# Mercy Medical Center FY2015 Community Benefit Report Narrative

**December 15**

**2015**

In response to the growing interest in the types and scope of community benefit services provided by Maryland Hospitals, the Maryland General Assembly passed House Bill 15 during the 2001 Legislative Session, which created a new responsibility under the Health Services Cost Review Commission (see Health General §19-303, Maryland Annotated Code). Under the law, HSCRC is responsible for collecting hospital community benefit information from individual hospitals to compile into a publicly available statewide Community Benefit Report (CBR). Moving forward, greater alignment of Community Benefit with the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system. Mercy Medical Center is pleased to submit its FY2015 Community Benefit Report Narrative to the HSCRC.

***For the Health Services Cost Review Commission***

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**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: |
|---|---|---|---|---|---|
| 207 | 13,739 and 5,728 Observation cases | 21217,21215, 21202,21213, 21218,21224, 21206,21229, 21223,21216, 21230,21201, 21207,21222, 21205,21234, 21244,21225, 21231,21117 | Bon Secours, Sinai, St. Agnes, Johns Hopkins, Johns Hopkins Bayview, MedStar Harbor MedStar Union Memorial, University of Maryland Medical Center, University of Maryland Midtown | Baltimore City: 46.7% Baltimore County: 24.6% All other counties: 28.7% | Baltimore City: 60.4% Baltimore County: 27.0% All other counties: 12.6% |

**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.*

**DEFINING MERCY'S COMMUNITY BENEFIT SERVICE AREA**

In order to conduct a Community Health Needs Assessment (CHNA) that satisfied the requirements of Section 501(r) of the IRS Code, the current CHNA for Mercy was completed and published before June 30, 2013. Mercy Medical Center (Mercy) is now in the process conducting a CHNA to be completed and published no later than June 30, 2016, in accordance with the requirement to update the CHNA at least every three years. It is Mercy's intent to continue to seek greater alignment among various regulatory reporting requirements which are sometimes due at different intervals (e.g., CHNA & Implementation Strategy, HSCRC Hospital Strategic Transformation Plan, and IRS & HSCRC Community Benefit Reporting). Several of Mercy's Community Benefit activities are aligned with our CHNA Implementation Strategy as well as 2015 Hospital Strategic Transformation Plan. For the purposes of the FY2015 Community Benefit Report Narrative to the HSCRC, Mercy will utilize its current CHNA published on June 30, 2013.

Prior to 2013, Mercy's community benefit outreach was focused on a large geographic area within Baltimore City. The hospital primary service area historically covered 17 zip codes in which 60% of all inpatient admissions originated. 15 of these 17 zip codes were previously selected as Mercy's Community Benefit Service Area ("CBSA") based on the prevalence and concentration of emergency room visits. While appropriate and well intentioned, the use of zip codes as the basis for Mercy's CBSA has proved cumbersome for the following reasons:

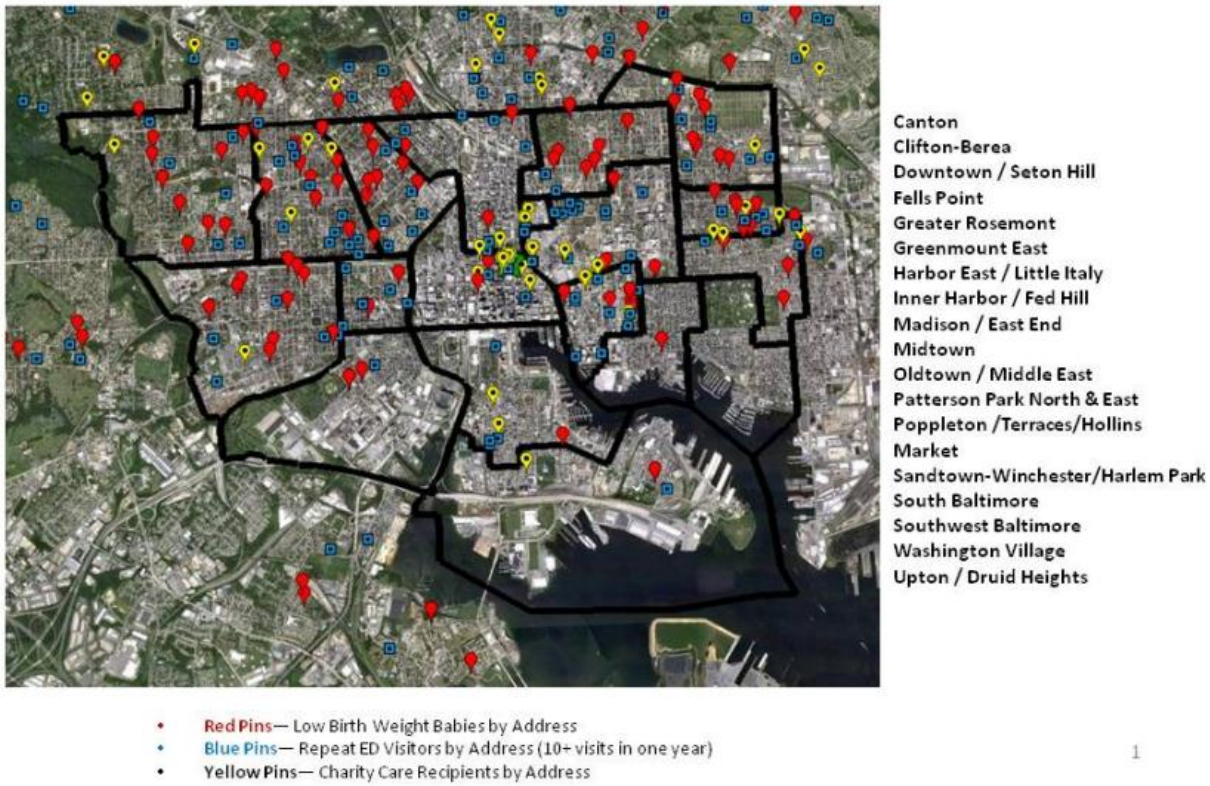
- Zip codes are by nature large. Mercy's previous CBSA covered almost 70 square miles within the City—the total land area in Baltimore is 81 square miles. Other peer hospitals have designated a much smaller CBSA footprint that tends to focus on the immediate neighborhood(s) in which they reside.
- A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

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

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

These data points were compiled and plotted by CSA to identify any concentrations or obvious areas in need of intervention. While these target populations are found throughout Baltimore City and into the surrounding Counties, the map below highlights the disproportionate share of low birth weight babies, repeat emergency department visitors, and charity care recipients in the downtown core. As a result of these findings, Mercy has determined that its community served for purposes of this CHNA includes the 18 CSAs that represent downtown and the communities east, west, and south of the city center. The Committee believes that this definition of Mercy's community, which represents a smaller geographic area than the CBSA previously utilized by Mercy, will foster greater coordination, better strategic partnerships and improved measurement of outcomes, in particular with respect to the targeted populations described above. Most importantly, Mercy believes that this definition of it's *CBSA does "reflect the geographic areas where the most vulnerable populations reside"*.

**Mercy Medical Center Community Benefit Service Area:**

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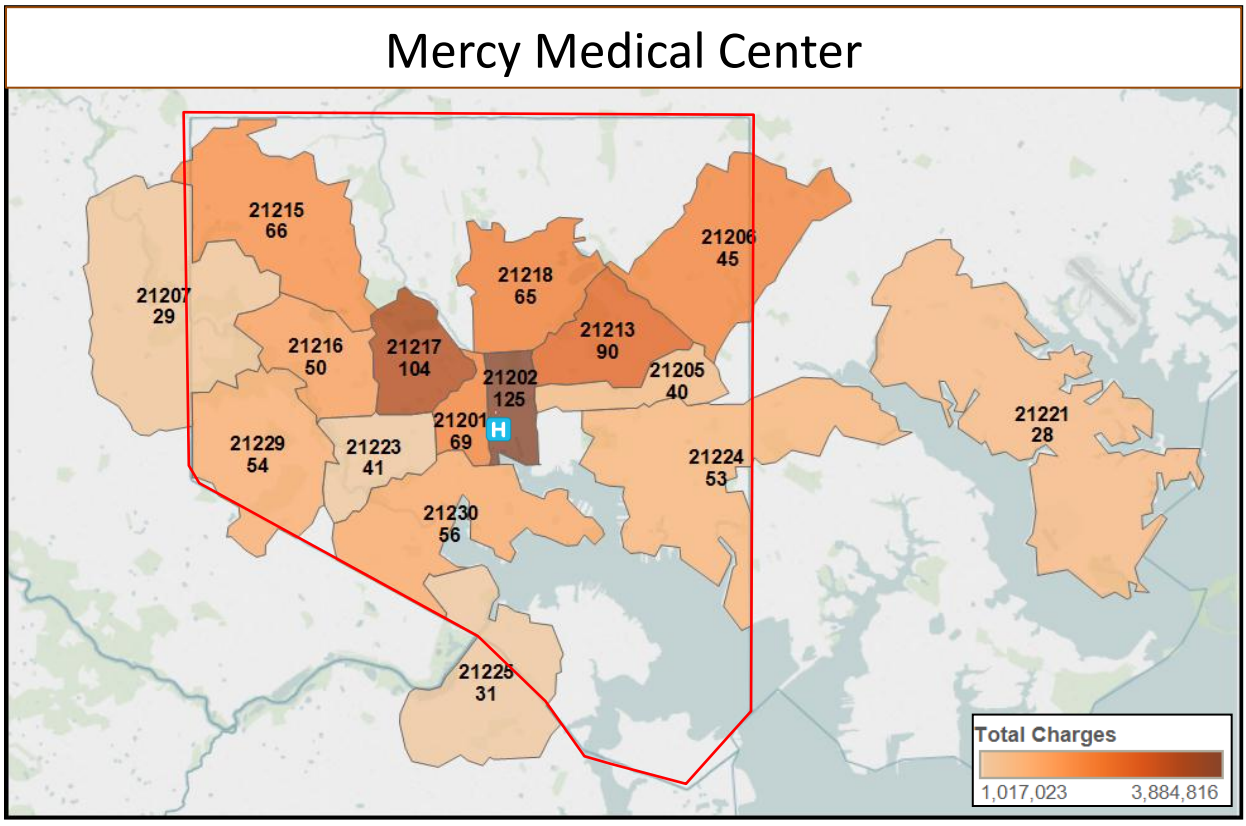
Additionally, since the implementation of the new Maryland all-payer model which followed the completion of Mercy's 2013 CHNA, Mercy is increasingly focused on high-utilizer patients, including those within our previously-defined CHNA Community Benefit Service Area. As expected, there is significant geographic overlap of high utilizer patient origin and our previously-defined CBSA, especially in the immediate areas where the most vulnerable populations reside (map below). The similarity of geography presents an ongoing opportunity to increase alignment between Mercy's Community Benefit Activities and Mercy's focused population health interventions to reduce potentially avoidable utilization as identified in Mercy's HSCRC Strategic Hospital Transformation Plan. Mercy believes our population health strategies are integral to our CHNA focus areas:

- Improving access to care and the frequency of care for our homeless neighbors.
- Identifying tactics and strategies to improve birth outcomes and pre-natal care for expectant mothers.
- Facilitating better care coordination with the City's Federally Qualified Health Centers.
- Providing support to victims of violence and addiction.
- Providing narrowly tailored health education to segments of the population within our community.

**Mercy Medical Center High Utilizer Patient Distribution:**




SOURCE:
Berkeley Research Group Analysis for Mercy Medical Center
Data period: Fiscal Year 2015
High Utilizer: > 2 Inpatient or Observation encounters (Bedded Care) in the year
Exclusions: Age 0-17; Mortalities

Notes:
[1] Shading reflects total high utilizer charges in zip code.
[2] Label shows count of unique high utilizer patients in each zip code.
[3] Map limited to zip codes with at least $1M total high utilizer charge

*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).*

Table II

| | |
|---|---|
| Median Household Income within the CBSA | $38,772 (Baltimore City Total)<br>*U.S. Census Data* |
| Percentage of households with incomes below the federal poverty guidelines within the CBSA | 21.4%<br>*Aggregated U.S. Census Data* |
| Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links:<br>http://www.census.gov/hhes/www/hlthins/data/acs/aff.html<br>http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml | 15.2% (Baltimore City Total)<br>*U.S. Census Data* |
| Percentage of Medicaid recipients by County within the CBSA. | Not available |
| Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).<br>See SHIP website:<br>http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles:<br>http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx | See table(s) below |
| Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). | See table(s) below |
| 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)<br>See SHIP website for social and physical environmental data and county profiles for primary service area information:<br>http://dhmh.maryland.gov/ship/SitePages/measures.aspx | See table(s) below |
| Available detail on race, ethnicity, and language within CBSA.<br>See SHIP County profiles for demographic information of Maryland jurisdictions.<br>http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx | See table(s) below |

QUANTATIVE ANALYSIS OF MERCY'S CBSA HEALTH PROFILE:

To obtain the quantitative data required to complete the assessment, Mercy's Community Benefit Committee used the high quality and comprehensive Neighborhood Health Profiles completed by the Baltimore City Health Department in 2008 and 2011 (and updated in March 2012). The Neighborhood Health Profiles present demographic, social and health outcome information at the CSA level in Baltimore City to support community-level health improvement efforts to achieve the Healthy Baltimore 2015 plan, the City's comprehensive public health agenda to improve health outcomes in Baltimore. The City plans to conduct these comprehensive Neighborhood Health Profiles every two to three years. By partnering with the Baltimore City Health Department, Mercy avoided the unnecessary expense of conducting a redundant community survey and received an extremely high quality and narrowly tailored dataset. Mercy was able to leverage this existing data source to help create a single community health profile that spans across the 18 CSAs in the hospital's community. Thus, Mercy can state specifically the demographic and health status of residents living in our specific community and not rely on extrapolations from aggregate citywide data. As we develop long term implementation strategies, this ability to measure trends in specific communities should prove to be very useful. **Beyond providing a solid foundation for data analysis and ongoing programmatic accountability, this strategic partnership with the City Health Department ensures that the community health priorities of Mercy Medical Center remain aligned with the health priorities of the City and the City Health Commissioner.**

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

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

Demographic Characteristics—Race, Age & Gender

The first chart below details the demographic makeup of Mercy's community. 187,714, or 30%, of the City's 620,961 residents live within Mercy's defined community. Of note, the total population of the City in the health profile does not include incarcerated residents. Mercy's community ranges from the Gwynns Falls to the west, Edison Highway to the east, North Avenue to the north and the South Baltimore peninsula to the south. The area of focus comprises an incredibly diverse cross section of the City. However, on the whole, the diversity of this geographic area represents an aggregate diversity;

there are distinctive concentrations of racial and ethnic groups as well as wealth and poverty within the eighteen community statistical areas. Almost 67% of the residents within Mercy's community are minorities. In 13 of the 18 CSAs, racial and ethnic minorities make up the majority of residents. In 8 of the 18 CSAs, the Black resident population exceeds 83%. White residents make up more than 75% of the population in Canton, Fells Point, Inner Harbor/Federal Hill, and South Baltimore. Hispanic/Latino residents comprise 4.4% of the population in our target area, which is slightly higher than the citywide percentage. The highest concentration of Hispanic/Latino residents in our community is located in Patterson Park North & East (21.1%) and Fells Point (15.1%). Though only 3.1% of our community's population is Asian, the percentage of Asian residents in our target area is higher than the citywide percentage. In particular, the Asian population in Downtown/Seton Hill (16%), Fells Point (7.6%), and Washington Village/Pigtown (5.3%) are all more than double the 2.2% citywide Asian representation.

**2011 Neighborhood Health Profile Summary**

**Mercy Health Services Proposed Community Benefit Service Area**

**1. Demographics**

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

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52% of residents within Mercy's community are female and 48% are male. Mercy's community has slightly more male residents and slightly fewer female residents when compared to Baltimore City as a whole. With respect to the age of the population within Mercy's community, residents in our community tend to be younger than the City as a whole. As portrayed in the chart below, 34.7% of residents in our focus area are between the ages of 25 and 44. Only 28.8% of residents in the entire City are between 25 and 44. The age data for the community is skewed upward by the high concentrations of young adults in some of the more affluent neighborhoods near the Inner Harbor. In Canton, Downtown/Seton Hill, Fells Point, South Baltimore, and the Inner Harbor/Federal Hill, the percentage of the population between the ages of 25 and 44 exceeded 47%. Mercy's community also has fewer senior

citizens when compared to the City as a whole. Only 9.8% of the community's residents are 65 and up as compared to 11.8% of the citywide population.

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

## 1. Demographics (continued)

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

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Socioeconomic Characteristics

In general, Mercy's community is poorer than the City as a whole. 40.6% of households in Mercy's community earn less than $25,000 compared to 33.3% for the City. Adult unemployment ranges from highs of 21% in Sandtown-Winchester/Harlem Park and 20% in Clifton-Berea to a low of 2.5% in the Inner Harbor/Federal Hill community. This alarmingly high range in unemployment rates highlights the severity of the socioeconomic disparities found within Mercy's community. 11 of the 18 CSAs in Mercy's service area have unemployment rates that exceed the City's already high unemployment rate of 11%. Poverty levels within Mercy's community are also disturbingly high. 21.4% of families in Mercy's community have incomes below the federal poverty level. Again, the range within our community is striking—48.8% of families in Upton/Druid Heights earn below the poverty level; only 1.6% of families in Canton earn below the poverty level. According to the Annie E. Casey Foundation's 2012 Kids Count Report, 84% of City school children receive free and reduced price meals, which is double the statewide average of 42%. These socioeconomic characteristics strike at the heart of the real world challenges confronting any government or hospital-led efforts to improve health outcomes in Mercy's community. If 1 in 8 adults are unemployed and more than 1 in 5 families are living below the poverty level, then

personal health choices and accessing health systems take a back seat to more basic day to day needs. Any effort to affect change in the community must be grounded in this fundamental reality.

Education

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

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

**3. Education**

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

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Physical, Built, and Social Environment

Though often overlooked in health surveys, the Baltimore City Health Department's health profile project compiled data on the built and social environment affecting residents in the City. These policy experts sought to identify and track environmental factors that directly contribute to the health and well-being of our community's residents. Scholarly research like the CDC's Adverse Childhood Experiences (ACE) study highlights the link between childhood trauma and later-life health. The CDC's ACE study found a strong correlation between adverse childhood experiences and poor health outcomes. The ACE Study suggests that children exposed to the "toxic stress" of violence, homelessness,

abuse, and neglect are at a greater risk for illness and premature death as well as a lower quality of life. Children are also greatly impacted by family dysfunction when their parents are separated, mentally ill or incarcerated. The chart below reveals that residents in Mercy's community are disproportionately exposed to alcohol and liquor stores, juvenile arrests, domestic violence and gun violence. In addition to these adverse social conditions, the built environment presents similar challenges within our community. Data from our health profile reveals that our community has more than twice the rate of vacant homes and lead paint violations as the rest of the City. Furthermore, an oversupply and over-reliance on carry out restaurants and corner stores for food supply also highlights the existence of food deserts within our community.

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

## 4. Community Built and Social Environment

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

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Community Health Indicators

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

In the citywide health profile, the City Health Department used life expectancy estimates that reflected the mortality rates in the City from 2005 thru 2009. The estimated citywide life expectancy at birth in Baltimore was 71.8 years. Life expectancy is a significant indicator of overall health. The City Health Department used the life expectancy and mortality rates to calculate the years of potential life lost (YPLL) throughout our community. YPLL measure the impact of premature mortality on a specific

population. The City Health Department defined premature mortality as death before age 75. The Health Department then calculated the YPLL by adding together the years of life that were not lived because people died before the age of 75. Thus, infant deaths and juvenile deaths can heavily impact a community's life expectancy data and YPLL.

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

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

## 7. Health Outcomes

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

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- Top Causes of Premature Death

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

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

## 7. Health Outcomes (continued)

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

+ Rate not calculated - fewer than five deaths

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

## 7. Health Outcomes (continued)

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

+ Rate not calculated - fewer than five deaths

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- Maternal and Child Health Indicators

The Sisters of Mercy were originally founded in Dublin, Ireland, to care for the needs of women and children. From our founding principles to the fact that more babies are born at Mercy than at any other hospital, Mercy Medical Center is highly invested in improving maternal and child health outcomes in our community for a variety of reasons. The data below suggests that despite the hospitals strong efforts and the early success of the City's B'more for Healthy Babies campaign, much more must be done to improve the health outcomes for mothers, infants, and children in our City. Despite reductions in the citywide teen birth rate in recent years, the rate of births to persons 15-19 years old remains 50% higher in Mercy's community. 10 of the 18 CSAs in our community have a teen birth rate that is at least 75% higher than the citywide average. With respect to the percentage of women receiving prenatal care in the first trimester, Mercy's community is on par with the Citywide average. However, the disparity within Mercy's community merits further attention. Only 50.2% of women in Madison/East

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

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Mercy Health Services Proposed Community Benefit Service Area

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

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

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

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

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

+ Rate not calculated - fewer than five deaths

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## II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

   _X__Yes
   ____No

   *Provide date here.* 3/28 /2013 (posted on website)

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

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

   __X_Yes Approved by the Mission and Ethics Committee on 6/12/13 and adopted by the Mercy Health Services Board of Directors on 6/19/13
   ____No

   *If you answered yes to this question, provide the link to the document here.*
   http://mdmercy.com/~/media/Mercy%20Site/Files/About%20Mercy/Policies%20and%20Corporate%20Documents/2013%20CHNA%20Implementation%20Strategy.ashx

## III. COMMUNITY BENEFIT ADMINISTRATION

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

**Community Benefit Planning**

Community Benefit planning is an important component of Mercy's Strategic Plan vision, strategies, goals and metrics which are approved by its Board. Specifically, Mercy's current strategic plan calls for "Continued leadership in our community benefits position among Maryland hospitals" and to Strengthen Baltimore City partnerships to improve access to and cost effectiveness of quality care, to enhance the health of our community."

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) Board Committee, Sr. VP for Institutional Advancement, VP for Corporate Affairs

*Describe the role of Senior Leadership.*

Mercy's senior leadership plays an active role in community benefit activities through our structured committee process including by participating regular meetings, setting the agenda, reviewing materials, and making recommendations.

ii. Clinical Leadership

1. _X_Physician
2. _X_Nurse
3. _X_Social Worker
4. _X_Other (please specify)

*Describe the role of Clinical Leadership*

Clinical leadership plays an active role in community benefit activities by collaborating through our structured committee process.

iii. Community Benefit Operations

1. ___Individual (please specify FTE)
2. _X_Committee (please list members)
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 following individuals play active and collaborative roles as part of the CB planning and reporting process: Assistant to the President for Mission, Senior Vice President for Institutional Advancement, Chief of Staff & Vice President for Corporate Affairs, Senior, Director of Financial Planning, Director of External Affairs, Director of Community Outreach, Director of Social Work, Director of Pastoral Care, a Community member who is a former State Legislator, agency head, and corporate executive. Additional individuals are consulted when appropriate.

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 |

A Finance Team member who is not involved in the preparation of the Community Benefit report reviews the spreadsheet and compares it to source data on a test basis. The Narrative is reviewed by key members of the Community Benefit Committee to assure it represents the intent and actions of the Committee throughout the year.

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 |

Due to timing of the Mission and Ethics Committee and Board of Directors meetings, the FY15 Community Benefit Report will be presented for approval retroactively at the Mission and Ethics Committee meeting in February 2016. An update of the report that was in-process was reported at the Mission and Ethics Committee at their September meeting.

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
_____ 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** |
|---|---|---|---|
| Healthcare For the Homeless | Kevin Lindamood | President | Efforts to improve access to care and the frequency of care for our homeless neighbors. |
| Total Health Care | Faye Royale-Larkins, RN., MPH | CEO | Focus on improving birth outcomes and pre-natal care for expectant mothers. |
| Family Health Centers of Baltimore | Paula Brooks McLellan, MSW | CEO | Focus on improving birth outcomes and pre-natal care for expectant mothers. |
| Park West Health System | Various | N/A | Focus on improving birth outcomes and pre-natal care for expectant mothers. |
| Baltimore City Health Department | Various | N/A | Community Health data development, standardization & support. Alignment of priorities. |

Additionally, below is a list of individuals that were interviewed as part of the 2013 CHNA process (Included in 2013 CHNA):

| Name | Role/Title | Organization | Special Knowledge or Expertise | Interview Date |
|---|---|---|---|---|
| J. Kirby Fowler | President | Downtown Partnership of Baltimore | Runs non-profit focused on maintaining a vibrant and economically strong downtown. Operates a Clean & Safe team, many of whom are ex-offenders. Corporate sponsors affected by perception of crime, lack of cleanliness, and homelessness. Serves on Board of American Diabetes Society. | 12/11/2012, 9 a.m. |
| Cyrus J. Lawyer III, M.D. | Medical Director | Metropolitan OB/GYN Associates | Served as OB/GYN for 27 years. 95% of career focused on underserved in City. Works in at least three different FQHCs. His group delivers more than 1,000 babies at Mercy. | 12/13/2012, 9 a.m. |
| Hon. William Cole IV | City Councilman & Assoc V.P., Univ of Baltimore | Baltimore City Council | Mercy's City Council representative. Former President of Otterbein Community Assoc. Lives, works, worships in CBSA. | 12/14/2012, 1 p.m. |
| Olivia D. Farrow | Director, Mayor's Office of Human Services | Mayor's Office of Human Services | Former Interim City Health Commissioner. Oversees homeless shelter, re-entry, Head Start, and Community Action Centers. | 12/14/2012, 3 pm |
| Molly McGrath | Director, Baltimore Dept of Social Services | Baltimore City DSS | City resident and leader of State DSS Office in Baltimore City. Provides public assistance to more than 214,000 Baltimore residents and more than 3,000 foster kids thru age 21. | 12/18/2012, 2 p.m. |
| Rafael Lopez | Associate Director for Talent Management and Leadership Development | Annie E. Casey Foundation | Former head of the Family League of Baltimore. Former elected official in California. Advocate for effective systems to address needs of families and children. | 12/20/2012, 9 a.m. |
| Dennis Dorsch | Minister | Retired United Methodist Church | Retired minister. Retired Assitant Comptroller at Johns Hopkins Hospital. Homeless advocate. | 12/21/2012, 9 a.m. |
| Kathy Westcoat | President and CEO | HealthCare Access Maryland | One of most knowledgable leaders in State on providing access insurance to the uninsured. | 1/2/2013, 2 p.m. |
| Kevin Lindamood | President and CEO | Healthcare for the Homeless | Local and national leader on homelessness and health. Chair of Maryland Medicaid Advisory Committee. Serves on Board of Mid Atlantic Association of Community Health Centers | 1/4/2013, 1 p.m. |
| Rebecca Dineen | Asst Commissioner for Maternal and Child Health | Baltimore City Health Department | Runs the B'more for Healthy Babies Campaign (BHB) and is a passionate advocate for maternal and child health. | 1/4/2013, 2:15 p.m. |
| Stephen Shen | Board Member | Mount Vernon-Belvedere Assoc | Mr. Shen is a Mt. Vernon resident and officer within the MVBA. Architect by trade. | 1/23/2013, 4 p.m. |
| Michael Marcus | Program Director for Older Adult Services | Weinberg Foundation | Top expert on aging and older adult services in Baltimore region. | 1/8/2013, 3 p.m. |
| Paula McLellan | CEO | Family Health Centers of Baltimore | Chief Executive of FQHC in City with three clinic locations; Mercy Board member | 2/7/2013, 1 pm |

*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?*

_____yes __X__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?*

_____yes __X__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?*

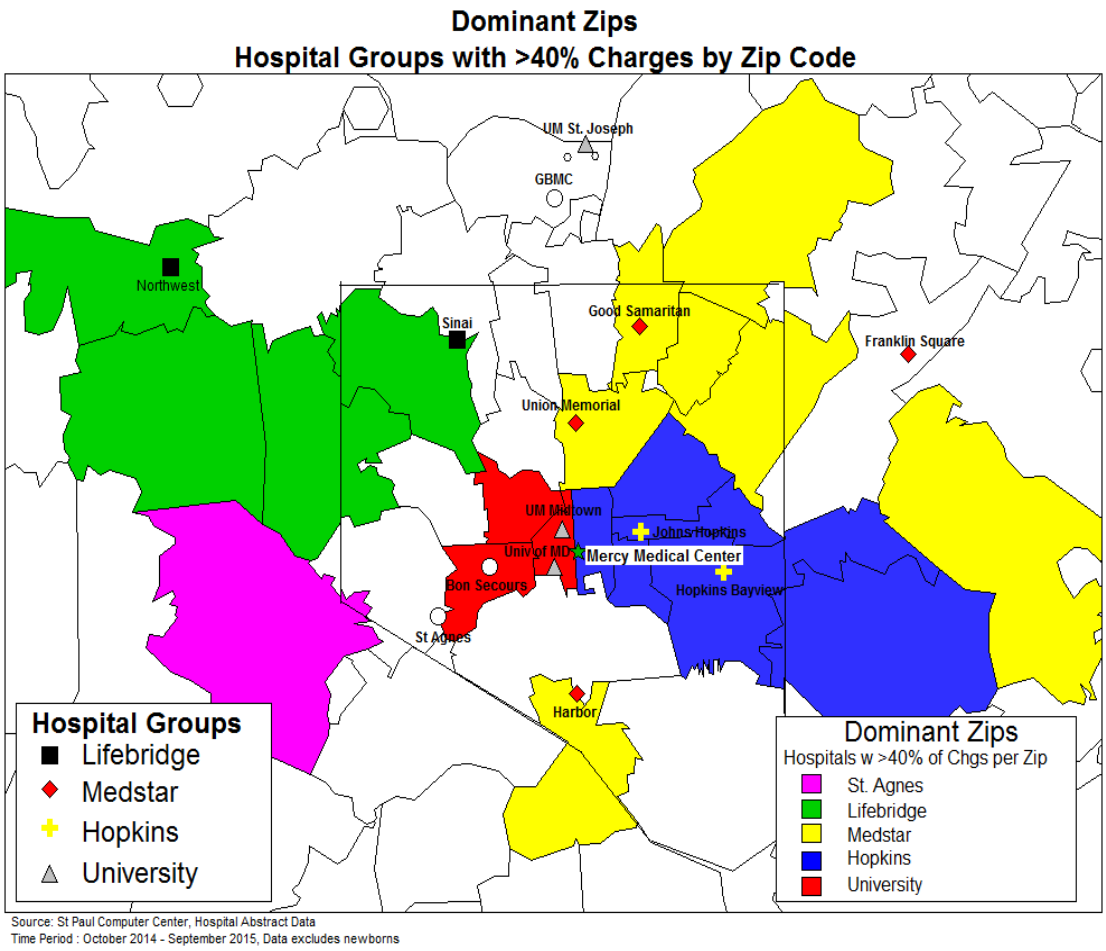
k. *Expense:*
*A. What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.*
*B. Of the total costs associated with the initiative, what, if any, amount was provided through 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.*

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

EXISTING HEALTH CARE FACILITIES & OTHER COMMUNITY RESOURCES

Seven of the sixteen acute care hospitals in Baltimore City are located within Mercy's Community Benefit Service Area. Due to Mercy Medical Center's downtown location between other larger hospitals Mercy is not the dominant hospital provider in any Baltimore City zip codes. The map below demonstrates which hospital providers represent the dominant number (>40%) of hospital charges in various Baltimore area zip codes. However, Mercy maintains an array of specialized citywide support programs for pregnant women, homelessness, substance abusers (Inpatient Medical Detoxification Unit), and Federally Qualified Health Centers) supported, in part, by our community benefits program. Mercy also houses the Sexual Assault Forensic Examination program (SAFE) and domestic violence program (FVRP).




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

http://dhmh.maryland.gov/maps/services/fqhc_3-2-11.pdf

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

3. *How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health?*

Under the new All Payer Model Mercy continues improving quality, lowering costs and responding to population/community needs. Through Global Budget Revenue (GBR) incentives, Mercy has broadened

its focus and reached further into the community to work towards Maryland's statewide population health goals.

Several of Mercy's Community Benefit activities are aligned with our CHNA Implementation Strategy and Mercy's focused population health interventions as identified in Mercy's 2016 HSCRC Strategic Hospital Transformation Plan, including:

- Reducing the cost of care by achieving further reductions of potentially avoidable utilization with a focus on Medicare high utilizers
- Improving population health by increasing supports for PCP's management of complex/high risk and rising risk populations
- Improving population health by increasing community health center capacity to manage complex/high risk pregnancies
- Improving population health by improving the integration of physical and behavioral health services

## 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.*

As a major provider of medical services to patients throughout the City of Baltimore, Mercy Medical Center is a vital safety net for the medically underserved. This safety net is necessary in every specialty, and is particularly needed for patients who present via the Emergency Department. The following medical and surgical sub specialties at Mercy respond to the needs of the uninsured through the Emergency Department on an initial or follow-up basis. Many of these services support Mercy's CHNA focus areas, especially efforts to improve access to care and the frequency of care for our homeless neighbors and to provide support to victims of violence and addiction.

- Orthopedics
  This specialty is especially problematic in terms of Emergency Department coverage. Four orthopedic surgeons provide coverage. A significant proportion of patients are uninsured. Mercy supports a weekly Orthopedic Clinic which provides follow-up care to patients initially seen in the Emergency Department and other outpatient sites. Of these patients, 99% are either uninsured or underinsured. In addition, orthopedic services are so limited for Baltimore City residents with inadequate insurance that many patients are referred to the Mercy orthopedic physicians from non-Mercy settings throughout the metropolitan area.

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

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

- Substance Abuse and Medical Detoxification
  Mercy offers one of two inpatient detoxification units in Baltimore City and cares for over 1,200 patients annually. Over 90% of patients are under or uninsured. Mercy provides physician subsidies for the professional component of these inpatient services. Of note, a number of diseases and medical conditions are over-represented in patients with substance abuse (e.g. Infectious Disease, Gastroenterology). Consultative and follow up care with appropriate specialists are also supported.

- Dentistry & Oral Surgery
  Mercy has one of the few community hospital based Dentistry & Oral Surgery Program in the City of Baltimore. This program provides services for adults (not covered under the State's Medicaid Program) and pediatric patients seen in the Emergency Department and at local community health centers.

- General Surgery
  Mercy provides higher levels of uncompensated care to patients in this discipline than any other community hospital in the City of Baltimore, in part because of its close, integrated clinical relationship with Health Care for the Homeless.

- Dermatology
  Mercy supports the only community hospital-based Dermatology practice in downtown Baltimore, which serves as a referral center for dermatologic disease from numerous urban clinics and settings throughout the Baltimore area. Of note, Dermatologic disease is often present in patients with advanced HIV disease.

- Mammography/Women's Imaging:
  Mercy provides the largest hospital-based mammography service to the residents of Baltimore City. The Tyanna O'Brien Center for Women's Imaging provides over 12,000 imaging exams annually; 25% of patients who receive imaging exams are without insurance or are underinsured.

- Gastroenterology
  Mercy's regionally recognized Posner Institute for Digestive Health and Liver Disease treats a number of illnesses, including Hepatitis C, pancreatitis, and cirrhosis that overrepresented in uninsured and underinsured patients.

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

Category: Non-resident house staff and hospitalists –

PA support for charity services of $3,397,703

OB coverage subsidy of $1,533,930

Detox coverage subsidy of $590,539

ED physician subsidy of $3,371,429

Category: Coverage of Emergency Department Call

Psychiatric coverage subsidy of $196,862

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

Physician Charity Care of $2,484,253

Dental Clinic charity care $301,817

Due to the lack of reimbursement, or significant reduced reimbursement for their professional services, physician coverage requires a subsidy from the hospital to provide these important services.

## 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).

Appendices I through V as noted above are summited as separate files.

Mercy Medical Center
FY 2015 Community Benefit Report

**Table III-1**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi Year Initiative Time Period | Key Partners and/or Hospitals in initiate development and/or implementation | How were the outcomes evaluated? | Outcome (include process and impact measures) | Continuation of Initiative | A. Cost of Initiative for FY 2015 | B. Amount of direct offsetting revenue from restricted grants |
|---|---|---|---|---|---|---|---|---|---|
| Improving access to care and the frequency of care for our homeless neighbors. This focus area was identified as part of the 2013 CHNA process. | Healthcare for the Homeless (HCH) | Mercy provides primary medical and pediatric physicians, nurse practitioners, PA and social work providers to support the mission of primary care, preventative medicine and support services at the HCH site. The Imitative supports a continuum of care for patients utilizing HCH and Mercy services. Effective preventative care for this higher risk population reduces avoidable utilization. | Multi | - Healthcare for the Homeless<br>- Baltimore City Office of Homeless Services<br>- Baltimore Mental Health Systems | annually | Monitoring of all HCH patient visits will not be available. Mercy ED utilization and ED hospital admissions have declined during the reporting period. Mercy supported HCH efforts to expand services with a new mobile clinic. | Yes | $ 1,801,259 | $ 866,629 |

Mercy Medical Center
FY 2015 Community Benefit Report

**Table III-2**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi Year Initiative Time Period | Key Partners and/or Hospitals in initiate development and/or implementation | How were the outcomes evaluated? | Outcome (include process and impact measures) | Continuation of Initiative | A. Cost of Initiative for FY 2015 | B. Amount of direct offsetting revenue from restricted grants |
|---|---|---|---|---|---|---|---|---|---|
| Improving access to care and the frequency of care for our homeless neighbors. This focus area was identified as part of the 2013 CHNA. | ED Social Work | An emergency department visit provides a critical opportunity to identify and interact with high-risk patients and prevent future visits. Mercy provide case management/Social Worker (LCSW) capacity in the Emergency Department for homeless, substance abuse and psychiatric patient populations in need of primary care and social support referrals. | Multi | HealthCare for the Homeless - Family Health Centers of Baltimore - Health Care Access Maryland - Baltimore behavioral Health Systems | annually | Mercy ED utilization and ED hospital admissions have declined during the reporting period. | Yes | $ 82,143 | |

Mercy Medical Center
FY 2015 Community Benefit Report

**Table III-3**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi Year Initiative Time Period | Key Partners and/or Hospitals in initiate development and/or implementation | How were the outcomes evaluated? | Outcome (include process and impact measures) | Continuation of Initiative | Cost of Initiative for FY 2015 | B. Amount of direct offsetting revenue from restricted grants |
|---|---|---|---|---|---|---|---|---|---|
| Access to Emergency Care for uninsured and underinsured patients aligns with our CHNA focus areas for Homeless population, FQHC Coordination, improving birth outcomes and pre-natal care, and support for addiction and victims of violence. | ED Physician loss subsidy | Provide accessible emergency health care regardless of insurance status. Mercy provides subsidized support to the Emergency Department Physician practice to subsidize Medicaid and underinsured patients . | multi year | St. Paul Place Specialists ED Physician Practice | annually | Medicaid and underinsured patients accounted for 59.8% of Mercy's FY2015 visits . | yes | $3,371,429 | $ 0 |
| Access to Emergency Psychiatric Care for uninsured and underinsured patients aligns with our 2013 CHNA focus areas for the Homeless population, FQHC Coordination, and support for addiction and victims of violence. | Psych coverage in the ED | Provide accessible emergency psychiatric care regardless of insurance status. Mercy provides subsidized coverage for Psychiatry coverage for the Emergency Department for Medicaid and underinsured patients. Fifty two percent (52%) of Mercy's high utilizers (all-payers) have a mental health or substance abuse diagnosis. | multi year | St. Paul Place Specialists ED Physician Practice | annually | Medicaid and underinsured patients accounted for 59.8% of Mercy's FY2015 visits . | yes | $196,862 | $ 0 |

Mercy Medical Center
FY 2015 Community Benefit Report

**Table III-4**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi Year Initiative Time Period | Key Partners and/or Hospitals in initiate development and/or implementation | How were the outcomes evaluated? | Outcome (include process and impact measures) | Continuation of Initiative | Cost of Initiative for FY 2015 | B. Amount of direct offsetting revenue from restricted grants |
|---|---|---|---|---|---|---|---|---|---|
| Access to Primary Care for uninsured and underinsured patients through collaboration with FQHCs. Focus area was identified as part of the 2013 CHNA process. | Support of Family Health Centers of Baltimore (FQHC) | Mercy provides subsidized support to Adult and Pediatric physician offices through the Family Health Centers of Baltimore (an FQHC). Effective preventative care reduces avoidable utilization. Provides cost-efficient and accessible health care regardless of insurance status, can arrange for sliding scale fees to assist the uninsured with physician and other expenses. | multi year | Family Health Centers of Baltimore | annually | Tracking of FQHC visits to Mercy specialists is not available. Access to primary care services for higher risk populations reduces avoidable | yes | $1,698,745 | $ 0 |
| Facilitating better care coordination with the City's Federally Qualified Health Centers. | Participation on Community Workforce Boards (FQHC Board Leadership) | Senior Mercy Executives volunteer to serve on the boards of several Baltimore City Federally Quality Health Centers to promote collaboration and FQHC stewardship and sustainability. | multi year | Total Health Care, HealthCare for the Homeless, Family Health Centers of Baltimore | annually | N/A | yes | $26,961 | $ - |

Mercy Medical Center
FY 2015 Community Benefit Report

**Table III-5**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi Year Initiative Time Period | Key Partners and/or Hospitals in initiate development and/or implementation | How were the outcomes evaluated? | Outcome (include process and impact measures) | Continuation of Initiative | Cost of Initiative for FY 2015 | B. Amount of direct offsetting revenue from restricted grants |
|---|---|---|---|---|---|---|---|---|---|
| Access to OB and NICU services for uninsured and underinsured patients aligns with strategies to improve birth outcomes and pre-natal care for expectant mothers as indentified in our 2013 CHNA. | PA Support for Charity Services | Provide OB and NICU health care regardless of insurance status. Mercy provides support to these physician practices through subsidies for PA and NP physician extenders. The cost included as community benefit represents this percentage of the cost of providing this service. | multi year | St. Paul Place Specialists Physician Practices, B'more for Healthy Babies | annually | FY2015 Medicaid and Uninsured patients served were 67.5% OB patients and 76.4% NICU patients | yes | $1,546,842 | $ 0 |
| Access to OB and NICU services for uninsured and underinsured patients aligns with strategies to improve birth outcomes and pre-natal care for expectant mothers as indentified in our 2013 | OB Coverage for patients presenting for delivery | Provide OB health care regardless of insurance status. Mercy provides support to these physician practices through subsidies for OB coverage. | multi year | St. Paul Place Specialists Physician Practices, B'more for Healthy Babies | annually | FY2015 Medicaid and Uninsured patients served were 67.5% OB patients. | yes | $1,533,930 | $ 0 |

Mercy Medical Center
FY 2015 Community Benefit Report

**Table III-6**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi Year Initiative Time Period | Key Partners and/or Hospitals in initiate development and/or implementation | How were the outcomes evaluated? | Outcome (include process and impact measures) | Continuation of Initiative | Cost of Initiative for FY 2015 | B. Amount of direct offsetting revenue from restricted grants |
|---|---|---|---|---|---|---|---|---|---|
| Improve birth outcomes and pre-natal care for expectant mothers. Facilitate better care coordination with the City's Federally Qualified Health Centers. Provide narrowly tailored health education to segments of the population within our community. All indentified in our 2013 CHNA. | Baby Basics Prenatal Health Literacy Program | The Baby Basics Prenatal Health Literacy Program provides health education to expectant mothers at Federally Qualified Health Centers read, understand, and act upon pregnancy information. The program empowers underserved populations to be active participants and to effectively navigate the healthcare system. Patients participating in Baby Basics increase adherence to prenatal visits. | multi year | Total Health Care, Family Health Centers of Baltimore, Park West Health System, B'more for Healthy Babies | annually | Get 3,109 Books 7 Trainings from SallyRatcliff | yes | $56,785 | $ 10,000 |
| Improve birth outcomes and pre-natal care for expectant mothers. | HCAM/ED Linkage & Referral Initiative for Pregnant Women | Pregnant mothers presenting to the Mercy ED are provided resources and referrals for insurance coverage | multi year | HealthCare Access Maryland (HCAM) | annually | | yes | $48,672 | |

Mercy Medical Center
FY 2015 Community Benefit Report

**Table III-7**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi Year Initiative Time Period | Key Partners and/or Hospitals in initiate development and/or implementation | How were the outcomes evaluated? | Outcome (include process and impact measures) | Continuation of Initiative | Cost of Initiative for FY 2015 | B. Amount of direct offsetting revenue from restricted grants |
|---|---|---|---|---|---|---|---|---|---|
| Providing support to victims of violence and addiction. This focus area was identified as part of the 2013 CHNA. | Sexual Assault Forensic Exam (SAFE) program | SAFE is a program in which nurses provide examinations for male and female sexual assault victims as well as provide evidence collection for the homicide, rape, sex offense and child abuse units of law enforcement agencies. The Mercy SAFE program is the designated site for forensic patients in Baltimore City and the only comprehensive program of its kind in Maryland. In addition, the program's leadership and certified nursing staff provide community education about domestic violence and sexual assault to law enforcement, the legal community, community organizations and local high schools and colleges. | multi year | - Sex and Family Crimes Division of the Baltimore City Police Department<br>- Family Crisis Center of Baltimore | annually | 394 patients served in FY2015 | yes | $ 668,303 | $ 53,576 |

Mercy Medical Center
FY 2015 Community Benefit Report

**Table III-8**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi Year Initiative Time Period | Key Partners and/or Hospitals in initiate development and/or implementation | How were the outcomes evaluated? | Outcome (include process and impact measures) | Continuation of Initiative | Cost of Initiative for FY 2015 | B. Amount of direct offsetting revenue from restricted grants |
|---|---|---|---|---|---|---|---|---|---|
| Providing support to victims of violence and addiction. This focus area was identified as part of the 2013 CHNA. | Mercy Family Violence Response Program | The program services victims of child abuse and neglect, sexual assault and abuse, domestic violence and vulnerable adult abuse. Services include: crisis counseling intervention, safety planning, danger assessment, documentation, and community resource referral for patients of MMC and it's associated physicians. | multi year | - Domestic Violence Coordinating Council<br>- Turn Around<br>- House of Ruth | annually | 687 patients served in FY2015 | yes | $ 695,989 | $ 116,894 |

Mercy Medical Center
FY 2015 Community Benefit Report

**Table III-9**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi Year Initiative Time Period | Key Partners and/or Hospitals in initiate development and/or implementation | How were the outcomes evaluated? | Outcome (include process and impact measures) | Continuation of Initiative | Cost of Initiative for FY 2015 | B. Amount of direct offsetting revenue from restricted grants |
|---|---|---|---|---|---|---|---|---|---|
| Providing support to victims of violence and addiction. This focus area was identified as part of the 2013 CHNA. | Mercy Inpatient Detoxification Program | Mercy's Substance Abuse and Medical Detoxification Program Mercy offers one of two inpatient detoxification units in Baltimore City and provides physician subsidies for the professional component of these inpatient services. Of note, a number of diseases and medical conditions are over-represented in patients with substance abuse (e.g. Infectious Disease, Gastroenterology). Consultative and follow up care with appropriate specialists also are supported. | multi year | | annually | 1005 patients served in FY2015 | yes | $ 590,539 | |

Mercy Medical Center **Appendix I**
HSCRC Community Benefit Report
FY 2015

**Describe your Financial Assistance Policy (FAP). 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.**

Mercy attempts to be very proactive in communicating its financial assistance policy and financial assistance contact information to patients. The financial assistance policy and financial assistance contact information is posted in all admissions areas, including the emergency room. A copy of the policy and financial assistance contact information is also provided to patients or their families during the pre-admission, pre-surgery and admissions process.

Mercy utilizes a third party, as well as in-house financial counseling staff, to contact and support patients in understanding and completing the financial assistance requirements. They also discuss with patients or their families the availability of various government benefits and assist patients with qualifications for such programs. Patients may also request a copy of the Financial Assistance Policy at any time during the collection process. Upon request, the policy can be provided in several languages and interpreter services are also available.

Even after the patient is discharged, each billing statement contains an overview of Mercy's Financial Assistance Policy, a patient's rights and obligations, and contact numbers for financial assistance, financial counseling, and Maryland Medicaid. Follow-up phone calls by hospital billing/collection staff made to patients with unpaid balances also stress the availability of financial assistance and financial assistance availability.

Mercy Medical Center **Appendix II**
HSCRC Community Benefit Report
FY 2015

**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.**

Mercy has completed an in-house and legal review of our Financial Assistance Policy and has concluded that the policy last reissued in March 2012 meets or exceeds all requirements associated with the ACA's Health Care Coverage Expansion Option and no changes were necessary.

# MERCY MEDICAL CENTER
POLICY AND PROCEDURE
PATIENT FINANCIAL SERVICES

## FINANCIAL ASSISTANCE POLICY

POLICY #: 602-176-93 ISSUE/REISSUE DATE: 03/12

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

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

### Financial Assistance

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

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

## Notification and Application

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

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

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

## Eligibility & Benefits

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

### Statutory and Regulatory Required Categories

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

2. A patient not otherwise eligible for Medicaid or CHIP who is a beneficiary/ recipient of a means-tested social services program, including but not necessarily limited to the following programs, is deemed eligible for Financial Assistance in the form of free medically necessary care, provided that the patient submits proof of enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days:

    a. households with children in the free or reduced lunch program;

    b. Supplemental Nutritional Assistance Program ("SNAP");

    c. Low-income-household energy assistance program;

    d. Primary Adult Care Program ("PAC"), until such time as inpatient benefits are added to the PAC benefit package; or

    e. Women, Infants, and Children ("WIC").

3. A patient with family income at or below 400% of FPL, with less than $10,000 in household monetary assets qualifies for partial Financial Assistance in the form of reduced-cost medically necessary care. The amount of financial assistance in this case is based on a sliding scale of income and shown in the attached table and other factors.

4. A patient with: (i) family income at or below 500% of FPL; (ii) with medical debt incurred within the 12 month period prior to application that exceeds 25% of family income for the same period; and (iii) with less than $10,000 in household monetary assets will qualify for partial Financial Assistance in the form of reduced-cost medically necessary care. The amount of financial assistance in this case is based on a sliding scale of income, amount of medical debt, and other factors.

    a. An eligible patient or any immediate family member of the patient living in the same household shall remain eligible for reduced-cost medically necessary care when seeking subsequent care at MMC during the 12-month period beginning on the date on which the reduced-cost medically necessary care was initially received.

    b. To avoid an unnecessary duplication of MMC's determinations of eligibility for Financial Assistance, a patient eligible for care under Paragraph 4.a shall inform the hospital of his or her eligibility for the reduced-cost medically necessary care.

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

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

6. A homeless patient qualifies for Financial Assistance.

7. A deceased patient, with no person designated as director of financial affairs, or no estate number on file at the applicable Registrars of Wills Department, qualifies for Financial Assistance.

8. A patient who has a remaining balance after Medical Assistance qualifies for Financial Assistance.

9. MMC may elect to grant presumptive charity care to patients based on information gathered during a debt collection process. Factors include propensity to pay scoring, eligibility and participation in other federal programs, and other relevant information.

10. A patient who does not qualify under the preceding categories may still apply for Financial Assistance, and MMC will review the application and make a determination on a case-by-case basis as to eligibility for Financial Assistance. Factors that will be considered include:

    a. Fixed income such as Social Security, Retirement or Disability with no additional income sources available;

    b. Medical expenses; and/or

    c. Expenses related to necessities of life compared to income.

**Defined Terms**

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

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

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

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

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

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

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

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

Developed by: Justin Deibel
Edna Jacurak
Betty Bopst

**APPROVED BY:**

John Topper, SVP, CFO

Mary Crandall, Director PFS

Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General 19-214.1(e).

Attached are a copy of Mercy's patient Information Sheet and a print of the reverse side of our billing statement which outlines Financial Assistance contact information.

Mercy
HEALTH SERVICES

# PATIENT INFORMATION:
# BILLING AND FINANCIAL ASSISTANCE POLICY

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

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

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

Services will be provided at no charge or at a reduced charge (based on a sliding scale) to patients who are unable to pay based on incomes up to approximately 400% above the federal poverty guidelines. (These guidelines are issued each year by the U.S. Department of Health and Human Services). MMC's financial assistance program is more generous than that required by Maryland law. Please see MMC's full Financial Assistance Policy for eligibility requirements and other information.

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

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

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

| | |
|---|---|
| • MMC Billing Inquiries / Statements | (410) 951-1700 |
| • MMC Financial Assistance Application | (410) 951-1700<br>www.hscrc.state.md.us/consumers_uniform.cfm |
| • MMC Financial Counseling | (410) 332-9273 |
| • MMC / Maryland Medical Assistance | (410) 332-9396 or 9273 |
| • Maryland Medical Assistance | (800) 332-6347 or TTY (800) 925-4434<br>www.dhr.state.md.us |

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

Update: 6/1/09

IF YOUR MEDICAL BILLS ARE COVERED BY ONE OF THE FOLLOWING, PLEASE COMPLETE THE STUB BELOW AND RETURN TO OUR OFFICE FOR PROCESSING.

BLUE CROSS / BLUE SHIELD – MEDICARE – MEDICAL ASSISTANCE – WORKMAN'S COMPENSATION – HMO

COMPLETE AND RETURN STUB

| SUBSCRIBER / CARDHOLDER NAME | HOME PHONE NUMBER | RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER | PATIENT DATE OF BIRTH / / |
|---|---|---|---|
| | | | |

| BLUE CROSS - MEMBERSHIP NUMBER | PREFIX OR GROUP | PLAN CODE | ADDRESS OF PLAN (CITY/STATE) |
|---|---|---|---|
| | | | |

| HMO I.D. CARD NUMBER | HMO SITE | PRIMARY CARE PHYSICIAN |
|---|---|---|
| | | |

| MEDICARE NUMBER | DATE RETIRED |
|---|---|
| | |

| MEDICAL ASSISTANCE I.D. CARD NUMBER | TYPE | EFFECTIVE DATE / / | EXPIRATION DATE / / |
|---|---|---|---|
| | | | |

| EMPLOYER NAME | ADDRESS |
|---|---|
| | |

| JOB CONNECTED ILLNESS OR INJURY? ☐ YES ☐ NO | AUTO ACCIDENT? ☐ YES ☐ NO | DATE OF ONSET OR ACCIDENT / / | ATTENDING PHYSICIAN |
|---|---|---|---|
| | | | |

DETACH HERE RETURN ABOVE STUB

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

**Overview of MMC's Financial Assistance Policy:** Mercy Medical Center (MMC) provides emergency services to all patients without regard to their ability to pay for such services. MMC also accepts, within the limits of its financial resources, all patients requiring non-emergency hospital care, without regard to their ability to pay for such services. These policies, however, do not preclude MMC from reviewing a patient's ability to pay, the availability of insurance benefits, or the patient's eligibility for Medical Assistance.

Services will be provided at no charge or at a reduced charge to patients who are unable to pay as determined on a sliding scale based on incomes up to approximately 400% above the federal poverty guidelines. (The poverty guidelines are issued annually by the Department of Health and Human Services.) Mercy's financial assistance program is more generous than that required by Maryland law. Please see MMC's full Financial Assistance Policy for eligibility requirements and other information.

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

- Rights include: to apply for financial assistance or Medical Assistance, to request a copy of MMC's Financial Assistance Policy, and to have a contact to discuss billing questions or concerns.
- Obligations include: to provide accurate and timely information to MMC, to cooperate with MMC / State personnel if financial assistance or Maryland Medical Assistance is sought and to satisfy their financial obligations.

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

- MMC Billing Inquiries / Statements — (410) 951-1700
- MMC Financial Assistance Application — (410) 951-1700 www.hscrc.state.md.us/consumers_uniform.cfm
- MMC Financial Counseling — (410) 332-9273
- MMC / MD Medical Assistance — (410) 332-9396 or 9273
- Maryland Medical Assistance — (800) 332-6347 or TTY (800) 925-4434 www.dhr.state.md.us

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

## PAYMENT ON ACCOUNT

1. PAYMENT IS DUE WITHIN 30 DAYS FROM RECEIPT OF THIS STATEMENT.
2. YOU ARE RESPONSIBLE FOR PAYMENT ON YOUR ACCOUNT REGARDLESS OF YOUR INSURANCE CLAIM, SETTLEMENT OF DISPUTED INSURANCE CLAIMS, OR SETTLEMENT IN COURT CASES, ETC.
3. IT IS ESSENTIAL FOR YOU TO NOTIFY THIS OFFICE OF ANY ADDRESS CHANGES-UNDELIVERABLE STATEMENTS WILL BE TURNED OVER TO COLLECTION AGENCIES IMMEDIATELY.

***Our Mission***

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

***Our Values***

- Dignity
- Hospitality
- Justice
- Excellence
- Stewardship
- Prayer

***Our Vision***

As a highly integrated Catholic health system sponsored by the Sisters of Mercy, Mercy Health Services will offer to all those in greater Baltimore, with a special commitment to poor and underserved persons:

- The hospital of choice in our market;
- Seamless and cost-effective care, rooted in our values, across the continuum for each person;
- A comprehensive ambulatory network readily accessible to everyone;
- Regionally recognized, patient-focused Centers of Excellence;
- A recognized leader in quality care and patient safety; and
- Innovative senior care to meet evolving needs.