FY2015 BON SECOURS BALTIMORE HEALTH SYSTEM

COMMUNITY BENEFIT REPORT (CBR)

PREPARED FOR

HEALTH SERVICES COST REVIEW COMMISSION (HSCRC)

BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

On January 10, 2014, the Center for Medicare and Medicaid Innovation (CMMI) announced its approval of Maryland's historic and groundbreaking proposal to modernize Maryland's all-payer hospital payment system. The model shifts from traditional fee-for-service (FFS) payment towards global budgets and ties growth in per capita hospital spending to growth in the state's overall economy. In addition to hitting aggressive quality targets, this model must save at least $330 million in Medicare spending over the next five years. The HSCRC will monitor progress overtime by measuring quality, patient experience, and cost. In addition, measures of overall population health from the State Health Improvement Process (SHIP) measures will also be monitored (see Attachment A).

To succeed, hospital organizations will need to work in collaboration with other hospital and community based organizations to increase the impact of their efforts in the communities they serve. It is essential that hospital organizations work with community partners to identify and agree upon the top priority areas, and establish common outcome measures to evaluate the impact of these collaborative initiatives. Alignment of the community benefit reporting with these larger delivery reform efforts such as the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system.

> For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), the IRS defines a CHNA as a:
>
>> Written document developed for a hospital facility that includes a description of the community served by the hospital facility: the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

The written document (CHNA), as provided in the ACA, must include the following:

A description of the community served by the hospital and how it was determined;

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. If a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties;

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility, (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions ("LHIC's)[see: http://dhmh.maryland.gov/healthenterprisezones/Documents/Local_Population_Health_Improvement_Contacts_4-26-12.pdf] schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input, who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and

A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

Examples of sources of data available to develop a CHNA include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments.

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, as provided in the ACA, 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, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and
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.

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 acute care

hospitals by the HSCRC. (Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

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:
152	4,343	21223 21216 21217 21229 21202 21230 21201	St. Agnes Hospital (21229)	Baltimore City- 86.11% Baltimore County- 7.48% Prince Georges County- 0.92% Anne Arundel County- 0.67% Other Counties- 4.82%	Baltimore City- 91.81% Baltimore County- 4.75% Howard County- 0.94% Anne Arundel County- 0.84% Other Counties- 1.67%

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. Based on findings from the CHNA, provide a list of the Community Benefit Service Area (CBSA) zip codes. These CBSA zip codes should reflect the geographic areas where the most vulnerable populations reside. Describe how the CBSA was determined, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

Bon Secours Hospital (BSB or the Hospital) has played a vital role in West Baltimore since 1919 and the Sisters of Bon Secours have maintained a constant presence in the community since 1881. Bon Secours Hospital serves west and southwest Baltimore. Dominated by the elderly, women and children, BSB's Primary Service Area (PSA) includes some stable neighborhoods, but far too many neighborhoods facing significant social challenges in the areas of housing, employment, education and health. BSB's Community Health Needs Assessment has taken into account challenges and conditions in its PSA (zip codes in PSA as listed above), with a special emphasis on the neighborhoods surrounding BSB (including, but not limited to, Mount Clare,

Franklin Square, Union Square, Boyd-Booth, Carrollton Ridge, Mill Hill, Shipley Hill and Fayette Street Outreach communities). Bon Secours has maintained a constant presence in this part of Baltimore for over 130 years and it is the community where most of Bon Secours Baltimore Health System's (BSBHS) services are located. A long standing tradition of close engagement with this community has led to the creation of many of the programs and services that BSBHS delivers, particularly those addressing the social determinants of health. The relationship between BSBHS and the surrounding community of Old Southwest Baltimore was of great benefit to many of the assessment activities outlined below.

In fact, many of the conditions and social determinants of health in the direct area serviced by BSBHS are of concern in the broader service area – West Baltimore, as a whole. Taking that into account, assessment findings and interventions identified for the areas immediately surrounding our hospital are relevant and applicable to the entire West Baltimore community.

Designated as a federal medically-underserved community, Southwest Baltimore also suffers from a high rate of foreclosures as many residents do not have the financial capacity to maintain their homes. Many of the streets are lined with neglected and vacant houses, many are boarded up and hazardous to the health and safety of children and adults. Homes are twice as likely to be sold in foreclosure or to have housing code violations as in Baltimore City as a whole.

The overall crime rate in Southwest Baltimore is 32% higher than the overall city, with homicides occurring more than twice as often per capita as in the City as a whole.

Despite these challenging statistics and circumstances, the neighborhoods of Southwest Baltimore show signs of new life and hope. Through our community partnerships, Bon Secours has initiated and supported neighborhood development and community-driven revitalization efforts that complement the health system's comprehensive services. Despite enormous challenges, BSB serves as an anchor of stability and hope for the residents of Southwest Baltimore, providing health and wholeness to all in need.

>b. In Table II, describe the population within the CBSA, including 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. (Examples: gender, age, alcohol use, income, housing, access to quality health care, transportation, education and healthy environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

>Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its Area Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%

20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.p
df), The Maryland State Department of Education (The Maryland Report Card)
(http://www.mdreportcard.org) Direct link to data–
(http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Table II

Median Household Income within the CBSA	$25,198 *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore)*
Percentage of households with incomes below the federal poverty guidelines within the CBSA	33% *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore)*
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	16.6% *(Data Source: 2013 Baltimore City Health Disparities Report Card)*
Percentage of Medicaid recipients by County within the CBSA.	36.9% *(Data Source: U.S Census Bureau 2014 Estimate, Hilltop Institute 2015)*
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	CBSA:68.3; Baltimore City: 73.5 *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore)*
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	2013 Rates per 10,000 residents in age group (CBSA/Baltimore City): Infant Mortality: 11.7/10.7 Mortality by Age (1-14 years old): 3.8/1.9 Mortality by Age (15-24 years old): 16.3/9.1 Mortality by Age (25-44 years old): 34.9/18.9 Mortality by Age (45-64 years old): 131.8/92.8 Mortality by Age (65-84 years old): 372.2/303.4 Mortality by Age (85 and over): 1052.6/1036.5 *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA)*

	Profiles: Southwest Baltimore)
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	**Access to Healthy Food:** Fast Food Outlet Density (per 1,000 Residents): 2.3 Liquor Outlet density (per 1,000 Residents): 2.2 **Transportation:** Households with No Vehicles Available: 54.2% **Education:** Population (25 years and over) With High School Diploma: 59.1% Population (25 years and over) With Less Than a High School Diploma or GED: 31.4% Population (25 years and over) with Some College Education and Above: 9.5% **Housing Quality:** Residential Properties that are Vacant and Abandoned: 27.1% Median Price of Homes Sold: $22,000 **Exposure to Environmental Factors:** Children (aged 0-6) with Elevated Blood Lead Levels: 5.5% Rate of Clogged Storm Drain Reports per 1,000 Residents: 12.1 Rate of Dirty Streets and Alleys Reports per 1,000 Residents: 152.8 *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore)*
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	75.8% Black/African-American (Non-Hispanic) 16.8% White/Caucasian (Non-Hispanic) 3.6% Hispanic 1.1% Asian (Non-Hispanic) 0.6% All Other Races (Hawaiian/Pacific Islander, Alaskan/Native American Other Race) (Non-Hispanic) 2.1% Two or More Races (Non-Hispanic) *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore)*
Other	Unemployment Rate for Southwest Baltimore is 24.9% vs. 14.2% for Baltimore City as a whole. *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore)*

II.   COMMUNITY HEALTH NEEDS ASSESSMENT

- 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?

    _x__Yes

___No

Provide date here.   05/07/ 13 (mm/dd/yy)

If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

http://baltimore.bonsecours.com/assets/pdfs/CHNA-FINAL.pdf

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

  _x_Yes   _07/15/13 (mm/dd/yy) Enter date approved by governing body here:
  __No

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

  http://bonsecoursbaltimore.com/assets/pdfs/CHNA-ImplementationPlan-BSBHS-071513.pdf

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? **(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b,)**

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

       _x_Yes
       __No

       If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

       As a part of Bon Secours Health System, Bon Secours Baltimore Health System conducts strategic planning on a three-year cycle. This product of this process, the "Strategic Quality Plan" serves as the driver for strategic initiatives at both the national and local system level.   Fiscal year 2015 was the third year in the cycle (2013-2015) that had the following priorities:
       - Bring our communities to wholeness
       - Ensure that our care is extraordinary
       - Transform our health delivery
       - Express our Catholic Identity
       - Liberate the potential of people

All strategic initiatives, including community benefit, must address one or more of these priorities, the development of which are informed in part by local system community benefit reports, the most recent community health needs assessment and other community engagement activities. The following describes the scope of work for the development of the current local system strategic plan which is currently underway:

1. Facilitate development of the integrated 3-year strategic plan (2016 – 2018) in accordance with the requirements outlined in the Work Products section of this RFI
   a. Produces a quality CHNA/CHIP in accordance with required content and due dates
   b. Produces quality and range of information for inclusion on Community Benefit Reports
2. Document processes and procedures for strategic plan development to facilitate future , such as:
   a. Meeting minutes
   b. Work plans
3. Develop structures and systems for:
   a. Data collection
   b. Reporting
   c. Evaluation
4. Develop work products within the following required time frames:
   a. Local-system (Bon Secours Baltimore Strategic Plan aligns with BSHSIQP starting in 2016.
   b. Next CHNA must be presented to and approved by the Board of Directors in May 2016
   c. CHIP must be completed by July 2016
   d. BSCW growth plan ongoing

   Work Product(s)

1. A local-system (Bon Secours Baltimore) 3-year strategic plan (2016 – 2018) that:
   a. Integrates/Incorporates the key existing and upcoming required plans, including:
      i. *Existing* BSHSI Strategic Quality Plan (2016 – 2018)
      ii. *Required upcoming* Community Health Needs Assessment and associated Community Health Improvement Plan (CHIP) (due by May/July 2016)
      iii. *Required upcoming* Bon Secours Community Works growth plan (due to BSCW Board of Directors by May 2016)
      iv. Other *existing* plans and commitments (e.g. substantive current and upcoming projects, new and annually renewable grant-funded programs). Examples include:
         1. Bon Secours Baltimore Health System
            a. New Vision (Healthy People, Healthy Economy, Healthy Environment)
         2. Bon Secours Baltimore Hospital's:

- a. Health Enterprise Zone (West Baltimore CARE)
- b. Department of Behavioral Health's Behavioral Health System Baltimore grants (ACT, Substance Abuse Treatment, Specialized Case Management Program, etc.)
- c. St. Martins Wellness Center
- d. Primary Care (Family Care Center, St. Francis Clinic)
- e. Behavioral Health Homes
- f. Global Budget Revenue and Total Population Health strategies
- g. Accountable Care Organization – Managed Care Savings Program
  - i. In-patient clinical
  - ii. Patient Satisfaction
- 3. Bon Secours Community Works':
  - a. Mayor's Office of Human Services' Consolidated Funding Application (Eviction Prevention)
  - b. Community Development Block Grant (Clean & Green)
  - c. Maryland Family Network (Early Head Start)
  - d. Family League of Baltimore (Home Visiting Program)
- 4. Unity Properties, Inc.'s:
  - a. Department of Housing and Urban Development (Resident Services)
  - b. Unity Properties' housing program expansion (e.g. Gibbons Housing Project)
- v. *As part of the assessment process, the existing* and *upcoming* City, State, Regional healthcare plans and priorities, such as those from:
  - 1. Maryland Health Services Cost Review Commission
  - 2. Maryland Department of Health and Mental Hygiene
  - 3. Behavioral Health System Baltimore
  - 4. Baltimore City Health Department
- b. <u>Involves an Advisory Group consisting of representation from:</u>
  - i. Includes a CHNA advisory board with at least the following membership representation (required per Ed Gerardo and the HSO):
    - 1. St. Agnes Hospital
    - 2. University of Maryland
    - 3. Public Health Department
    - 4. Primary Care
    - 5. Behavioral Health
- c. <u>Incorporates clear mechanisms for:</u>
  - i. Evaluating progress
  - ii. Identifying and addressing obstacles
  - iii. Achieving milestones
  - iv. Tracking priority performance metrics

1. Outcomes/community impact (not just outputs)
      v. Engaging key stakeholders
      vi. Scaling operations effectively
      vii. Evaluating potential service lines or business opportunities effectively and
           efficiently
   d. Promotes a culture of accountability through:
      i. Clearly defined roles and responsibilities
      ii. Detailed work plans including target/due dates
      iii. Understandable performance metrics
      iv. Regular communication on progress to key stakeholders
   e. Produces information required for inclusion or reporting in:
      i. BSHSI Strategic Quality Plan
      ii. Community Health Implementation Plan
      iii. 990
      iv. Community Benefit Report
      v. Annual Report to the Community
      vi. Accountable Care Organization – Managed Care Savings Program
           1. In-patient clinical
           2. Patient Satisfaction

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 describe the role each plays in the planning process (additional positions may be
   added as necessary)

      i. Senior Leadership

           1. _x_CEO
           2. _x_CFO
           3. _x_Other (please specify): Vice President, Mission; Vice President,
           Philanthropy

           Describe the role of Senior Leadership.

           The Vice President, Mission, serves as the Chair of the Community Benefit
           Committee and ensures that all committee members are aware of the overall
           goals for the Community Benefit Report, CHNA, and are aware of and
           supported as we work to meet deadlines. The CFO and CEO review
           community benefit initiatives and approve initiatives prior to their
           implementation. Further, the Director of Finance and CFO review the entire
           Community Benefit Report for accuracy and provide approval before report is
           submitted to the HSCRC. The Community Benefit Report also goes before the
           Board of Directors and at subsequent meetings for their overall knowledge
           and awareness.

    ii. Clinical Leadership

      1. _x_Physician
      2. _x_Nurse
      3. __Social Worker
      4. __Other (please specify)

    Describe the role of Clinical Leadership

    iii. Community Benefit Operations

      1. __Individual (please specify FTE)
      2. _x_Committee (please list members):
        a. Vice President- Mission (Chair);
        b. Manager- Financial Grants
        c. Senior Director of programs- Community Works
        d. Executive Director- Housing & Community Development
        e. Director- Marketing
        f. Vice President- Philanthropy
        g. Manager- Budget & Business Intelligence
        h. Director- Finance
      3. __Department (please list staff)
      4. __Task Force (please list members)
      5. __Other (please describe)

    Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

The Vice President, Mission chairs the Community Benefit committee and facilitates all meetings. He ensures that all committee participants are aware of the overall goals of the committee and how we contribute to our overall goals related to community benefit. The Executive Director- Housing and Community Development is also involved in the generation of the CHNA. Thus, he serves as a resource for information on the identification of priority needs area for CHNA and strategic development while also providing community benefit information related to housing. The Senior Director of Program- Community Works provides oversight of the initiatives conducted at the off-site Community Works center for a number of programs directly related to service members of the Southwest Baltimore community for which we serve. The Manager of Budget and Business Intelligence and Financial Grants Manager compile the CB financial and narrative components. The Director of Finance evaluates the Community Benefit Report as a whole to ensure that all relevant components are captured and financials are accurate. The Finance department participates also to help with the budgeting and financial needs around the committee.

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

    Spreadsheet   _x__yes   ____no
    Narrative   _x___yes   ____no

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

The Manager of Budget and Business Intelligence and Financial Grants Manager compile the CB financial and narrative components. The Director of Finance evaluates the Community Benefit Report as a whole to ensure that all relevant components are captures and financials are accurate. After the Director of Finance has evaluated the compiled report for accuracy, it is forwarded to the CFO for a final review of all components. Once all reviews are completed and the CFO gives approval, the report is submitted to the HSCRC.

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

Spreadsheet   __x__yes   ____no
Narrative   __x__yes   ____no

If no, please explain why.

IV.   COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

__x__ Other hospital organizations
__x__ Local Health Department
__x__ Local health improvement coalitions (LHICs)
__x__ Schools
__x__ Behavioral health organizations
_ x__ Faith based community organizations
__x__ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

Organization	Name of Key Collaborator	Title	Collaboration Description
University of Maryland School of Social Work	Dick Cook	Executive Director	Community Engagement (planning, coordination, facilitation)
Operation ReachOut Southwest	Joyce Smith	President	Community Engagement (planning, convening)
Baltimore City Health Department	Joshua Sharfstein, MD	Commissioner	Data support & analysis, convener
Maryland State Legislature	Verna Jones-Rodwell	Senator	Convener
John Snow, Inc	Alec McKinney	Senior Project Director	Public Health Research, data analysis, survey design
Michelle Gourdine & Associates	Michelle Gourdine	Principal	Public Health/Policy Analysis
The Hatcher Group	Tom Waldron	Vice President	Communications, marketing/outreach, advocacy
Mid-Atlantic Association of Community Health Centers	Miguel McGinnis	CEO	Convener, Advocacy

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?

__x__yes   ____no

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

__x__yes ____no

V.   HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), 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 example of how to report.

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

   a. 1. 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. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.
   2. Please indicate whether the need was identified through the most recent CHNA process.

   b.   Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following link: http://www.thecommunityguide.org/) (Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

   c. Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?

   d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?

   e. 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.

   f.   Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

   g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.

   h. Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.

      - What were the measurable results of the initiative?

      - For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.

j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome?   What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:
A. 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.
B. Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

2. Were there any primary community health needs 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.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

STATE INNOVATION MODEL (SIM) http://hsia.dhmh.maryland.gov/SitePages/sim.aspx
MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
HEALTH CARE INNOVATIONS IN MARYLAND
http://www.dhmh.maryland.gov/innovations/SitePages/Home.aspx
MARYLAND ALL-PAYER MODEL http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/
COMMUNITY HEALTH RESOURCES COMMISSION
http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

1. Identified Need 2. Was this identified through the CHNA process?	1. **Healthy People Priority Need:** Southwest Baltimore residents have evolving needs for comprehensive and integrated health services, including behavioral health. Bon Secours has expanded its service line over the last several years to become one of the most extensive in the City of Baltimore as it relates to behavioral health services and is an invaluable asset to the Southwest Baltimore community. In an effort to meet the growing demand for integrated services in our community, the focus for FY13-FY16 is program growth and development. 2. Yes, this need was identified through the CHNA process and in collaboration with community groups.
Hospital Initiative	The Department of Behavioral Health provides the following outpatient mental health and substance abuse programs: **Assertive Community Treatment (ACT)** ACT is a multi-faceted approach to caring for and treating individuals having a severe mental health diagnosis, and who are unable to utilize traditional OMHC Services as a way to manage their illness. ACT assists clients with nursing care and medication management and administration, psychiatrist on staff to lead psychiatric care, individual and group mental health treatment, individual and group substance abuse treatment, Crisis Management/24 hour availability trough on-call phone, rehabilitation skills development, discharge planning, job development/placement/coaching, life skills development, procurement of Community Resources/Case Management Services, and assertive outreach/tracking of clients in the community/home visits. **Specialized Case Management (SCMP)** SCMP provides clients with assistance in gaining access to needed medical, mental health, social, educational, and other community based services. SCMP assists clients with obtaining and maintaining medical insurance , income (SSI, SSDI, employment, TDAP, TCA, etc.,) assistance with obtaining eligible benefits (food assistance, daycare vouchers, WIC, etc.), mental health treatment, primary

care doctor, substance abuse treatment, housing (permanent housing, assisted living, shelter) crisis assistance , and support with increasing living skills (parenting classes, family preservation, budgeting, securing a payee, etc.)

Homeless Outreach

Provides ongoing support to Baltimore City's homeless and transient population including ongoing support to homeless individuals until they are willing to be linked to supportive services such as Case Management, Assertive Community Treatment, or other Outpatient Mental Health Services. The team responds to help calls from the city and concerned citizens via 311 regarding homeless clients and is actively involved with Code Blue and Code Red. Code Blue, the State Health Commissioner deems that it is too cold for individuals to be on the street. Code Red, the State Health Commissioner deems it too hot for individuals to be on the street. The team also assists individuals with filling out paperwork necessary for obtaining permanent housing

Adult Day Psychiatric Rehabilitation Program (PRP)

PRP is an Adult Day program providing support and structure to those individuals living with a severe mental illness and is designed to assist individuals with social re-integration and activities that promote symptoms management and community independence.

These activities include case management, assist with links to Mental Health and Substance Abuse services, provide support with modeling and practicing daily living skills, Symptom Management Groups, men and women support groups, supported employment and job placement, budgeting, community Integration, Off-Site trips, breakfast and lunch are provided, social Integration Activities, and transportation to and from program and appointments.

Residential (RRP)

A housing program serving the severely mentally ill that provides supervision and rehabilitation aimed at helping the individual re-integrate into society with the core goal of obtaining independent housing. RRP assists with Activities of Daily Living, social integration, grocery shopping, medication management, entitlements, socialization, and transportation to and from

appointments.

Outpatient Mental Health (OMHC)

Bon Secours OMHC believes in the connection of mind, body, and spirit, and recognizes and appreciates the uniqueness of each individual in building an alliance toward the healing process. A wide range of therapeutic modalities are tailored to meet the needs of each individual.

Services offered include individual, family, and couple services, symptom management, psychiatric evaluation, psychiatric medication, medication review, and referrals for lab work and other medical tests.

Partial Hospitalization Programs for Adults and Children (PHEP)

PHEP is a therapeutic intensive day treatment program for adults and children ages 5-12. It is a culturally sensitive, highly structured program that teaches children adaptive skills and healthy approaches to solving real problems.

Treatment involves child and his/her family, individual therapy, group therapy, family therapy, medication management, and crisis stabilization.

A.D.A.P.T Cares (Anti-Drug Abuse Program With Therapy)
Provides treatment services to individuals with a primary diagnosis of Opioid Dependence. To support males and females in their pursuit of recovery the following treatment services are offered:

- Methadone Maintenance
- Outpatient Group Therapy
- Comprehensive Substance Use Assessment
- Individualized Treatment Planning
- Primary Care
- Psychiatric Evaluation and Referral
- Overdose Prevention
- Smoking Cessation
- DUI/DWI Education & Counseling
- Random Drug Screens

New Hope Treatment Center

The mission of New Hope is to provide quality intensive

inpatient/outpatient wrap around services to individuals seeking help in re-establishing their lives from substance abuse. Treatment services include: Methadone Maintenance, Suboxone Therapy, Level I (Outpatient), Level II (Intensive Outpatient). Programming Includes:

- Individual comprehensive assessments
- Individualized treatment planning
- Opiate maintenance therapy
- Individual/Group counseling
- Men's/Women's group
- HIV pre and post-test counseling
- HIV blood screening

Next Passage Substance Abuse Treatment Center

Next Passage Substance Abuse Treatment Program is one of three Opioid Treatment Programs under the BSBHS umbrella that provides Drug Free Outpatient and Intensive Outpatient Treatment Services, as well as Suboxone Therapy to adult men and women diagnosed with a substance use disorder. Treatment services include:

- Drug Free Intensive (IOP) and Standard Outpatient Services (OP)
- Education/Vocational Services
- Men's/Women's Group
- Primary Care
- Psychiatric Evaluation and Referral
- Overdose Prevention
- Smoking Cessation
- DUI/DWI Education & Counseling
- Random Drug Screens
- Family & Individual Counseling
- Referrals to other agencies & facilities based on assessed treatment needs.

Psychiatric Rehabilitation Services (New Phases)

A psychiatric rehabilitative program is designed to help adults and children who suffer with chronic mental illness. Support services include personal development, social skills training and community integration. Additional services include medication management, vocational training and job placement. Vocational training is provided tin the area of food preparation and catering, clerical and computer jobs and maintenance repair.

Total Number of People Within the Target Population	The goal of the Outpatient Behavioral Health programs is to reduce in-patient utilization of services by providing effective outpatient services to meet the client's needs within our primary and secondary service area. The goal of the CIBS programs are to retain current clients until they have a sense of stability in their lives and can obtain and maintain mental wellness. Openings are filled with new clients when current clients reach stability in their lives. New clients come from within West Baltimore via hospital volume or referrals from city shelters and the prison system.
Total Number of People Reached by the Initiative Within the Target Population	Total Number of Individuals Reached by Program for FY2015: • Assertive Community Treatment (ACT): 1,089 • Specialized Case Management (SCMP): 1,645 • Adult Day Psychiatric Rehabilitation Program (PRP):2,357 • Residential (RRP): • Outpatient Mental Health (OMHC): 9,222 • Partial Hospitalization Programs for Adults and Children (PHEP): 519 • A.D.A.P.T Cares (Anti-Drug Abuse Program With Therapy): 3,425 • New Hope Treatment Center: 4,929 • Next Passage Substance Abuse Treatment Center: 1,704 • New Phases: 1,806
Primary Objective of the Initiative	Our objective is to improve access to and increase utilization of our community-based behavioral health and medical services. Metrics include program performance targets and population served.
Single or Multi-Year Initiative –Time Period	Multi-Year
Key Collaborators in Delivery of the Initiative	• Department of Health and Mental Hygiene (DHMH) • Behavioral Health Systems Baltimore (BHSB) • Baltimore Crisis Response, Inc. (BCRI) • National Alliance on Mental Illness (NAMI) • Substance Abuse and Mental Health Services Administration (SAMHSA) • Hospitals within the zip codes of 21201, 21229 and 21215
Impact/Outcome of Hospital Initiative?	Each program develops quality indicators to identify opportunities for improvement in the areas of service delivery and treatment outcomes. Data is collected and tracked on a monthly basis to identify trends and ensure compliance with established

	performance measures. Program specific patient satisfaction surveys are conducted on a monthly basis. Survey findings are reviewed and analyzed. Based on findings, program enhancements and improvements are implemented accordingly.
Evaluation of Outcomes:	Outcomes are evaluated through grant deliverables, the client's ability to obtain housing, reduction in hospitalizations and in increase in stability in the client's life. Patients also complete satisfaction surveys.
Continuation of Initiative?	Yes
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $11,069,558	B. Direct Offsetting Revenue from Restricted Grants $2,087,180

a. 1. Identified Need 2. Was this identified through the CHNA process?	1. **Healthy People Priority Need:** • Expand Primary Care and capacity along with expanded access to case/care management services. • Improve and expand access to primary care and preventive services. • 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 2. Yes. The combined West Baltimore zip codes of 21216, 21217, 21223, and 21229 have the highest disease burden and worst indicators of social determinants of health than most any other community in Maryland. These neighborhoods establish the lower extremes for health disparities in the City and the State across all major chronic illnesses. Families in the Zone experience poverty (20%) at higher rates than those in Maryland (6%) and in Baltimore City (17%). Life expectancy can be up to 12 years shorter in these zip codes than in other parts of Maryland.	
b. Hospital Initiative	Health Enterprise Zone (HEZ)	
c. Total Number of People Within the Target Population	86,000 West Baltimore residents who have or are at risk for cardiovascular disease (CVD) in zip codes of 21216, 21217, 21223, and 21229.	

d.	Total Number of People Reached by the Initiative Within the Target Population	112,358 West Baltimore residents have participated in HEZ activities by the following mechanisms : 1) health fairs 2) care coordination 3) primary care services and 4) community based activities (i.e. fitness, cooking and nutrition classes) Community Health Workers (CHWs) are deployed across the HEZ and are embedded in the community. CHW Community Outreach Encounters through October 2014–March 2015: • To date total encounters 3,542 • Home visits 173 • Health screenings 1,927 • Education 945 • ED visits 75 Held 254 fitness classes (about 11 free fitness classes per week) with an average of 258 participants per month. Held 20 nutrition and cooking classes with 80 participants. Awarded 60 scholarships to West Baltimore residents who are pursuing degrees/certificates in health careers. To date, $171,483 in scholarships have been committed to these 60 HEZ scholars. Total # of unduplicated patients seen in reporting period (if possible to generate) since January 2014: 108,750 patients (cumulative) Total # of patient visits in reporting period: 187,924 patients (cumulative)
e.	Primary Objective of the Initiative	This initiative implemented a two-part approach: 1) increased care coordination through the patient-centered medical home for patients with cardiovascular disease at high risk of hospitalization and emergency department (ED) use; and 2) community-based risk factor reduction for patients at risk of developing cardiovascular disease. These strategies are designed to be mutually reinforcing to improve cardiovascular outcomes.
f.	Single or Multi-Year Initiative –Time Period	Multi- Year from 2013-2017
g.	Key Collaborators in Delivery of the Initiative	• Baltimore Medical System • Bon Secours Baltimore Health System • Coppin State University • Equity Matters

		• Light Health and Wellness Comprehensive Services, Inc. • Mosaic Community Services • National Council on Alcohol and Drug Dependence Maryland • Park West Health System, Inc. • People's Community Health Centers • Saint Agnes Hospital • Senator Verna Jones-Rodwell • Sinai Hospital of Baltimore • Total Health Care, Inc. • University of Maryland Medical Center • University of Maryland, Midtown Campus • University of Maryland, Baltimore.
h.	Impact/Outcome of Hospital Initiative?	Community health workers (CHWs) are responsible for care coordination, staffing health fairs, and registering Passport to Health participants during events (including fitness and nutrition classes). The Passport to Health program incentivizes activities that reduce CVD risk. Participants receive a registration card that is scanned at each staffed activity. Attendance is tracked using an online system developed by the Delmarva Foundation and points are assigned for attendance. At the end of a session points are tallied and healthy incentives are distributed.
i.	Evaluation of Outcomes:	Data analysis and reporting occur at quarterly and annual intervals, depending on the data being produced. This project has allowed us to create a data sharing infrastructure among clinical partners that promotes a "learning healthcare system" and motivates continued progress toward achievement of targets. This has enabled us to generate important baseline data and a review of best practices which in turn helped us to define certain process measure goals in the current plan. As a result lessons learned, we made significant changes in our patient tracking system. These improvements are helping us to capture more specific data as well as data that reflect our efforts to impact the legislatively specified outcomes. We've identified the importance of continuing to leverage technology. Therefore, we integrated a web-based care coordination platform, Care at Hand into our program. This software allows us to clearly target high utilizers and prevent/reduce hospital readmissions within 30 days of discharge as well as avoidable/unnecessary ED utilization. We expanded our use of CRISP to our entire care coordination program. Additionally, we worked with the Delmarva Foundation to provide technical assistance for their web-based application that tracks attendance for our Passport to Health program. The Passport to

	Health program incentivizes activities that reduce CVD risk for nearly 500 participants. All of these changes should improve data integrity and reliability.		
j. Continuation of Initiative?	Yes		
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 1,352,994	B. Direct Offsetting Revenue from Restricted Grants $931,935	

1. Identified Need 2. Was this identified through the CHNA process?	**1. Healthy Economy Priority Need:** Every day, thousands of families in Southwest Baltimore struggle to meet their basic needs. Compared to Baltimore City as a whole, Southwest Baltimore's median household income is $15,702 lower ($38,772 vs. $25,198); unemployment is nearly double at 19.67%; and the percent of single parents and married couples with children earning below the Maryland Self-Sufficiency Wage Standard is significantly higher (88.46% vs. 81.70% and 64.75% vs.41.30%, respectively). According to The Association of Baltimore Area Grantmakers, at a time when the complexity of financial products has increased significantly, only 10% of Marylanders receive a financial literacy education during their K-12 school years. Many adults, especially those in low-income households like Southwest Baltimore, do not have a good understanding of basic financial tools and planning. Our clients are often unemployed or the "working poor", living in and out of crisis – often on the edge of homelessness. Families using our Financial Services frequently have significant debt burdens; low credit scores and are generally un-banked (95%). 2. Yes, this need was identified through the CHNA process and in collaboration with community groups.
Hospital Initiative	Financial Services Program Bon Secours Community Works Financial Services program offers services to help residents become more financially aware, begin building assets, and create stronger financial futures for their families. Participants learn about financial and other resources that are available as well as learn how to become economically

	self-sufficient through the following services:
	
	  A. Low-cost Tax Preparation Services:
	       Financial Services personnel offer low-cost tax preparation services for area residents.
	
	  B. Benefits Screenings:
	       Financial Services personnel conduct ongoing screenings for residents to determine eligibility for a wide range of public benefits.
	
	  C. Eviction Prevention Program:
	       Financial Services personnel provide residents who are at risk of imminent eviction with individual and group financial counseling as well as direct cash assistance to prevent eviction.

Total Number of People Within the Target Population	Southwest has a population of 17,885 with 33 % of families living in poverty *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore)*
Total Number of People Reached by the Initiative Within the Target Population	• 237 clients received cash assistance to help prevent imminent evictions. • 406 residents were screened for earn benefits. • 440 clients received low cost tax preparation.
Primary Objective of the Initiative	Financial Services primary goal is to help residents, many of whom have the limited education and employment experience, to establish immediate financial stability, build economic security, and achieve sustained self-sufficiency.
Single or Multi-Year Initiative –Time Period	Multi-Year
Key Collaborators in Delivery of the Initiative	• Mayor Office of Human Services • Bank of America • T Rowe Price • Bon Secours Community Works • SunTrust
Impact/Outcome of Hospital Initiative?	Of the 406 screened, 396 were eligible for benefits. • Total federal refund: $770,361 • Total state refund: $244,970
Evaluation of Outcomes:	Outcomes were evaluated based on program targets set by grantors.
Continuation of Initiative?	Yes, we will continue to provide Eviction Prevention assistance to an additional 70 participants in FY 2016.

Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $350,584	B. Direct Offsetting Revenue from Restricted Grants $132,158

1. Identified Need 2. Was this identified through the CHNA process?	1. **Healthy People - Physical and Mental Health Priority Need:** **<u>Infants Born at Low Birthweight/ Pre-Term</u>** For the residents of Southwest Baltimore, there is a need to ensure that babies are supported from infancy through 3 years of age to ensure that the child develops properly and is connected to necessary resources to support health. 13.3% of infants born in Southwest Baltimore were born at a low birthweight and 10.2% arrived pre-term (U.S. average was 8.0% born with low birthweight and 11.4% born preterm in 2013). Low birth weight and preterm birth put the infant at risk for death in the first few days of life and can lead to devastating and lifelong disabilities including visual and hearing impairments, developmental delays, and behavioral and emotional problems that range from mild to severe. Only 41.6% of pregnant women in Southwest Baltimore access prenatal care; the remaining women jeopardize their babies' health. Babies of mothers who do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who receive prenatal care. *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore* *(Data Source: CDC's National Center for Health Statistics , 2013 National Vital Statistics Reports volume 64, number 1)* **<u>Teen Pregnancy</u>** Teen pregnancy accounts for nearly $11 billion per year in costs to U.S. taxpayers for increased health care and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers. Pregnancy and birth are significant contributors to high school

	dropout rates among girls as only about 50% of teen mothers receive a high school diploma by 22 years of age. In contrast, approximately 90% of women who had not given birth during adolescence receive a high school diploma. Children born to teen mothers face difficult circumstances that affect various aspects of their life. The children of teenage mothers are more likely to have lower school achievement and drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult. (Source: CDC's National Center for Health Statistics; According to the Centers for Disease Control and Prevention) 2. Yes, this need was identified through the CHNA process and in collaboration with community groups.
Hospital Initiative	Family Support Center (FSC) Program serves pregnant mothers and families with children up to age three. The Center offers non-traditional Early Head Start services, teen parent services, and in-home support. Families receive support, encouragement, and resources such as child developmental, parenting classes, counseling, and life skills. **<u>Early Head Start</u>** The Early Head Start program provides support services to 47 pregnant women, children 0 to 3 years old, and their families through federal funding. 10 additional children are supported by private funding from the Maryland Family Network. **<u>Home Visiting Program</u>** Provides "Healthy Families America" model services to pregnant and parenting mothers that 1) Cultivate nurturing and responsive parent-child relationships 2) promote healthy child growth and development 3) Build solid foundations for family functioning. **<u>Teen Parent Program</u>** The Teen Parent program provides services to pregnant and parenting teen mothers aged 15-19.
Total Number of People Within the Target Population	Southwest Baltimore's teen (ages 15-19) pregnancy rate of 60.1 per 1,000 is substantially higher than Baltimore City at 36.2 per 1,000.

	(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore)
Total Number of People Reached by the Initiative Within the Target Population	• 57 children enrolled in the Early Head Start Program. • 34 teens participated in the teen parent program. • 31 women were serviced through the Family League home visiting program.
Primary Objective of the Initiative	The overall purpose of FSC: • Educate parents who are expecting or have infants/toddlers to whom they assume the "primary role" in the child's life and assist parents in acquiring appropriate parenting skills and knowledge. • Equip pregnant and parenting teenagers (ages 15-19) with healthy and appropriate parenting knowledge and skills, continued education, and independent self-sufficient adult life • Strengthen young families through the provision of in-home intervention services.
Single or Multi-Year Initiative –Time Period	Multi Year
Key Collaborators in Delivery of the Initiative	• Maryland Family Network • Family League • Bon Secours Community Works
Impact/Outcome of Hospital Initiative?	• 12 teen parents graduated from the teen parent program. • 5 teen parents participated in the summer Youth Employment Entrepreneurship Program (YEEP). • 15 babies were born full term with 13 babies born of a healthy birth weight in the Family League Home Visiting Program. • 4,447 combined visits for the teen parent program, Family League home visiting program, and Early Head Start program were recorded for FY15.
Evaluation of Outcomes:	Outcomes were evaluated based on program targets set by grantors.
Continuation of Initiative?	Yes

Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $1,820,440	B. Direct Offsetting Revenue from Restricted Grants $971,143

1. Identified Need 2. Was this identified through the CHNA process?	1. **Healthy People - Physical and Mental Health Priority Need** In Southwest Baltimore: • More than 50% of the women were single and 90% have children • Over 85% are African-American • Nearly half did not complete high school • 75% reported a current issue or history of mental illness and/or substance abuse; the vast majority were unemployed (reporting a chronic health condition as the primary barrier to employment) • 95% had minimal monthly income (with 35% working low-wage and/or part time jobs and 95% receiving public benefits). The most critical asset participants bring to the program is a motivation to improve life for themselves and their families. 2. Yes, this need was identified through the CHNA process and in collaboration with community groups.
Hospital Initiative	Women's Resource Center (WRC) The WRC is a day drop-in center for women who are struggling with a range of life challenges, including substance abuse, domestic violence, homelessness, anger, and depression, and other mental health issues, can come for help, relief, and support with issues they are facing.
Total Number of People Within the Target Population	3,000 people will experience homelessness on any given night in Baltimore per the 2007 Baltimore City Census.
Total Number of People Reached by the Initiative Within the Target Population	• 147 women, who are homeless or at-risk of homelessness, received services such as hot breakfasts and lunches, showers, laundry, and computer access. • 61 women participated in at least one health screen. • 40 women were screened for EarnBenefits (this program screens for eligibility in a range of benefit programs including food stamps, health insurance programs, tax credits and housing and utility assistance…) • 83 clients developed an individualized plan (My Journey Life skills).
Primary Objective of the Initiative	The overall purpose during the day at the WRC is to meet immediate, basic needs, and help women build self-sufficiency by

	offering the following services:
	- Hospitality services (showers, laundry, meals, telephone, mail, etc.) - Case management services (information and referral) - Individual Planning and Training (financial literacy, life skills, etc.)
Single or Multi-Year Initiative –Time Period	Multi Year
Key Collaborators in Delivery of the Initiative	- Mayor's Office of Human Services - United Way Central Maryland - Bon Secours Community Works
Impact/Outcome of Hospital Initiative?	- Of the 40 women screened for EarnBenefits, 32 clients secured at least one new benefit. - Of the 83 clients who completed an individualized plan, 52 clients achieved at least one goal. - Women's Resource Center conducts at least three health screens a year.
Evaluation of Outcomes:	Outcomes were evaluated based on program targets set by grantors.
Continuation of Initiative?	Yes, we will continue to grow and expand our Women's Resource Center to serve men, teens, and seniors Mon- Fri from 1:00PM- 5:00PM.
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $391,846	B. Direct Offsetting Revenue from Restricted Grants $196,343

| 1. Identified Need

2. Was this identified through the CHNA process? | 1. **Healthy Economy Priority Need:**

Every day, thousands of families in Southwest Baltimore struggle to meet their basic needs. Southwest Baltimore's median household income is $25,198 with 33% reporting household income less than $25,000 per Southwest Baltimore Health Profile.

Overall, Southwest Baltimore continues to rank first among Baltimore neighborhoods for the percentage of population age 16-64 that are unemployed and seeking employment. The 2013 unemployment rate for Southwest Baltimore (24.9%) has changed slightly form the 2012 level of 25.3% and is nearly double that of 14.2% Baltimore City unemployment rate.

There were approximately 700,000 Marylanders between the ages |

	of 16 and 24 as of 2014. Almost 8.0% of them, or 74,000 youth, were neither working nor enrolled in school. These youth are considered "disconnected," lacking the social, academic, and employment connections that lay the foundation for a successful future. Some are high school dropouts. Others may be unsuccessful in making workforce connections due to family obligations, lack of marketable employment skills, substance abuse, homelessness, incarceration, disability, or difficulty aging out of the foster care system. In addition, Baltimore City receives approximately 59% of all state prison releases—close to 9,000 individuals annually. Of those, 30% return to just six communities with West Baltimore–the community Bon Secours serves–at the top of the list. *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore)* *(Data Source: Maryland Stat Data Center, 2014Estiamtes by Age, Race and Gender for Maryland and it's Jurisdictions (6/15))* **2.** Yes, this need was identified through the CHNA process and in collaboration with community groups.
Hospital Initiative	Career Development Program Bon Secours Community Works Career Development Program (CDP) offers teens and adults the training and support needed to develop job readiness skills. CDP provides assistance for job placements, career goals, and/or on the job training through Clean and Green Landscaping program and other partnerships. **Clean and Green Landscaping Program** This program that trains local workers to transform vacant lots in West Baltimore into green, well-maintained, usable spaces. For six months, participants learn on-the-job skills, such as plant identification, equipment operation, safety and teamwork. They also receive financial counseling and learn to create career and life goals. **Tyro Re-entry Program** Offers case management, expungement, career coaching and a 12-week course for ex-offenders to address a wide range of issues,

	help build skills and set them on a path to success. **Community Job Hub** In collaboration with the Mayor's Office of Employment Development, offers a daily computer lab and computer literacy trainings on Thursdays for proficiency in computer basics and Microsoft Office applications.
Total Number of People Within the Target Population	Southwest Baltimore has a population of 17,885 with 24.9% of unemployed. *(Data Source: 2013 Vital Signs 12 Community Statistical Area (CSA) Profiles: Southwest Baltimore)*
Total Number of People Reached by the Initiative Within the Target Population	• 70 clients enrolled in the job readiness training program • 294 clients utilized the computer lab/ computer job hub • 47 Clients enrolled in the newly implemented Tyro program (Breaking the Cycle of Incarceration).
Primary Objective of the Initiative	The primary objectives of the Career Development program are: • Gain the basic and technical education needed to get livable-wage jobs • Obtain the range of life skills they need to sustain employment and economic stability • Develop sound money management skills and habits as a means of attaining and maintaining economic self-sufficiency • Stabilize their economic situation and create a foundation for building toward economic self-sufficiency
Single or Multi-Year Initiative –Time Period	Multi Year
Key Collaborators in Delivery of the Initiative	• Bank of America • T Rowe Price • Baltimore City Foundation • Bon Secours Health System • United Way • Bon Secours Community Works
Impact/Outcome of Hospital Initiative?	• 18 clients graduated from the job readiness program. • 12 clients graduated from the Tyro program. • 6 clients of the job readiness program received training through Clean and Green Landscaping program.
Evaluation of Outcomes:	Outcomes were evaluated based on program targets set by grantors.

Continuation of Initiative?	Yes, we will continue to build the Career Development program to include CNA/GNA training and placements in industry related jobs.
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $540,269 B. Direct Offsetting Revenue from Restricted Grants $130,894

1. Identified Need 2. Was this identified through the CHNA process?	1. **Health People Priority Needs:** For the population of Southwest Baltimore served, more than 60,000 of Baltimore's 622,800 residents have a history of excessive alcohol and/or illegal drug use. (Sources: The United States Census Bureau, 2014, and Baltimore City Dept. of Health) 2. This need was identified during the Community Health Needs Assessment ("CHNA") process through collaboration with community groups.
Hospital Initiative	Bon Secours Hospital Screening Brief Intervention Referral to Treatment ("SBIRT") Peer Recovery Support Program
Total Number of People Within the Target Population	Of the estimated 622,800 people in Baltimore City, Bon Secours Hospital serves 66,950 people in the Southwest area of Baltimore. (Source: The United States Census Bureau, 2014)
Total Number of People Reached by the Initiative Within the Target Population	July 1, 2014 through June 30, 2015 Data: 1. Number of distinct patients encounter in ED: 27,369 2. Number of ED encounters screened: 26,264 3. Number of ED encounter with positive screens: 8,607 4. Positive screens as % of total ED encounters screened: 32.8% 5. Positive screens as % of total ED nurse screens: 31.4% • Number of encounters confirming Alcohol use >=4/day: 1,913 • Number of encounters confirming drug use (legal or illegal): 4,771 • Number of encounters confirming Cocaine use: 1,162 • Number of encounters confirming Heroin use: 1,692 • Number of encounters confirming Marijuana use: 2,069 • Number of encounters confirming Other Substance use:

	424
	6. Number of brief interventions conducted by coaches: 2,547
	7. Number of referrals to treatment by coaches: 372
Primary Objective of the Initiative	The SBIRT program is designed so that all patients that enter the hospital through either the Emergency Department or through a direct admission are screened by hospital nursing staff as part of the nursing assessment. Based on established criteria, nurses and other members of the care team refer patients at high risk to the peer recovery coaches ("PRC") to provide brief interventions and referrals to treatment, as appropriate.
	Three full-time peer recovery coaches are employed by Bon Secours Hospital to support the program. The three coaches provide brief interventions using motivational interviewing techniques to targeted high-risk patients. The PRCs follow-up with patients that are admitted or discharged to continue to provide support and linkage to treatment services, as necessary, and where appropriate. Services are integrated and coordinated with the hospital nursing staff, social work discharge planning staff and other case managers that provide support to patients.
	Although many Emergency Departments conduct drug/alcohol screening and some conduct nurse/provider Screening-Brief Intervention-Referral to Treatment ("SBIRT"), Bon Secours is one of only two Maryland hospitals that have peer recovery coaches in the Emergency Department assisting our community members with substance abuse addiction and referring them to treatment.
Single or Multi-Year Initiative –Time Period	Multi-Year
Key Collaborators in Delivery of the Initiative	- Behavioral Health System Baltimore - Bon Secours New Hope Treatment center - Bon Secours Adapt Cares - Bon Secours Next Passage - Bon Secours inpatient and outpatient mental health services. Collaborative relationships for shared care planning have been developed with the on-site hospital social work staff, discharge planning staff and specialized case managers. - On-site HIV liaisons stationed in the Emergency Department are also partnering with the PRCs to identify patients in need of brief interventions and to help facilitate linkage to HIV services along with substance abuse treatment, as necessary. - Additional collaborations have been developed with a

	number of the other inpatient and outpatient treatment programs in the area that provide treatment resources for patients.
Impact/Outcome of Hospital Initiative?	• 96% of Emergency Department patients screened by Emergency Department Nurse • 33% of patients screened were positive for drug and alcohol use • 30% with positive screen received a Brief Intervention • 14% referred to treatment from Brief Intervention • 54% confirmed attendance at treatment
Evaluation of Outcomes:	Based on outcomes, the Peer Recovery Coaches have been very successful in appropriately identifying those ready to change and referring patients to treatment with a 54% attendance rate.
Continuation of Initiative?	Yes

Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $219,906	B. Direct Offsetting Revenue from Restricted Grants $123,931

1. Identified Need 2. Was this identified through the CHNA process?	1. **Health People Priority Needs:** According to The Department of Mental Health and Hygiene for Maryland current data shows that as of 9/2015, Baltimore City accounts for 37.5% of HIV cases in the state of Maryland and has the 6th largest metropolitan HIV population in the nation. West Baltimore continues to have a very high prevalence of IV drug abuse and unprotected sex which is contributing to the high HIV rates in the region. The HIV rate for BSBHS's zip code is 127.0. Additionally, there are an estimated 18.7% of patients in Maryland with HIV that remain undiagnosed. According to Bon Secours Health System, Inc. Baltimore's Community Health Needs Assessment ("CHNA") "…old Southwest Baltimore…the leading causes of health-related deaths are heart disease, HIV/AIDS" 2. This need was identified during the Community Health Needs Assessment ("CHNA") process through collaboration with community groups.

Hospital Initiative	Rapid HIV Testing
Total Number of People Within the Target Population	From January 1, 2015- December 31, 2015- Complete at least 3,000 HIV tests at Bon Secours Baltimore Hospital
Total Number of People Reached by the Initiative Within the Target Population	From January 1 – September 30 2015: 2,105 encounters From September 2014 – August 2015: 2,564 encounters
Primary Objective of the Initiative	The primary purpose of this grant is to promote safe practices, promote HIV testing and link HIV patients to care. Patients receive pre-counseling; testing and post-counseling in the Emergency Department Those patients who test positive are referred for further care. An additional focus for this initiative is to provide counseling on abstinence, safe sex and the risks associated with IV Drug abuse. Depending on the results of the HIV test, clients are either linked to care, or they are educated on safe practices if they test negative.
Single or Multi-Year Initiative –Time Period	Multi-Year
Key Collaborators in Delivery of the Initiative	• Bon Secours Baltimore Health System • Baltimore City Health Department • Johns Hopkins Hospital • Jacques Initiative: Institute of Human Virology (University of Maryland School of Medicine) • Sinai Hospital
Impact/Outcome of Hospital Initiative?	From September 2014 – August 2015: • 3 patients tested positive • 10 were pre-positive • 13 were linked to care • Over 2700 clients received counseling on safe sex and IV drug use. • 100% of patients who tested positive were referred to both care and partner services. Patients that communicate drug use are connected with the Screening, Brief Intervention, Referral and Treatment team for additional counseling.
Evaluation of Outcomes:	Outcomes were identified by the number of tests provided, the continued identification of new positives, and re-linking those patients with HIV that have fallen out of care.

Continuation of Initiative?	Yes
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 178,083	B. Direct Offsetting Revenue from Restricted Grants $93,830

1. Identified Need 2. Was this identified through the CHNA process?	1. **Healthy People Priority Need:** There is a critical need for patients to have access to services and education to assist in management as well as improve outcomes in their physical and mental health and well-being. 2. Yes the need was identified through the CHNA process. Prevalence of chronic diseases and premature death is significantly high in West Baltimore. The life expectancy in our West Baltimore community is among the lowest in the state.
Hospital Initiative	Community Disease Management Nurse Ministry (formerly called Tele-Heart Program; Parish Nursing
Total Number of People Within the Target Population	The target population of the initiative is the 43,253 West Baltimore residents.
Total Number of People Reached by the Initiative Within the Target Population	Tele-Heart Program – September 2014 through August 2015 • Total Occurrence- 9,867 • Total Encounters- 11,170 Parish Nurse Ministry – September 2014 through August 2015 • Total Occurrence – 1,368 • Encounters – 3,555
Primary Objective of the Initiative	A disease management and health education nurse ministry empowering West Baltimore residents, especially seniors & those with chronic diseases. The program is staffed by an RN who helps to identify newly diagnosed Congestive Heart Failure patients through nurse review of hospital records, interdisciplinary patient rounds or physician referral. The program educates patients about disease management and enrolls patients in Tele-Heart, conducts individualized post-discharge education and home assessments, provide individual monitoring, education, medication recommendations and support, and coordinate and provide reports on patient care to physicians for Tele-Heart enrollees. The RN also conducts health education and disease management

	classes and screenings for Tele-Heart enrollees, seniors and community residents, develops and distributes a monthly newsletter on health maintenance, disease prevention and related topics to Tele-Heart enrollees, seniors and partner groups. Further, outreach and education is conducted for physicians and healthcare providers on Tele-Heart and Community Nurse Ministry Alliance programs.
	The Parish Nurse Ministry (Community Faith Nurse Ministry Alliance) is a Faith-Based Disease Management Ministry which is RN lead. The RN collaborates and networks with 61 Faith Communities within and outside the West Baltimore area. The faith-based communities communicate with our nurse ministry daily and we collaborate to address needs as a team. The Nurse Ministry meets and holds luncheons bi-annually as a group to increase collaboration, provide information, expand education, disseminate information and promote new membership.
	The intake, distribution of medical equipment and supplies used by the program made available through the generous donations of our Faith Community Nurses and congregation members. The Nurse Ministry develops and instructs disease management classes for their faith ministries along with home visitation, caring for the sick and dying through holistic care for the whole self and family.
	We work together to help those in need find shelter, clothing and other basic needs including referrals for health services both inside and outside our service area if needed.
	We are currently working towards a Nurse Ministry Liaison group to buddy with our high-risk discharged patients to help them focus on better health maintenance, prevent a needless readmission and increase compliances.
	Nurse Ministry members also adopted one of our Bon Secours senior buildings and focus on the needs of the residents. As a part of this initiative, members of the nurse ministry visit the senior residence on a weekly schedule, provides educational classes, helps with referral to doctors and services, food and clothing, and provide socialization with the residence thru games and prizes. The ministry nurses will visit seniors in their apartment as needed per request.

Single or Multi-Year Initiative –Time Period	This is a multi-year, on-going initiative.
Key Collaborators in Delivery of the Initiative	- Bon Secours Baltimore Health System - Faith-based organizations include: Transfiguration Catholic Church, St. Bernadine's Catholic Church, Central Baptist Church, Jones Tabernacle, St. Gregory Catholic Church, St. James Episcopal Church, St. Edward's Catholic Church, Saint Peter Claver and St. Benedict Catholic Community among others. 21 Senior Living Buildings and Senior Centers in the West Baltimore - St. Agnes Hospital - University of Maryland Medical System and School of Nursing are partners that are referral sources for services not provided at Bon Secours. - Partnership with Community Home Health to provide Skilled Home Health, Disease Mgt.Education in the home for the discharged patient. - Health Care for All- partnership to establish faith community transitional care liaisons to partner with discharge patients that will help guide them thru their process to recovery. - Partnership with drug and nutrition companies (Novartis, Amgen. Abbott, etc.) To help patients and our community with nutritional supplements, educational materials and discounts on medications.
Impact/Outcome of Hospital Initiative?	As a result of the services offered by the Parish Nursing Ministry initiative the following impacts/ outcomes has been noted: - Reduction in the re-admission rate for Congestive Heart Failure patients, improving adherence to weight management, medication compliancy as well as recommended dietary restrictions and establishing a wellness base for treatment and support. - Treatment of Chronic Diseases thru direct referral to physician and arrangement of doctor visits, along with disease management education, rather than frequent trips to the emergency department. - Decrease in number of emergency visits and compliance with keeping scheduled physician visits - Decrease in the number of Heart Failure Admissions - Improvement in patient trust and communication - Establishing good relationships within our patient base and community - Growing services through patient need and request
Evaluation of Outcomes:	We utilize CBISA community benefit software to track volume and cost of these services and to develop reports for grantors. We also look at various health trends/indicators to show

	impact of interventions i.e. ER visits, admissions, Quality Metrics for ACO, Post Discharge Office Visits within 3 days, and teach back (patient able to repeat learned information) results.	
Continuation of Initiative?	These community initiatives are ongoing and supported by the hospital and donations.	
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	**A. Total Cost of Initiative** $166,734	B. Direct Offsetting Revenue from Restricted Grants $0

1. Identified Need 2. Was this identified through the CHNA process?	1. Lack of safe, affordable housing opportunities. 2. Yes, "Healthy Economy: Support the creation and preservation of strong healthy blocks via the development and management of affordable housing."
Hospital Initiative	Community Housing
Total Number of People Within the Target Population	• Approximately 18,000 (population of Southwest Baltimore, Community Statistical Area 51 in Baltimore City) • 56.5% of renters and 33.7% of homeowners pay more than 30% of their income for housing.
Total Number of People Reached by the Initiative Within the Target Population	• 649 families housed • 115 persons attended homeownership workshops • 15 persons closed on home purchases
Primary Objective of the Initiative	Develop and manage safe/affordable housing; connect residents of housing to needed services – and to one another. Goal is to expand portfolio to 1,200 units in next 5-7 years.
Single or Multi-Year Initiative –Time Period	Multi-Year (1988 – present)
Key Collaborators in Delivery of the Initiative	• Enterprise Community Partners • Enterprise Homes • United States Department of HUD • Baltimore City Department of Housing and Community Development • Maryland State Department of Housing & Community Development • Wayland Baptist Church

	• New Shiloh Baptist Church • St. Agnes Hospital
Impact/Outcome of Hospital Initiative?	• 648 units in service • Service coordination at each (6) senior housing site • Construction on 80 unit family apartment building began May 2015. Housing occupancy for FY15 was 97.5% for 648 units.
Evaluation of Outcomes:	Occupancy rates of properties along with quantitative (number of residents served, services utilized) and qualitative (resident satisfaction, individual practice assessment) are tracked; We utilize CBISA community benefit software to track volume and cost and contract with National Church residences for 3rd party quality assurance & review; Resident satisfaction averaged 37.7 per property out of a possible score of 40; Individual practice assessments averaged 44 out of a possible score of 44; and file review averaged 19.9 out of a possible 21 (as evaluated by National Church Residences and U.S. Department of H.U.D.)
Continuation of Initiative?	Yes

Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $3,770,346	B. Direct Offsetting Revenue from Restricted Grants $258,606

1. Identified Need 2. Was this identified through the CHNA process?	1. **Healthy People Priority Need:** Physical and Mental Health: Improve the health status of residents, with a particular focus on substance abuse, infant mortality, chronic illness and mental health. 2. Yes, this need was identified through the CHNA process and collaboration with community groups.
Hospital Initiative	Affordable Care Act (ACA) Education and Enrollment This initiative increased awareness of the importance and benefits of enrollment available through the ACA Education and Enrollment initiative include the following methods:

	Fitness Classes and Community Events
	Grant funding will support Affordable Care Act (ACA) education and enrollment efforts through promotion at fitness classes, a community health education held March/April and screening, and an annual June year-end celebration in West Baltimore. The Bon Secours Baltimore Health System's Health Enterprise Zone (HEZ) project, launched fitness classes in 2013. A total of 44 events (an average of 11 classes every week) of health and fitness activities conducted throughout West Baltimore between March 1, 2015 and June 30, 2015.

Program personnel provided transportation assistance for individuals on an as-needed basis (estimated at 30% of the total 450 residents to be reached) to community events and in accordance with the project budget to facilitate attendance at one of the identified activities.

Bon Secours Community Works Financial Services (BSCWFS)

In collaboration with BSCWFS, program personnel will provide information packets inclusive of education about the benefits of, and process available for, enrollment will be provided when providing services to program clients.

ACA Education and Enrollment Multi-Media Campaign
The multi-media campaign mechanisms included coordination of education efforts with community partners such as neighborhood associations, other community service providers that currently collaborate with Bon Secours Community Works programs (e.g. schools that collaborate with Community Works' Family Support Center to enroll children in Center programs. Also, coordination of education and enrollment strategies with other Bon Secours Baltimore departments such as Unity Properties-managed affordable housing residents (primarily seniors, low-income families and individuals with disabilities) and Bon Secours Baltimore Hospital health insurance enrollment personnel.

There was also a social media initiative (e.g. Twitter, Facebook) developed and implemented in coordination with Bon Secours Baltimore's Marketing department. Education materials packet design were updated as needed to reflect current resource and enrollment information and customized as necessary for use in the various strategies. |

Total Number of People Within the Target Population	Performance Measures 1. Provided 450 people with ACA education and enrollment information provided at weekly community-based health and fitness sessions and year-end celebration 2. Provide 750 people with ACA education and enrollment information while obtaining services from Bon Secours Community Works' Financial Services personnel for tax preparation, benefits screening, and eviction prevention. 3. Reach 2,000 people and 8 media mechanisms through a multi-media campaign utilizing multiple mechanisms and include broad outreach efforts combined with more customized communications tailored to specific audiences
Total Number of People Reached by the Initiative Within the Target Population	3,200 people reached through media, community-based efforts, and Bon Secours Community Works' Financial Services collaboration.
Primary Objective of the Initiative	Bon Secours Baltimore will utilize multiple strategies and mechanisms to promote ACA enrollment and facilitate education about enrollment during the grant period ending June 30, 2015.
Single or Multi-Year Initiative –Time Period	Single Year Initiative
Key Collaborators in Delivery of the Initiative	• Bon Secours Community Works • West Baltimore Health Enterprise Zone • Health Care Access Maryland • Congressman Elijah Cummings • Neighborhood Associations • Neighborhood Schools • Steuart Hill Academic Academy • Bon Secours Family Health and Wellness Clinic • Bon Secours Unity Properties
Impact/Outcome of Hospital Initiative?	• E-blast campaign reached 2,000 people and organizations. • 2,500 flyers were disseminated for the Medicaid enrollment event. • 3,200 education packets were created and tailored for the event. *Medicaid Enrollment Event(Community Event held* June 27, 2015 at Steuart Hill Academic Academy) Bon Secours' invited Health Care Access Maryland to help execute a Medicaid Resource Zone (Medicaid enrollment event). Congressman Elijah Cummings helped to kick off our event by

	hosting a press conference.
	1. West Baltimore Care program personnel provided education to 70 individuals.
	2. Health Care Access program personnel assessed 45 individuals and enrolled 32 individuals into some sort of health insurance plan (3 Qualified Health Plan enrollments, 29 MA enrollments, 0 MCHIP enrollment and 0 Quality Dental Plan enrollments).
	3. Promotional items (personal fitness tracking booklets, workout shirts, produce bags, cutting boards, fit bit zips, small food processors and resistance bands) offered to encourage participants to take advantage of the benefits of the activity as well as enrollment.
	4. Transportation assistance for individuals on an as-needed basis to facilitate attendance at one of the identified activities. $432 worth of bus tokens were exhausted between March 1, 2015 and June 30, 2015.

Evaluation of Outcomes:	1. Deliverable: ACA education and enrollment information provided at weekly community-based health and fitness sessions and year-end celebration Result: 559 health and fitness participants provided with education and enrollment information (Target: 459) 2. Deliverable : ACA education and enrollment information provided by Bon Secours Community Works' Financial Services personnel to tax preparation, benefits screening, and eviction prevention clients Result: 863 Bon Secours Community Works Financial Services tax preparation, benefits screening, and eviction prevention clients provided with ACA education and enrollment information while obtaining (Target: 750) 3. Deliverable: Multi-media campaign utilizing multiple mechanisms and include broad outreach efforts combined with more customized communications tailored to specific audiences. Result: Provided 7,000 f individuals provided with education and enrollment information (Target: 2, 000) 4. Met the target of 8 outreach mechanisms used

Continuation of Initiative?	No	
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 27,956	B. Direct Offsetting Revenue from Restricted Grants $20,020

1. Identified Need 2. Was this identified through the CHNA process?	1. **Healthy People Priority Need:** Physical and Mental Health: Improve the health status of residents, with a particular focus on mental health. This initiative provides mental health services for at-risk youth in the Park Heights community. 2. Yes, this need was identified through the CHNA process and collaboration with community groups.
Hospital Initiative	Project Engage
Total Number of People Within the Target Population	Project Engage offers a high impact, best practice-based approach to reaching, consistently engaging, and advancing 200 at-risk and high risk youth in the Park Heights/Pimlico neighborhoods – bringing them in off the streets and onto a positive development path.
Total Number of People Reached by the Initiative Within the Target Population	As of June 2015: - 199 youths have actively engaged in positive youth programming through the Project Engage initiative.
Primary Objective of the Initiative	The primary objective of the Project Engage initiative is to provide 200 at-risk Park Heights/Pimlico area youth (ages 14-21) with positive youth programming, mental health and HIV/AIDS education and prevention services.
Single or Multi-Year Initiative –Time Period	Multi-year-initially for 18 months, but is now being extended. The project has been extended from July 1, 2015- June 30, 2016.
Key Collaborators in Delivery of the Initiative	- The Boys and Girls Club of Metropolitan Baltimore - Bon Secours Baltimore Health System, Inc.
Impact/Outcome of Hospital Initiative?	- 199 youths have actively engaged in Project Engage to this day, resulting in almost 100% goal met. - 20 youths have actively engaged in participating in mental health and wellness services.
Evaluation of Outcomes:	*Commitment to Quality* Specific to Project Engage, the Project Director will be the designated lead for program evaluation, working closely with the funder's Evaluation Team to review and adjust the project metrics and outcomes to be evaluated. She will also work with the Technical Assistance representative on continued capacity building for successful collaborative implementation and operation. The Project Engage primary quality assessment forum will review the Results-Based Accountability information and

	Logic Model at our Quarterly Project Team Meetings.
Continuation of Initiative?	Yes- Project Engage has been extended from July 1, 2015- June 30, 2016.
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Cost of Initiative $176,337	B. Direct Offsetting Revenue from Restricted Grants $108,774

Identified Need	**1. Healthy People-Physical and Mental Health Priority Need:** Improve the health status of residents, with a particular focus on substance abuse, infant mortality, chronic illness and mental health. Academic researchers are not always effective in relating with community residents and thus are challenged when designing research interventions for addressing health disparities. 2. Yes, in conjunction with community representation during the CHNA process.
Hospital Initiative	**The PATient-centered Involvement in Evaluating the effectiveNess of TreatmentS (PATIENTS) Program** Bon Secours Baltimore has partnered with researchers from the University of Maryland to empower patients to propose questions about their health care concerns and actively participate in studies to answer them. Unlike many other research programs, The PATIENTS Program encourages patients to get involved in every aspect of its studies. Researchers are committed to working with communities to address real-world problems and meet the needs of the patients they serve. They remain involved with the community even after the research has been completed. As one of eight partners with representation on the Internal Steering Committee of The PATIENTS Program, Bon Secours Baltimore is charged with teaching and assisting academic researchers with how to: (**1**) "pre-engage" the West Baltimore community, (**2**) develop sustainable community ties, and (**3**) communicate more effectively with individuals in the community.

Total Number of People within the Target Population	The outreach activities led by Bon Secours Baltimore target the individuals served by the West Baltimore Health Enterprise Zone. The PATIENTS program has always noted the importance of including in studies diverse populations with respect to age, gender, race, ethnicity, geography, or clinical status. We have developed a more detailed list of "hard-to-reach" or lesser-studied populations to guide our research and engagement efforts: • Racial and ethnic minority groups • Low-income groups • Women • Children (age 0–17 years) • Older adults (65 years and older) • Residents of rural areas • Individuals with special healthcare needs, including individuals with disabilities • Individuals with multiple chronic diseases • Individuals with rare diseases • Individuals whose genetic makeup affects their medical outcomes • Patients with low health literacy/numeracy and/or limited English proficiency • Lesbian, gay, bisexual, and transgender persons • Veterans and Members of the Armed Forces and their families
Total Number of People Reached by the Initiative Within the Target Population	The PATIENTS Program staff have participated in eight health fairs with nine more scheduled through November 2015. At these fairs we: • Engaged approximately 370 individuals • 174 individuals chose to sign up for more information from us about program activities and opportunities to partake in research.

Primary Objective of the Initiative	The primary objective is to improve health care research by: • Building partnerships with local, regional, and national patient communities and health care systems. • Conducting and expanding patient-centered outcomes research (PCOR) to help patients make better decisions and improve how doctors and nurses provide care. • Putting new programs in place for hospitals, doctors, nurses, and patients based on research findings. The PATIENTS program engages patients to participate in the program through focus groups, advisory board meetings, and partnerships with community organizations and groups. We also provide education and awareness about health-related issues of concern to patients in the program.
Single or Multi-Year Initiative – Time Period	Multi-Year (2013 – 2018)
Key Collaborators in Delivery of the Initiative	• Bon Secours Baltimore Health System • Agency for Healthcare Research and Quality • University of Maryland, Baltimore • University of Maryland, College Park • University of Maryland Medical Center • PatientsLikeMe • Mount Lebanon Baptist Church • The Center for Medical Technology Policy • Westat • Riverside Health System • The Association of Black Cardiologists
Impact / Outcome of Hospital Initiative?	Bon Secours is committed to training University of Maryland researchers in <u>cultural competency</u> and <u>community engagement best practices</u>. We, along with our partners: (1) Educated researchers and health care organizations on the importance of community education and held discussion regarding strategies on how to engage communities and individuals in the research process (2) Held meaningful roundtable discussions at the University of Maryland Baltimore on the process of identifying individuals in the community and educating them on the importance of participation in research activities and partnering with researchers to answer health-related questions (3) Reviewed and discussed outcomes from our interactions with individuals at Community Day and made recommendations on

	how to further understand and meet the needs of the population we serve (4) Have representation as one of three pilot project reviewers for the program, where we provide feedback for investigators who are new to patient engagement and seeking funding to begin a patient-centered outcomes research study The University of Maryland supports the development of a sustainable research infrastructure at Bon Secours Baltimore. This support takes the form of in-person meetings and customized training videos. The video training archive includes topics such as "Partnering and Invoicing for Federal Proposals", "Guide to Becoming a Federal Subcontractor", and "Federal wide Assurance for the Protection of Human Subjects." The PATIENTS Program also provides in-person, experiential training for researchers to work directly with Bon Secours Baltimore to identify and apply for funding opportunities.
Evaluation of Outcomes:	Outcomes are evaluated via a both an <u>External Advisory Board</u> and a <u>Formative and Impact Evaluation</u>. **Annual External Advisory Board Site Visit** The External Advisory Committee (EAC) meets annually with the Internal Steering Committee (ISC) and the Formative and Impact Evaluation group (Westat) to provide pertinent project updates and lessons learned to the EAC for advice and feedback. **Formative and Impact Evaluation** The Westat evaluation team gathers and summarizes information on the progress and achievements of The PATIENTS Program to provide an understanding of the formation and evolution of the program; the roles of community and academic partners, advisors, and investigators; and the impact of PATIENTS on the field of patient-centered outcomes research (PCOR). The purpose of this report was to document our productivity, highlight our strengths, assist with setting priorities for future activities, and identify potential challenges to achieving our goals.
Continuation of Initiative?	Yes – the program, and the partnership between organizations, is designed to be sustainable beyond the grant end date of 2018.

Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants / Direct Offsetting	Cost of Initiative $125,177	B. Direct Offsetting Revenue from Restricted Grants $80,349

Revenue		

VI. 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.

Below answers Question 1 above and Question 2 below:

Across the country, the vast majority of specialist providers rely upon reimbursement from Medicare, Medicaid, Managed Care and patients to provide financial support for their practices. However, for hospitals such as Bon Secours that serve low-income individuals without insurance, urban poor areas, the opportunities for specialists to be compensated through these vehicles are extremely low. Consequently, if these specialist providers were to provide the needed health care services for these hospitals, through only the support of paying patients, they would quickly be forced to close their practices or move to a community with a far more favorable payer mix.

For a hospital like Bon Secours to continue to support the community with the varied specialist providers necessary for a full-service medical/surgical hospital with Emergency and Surgical Service, some manner of support is required to ensure the provision of this professional specialized medical care. With approximately 51% of the patient population presenting as charity, self-pay and Medicaid, specialist physicians serving patients at Bon Secours are simply unable to cover their costs.

In particular, the primary shortages in availability, absent some form of financial support, come in the form of ED, ICU, regular physician staffing, in addition to the "on call coverage necessary to support 24 hour services in these areas. As a result, in Bon Secours' fiscal 2014 Annual Filing, the "Part B" support provided by the Hospital as indicated in the "UR6" Schedule totals $15.4 million. The fiscal year 2015 Annual Filing has not been completed at this time, however FY15 "UR6" schedule totals are anticipated to be comparable to FY14. To a hospital the size of Bon Secours, this is a significant outlay of support that is necessary to provide the specialist care required to compassionately and equitably care for our patients. Therefore, real and significant "gaps" in the availability of specialist providers in this community exist. Those gaps currently are only being filled via support from the Hospital. The gaps are currently being filled in the following specialist areas: The gaps are currently being filled in the following specialist areas:

- ED Coverage (approx. $4.9 million)
- Anesthesia (approx. $1.7 million)

- Medical/Surgical "House Coverage" (approx. $1.7 million)
- Psychiatry (approx. $1.6 million)
- Intensive Care (approx. $0.7 million)
- Radiology (approx. $0.7 million)
- OR On-Call (approx. $0.6 million)
- Primary Care/Op Specialty Care Services (approx. $0.5 million)
- Cardiology/Vascular/EEG (approx. $0.4 million)
- Substance Abuse (approx. $0.2 million)
- Other Specialties, including Laboratory, Hemodialysis, and Pathology

In addition to these gaps currently filled via subsidy, relatively unmet specialist needs for both the insured and uninsured within our facility include ENT Specialist, limited G.I. (Gastrointestinal Specialist), Neurologist, Urologist, and Endocrinologist.

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.

Please refer to number 1 in this section for answer, information relating to both questions is included with question #1.

VII.   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)

   For ***example***, state whether the hospital:

   - Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
     - in a culturally sensitive manner,
     - at a reading comprehension level appropriate to the CBSA's population, and
     - in non-English languages that are prevalent in the CBSA.
   - posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;

- provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
- provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
- includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
- Discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).

c. Include a copy of your hospital's FAP (label appendix III).

d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

2. Attach the hospital's mission, vision, and value statement(s) (label appendix V). Attachment A

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) SLECTED POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy

- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization

- Reduce the % of adults who are current smokers

- Reduce the % of youth using any kind of tobacco product

- Increase the % vaccinated annually for seasonal influenza

- Increase the % of children with recommended vaccinations

- Reduce new HIV infections among adults and adolescents

- Reduce diabetes-related emergency department visits

- Reduce hypertension related emergency department visits

- Reduce the % of children who are considered obese

- Increase the % of adults who are at a healthy weight

- Reduce hospital ED visits from asthma

- Reduce hospital ED visits related to behavioral health

- Reduce Fall-related death rate

Appendix 1. Financial Assistance Policy

Appendix 1 follows the Appendix 2.

Appendix 2: Description of Mission, Vision, and Values

While in many ways the Mission of Bon Secours speaks for itself, an outside observer would benefit from the knowledge that the Mission is driven by and sustained through the Eight Core Values of the system. They are Respect, Justice, Integrity, Stewardship, Innovation, Compassion, Quality, and Growth.

It is part of the culture of Bon Secours to live these values on a day to day basis. They drive the System's desire to treat patients in a holistic way, by treating mind, body, and spirit.

Our community benefits program reflect the System's desire to help the people of West Baltimore attain and maintain good health by helping in the areas of housing, career development, and health awareness.

It is through the values of Respect and Justice that we strive to provide adequate housing. It is because of the values of Integrity and Stewardship that we seek to use the resources available in the most effective manner. Compassion and Quality compel us to treat all patients in a caring way. And Innovation and Growth drives our desire to continue to serve the community for many years into the future.

The policy is attached.

MISSION

The mission of Bon Secours Health System is to bring compassion to health care and to be Good Help to Those in Need®, especially those who are poor and dying. As a system of caregivers, we commit ourselves to help bring people and communities to health and wholeness as a part of the healing ministry of Jesus Christ and the Catholic Church.

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VISION

*Inspired by the healing ministry of Jesus Christ and the Charism of Bon Secours....*As a prophetic Catholic health ministry we will partner with our communities to create a more humane world, build health and social justice for all, and provide exceptional value for those we serve.

VALUES

RESPECT
JUSTICE
INTEGRITY
STEWARDSHIP
INNOVATION
COMPASSION
QUALITY
GROWTH

Description of Bon Secours Baltimore Hospital Financial Assistance Intake Process

Currently Bon Secours Baltimore staff provides self-pay patients with financial assistance applications, along with cover sheets, available in both English and Spanish, upon registration. Additionally, signage is posted in all registration areas informing patients of the availability of financial assistance options. The Hospital also has a script for all registrars to use at registration to inform patients about the financial assistance policy options and whom to contact for more information. Finally, patients who apply for financial assistance and are approved receive a CareCard. The CareCard shows that the patient applied for financial assistance, gives them a policy number, and effective date for which the CareCard applies.

Need help paying your hospital bill?

Our staff is available to assist you in applying for all government-sponsored programs and the Bon Secours Financial Assistance Program.

Contact our Financial counseling office at (410) 362-3319

BON SECOURS HEALTH SYSTEMS

Script:

Not all medical costs are covered by insurance. You have the right to receive medically necessary care without the ability to pay. Financial assistance is available through government programs and Bon Secours Baltimore Health System, if you qualify for our Financial Assistance Program

Please contact the Bon Secours Financial Counselor, Phyllis Brown at 410-362-3319 for additional information.

BON SECOURS
BALTIMORE
HEALTH SYSTEM

PATIENT BILLING RIGHTS AND OBLIGATIONS

Not all medical costs are covered by insurance. You have the right to receive medically necessary care without the ability to pay. Financial assistance is available through government programs and Bon Secours Baltimore Health System, if you qualify for our Financial Assistance Program. The Bon Secours Health System (BSHSI) exists to benefit people in the communities they serve. It is up to you to provide complete and accurate information about your health insurance coverage when you come to the hospital.

These services and procedures address the needs of patients who have limited financial means and are not able to pay in part or full for the services provided with out undue financial hardship.

FINANCIAL ASSISTANCE

If you are unable to pay for medical care, you may qualify for free or reduced cost care. Financial counselors are available; to assist you in applying for government-sponsored financial assistance or for the Bon Secours Financial Assistance Program. **Please contact Phyllis Brown at 410-362-3319 concerning:**

- Your hospital bill
- Your patient rights and obligations with regard to hospital bill
- How to apply for free and reduced care
- How to apply for the Maryland Medical Assistance Programs and any other programs that may help pay your bill

For information about the Maryland Medical Assistance Programs; contact the help line at 1-800-456-8900, TTY 800-735-2258 or visit the website www.dhmh.state.md.us/ma4families

PHYSICIAN BILLING

Professional services provided to you by a physician will be billed separately and apart from the fees charged by the hospital.

Thank you and we look forward to providing you the "Good Help" Bon Secours Baltimore stands for.

DERECHOS Y OBLIGACIONES DE FACTURACIÓN DEL PACIENTE

No todos los costos médicos están cubiertos por el seguro. Tiene derecho a recibir la atención médica necesaria aunque no pueda pagarla. Puede acceder a asistencia financiera a través de programas del gobierno y del sistema de salud Bon Secours Baltimore Health System, si califica para nuestro programa de asistencia financiera Financial Assistance Program. El sistema Bon Secours Health System (BSHSI) existe para ayudar a personas dentro de las comunidades en las que trabajan. Cuando viene al hospital, es su responsabilidad entregar información completa y precisa acera de su cobertura de seguro de salud.

Estos servicios y procedimientos están orientados a atender las necesidades de pacientes cuyos medios financieros son limitados y no pueden pagar en forma parcial o total los servicios prestados sin atravesar excesivas dificultades financieras.

ASISTENCIA FINANCIERA

Si no puede pagar la atención médica, es posible que califique para obtener atención sin cargo o a un costo reducido. Contamos con asesores financieros que podrán ayudarlo a solicitar asistencia financiera patrocinada por el gobierno o a ingresar al programa Bon Secours Financial Assistance Program. **Póngase en contacto con Phyllis Brown al 410-362-3319 respecto de los siguientes temas:**

- Su factura del hospital
- Sus derechos y obligaciones como paciente en relación con la factura del hospital
- Cómo solicitar atención médica sin cargo o a un costo reducido
- Cómo solicitar el ingreso a los programas Maryland Medical Assistance Programs y a cualquier otro programa que pueda ayudarlo a pagar la factura

Para obtener más información sobre los programas Maryland Medical Assistance Programs, comuníquese con la línea de ayuda al 1-800-456-8900, teléfono de texto para sordomudos 800-735-2258 o visite el sitio Web en www.dhmh.state.md.us/ma4families

FACTURACIÓN DEL MÉDICO

Los servicios profesionales que el médico le brinde serán facturados por separado y aparte de los honorarios que cobre el hospital.

Muchas gracias y esperamos proporcionarle esa "Buena Ayuda" que es el sentido de Bon Secours Baltimore.

BON SECOURS
Baltimore Health System
2000 West Baltimore Street * Baltimore, MD 21223

***************single-piece   BAL   May 11, 2009
                               1 (26)

Sample

Dear ~~████████████~~

Thank you for entrusting your healthcare needs to us. Your CareCard application has been approved. Bon Secours providing *"Good Help to Those in Need"®*

You have been approved to participate in the Bon Secours Financial Assistance Program and will be required to cooperate with the Eligibility Team on each visit. The Eligibility Team working on behalf of Bon Secours will assist with your application for a government-sponsored health plan. If you do not qualify for a government-sponsored health plan or other insurance product, the CareCard program will allow you to access health care services at any Bon Secours hospital. Please note the CareCard only covers charges associated with hospital services. The CareCard does not cover charges billed to you by physicians or other caregivers involved in your visit.

Please understand the financial assistance program does not apply to treatment related to work injuries, accidents or other treatment for which you receive compensation for your medical bills, pain and suffering and other damages.

Your CareCard is valid for one year, unless you qualify for a government-sponsored health plan or other insurance product. If you need assistance with completing the application, please call our toll free Customer Service Center at 1-877-342-1500 during the hours of 8:30 AM to 1:00 PM and 2:00 PM to 5:00 PM Monday through Friday.

We are committed to helping people and communities achieve health and wholeness as part of the healing ministry of Bon Secours.

CareCard
BON SECOURS HEALTH SYSTEM

Member: ████████████
Issuing Facility Code: Baltimore Hospital
Policy #: ████████
Plan: ████
Effective Date: 04/09 THRU 04/10
Family Yearly Deductible: $0.00

↕ Peel up to remove card ↕

FA04

CARE CARD (11/08)

Bon Secours Health System, Inc.
System-Wide Policy Manual

TOPIC: Patient Financial Assistance Services	POLICY NO.: CYC-01 / FAP0025 and E5101	DATE: September 1999 REVISED: July 9, 2010

| AREA: Patient Financial Services Patient Financial Assistance | APPROVED BY: Rich Statuto | |

PURPOSE

Bon Secours Health System, Inc. ("BSHSI") is committed to ensuring access to needed health care services for all. BSHSI treats all patients, whether insured, underinsured or uninsured, with dignity, respect and compassion throughout the admissions, delivery of services, discharge, and billing and collection processes.

Policy

The Bon Secours Health System ("BSHSI") exists to benefit people in the communities served. Patients and families are treated with dignity, respect and compassion during the furnishing of services and throughout the billing and collection process.

To provide high quality billing and collection services, standard patient financial assistance services and procedures are utilized. These services and procedures address the needs of patients who have limited financial means and are not able to pay in part or in full for the services provided without undue financial hardship (excluding cosmetic or self pay flat rate procedures).

The BSHSI financial assistance policy provides 100% financial assistance to uninsured patients with annual family incomes at or below 200% of the Federal Poverty Guidelines ("FPG"), as adjusted by the Medicare geographic wage index for each community served to reflect that community's relative cost of living ("Adjusted FPG").

Based on research conducted by the Tax Foundation, the maximum annual family liability is based on a sliding scale determined by family income and size. A standard BSHSI sliding scale is adjusted by the Medicare geographic wage index of each community served to reflect that community's relative cost of living.

Procedures

The standard patient financial assistance services and procedures are organized as follows.

Procedure	Policy Section
Communication and Education of Services	• 1
Preliminary Determination of Insurance and Financial Status	• 2
Financial Counseling	• 3
Prompt Pay Discounts	• 4
Billing and Letter Series	• 5
Payment Options	• 6
Program Enrollment Assistance	• 7
Patient Financial Assistance Program	• 8
Pursuit of Non Payment	• 9
Accountability and Monitoring	• 10
State Requirements and Policy Revisions	• 11

Definitions

- Charity – "the cost of free or discounted health and health related services provided to individuals who meet certain financial (and insurance coverage) criteria" as defined the Catholic Health Association of the United States.
- Income – The total family household income includes, but is not limited to earnings, unemployment compensation, Social Security, Veteran's Benefits, Supplemental Security Income, public assistance, pension or retirement income, alimony, child support and other miscellaneous sources.
- Bad Debt – An account balance owed by a patient or guarantor that can afford to pay, but has refused to pay, which is written off as non-collectable.
- Baseline – 200% of the Federal Poverty Guidelines ("FPG") – utilized by all BSHSI Local Systems to determine eligibility for the Patient Financial Assistance Program.
- Medical Eligibility Vendor/Medical Assistance Advocacy - Advocacy vendor contracted by BSHSI to screen patients for government programs and BSHSI Financial Assistance.
- Patient Financial Assistance Program – A program designed to reduce the patient balance owed provided to patients who are uninsured and underinsured and for whom payment in full or in part of the financial obligation would cause undue financial hardship.
- Prompt Pay Discount – A discount on the patient balance owed if paid within thirty (30) days of billing.
- The Tax Foundation Special Report – Guidelines for calculating the patient balanced owed for individuals participating in the Patient Financial Assistance Program, which identifies the percent income set aside for savings and medical expenses. The source is "A Special Report from the Tax Foundation"; dated November 2003, document number 125.
- Community Service Adjustment ("CSA") – A reduction in total charges to an account, which reflects an offset to the cost of healthcare to our uninsured patients and families.
- Uninsured – Patients who do not have any insurance and are not eligible for federal, state or local health insurance programs.
- Local System Champion ("LSC") – The individual appointed by the Local System CEO to assist in the education of staff and monitor compliance with this policy.

- Head of Household ("Guarantor") – The individual listed on tax return as "Head of Household". This will be the individual used for tracking Family Annual Liability.
- Household Family Members ("Dependents") – Individuals "residing" in household which are claimed on the tax return of the Head of Household (Guarantor).

Communication and Education of Services	POLICY NO. CYC-01/FAP_0025 Section 1

1.1 All BSHSI representatives that have contact with patients regarding financial status are responsible for advising patients of the BSHSI Patient Financial Assistance Services Program.

1.2 Standard signs and brochures are prepared by BSHSI Patient Financial Services for limited customization (name and logo) by each Local System. Signs and brochures are available in English and Spanish. Each Local System is responsible for having the signs and brochures translated into the other dominant languages spoken in the respective community in a manner that is consistent with the English version.

1.3 A brochure and education on its content are provided to each patient upon registration. Signs and brochures are predominantly displayed in patient registration, customer service, waiting and ancillary service areas.

1.4 Brochures and education on the content are provided to physicians and their staff.

1.5 Changes to the brochure or signs are prepared by BSHSI Patient Financial Services and distributed to each Local System Director of Patient Financial Service for immediate use. All brochures must be approved by BSHSI Patient Financial Services and reviewed for Medicare and Medicaid compliance.

1.6 The LSC is responsible to ensure that all community service agencies are provided information regarding the BSHSI Patient Financial Services practices. It is recommended that this be done in a forum that is interactive.

1.7 Training, education and resources on the Patient Financial Assistance Services Policy and Procedures is provided to each Local System CEO, VP of Mission, Director of Patient Financial Services and the Local System Champion and staff, as needed, to ensure consistency in deployment and policy administration.

1.8 Accommodations will be made for non-English speaking patients.

Preliminary Determination of Insurance and Financial Status	POLICY NO. CYC-01/FAP_0025 Section 2

2.1 The Patient Access Staff, including Registration and Medical Eligibility Vendor/Medical Assistance Advocacy, screen all patients to identify individuals and their families who may qualify for federal, state or local health insurance programs or the Patient Financial Assistance Program (see section 8 of this Policy). Potentially eligible patients are referred to Patient Financial Services for financial counseling.

2.2 Although proof of income is requested for consideration of the Patient Financial Assistance Program some Local System DSH regulations may require proof of income. Such regulations will be handled on a case-by-case basis.

2.3 Automatic charity assessment and credit checks for accounts greater than $5,000 will be considered.

Financial Counseling	POLICY NO. CYC-01/FAP_0025 Section 3

3.1 Patient Financial Services Staff, including the Patient Access Staff, is responsible for assisting patients and their families in determining eligibility and applying for federal, state and local insurance programs and/or for the Patient Financial Assistance Program. If applicable, referral for debt counseling is made. Information will be made available at all patient access locations, including 24-hour emergency departments.

3.2 A standard financial information worksheet is used to collect and document the patient's insurance and financial status. The standard worksheet is reviewed as needed, but at least annually, by the BSHSI Director of Patient Financial Services. Any changes to the standard work sheet are communicated to each Local System Director of Patient Financial Services and Local System Champion for immediate use.

3.3 Patient cooperation is necessary for determination. If patient does not provide the financial information needed to determine eligibility for the Patient Financial Assistance Program, the patient will be given the opportunity for a Prompt Pay Discount.

3.4 All uninsured patients are provided a Community Service Adjustment, at the time of billing.

3.5 All BSHSI locations will have dedicated staff to assist patients in understanding charity and financial assistance policies.

Prompt Pay Discounts	POLICY NO. CYC-01/FAP_0025 Section 4

4.1 All patients are eligible for a 10% Prompt Pay Discount when the patient balance owed is paid in full within thirty (30) days of the bill date. Patient is responsible for deducting the 10% prompt pay discount at the time of payment.

4.2 The Local System Director of Patient Financial Services is responsible for ensuring compliance with all state laws and regulations regarding discounts for health care services.

Billing and Letter Series	POLICY NO. CYC-01/FAP_0025 Section 5

5.1 A standard letter series is used to inform the patient of the patient balance owed and the availability of the Patient Financial Assistance Program. (See BSHSI Patient Financial Services Policy No C1217.)

5.2 The BSHSI Director of Patient Financial Services or designee reviews as needed, but at a minimum on an annual basis, the standard letter series. Any changes to the standard letter series are communicated to each Local System Director of Patient Financial Service or designee and Local System Champion for immediate use.

5.3 A distinct letter series is used for the Patient Financial Assistance Program to inform the patient of eligibility status and the patient balance owed. (See BSHSI Patient Financial Services Policy No. C313.

5.4 The BSHSI Director of Patient Financial Services or designee reviews as needed, but at a minimum on an annual basis, the distinct letter series for Patient Financial Assistance Program. Any changes to the distinct letter series are communicated to each Local System Director of Patient Financial Service or designee and Local System Champion for immediate use.

5.5 It is the policy of BSHSI to provide notification to a patient at least thirty (30) days before an account is sent to collection. Written notice can be included with the bill.

Payment Options	POLICY NO. CYC-01/FAP_0025 Section 6

6.1 A variety of payment options are available to all patients and their families.

- **Monthly Pay Plan** - Patient pays the patient balance owed over an eight-month period with a minimum monthly payment of $50. In the State of New York, the monthly payment shall not exceed ten percent (10%) of the gross monthly income of the patient. A patient may receive a monthly payment due reminder or choose an automatic check debit or credit card payment method.

- **Loan Program** - Assistance in obtaining a low-cost retail installment loan with an independent finance company is provided if the patient is not able to pay the patient balance owed within eight months of the billing date.

- **Single Payment** – Patients may choose to wait to pay the patient balance owed until after their insurance company has paid its portion. The patient balance owed is due within thirty (30) days of the billing date.

6.2 The Patient Financial Services staff documents the payment option selected by the patient in the financial information system.

6.3 Payments will be applied in the following order, unless otherwise directed by the LS DPFS:
- In accordance with remittance advice or EOB
- As directed by the patient/guarantor

In the absence of the above two points:
- The most current account

This approach mitigates issues with the handling of Family Annual Liability and reduces expense to the organization.

7.1 The Medical Eligibility Vendor/Medical Assistance Advocacy screens referred patients for eligibility for the following programs (this list is not inclusive of all available programs) :
- SSI Disability / Federal Medicaid
- State Medicaid
- Local/County Medical Assistance Programs
- State-Funded Charity Programs
- BSHSI Patient Financial Assistance Program

7.2 The Medical Eligibility Vendor/Medical Assistance Advocacy assists the patient in completing and filing application forms for all programs for which the patient may be eligible, including the BSHSI Patient Financial Assistance Program.

7.3 The Medical Eligibility Vendor/Medical Assistance Advocacy forwards the completed Patient Financial Assistance Program application form (and any documentation) to Patient Financial Services for processing.

7.4 Patients should be encouraged to apply for financial assistance as soon as possible, and in the State of New York, Patients will have at least ninety (90) days from date of discharge or date of service to apply for financial assistance and at least twenty (20) days to submit the completed application (including any state or federally required documentation

7.5 Certain government programs may require proof of income.

7.6 Patients without US citizenship presenting as uninsured will be eligible for the CSA however they must also be screened for available programs and/or referred to an international case firm (as determined by the Local System).

7.7 Insured patients without US citizenship must be referred to an international case firm (as determined by the Local System) for processing.

| Patient Financial Assistance Program | POLICY NO. CYC-01/FAP_0025 Section 8 |

8.1 The Patient Financial Assistance Program assists uninsured and underinsured patients who are not able to pay in part or in full the account balance not covered by their private or government insurance plans without undue financial hardship.

8.2 The standard minimum income level to qualify for 100% charity through the Patient Financial Assistance Program is an income equal to or less than 200% of the Federal Poverty Guidelines. BSHSI will not include Patient's assets in the application process.

8.3 Individuals above the 200% of the Federal Poverty Guidelines can be found eligible for partial assistance. Determination of a patient's maximum annual liability considers the patient's income and size. The patient balance owed is calculated using the formula illustrated in the Tables below.

8.4 In Maryland, individuals between 200% and 300% of the federal poverty guidelines may qualify for partial financial assistance based on the BSHSI reduced scale. Individuals above 300% may also qualify for partial financial assistance based on the BSHSI reduced scale.

8.5 In New York, when a patient is above 200% but less than or equal to 250% of the Federal Poverty Guidelines, the hospital shall apply a graduated scale not to exceed the maximum that Medicare, Medicaid, the charge from a third party payor, or the charge from the BSHSI hospital as adjusted by the CSA, whichever is more generous.

8.6 In New York, when a patient is equal to or above 251% of the Federal Poverty Guidelines, the hospital shall collect no more than the greater of the amount that would have been paid for the same services by Medicare, Medicaid, or the "highest volume payor, or the charge from the BSHSI hospital as adjusted by the CSA, whichever is more generous.

UNINSURED ONLY:

Note: This Table Does Not Address New York Patients.

Step I	[Charges] x [Community Service Adjustment] = Adjusted Account Balance Owed
	Uninsured patients ONLY will receive an "account" balance reduction / Community Service Adjustment (CSA). The reduction is market adjusted and will insure that patient's will never pay 100% of charges. The patient is still fully responsible for their Annual Liability after FAP (Steps II & III below).
	NOTES: The Community Service Adjustment applies to the balance due on individual accounts. a) If patient is approved for financial assistance they are responsible for each adjusted account balance owed amount until they meet their annual family liability. b) If patient is not approved for financial assistance, they are responsible for each adjusted account balance owed without an annual threshold.
Step II	[Household Income] – [Federal Poverty Guidelines, Adjusted for Family Size] = Adjusted Household Income
Step III	[Adjusted Household Income] x [The Tax Foundation % which identifies the amount of Household Income Spent for Medical Expenses] = Patient/Family Maximum Annual Liability Once the annual liability is met any balances thereafter will be processed as 100% charity (see section 8.6).
Step IV	As applicable, [Patient Balance Owed] - [10% Prompt Pay Discount] = Discounted Patient Balance Owed.
Step V	As patients become eligible for FAP the CSA will be reversed and processed as a charity adjustment.

UNDERINSURED ONLY:

Note: This Table Does Not Address New York Patients.

Step I	[Household Income] – [Federal Poverty Guidelines, Adjusted for Family Size] = Adjusted Household Income
Step II	[Adjusted Household Income] x [The Tax Foundation % which identifies the amount of Household Income Spent for Medical Expenses] = Patient/Family Maximum Annual Liability Once the annual liability is met any balances thereafter will be processed as 100% charity (see section 8.6).
Step III	As applicable, [Patient Balance Owed] - [10% Prompt Pay Discount] = Discounted Patient Balance Owed
Step IV	As patients become eligible for FAP the CSA will be reversed and processed as a charity adjustment.

8.7 The BSHSI Director of Patient Financial Services prepares and distributes updates to the Federal Poverty Guidelines, The Tax Foundation Average % and the respective Local System Cost of Service Adjustment as a part of the annual Strategic Quality Plan and Budget Guidelines process. The Local System Champion is responsible to ensure Guidelines are followed.

8.8 Patient Financial Services determines and documents the patient's eligibility for the Patient Financial Assistance Program and notifies the patient. The letter of approval/denial is mailed to the patient after receipt of the application and supporting documentation.

8.9 Patients determined to be eligible for Patient Financial Assistance Program retain eligibility for a period of twelve (12) months from the date of approval. At the end of those twelve (12) months, the patient is responsible for reapplying for eligibility for the Patient Financial Assistance Program.

8.10 Services provided as a result of an accident are subject to all legal instruments required to ensure third party liability payment, even if these instruments are filed after the initial eligibility for the Patient Financial Assistance Program has been approved. If third party coverage exists, BSHSI will collect the balance owed from the third party payer.

8.11 Application can be made on behalf of the patient by the following parties, including but not limited to:
- Patient or guarantor
- Faith community leader or representative
- Physician or other health care professionals
- Member of the Administration

8.9   Validated denial of coverage will be considered as uninsured and will be provided CSA.

Pursuit of Non-Payment	Policy No. CYC-01/FAP_0025 Section 9

9.1   No collection efforts are pursued on any pending Patient Financial Assistance Program account.

9.2   Any collection attorneys working on behalf of BSHSI are NOT authorized to attach bank accounts and in no case file body attachments. BSHSI collection attorneys follow BSHSI's value-based procedures in the pursuit of estates, garnishments and judgments for non-payment of debts. In no event will BSHSI ever put a lien on a patient / guarantor's primary residence.

9.3   In New York, BSHSI payment plans will not contain an accelerator or similar clause under which a higher rate of interest is triggered by a missed payment.

9.4   Each Local System uses a reputable collections attorney for the processing of legal accounts.

9.5   The Local System Director of Patient Financial Services is responsible for reviewing balances of $5,000 and greater to confirm that all appropriate actions have been taken prior to the patient balance being written off to Bad Debt or sent for suit. Policy allows for the Local Systems to be more stringent in their practices with respect to authorization levels.

9.6   As State requirements permit, deceased patients with no estate or patients that have been discharged through a Chapter 7 bankruptcy are automatically qualified for 100% charity write off.

9.7   All collection-type vendors are required to comply with the BSHSI Code of Conduct.

Accountability and Monitoring	Policy No. CYC-01/FAP_0025 Section 10

10.1   Reports on the program status are issued monthly, as part of current patient financial services/ revenue cycle reporting, to each Local System CEO, CFO, VP of Mission, Director of Patient Financial Services, Local System Champion and staff and others as defined.

10.2   The indicators used to monitor the program are:
  - Main Indicators:
    o   Bad Debt as % of Gross Revenue
    o   Charity Care as % of Gross Revenue
  - Monitoring Indicator:
    o   Reduction to % of accounts/dollars in bad debt that have been reclassified to charity.

10.3   The Local System CEO is the responsible person to insure applicable standardization of implementation and compliance with the integrity of the program on an ongoing basis.

11.1 Due to the ever-changing environment and current proposed legislation it will be necessary to revise this policy as appropriate.

11.2 It may be necessary to address certain State requirements within this policy to insure compliance with applicable laws and regulations.

11.3 Maryland State Only Regulations

- The Maryland HSCRC (Health Service Cost Review Commission) requires all Maryland hospitals to use the Uniform Financial Assistance Application form beginning January 1, 2006.
- To maintain compliance with applicable Maryland laws, Bon Secours Maryland will not sell bad debt accounts to any third parties. Bon Secours may use third party vendors to assist in the collection of bad debt and charity accounts.
-

11.4 New York State Only Requirements:

- Appeals Process for Re-Consideration of a Denied Application – All patients that have been denied have the right to appeal by contacting the New York business office at 800-474-3900. .

- The following are the reporting requirements by the hospital:
  - A report on hospital costs incurred and uncollected amounts in providing services to the uninsured and under insured, including uncollected co insurance and deductible amounts.
  - The number of patients, organized by zip code, who applied for financial assistance, and the number of patients by zip code whose applications were approved and whose applications were denied.
  - The amount reimbursement received from the Hospital Indigent Care Pool.
  - The amount spent from charitable funds, trusts or bequests established for the purpose of providing financial assistance to eligible patients as defined by such trusts or bequests.
  - If local social services district in which the hospital is located permits the hospital to assist patients with Medicaid applications, the number of Medicaid applications the hospital helped patients complete, and the number approved and denied.
  - The hospital's losses resulting from providing services under Medicaid.

Prepared by/Title: Nick Dawson, Director Revenue Cycle Services

Signature/Date:

Reviewed by/Title: Joe Ingold, VP Integration, Revenue Cycle Services

Signature/Date: 7/12/10

Approved by/Title: Joe Ingold, VP Integration, Revenue Cycle Services

Signature/Date: 7/12/10

Related Policies & Procedures; Notes; Controls:

Revision Date: (Use if Revised.)		Review Date: (Use if Reviewed No Changes.)
		April 18, 2008
Nick Dawson	Additions for New York State	April 24, 2008
Nick Dawson	Additions for Maryland State	June 4th 2008
Nick Dawson	Inclusions of board approved language	January 6 2010
Nick Dawson	Addition of section 8.4 for Maryland HSCRC regulations	April 20 2010
Nick Dawson	Revised section 8.8.	July 9 2010

Filename: BC

E5101

Date: September, 1999

BON SECOURS
BALTIMORE
HEALTH SYSTEM

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These services and procedures address the needs of patients who have limited financial means and are not able to pay in part or full for the services provided with out undue financial hardship.

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Professional services provided to you by a physician will be billed separately and apart from the fees charged by the hospital.

Thank you and we look forward to providing you the "Good Help" Bon Secours Baltimore stands for.

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Estos servicios y procedimientos están orientados a atender las necesidades de pacientes cuyos medios financieros son limitados y no pueden pagar en forma parcial o total los servicios prestados sin atravesar excesivas dificultades financieras.

ASISTENCIA FINANCIERA

Si no puede pagar la atención médica, es posible que califique para obtener atención sin cargo o a un costo reducido. Contamos con asesores financieros que podrán ayudarlo a solicitar asistencia financiera patrocinada por el gobierno o a ingresar al programa Bon Secours Financial Assistance Program. **Póngase en contacto con Phyllis Brown al 410-362-3319 respecto de los siguientes temas:**

- Su factura del hospital
- Sus derechos y obligaciones como paciente en relación con la factura del hospital
- Cómo solicitar atención médica sin cargo o a un costo reducido
- Cómo solicitar el ingreso a los programas Maryland Medical Assistance Programs y a cualquier otro programa que pueda ayudarlo a pagar la factura

Para obtener más información sobre los programas Maryland Medical Assistance Programs, comuníquese con la línea de ayuda al 1-800-456-8900, teléfono de texto para sordomudos 800-735-2258 o visite el sitio Web en www.dhmh.state.md.us/ma4families

FACTURACIÓN DEL MÉDICO

Los servicios profesionales que el médico le brinde serán facturados por separado y aparte de los honorarios que cobre el hospital.

Muchas gracias y esperamos proporcionarle esa "Buena Ayuda" que es el sentido de Bon Secours Baltimore.

Maryland State Uniform Financial Assistance Application

Information About You

Name _____
        First   Middle   Last

Social Security Number ____-__-____   Marital Status: Single   Married   Separated

US Citizen: Yes   No   Permanent Resident: Yes   No

Home Address _____   Phone _____

_____

_____   _____   _____   _____
City   State   Zip code   Country

Employer Name _____   Phone _____

Work Address _____

_____   _____   _____
City   State   Zip code

Household members:

Name	Age	Relationship

Have you applied for Medical Assistance   Yes   No

If yes, what was the date you applied? _____

If yes, what was the determination? _____

Do you receive any type of state or county assistance?   Yes   No

       Hospital Name
       Return Address

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I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

Monthly Amount

Employment _____
Retirement/pension benefits _____
Social security benefits _____
Public assistance benefits _____
Disability benefits _____
Unemployment benefits _____
Veterans benefits _____
Alimony _____
Rental property income _____
Strike benefits _____
Military allotment _____
Farm or self employment _____
Other income source _____

Total _____

II. Liquid Assets

Current Balance

Checking account _____
Savings account _____
Stocks, bonds, CD, or money market _____
Other accounts _____

Total _____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home   Loan Balance _____   Approximate value _____
Automobile   Make _____ Year _____   Approximate value _____
Additional vehicle   Make _____ Year _____   Approximate value _____
Additional vehicle   Make _____ Year _____   Approximate value _____
Other property   Approximate value _____

Total _____

IV. Monthly Expenses

Amount

Rent or Mortgage _____
Utilities _____
Car payment(s) _____
Credit card(s) _____
Car insurance _____
Health insurance _____
Other medical expenses _____
Other expenses _____

Total _____

Do you have any other unpaid medical bills?   Yes   No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____   _____
Applicant signature   Date

_____
Relationship to Patient

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