be done to improve the health outcomes for mothers, infants, and children in our City. Despite reductions in the citywide teen birth rate in recent years, the rate of births to persons 15-19 years old remains 50% higher in Mercy's community. 10 of the 18 CSAs in our community have a teen birth rate that is at least 75% higher than the citywide average. With respect to the percentage of

women receiving prenatal care in the first trimester, Mercy’s community is on par with the Citywide average. However, the disparity within Mercy’s community merits further attention. Only 50.2% of women in Madison/East End received prenatal care in the first trimester compared to 75% in both Canton and South Baltimore. The southern boundary of Madison/East End is physically located five blocks (approximately 1700 feet) from a northern boundary of Canton. Furthermore, the data suggests that several areas within our community are unfortunately confronted by high rates of smoking during pregnancy, pre-term births, low birth weights, and infant deaths. These particular findings suggest that community specific interventions will be needed to affect real change.

**2011 Neighborhood Health Profile Summary  
Mercy Health Services Proposed Community Benefit Service Area**

**7. Health Outcomes (Maternal and Child Health)**

CSA	Live Births	Teen Birth	% of Live	% of Women
	per 1,000 Persons	Rate per 1,000 Persons 15-19 Years Old	Births with Inadequate Birth Spacing (<12 months)	Receiving Prenatal Care in the 1st Trimester
Canton	12.0	51.2	2.3	75.0
Clifton-Berea	18.1	123.9	5.5	51.2
Downtown/Seton Hill	9.8	58.7	2.2	63.8
Fells Point	15.4	168.9	2.2	61.3
Greater Rosemont	18.1	113.9	6.3	54.9
Greenmount East	17.9	114.7	6.5	56.2
Inner Harbor/Federal Hill	12.3	68.0	4.2	72.4
Jonestown/Oldtown*	16.6	89.6	5.7	54.7
Madison/East End	24.6	128.1	5.9	50.2
Midtown	6.7	10.7	2.1	66.1
Patterson Park North & East	20.3	122.9	4.4	53.5
Perkins/Middle East*	19.9	142.5	4.6	52.4
Poppleton/The Terraces/Hollins Market	18.1	94.0	7.4	58.0
Sandtown-Winchester/Harlem Park	18.5	116.0	5.2	52.8
South Baltimore	14.2	55.4	2.6	75.0
Southwest Baltimore	20.6	117.9	7.2	57.4
Upton/Druid Heights	21.9	116.9	5.1	55.3
Washington Village/Pigtown	14.5	82.6	4.3	65.3
Mercy Health Services Area Estimate	16.6	98.7	4.7	59.8
Baltimore City	15.5	65.4	4.7	59.5

2011 Neighborhood Health Profile Summary  
 Mercy Health Services Proposed Community Benefit Service Area

**7. Health Outcomes (Maternal and Child Health continued)**

CSA	% of Births to Mothers who Reported Smoking During Pregnancy	% of Live Births Occuring Preterm (<37 weeks)	% of Births Classified as Low Birth Weight (<5 lb. 8 oz.)	Infant Mortality Rate per 1,000 Live Births
Canton	3.1	10.3	6.6	+
Clifton-Berea	15.2	19.3	15.3	16.8
Downtown/Seton Hill	6.0	13.0	10.2	+
Fells Point	3.9	13.5	7.9	7.1
Greater Rosemont	12.2	16.4	14.8	13.8
Greenmount East	13.4	18.7	18.6	15.7
Inner Harbor/Federal Hill	3.9	10.6	7.2	+
Jonestown/Oldtown*	10.5	17.0	12.4	12.1
Madison/East End	13.5	19.3	16.3	16.7
Midtown	7.1	12.1	12.5	11.5
Patterson Park North & East	9.6	15.4	10.5	8.8
Perkins/Middle East*	11.6	19.1	14.3	+
Poppleton/The Terraces/Hollins Market	10.7	19.1	15.4	13.0
Sandtown-Winchester/Harlem Park	14.8	17.9	16.0	21.2
South Baltimore	7.7	10.5	6.1	8.8
Southwest Baltimore	17.3	18.3	15.2	13.6
Upton/Druid Heights	12.3	19.0	15.2	15.0
Washington Village/Pigtown	19.8	17.1	14.1	12.6
Mercy Health Services Area Estimate	10.7	15.9	12.7	12.0
Baltimore City	10.2	16.0	13.0	12.1

+ Rate not calculated - fewer than five deaths

Office of Epidemiology Services, Baltimore City Health Department 2011  
 NHP October 2012

**II. COMMUNITY HEALTH NEEDS ASSESSMENT**

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

The IMPLEMENTATION STRATEGY must:

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



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

Yes  
 No

Provide date here. 3/28/2013 Posted to Mercy website

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

<http://mdmercy.com/~media/Mercy%20Site/Files/About%20Mercy/Policies%20and%20Corporate%20Documents/Current%20CHNA%20Assessment.ashx>

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

Yes  
 No

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

<http://mdmercy.com/~media/Mercy%20Site/Files/About%20Mercy/Policies%20and%20Corporate%20Documents/2013%20CHNA%20Implementation%20Strategy.ashx>

### III. COMMUNITY BENEFIT ADMINISTRATION

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

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

Yes  
 No

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

- i. Senior Leadership

1.  CEO
2.  CFO

- 3. Other - Board Committee, Sr. VP for Institutional Advancement, VP for Corporate Affairs

ii. Clinical Leadership

- 1. XX Physician
- 2. XX Nurse
- 3. XX Social Worker

iii. Community Benefit Department/Team

- 1. \_\_\_ Individual (please specify FTE)
- 2. XX Committee (please list members)

Assistant to the President for Mission
Senior Vice President for Institutional Advancement
Chief of Staff & Vice President for Corporate Affairs
Senior Director of Financial Planning
Director of Community Outreach
Director of Social Work
Director of Pastoral Care
Community member who is a Licensed Clinical Social Worker who led both a hospital Social Work and Pastoral Care department
Community member who is a former State Legislator, agency head, and corporate executive.

- 3. \_\_\_ Other (please describe)

In addition to the Committee members named above, strategic advice and direction were provided to the Committee by the following individuals:

Chief Financial Officer, Mercy Health Services  
 Chair, Department of Obstetrics and Gynecology  
 Chair, Emergency Services Department

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

Spreadsheet    XX yes    \_\_\_no  
 Narrative      XX yes    \_\_\_no

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

Spreadsheet	XX yes	_____no
Narrative	XX yes	_____no

If you answered no to this question, please explain why.

#### IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

- a. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.
- b. Name of Initiative: insert name of initiative.
- c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (Use several pages if necessary)
- d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?
- e. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.
- f. How were the outcomes of the initiative evaluated?
- g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?

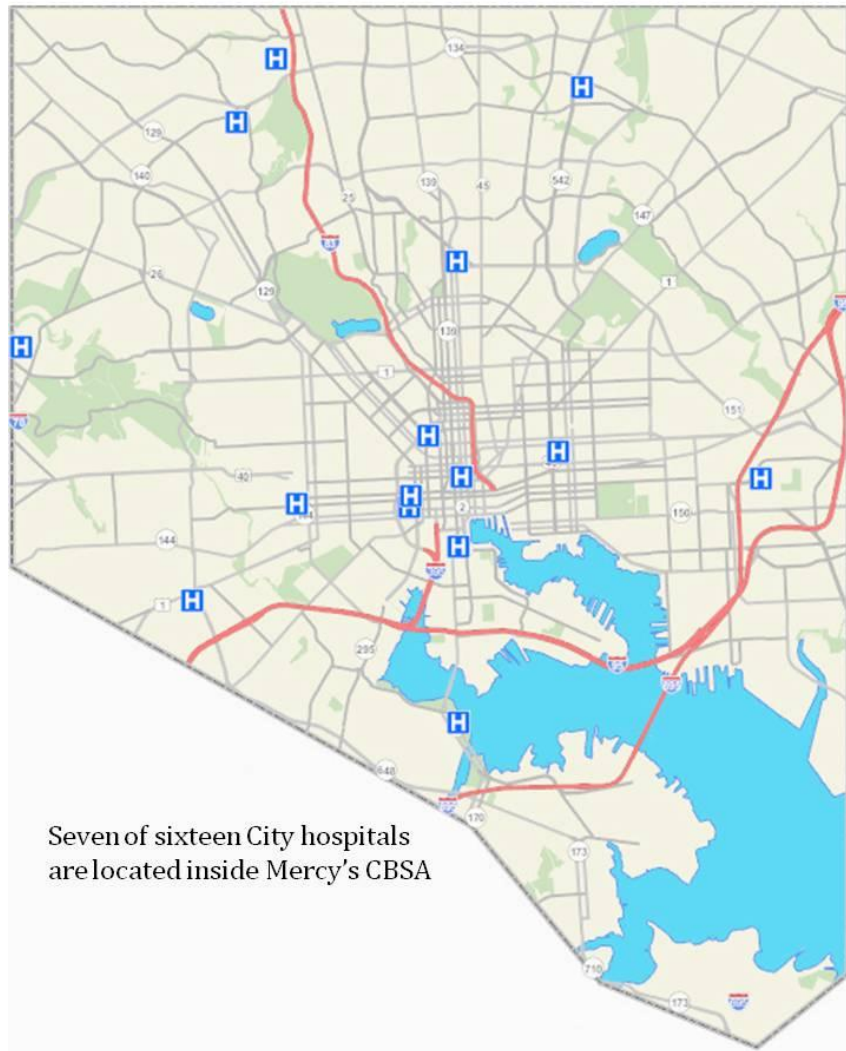
- h. Continuation of Initiative: Will the initiative be continued based on the outcome?
  - i. Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
2. Were there any primary community health needs that were identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

At this time Mercy does not intend to create a new community based program focused solely on heart disease and cancer. It is our belief that considerable local and state resources are currently invested in these key causes of premature death. Furthermore, two large, high quality academic medical centers exist within walking distance of our downtown hospital. Our Committee believes that Johns Hopkins Medical System and the University of Maryland Medical System may be better suited to address these overarching community needs given the size and specific makeup of their cardiology and cancer programs. While Mercy does not plan to create new stand alone programs in these two high priority fields, we do plan to continue our efforts to reduce these top causes of premature death through our existing clinical programs and by improving care coordination and health education in the community setting.

**EXISTING HEALTH CARE FACILITIES & OTHER COMMUNITY RESOURCES**

Baltimore is fortunate to be home to some of the finest health care institutions and providers in the world. Seven of the sixteen acute care hospitals in Baltimore City are located within Mercy's Community Benefit Service Area. A list and a map of the Baltimore City Hospitals are located below.

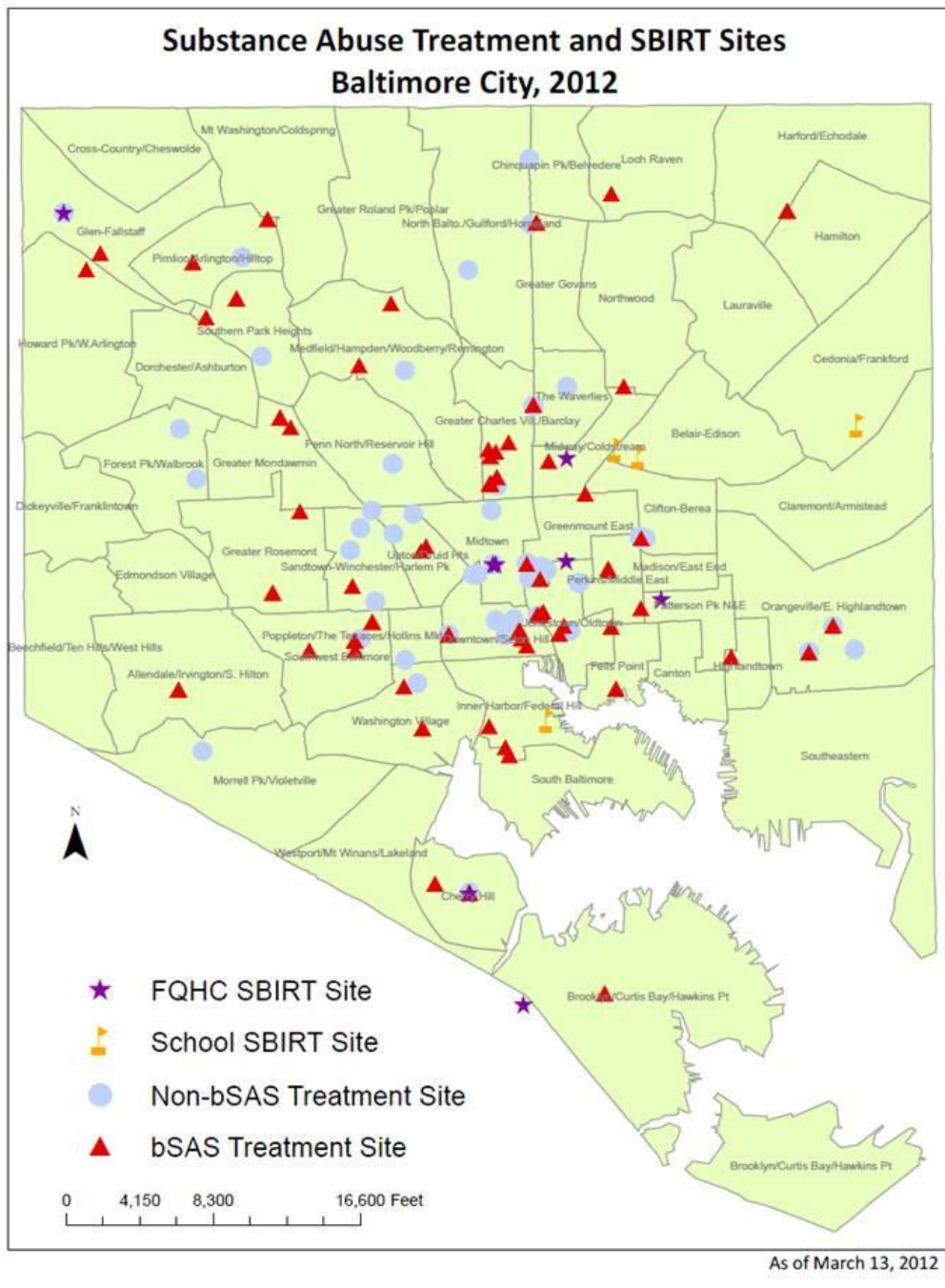
<b>NAME</b>	<b>ADDRESS</b>
John Hopkins Hospital	600 N. Wolfe St.
Maryland General Hospital	827 Linden Ave.
Bon Secours Hospital	2000 W. Baltimore St.
Sinai Hospital	2401 W. Belvedere Ave.
Harbor Hospital Center	3001 S. Hanover St.
St. Agnes Hospital	900 S. Caton Ave.
Union Memorial Hospital	201 E. University PW.
Good Samaritan Hospital	5601 Lockraven Bd.
John Hopkins Bayview Medical Center	4940 Eastern Ave.
Mercy Medical Center	345 St. Paul St.
University of Maryland Medical Center	22 S. Greene St.
VA Medical Center	10 N. Greene St
Kernan Hospital	2200 Kernan Dr
Mt. Washington Pediatric Hospital	1708 W Rogers Ave
University Specialty Hospital	611 S. Charles Street



In addition to hospitals, seven different federally qualified health centers (FQHCs) operate at least 15 different community health clinics inside or within walking distance of our community. A map of the statewide and city FQHCs can be found at the link below:

[http://dhmh.maryland.gov/maps/services/fqhc\\_3-2-11.pdf](http://dhmh.maryland.gov/maps/services/fqhc_3-2-11.pdf)

Furthermore, to address addiction and substance abuse, multiple providers have treatment centers and sites inside Mercy's community. The map below gives a sense for the location of treatment centers and SBIRT sites (**S**creening, **B**rief Advice, **B**rief **I**ntervention, **R**eferral to Treatment, **B**rief **T**reatment) in the City. A concentration of these facilities is housed within our community.



Source: Baltimore City Health Department

## V. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

As a major provider of medical services to patients throughout the City of Baltimore, Mercy Medical Center is a vital safety net for the medically underserved. This safety net is necessary in every specialty, and is particularly needed for patients who present via the Emergency Department. The following medical and surgical sub specialties at Mercy respond to the needs of the uninsured through the Emergency Department on an initial or follow-up basis.

- Orthopedics

This specialty is especially problematic in terms of Emergency Department coverage. Four orthopedic surgeons provide coverage. A significant proportion of patients are uninsured.

Mercy supports a weekly Orthopedic Clinic which provides follow-up care to patients initially seen in the Emergency Department and other outpatient sites. Of these patients, 99% are either uninsured or underinsured. In addition, orthopedic services are so limited for Baltimore City residents with inadequate insurance that many patients are referred to the Mercy orthopedic physicians from non-Mercy settings throughout the metropolitan area.

- Otolaryngology

A large percentage of patients presenting to the Emergency Department with the more urgent otolaryngologic problems are underinsured or have Medicaid. Mercy's three otolaryngologists provide care to these patients regardless of their ability to pay.

- Psychiatric Evaluation and Emergency Treatment

Mercy provides for professional services to evaluate patients presenting to the Emergency Department with psychiatric complaints, 90% of whom are uninsured or underinsured.

- Substance Abuse and Medical Detoxification

Mercy offers one of two inpatient detoxification units in Baltimore City and cares for over 1,200 patients annually. Over 90% of patients are under or



uninsured. Mercy provides physician subsidies for the professional component of these inpatient services. Of note, a number of diseases and medical conditions are over-represented in patients with substance abuse (e.g. Infectious Disease, Gastroenterology). Consultative and follow up care with appropriate specialists are also supported.

- Dentistry & Oral Surgery  
Mercy has one of the few community hospital based Dentistry & Oral Surgery Program in the City of Baltimore. This program provides services for adults (not covered under the State's Medicaid Program) and pediatric patients seen in the Emergency Department and at local community health centers.
- General Surgery  
Mercy provides higher levels of uncompensated care to patients in this discipline than any other community hospital in the City of Baltimore, in part because of its close, integrated clinical relationship with Health Care for the Homeless.
- Dermatology  
Mercy supports the only community hospital-based Dermatology practice in downtown Baltimore, which serves as a referral center for dermatologic disease from numerous urban clinics and settings throughout the Baltimore area. Of note, Dermatologic disease is often present in patients with advanced HIV disease.
- Mammography/Women's Imaging:  
Mercy provides the largest hospital-based mammography service to the residents of Baltimore City. The Tyanna O'Brien Center for Women's Imaging provides over 12,000 imaging exams annually; 25% of patients who receive imaging exams are without insurance or are underinsured.
- Gastroenterology  
Mercy's regionally recognized Posner Institute for Digestive Health and Liver Disease treats a number of illnesses, including Hepatitis C, pancreatitis, and cirrhosis that overrepresented in uninsured and underinsured patients.

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

Category: Non-resident house staff and hospitalists

OB coverage subsidy of \$1,744,195

PA support for charity services of \$3,010,122

Category: Coverage of Emergency Department Call

Psychiatric coverage subsidy of \$203,880

Category: Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies:

ED physician subsidy of \$3,420,364

Physician Charity Care of \$1,343,771

## VI. APPENDICES

### **To Be Attached as Appendices:**

1. Describe your Financial Assistance Policy (FAP):
  - a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's FAP. (label appendix I)
  - b. Include a copy of your hospital's FAP (label appendix II).
  - c. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).
2. Attach the hospital's mission, vision, and value statement(s) (label appendix IV).

Mercy Medical Center  
FY 2014 Community Benefit Report

**Table III-1**

<u>Identified Need</u>	<u>Hospital Initiative</u>	<u>Primary Objective of the Initiative</u>	<u>Single or Multi Year Initiative Time Period</u>	<u>Key Partners and/or Hospitals in initiate development and/or implementation</u>	<u>How were the outcomes evaluated?</u>	<u>Outcome (include process and impact measures)</u>	<u>Continuation of Initiative</u>	<u>A. Cost of Initiative for FY 2014</u>	<u>B. Amount of direct offsetting revenue from restricted grants</u>
Primary Care services to the population of homeless persons in Baltimore City	Healthcare for the Homeless	Provide primary medical and pediatric physicians, nurse practitioners, PA and social work providers to support the mission of primary care, preventative medicine and support services at the HCH site. Implement continuum of care for patients utilizing HCH and Mercy services.	Multi	- Healthcare for the Homeless - Baltimore City Office of Homeless Services - Baltimore Mental Health Systems	annually	1,680 referrals during FY14, of which 67% were kept. Further monitoring of HCH patient visits will not be available.	Yes	\$ 2,150,882	\$ 1,019,190

Mercy Medical Center  
FY 2014 Community Benefit Report

**Table III-2**

<u>Identified Need</u>	<u>Hospital Initiative</u>	<u>Primary Objective of the Initiative</u>	<u>Single or Multi Year Initiative Time Period</u>	<u>Key Partners and/or Hospitals in initiate development and/or implementation</u>	<u>How were the outcomes evaluated?</u>	<u>Outcome (include process and impact measures)</u>	<u>Continuation of Initiative</u>	<u>Cost of Initiative for FY 2014</u>	<u>B. Amount of direct offsetting revenue from restricted grants</u>
Access to Primary Care for uninsured and underinsured patients	Support of Family Health Centers of Baltimore	Provide cost-efficient and accessible health care regardless of insurance status, can arrange for sliding scale fees to assist the uninsured with physician and other expenses. Mercy provides subsidized support to Adult and Pediatric physician offices through the Family Health Centers of Baltimore (an FQHC).	multi year	Family Health Centers of Baltimore	annually	Tracking of FQHC visits to Mercy specialists is not available. Other coordination includes at least one Mercy manager now volunteers of each of our five partner	yes	\$1,778,348	\$ 0

Mercy Medical Center  
FY 2014 Community Benefit Report

**Table III-3**

<u>Identified Need</u>	<u>Hospital Initiative</u>	<u>Primary Objective of the Initiative</u>	<u>Single or Multi Year Initiative Time Period</u>	<u>Key Partners and/or Hospitals in initiate development and/or implementation</u>	<u>How were the outcomes evaluated?</u>	<u>Outcome (include process and impact measures)</u>	<u>Continuation of Initiative</u>	<u>Cost of Initiative for FY 2014</u>	<u>B. Amount of direct offsetting revenue from restricted grants</u>
Access to Emergency Care for uninsured and underinsured patients	ED Physician loss subsidy	Provide accessible emergency health care regardless of insurance status. Mercy provides subsidized support to the Emergency Department Physician practice to subsidize Medicaid and underinsured patients .	multi year	St. Paul Place Specialists ED Physician Practice	annually	Medicaid and underinsured patients accounted for 62.0% of Mercy's FY2014 visits .	yes	\$3,420,364	\$ 0
Access to Emergency Care for uninsured and underinsured patients	Psych coverage in the ED	Provide accessible emergency psychiatric care regardless of insurance status. Mercy provides subsidized coverage for Psychiatry coverage for the Emergency Department for Medicaid and underinsured patients.	multi year	St. Paul Place Specialists ED Physician Practice	annually	Medicaid and underinsured patients accounted for 62.0% of Mercy's FY2014 visits .	yes	\$203,880	\$ 0

Mercy Medical Center  
FY 2014 Community Benefit Report

**Table III-4**

<u>Identified Need</u>	<u>Hospital Initiative</u>	<u>Primary Objective of the Initiative</u>	<u>Single or Multi Year Initiative Time Period</u>	<u>Key Partners and/or Hospitals in initiate development and/or implementation</u>	<u>How were the outcomes evaluated?</u>	<u>Outcome (include process and impact measures)</u>	<u>Continuation of Initiative</u>	<u>Cost of Initiative for FY 2014</u>	<u>B. Amount of direct offsetting revenue from restricted grants</u>
Access to OB and NICU services for uninsured and underinsured patients	PA Support for Charity Services	Provide OB and NICU health care regardless of insurance status. Mercy provides support to these physician practices through subsidies for PA and NP physician extenders. The cost included as community benefit represents this percentage of the cost of providing this service.	multi year	St. Paul Place Specialists Physician Practices, B'more for Health Babies	annually	FY2014 Medicaid and Uninsured patients served were 70.5% OB patients and 74.1% NICU patients	yes	\$3,010,122	\$ 0
Access to OB and NICU services for uninsured and underinsured patients	OB Coverage for patients presenting for delivery	Provide OB health care regardless of insurance status. Mercy provides support to these physician practices through subsidies for OB coverage.	multi year	St. Paul Place Specialists Physician Practices, B'more for Health Babies	annually	FY2014 Medicaid and Uninsured patients served were 70.5% OB patients.	yes	\$1,744,195	\$ 0

Mercy Medical Center  
FY 2014 Community Benefit Report

**Table III-5**

<u>Identified Need</u>	<u>Hospital Initiative</u>	<u>Primary Objective of the Initiative</u>	<u>Single or Multi Year Initiative Time Period</u>	<u>Key Partners and/or Hospitals in initiate development and/or implementation</u>	<u>How were the outcomes evaluated?</u>	<u>Outcome (include process and impact measures)</u>	<u>Continuation of Initiative</u>	<u>Cost of Initiative for FY 2014</u>	<u>B. Amount of direct offsetting revenue from restricted grants</u>
Provide support for victims of sexual assault	Sexual Assault Forensic Exam (SAFE) program	SAFE is a program in which nurses provide examinations for male and female sexual assault victims as well as provide evidence collection for the homicide, rape, sex offense and child abuse units of law enforcement agencies. The Mercy SAFE program is the designated site for forensic patients in Baltimore City and the only comprehensive program of its kind in Maryland. In addition, the program's leadership and certified nursing staff provide community education about domestic violence and sexual assault to law enforcement, the legal community, community organizations and local high schools and colleges.	multi year	- Sex and Family Crimes Division of the Baltimore City Police Department - Family Crisis Center of Baltimore	annually	481 patients served in FY2014 140 training programs were held	yes	\$ 399,488	\$ 66,980



Mercy Medical Center  
FY 2014 Community Benefit Report

**Table III-6**

<u>Identified Need</u>	<u>Hospital Initiative</u>	<u>Primary Objective of the Initiative</u>	<u>Single or Multi Year Initiative Time Period</u>	<u>Key Partners and/or Hospitals in initiate development and/or implementation</u>	<u>How were the outcomes evaluated?</u>	<u>Outcome (include process and impact measures)</u>	<u>Continuation of Initiative</u>	<u>Cost of Initiative for FY 2014</u>	<u>B. Amount of direct offsetting revenue from restricted grants</u>
Confidential services to victims of violence	Mercy Family Violence Response Program	The program services victims of child abuse and neglect, sexual assault and abuse, domestic violence and vulnerable adult abuse. Services include: crisis counseling intervention, safety planning, danger assessment, documentation, and community resource referral for patients of MMC and it's associated physicians.	multi year	- Domestic Violence Coordinating Council - Turn Around - House of Ruth	annually	781 patients served in FY2014	yes	\$ 205,527	\$ 109,549

Mercy Medical Center  
HSCRC Community Benefit Report  
FY 2014

**Appendix #1**

**Describe your charity policy. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's charity care policy.**

See attached pages

## **Credit & Collections Policy Including Procedures**

### **Philosophy**

Mercy Medical Center (MMC or the Hospital) provides and promotes health services for the people of Baltimore of every creed, color, economic and social condition.

### **General Principles**

All Hospital employees and representatives will treat all patients with dignity and respect regardless of their ability to pay.

The HSCRC & Medicare expect hospitals to collect payment from those who have the resources to pay their bills.

### **Financial Assistance (also see full policy under separate cover)**

Mercy Medical Center provides emergency services to all patients without regard to their ability to pay for such services. MMC also accepts, within the limits of its financial resources, all patients requiring non-emergency hospital care without regard to their ability to pay for such services. These policies however, do not preclude MMC from reviewing a patient's ability to pay, the availability of insurance benefits, or the patient's eligibility for Medical Assistance. Free care will be provided for patients whose income level is at or below 2 times the HHS poverty guidelines. In addition patients may be granted charity on a sliding scale basis, for those incomes at or below 500% of the federal poverty guidelines. Other charity may be available based on additional factors which are outlined in the financial assistance policy.

### **Patients Rights & Obligations**

MMC encourages patients to seek information and / or assistance related to their financial obligations. Each patient's circumstance is unique, but all patients have similar rights and obligations. Patients' rights include the right to apply for financial assistance or Medical Assistance, to request a copy of MMC's Financial Assistance Policy, and to have a contact to discuss billing questions or concerns. Patients' obligations include the need to provide accurate and timely information to MMC, to cooperate with MMC/State personnel if financial assistance or Maryland Medical Assistance is sought and to satisfy their financial obligations.

### **Typical Hospital Collections Process**

All patients with self-pay balances are billed. Self pay balances are defined as the patient's financial responsibility, as determined by insurance coverage, and after the availability of financial assistance has been determined. Patients are expected to satisfy their financial obligation upon statement receipt. If the obligation is not satisfied, other collection efforts may be employed including additional statements, telephone calls, placement of account with a collection agency, reporting to credit bureaus, and litigation. Depending on the patient's financial situation and willingness to cooperate, payment plans may also be available.

## **Credit and Collections Policies and Procedures (cont'd)**

In order for a patient account to be transferred to bad debt and therefore outsourced to a collection agency, one of the following criteria must be met:

1. The patient has been sent 3 billing statements, (approximately 120 days from the date of service or from the date of the insurance payment). The patient has not contacted the Hospital Patient Accounting Department or made a payment toward satisfying the account.
2. The patient has not returned necessary financial information or completed a Medical Assistance application timely.
3. Billing statements have been returned to the MMC and other methods to locate the patient have failed.

In reviewing an account to determine if it is eligible for transfer to bad debt and therefore collections, the following steps should be taken:

- Review notes and resolve any outstanding issues.
- Exclude accounts of Religious Priests, Sisters or Brothers.
- Exclude accounts when the patient's address is a shelter.
- Manager review of all accounts over \$2,500
- Director review of accounts over \$5,000

In reviewing accounts to determine if they are eligible for suit, the following actions should be taken:

- Include only accounts with a balance (or cumulative balance) of \$500 or more.
- Legal counsel review of the patient's employer, likely income, their assets, outstanding liabilities, etc.
- Accounts with balances resulting from co-pays and or deductibles \$500 and above are reviewed and approved by the Director.
- Accounts with balances other than co-pays and deductibles over \$2,500 are reviewed and approved by the VP of Clinical Economics.

### **Vendor Expectations**

Mercy Medical Center authorizes a select few vendors to act on behalf of the Hospital related to collection activities. MMC expects all vendors acting on behalf of the Hospital to act responsibly and professionally. MMC expects all vendors acting on behalf of the Hospital to understand the Hospital's Financial Assistance Policy, and the first communication from the vendor to the patient should include a statement regarding the availability of financial assistance.

In addition, all vendors must comply with all state and federal regulations including the Fair Debt Collection Practices Act (FDCPA) and the Health Information Privacy Act (HIPAA). All vendors and their employees must also adhere to the internal policies of Mercy Medical Center.

## **Credit and Collections Policies and Procedures (cont'd)**

All vendors are expected to respond to all patient inquiries, document all account activity, make payment arrangements, settlements and initiate charity applications. MMC will review the collection agencies collection policies/procedures periodically, investigate patient complaints and review the agency's performance. If MMC determines that a vendor does not perform up to the standards of MMC, the relationship may be terminated. When a patient is found to be eligible for free care the agencies will be notified of the write off and it will be requested at that time to have any and all adverse information removed from the patients credit file.

### **Unacceptable Practices**

MMC **does not permit** the following actions under any circumstances. This applies to Hospital employees and vendors.

- Sale of debt
- Charging patients interest prior to court judgment.

For questions related to this policy and procedures, please contact Mary Crandall, Director of Hospital Patient Accounts.

**MERCY MEDICAL CENTER**  
POLICY AND PROCEDURE  
PATIENT FINANCIAL SERVICES

**FINANCIAL ASSISTANCE POLICY**

POLICY #: 602-176-93

ISSUE/REISSUE DATE: 03/12

Mercy Medical Center ("MMC") provides and promotes health services for the people of Baltimore of every creed, race, economic, and social condition. In the spirit of the Sisters of Mercy who are its sponsors, MMC has a special commitment to the underserved and the uninsured.

Consistent with this mission, MMC provides, without discrimination, care for emergency medical conditions to patients regardless of their ability to pay and regardless of their eligibility for financial assistance under this Financial Assistance Policy. It is also MMC's policy to accept, within the limits of its financial resources, all patients who require non-emergency hospital care without regard to their ability to pay for such services. These policies, however, do not preclude MMC from reviewing a patient's ability to pay, the availability of insurance benefits, or the patient's eligibility for Medical Assistance.

**Financial Assistance**

MMC provides free and reduced-cost medically necessary care to patients based on factors such as income, assets, medical debt, and other criteria specific to an individual patient's situation ("Financial Assistance"). The amount of Financial Assistance generally is determined using a sliding scale for income and taking into account other considerations.

In no event shall a patient receiving Financial Assistance be required to make a payment for the covered care in excess of the charges less MMC's mark-up, nor shall such a patient be billed gross charges (although bills may show itemized reductions to gross charges). In no event shall a patient receiving Financial Assistance be billed an amount for medically necessary care or emergency medical procedures that is more than the amount generally billed to individuals who have insurance covering such care. If a patient is eligible for Financial Assistance under more than one of paragraphs 1 through 5 below, MMC shall provide the Financial Assistance for which the patient qualifies that is most favorable to the patient.

### Notification and Application

MMC will make patients aware of its Financial Assistance policy by posting notices in several areas of the hospital, including the billing office, admissions office, business office, and emergency department areas. The notice will inform patients of their right to apply for financial assistance and providing contact information for additional information. MMC will also provide patients with a Financial Assistance information sheet upon admission, when presenting the bill for services (which bills themselves reference the Information sheet), and upon request. Patients may also request a copy of this Financial Assistance Policy at any time during a collection process. Upon request, the policy can be provided in several languages and interpreter services are also available.

MMC also makes available staff who are trained to work with patients, family, and authorized representatives to understand (1) bills; (2) rights and obligations with regard to the bill, (3) how to apply for Maryland Medical Assistance Program ("MMAP"), (4) information regarding the Financial Assistance Policy, and (5) how to contact MMC for additional assistance.

A patient may apply for Financial Assistance by completing and submitting the Maryland State Uniform Financial Assistance Application ("UFAA"). MMC uses the completed application to determine eligibility under the requirements described below. Within two business days following a patient's submitting a UFAA, application for medical assistance, or both, MMC will make a determination of probable eligibility for Financial Assistance. MMC will only require applicants to produce documents necessary to validate the information provided in the UFAA, and patients are responsible for cooperating with MMC's Financial Assistance application process. A patient who disagrees with a determination by MMC that the patient is not entitled to Financial Assistance may contact MMC by telephone, mail, or e-mail and request MMC reconsider such denial. Patients determined to be eligible for Financial Assistance subsequent to the date of service may be eligible for a refund of payments made, depending on certain circumstances.

### Eligibility & Benefits

In order to qualify for Financial Assistance, a patient must be a U.S. citizen or permanent legal resident who qualifies under at least one of the following conditions:

#### Statutory and Regulatory Required Categories

1. A patient with family income at or below 200% of the Federal Poverty Level ("FPL"), with less than \$10,000 in household monetary assets qualifies for full Financial Assistance in the form of free medically necessary care.

2. A patient not otherwise eligible for Medicaid or CHIP who is a beneficiary/recipient of a means-tested social services program, including but not necessarily limited to the following programs, is deemed eligible for Financial Assistance in the form of free medically necessary care, provided that the patient submits proof of enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days:
  - a. households with children in the free or reduced lunch program;
  - b. Supplemental Nutritional Assistance Program ("SNAP");
  - c. Low-income-household energy assistance program;
  - d. Primary Adult Care Program ("PAC"), until such time as inpatient benefits are added to the PAC benefit package; or
  - e. Women, Infants, and Children ("WIC").
3. A patient with family income at or below 400% of FPL, with less than \$10,000 in household monetary assets qualifies for partial Financial Assistance in the form of reduced-cost medically necessary care. The amount of financial assistance in this case is based on a sliding scale of income and shown in the attached table and other factors.
4. A patient with: (i) family income at or below 500% of FPL; (ii) with medical debt incurred within the 12 month period prior to application that exceeds 25% of family income for the same period; and (iii) with less than \$10,000 in household monetary assets will qualify for partial Financial Assistance in the form of reduced-cost medically necessary care. The amount of financial assistance in this case is based on a sliding scale of income, amount of medical debt, and other factors.
  - a. An eligible patient or any immediate family member of the patient living in the same household shall remain eligible for reduced-cost medically necessary care when seeking subsequent care at MMC during the 12-month period beginning on the date on which the reduced-cost medically necessary care was initially received.
  - b. To avoid an unnecessary duplication of MMC's determinations of eligibility for Financial Assistance, a patient eligible for care under Paragraph 4.a shall inform the hospital of his or her eligibility for the reduced-cost medically necessary care.



5. An uninsured patient with family income between 200% and 500% of FPL who requests assistance qualifies for a payment plan.

MMC's Expanded Coverage  
(Categories Not Covered by Maryland Statute or Regulation)

6. A homeless patient qualifies for Financial Assistance.
7. A deceased patient, with no person designated as director of financial affairs, or no estate number on file at the applicable Registrars of Wills Department, qualifies for Financial Assistance.
8. A patient who has a remaining balance after Medical Assistance qualifies for Financial Assistance.
9. MMC may elect to grant presumptive charity care to patients based on information gathered during a debt collection process. Factors include propensity to pay scoring, eligibility and participation in other federal programs, and other relevant information.
10. A patient who does not qualify under the preceding categories may still apply for Financial Assistance, and MMC will review the application and make a determination on a case-by-case basis as to eligibility for Financial Assistance. Factors that will be considered include:
  - a. Fixed income such as Social Security, Retirement or Disability with no additional income sources available;
  - b. Medical expenses; and/or
  - c. Expenses related to necessities of life compared to income.

Defined Terms

For purposes of this Financial Assistance Policy, the following terms have the following meanings:

Emergency Medical Conditions: A medical condition (A) manifesting itself by acute systems of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -- 1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. serious impairment to bodily functions, or 3. serious dysfunction of any bodily organ or part, or (B) with respect to a pregnant woman who is having contractions -- 1. that there is inadequate time to effect a safe transfer to

another hospital for delivery, or 2. that transfer may pose a threat to the health or safety of the woman or the unborn child.

Family income: Wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits, unemployment benefits, disability benefits, Veteran benefits, alimony and other income as defined by the Internal Revenue Service, for the Patient and/or responsible party and all immediate family members residing in the household (as defined by Medicaid).

Federal Poverty Level: Guidelines for federal poverty issued each year by the Department of Health and Human Resources.

Medical Debt: out-of-pocket expenses, excluding co-payments, coinsurance, and deductibles, for medical costs billed by a hospital.

Medically Necessary Care: Medical treatment that is absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient. Medically necessary does not include cosmetic, non-covered and optional procedures.

Monetary assets: Assets that are convertible to cash. In determining a patient's monetary assets for purposes of making an eligibility determination under this financial assistance policy, the following assets are excluded: (1) the first \$10,000 of monetary assets; (2) equity of \$150,000 in a primary residence; and (3) retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, qualified and nonqualified deferred compensation plans.

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**PATIENT INFORMATION:  
BILLING AND FINANCIAL ASSISTANCE POLICY**

**Overview of MMC's Financial Assistance Policy:** Mercy Medical Center (MMC) provides and promotes health services for the people of Baltimore of every creed, race, economic, and social condition. In the spirit of its sponsor, the Sisters of Mercy, MMC has a special commitment to the underserved and the uninsured.

MMC renders emergency care to all patients without regard to their ability to pay for such services. MMC also accepts, within the limits of its financial resources, all patients who require non-emergency hospital services, without regard to their ability to pay for such services. These policies, however, do not preclude MMC from reviewing:

- a. The patient's ability to pay;
- b. The availability of insurance benefits; or
- c. The patient's eligibility for Medical Assistance.

Services will be provided at no charge or at a reduced charge (based on a sliding scale) to patients who are unable to pay based on incomes up to approximately 500% above the federal poverty guidelines. (These guidelines are issued each year by the U.S. Department of Health and Human Services). MMC's financial assistance program is more generous than that required by Maryland law. Please see MMC's full Financial Assistance Policy for eligibility requirements and other information.

**Patient's Rights and Obligations:** MMC encourages patients to seek information and / or assistance related to their financial obligations to MMC. Each patient's circumstance is unique, but all patients have similar rights and obligations:

- Patients may request a financial assistance application at any point in the billing and collection process
- Patients may apply for Medical Assistance through MMC or directly with the Department of Health and Mental Hygiene. MMC offers an on-site State case worker to assist.
- Patients should contact the MMC billing office with any questions related to their bill, collection activities or to request a copy of MMC's Financial Assistance Policy.
- Patients are responsible for satisfying their financial obligations.
- Patients are responsible for providing timely, accurate information which is needed to verify insurance coverage or to determine eligibility for financial assistance, if they seek such assistance.

**Contact Information:** If you have any questions regarding an MMC bill, your financial obligations, or want more information about MMC's Financial Assistance Policy or Maryland's Medical Assistance program, you are encouraged to use the following contact information:

- MMC Billing Inquiries / Statements (410) 951-1700
- MMC Financial Assistance Application (410) 951-1700  
[www.hsrc.state.md.us/consumers\\_uniform.cfm](http://www.hsrc.state.md.us/consumers_uniform.cfm)
- MMC Financial Counseling (410) 332-9273
- MMC / Maryland Medical Assistance (410) 332-9396 or 9273
- Maryland Medical Assistance (800) 332-6347 or TTY (800) 925-4434  
[www.dhr.state.md.us](http://www.dhr.state.md.us)

**Please Note: Physician Services are NOT included in the Hospital bill.  
Physician services are billed SEPARATELY**

# Mercy Health Services Mission and Values

*Adopted by the Board of Trustees April 21, 2010*

## **Mission:**

Like the Sisters of Mercy before us, we witness God's healing love for all people by providing excellent clinical and residential services within a community of compassionate care.

## **Values:**

**DIGNITY** - We celebrate the inherent value of each person as created in the image of God. We respond to the needs of the whole person in health, sickness and dying.

**HOSPITALITY** - From many religious traditions and walks of life, we welcome one another as children of the same God, whose mercy we know through the warmth, fidelity and generosity of others.

**JUSTICE** - We base our relationships with all people on fairness, equality and integrity. We stand especially committed to persons who are poor or vulnerable.

**EXCELLENCE** - We hold ourselves to the highest standards of care, and to serving all with courtesy, respect and compassion. Maintaining our involvement in the education of physicians and other healthcare professionals is a priority.

**STEWARDSHIP** - We believe that our world and our lives are sacred gifts which God entrusts to us. We respond to that trust by constantly striving to balance the good of all with the good of each, and through creative and responsible use of all our resources.

**PRAYER** - We believe that every moment in a person's journey is holy. Prayer is our response to God's faithful presence in suffering and in joy, in sickness and in health, in life and in death.