COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2015 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

Submitting by: Sheppard Pratt Health System, Inc.

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BACKGROUND

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

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

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

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

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), the IRS defines a CHNA as a:

> Written document developed for a hospital facility that includes a description of the community served by the hospital facility: the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

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

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

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

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility, (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions ("LHIC's)[see: http://dhmh.maryland.gov/healthenterprisezones/Documents/Local_Population_Health Improvement_Contacts_4-26-12.pdf] schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input, who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

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

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

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

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);

(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments.

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

The IMPLEMENTATION STRATEGY, as provided in the ACA, must:

a. Be approved by an authorized governing body of the hospital organization;
b. Describe how the hospital facility plans to meet the health need, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and
c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. (Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

Table I

Bed Designation	Psychiatry
Inpatient Admissions	9,228
Primary Service Area Zip Codes	21234, 21601, 21215, 21222, 21122, 21204, 21228, 21206, 21030, 21227, 21229, 21207, 21225, 21401, 21221, 21117, 21060, 21093, 21045, 21236, 21244, 21212, 21403, 21042, 21224, 21218, 21044, 21216, 21286, 21217, 21014, 21144, 21136, 21220, 21043, 21239, 21133, 21213, 21214, 21037, 21208, 21012, 21223, 21114, 21146, 21040, 21113, 21237, 21409, 21075, 21009
All other Maryland Hospitals sharing Primary Service Area (with psychiatric units)	Howard County General Hospital; 21044 Johns Hopkins Bayview; 21224 Levindale Hebrew Geriatric Center and Hospital; 21215 MedStar Franklin Square Medical Center; 21237 MedStar Union Memorial Hospital; 21218 Northwest Hospital Center; 21133 Sinai Hospital; 21215 University of Maryland Baltimore Washington Medical Center , 20161 University of Maryland St. Joseph's Medical Center; 21204
Percentage of Uninsured Patients by County	Anne Arundel: 38.95% Baltimore: 47.37% Howard: 13.68%
Percentage of Patients who are Medicaid Recipients by County	Anne Arundel: 30.58% Baltimore: 60.64% Howard: 8.78%

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.

Sheppard Pratt Health System is a private, non-profit behavioral health organization that provides a range of services to meet the needs of children, adolescents, adults and older adults. Headquartered in Towson, Maryland, Sheppard Pratt Health System serves more than 77,000 individuals annually and provides nearly one million units of mental health services including hospitalization, residential treatment, respite care, special education, psychiatric rehabilitation, general hospital services, and outpatient programming.

Sheppard Pratt Health System partnered with Greater Baltimore Medical Center and University of Maryland St. Joseph Medical Center to conduct a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area within Greater Baltimore. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment examined a variety of indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease).

Community Profile

The hospitals defined their current service area based on an analysis of the geographic area where individuals utilizing the partner hospitals' health services reside. The primary service area is considered to be the Greater Baltimore community within Baltimore County, Maryland including the following towns:

Zip Code	County	Towns
21030	Baltimore	Cockeysville
21093	Baltimore	Lutherville, Timonium
21204	Baltimore	Pikesville, Towson
21207	Baltimore	Pikesville
21286	Baltimore	Towson
21117	Baltimore	Owings Mills
21222	Baltimore/Baltimore City	Dundalk
21234	Baltimore/Baltimore City	Parkville
21236	Baltimore/Baltimore City	Nottingham

Community engagement and feedback were an integral part of the CHNA process. The Greater Baltimore hospitals sought community input through Key Informant interviews with community stakeholders and inclusion of community partners in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise

about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community served by the hospitals including medically underserved, low income, and minority populations. Following the completion of the CHNA research, GBMC, SPHS, and UM-SJMC prioritized community health issues and developed implementation plans to address prioritized community needs.

One of the initial undertakings of the CHNA was to create a "Secondary Data Profile." Data that is obtained from existing resources is considered "secondary." Demographic and health indicator statistics were gathered and integrated into a report to portray the current health status of the Greater Baltimore service area. Quantitative data was collected from reputable sources including the U.S. Census Bureau, Centers for Disease Control and Prevention, National Cancer Institute, and Maryland Department of Health & Mental Hygiene. Data sources are listed throughout the report and a full reference list is included in Appendix A. The most recent data available was used wherever possible. When available, state and national comparisons were also provided as benchmarks.

Demographic Statistics

According to U.S. Census Bureau (2010) estimates, the total population in the Greater Baltimore community is 298,273. The population increased 7.3% between 2000 and 2010. Howard County's population increased by 2.1%.from 2010 to 2011.

Table 1. Overall Population (2010)

	U.S.		Maryland		GB Service Area		Howard County	
Population	308,745,538		5,773,552		298,273		288,225	
Population Change (00' - 10')	9.7%		9.0%		7.3%		2.1%	
Gender	N	%	N	%	N	%	N	%
Male	151,781,326	49.2	2,791,762	48.4	139,822	46.9	141,065	49%
Female	156,964,212	50.8	2,981,790	51.6	158,451	53.1	147,160	51.1

Source: U.S. Census Bureau, 2010

The median age in the area is 37.9 years, which is similar to the state and nation (MD: 38.0; US: 37.2). However, the Greater Baltimore service area has a slightly higher proportion of adults who are 65 years and over compared to the state and nation (GB: 15.0%; MD: 12.3%; US: 13.0%). In Howard County, the median age is 38.4 years with 10.2% of adults over age 65.

Table 2. Population by Age (2010)

	U.S.	Maryland	GB Service Area	Howard County
Median Age	37.2	38.	37.	38.4
% 18 years and over	76.0	76.6	79.0	74.2
% 65 years and over	13.0	12.3	15.0	10.2

Source: U.S. Census Bureau, 2010

According to the U.S. Census Bureau (2010), nearly two-thirds of Greater Baltimore residents are White (65.2%) and approximately 24% are Black/African American. Only about 4.7% identify as Hispanic/Latino which is notably less compared to Maryland (8.2%) and the Nation (16.3%). Compared to Maryland and the U.S. as a whole, the percentage of the population who speak a language other than English in Greater Baltimore is lower (GB: 13.6%; MD: 15.9%; US: 20.1%). Howard County's population is 62.4% White, 17.8 % African-American and 14.4% Asian. In Howard County, 77.7% of residents speak English only while 22.3% speak a language other than English.

Table 3. Racial Breakdown (2010) [a]

	U.S.		Maryland		GB Service Area		Howard County	
	n	%	N	%	N	%	N	%
White	223,553,265	72.4	3,359,284	58.2	194,333	65.2	179,820	62.4
Black/African American	38,929,319	12.6	1,700,298	29.4	72,716	24.4	51,384	17.8
American Indian/ Alaska	2,932,248	0.9	20,420	0.4	1,124	0.4	495	0.2
Asian	14,674,252	4.8	318,853	5.5	16,722	5.6	41,469	14.4
Native Hawaiian or Other Pacific	540,013	0.2	3,157	0.1	12 4	0.0	135	0.0
Two or more races	9,009,073	2.9	164,708	2.9	7,776	2.6		
Hispanic or Latino (*of any race*)[b]	50,477,594	16.3	470,632	8.2	13,894	4.7	16,887	5.9

Source: U.S. Census Bureau, 2010 and 2012

[a] *Percentages may equal more than 100% as individuals may report more than one race*

[b] *Hispanic/Latino residents can be of any race*

The median income for households in the Greater Baltimore community ($61,351) is lower than Maryland ($70,647) but higher than the nation ($51,914). According to the U.S. Census Bureau (2010), unemployment rates in Greater Baltimore (6.0%) are below state (6.6%) and national rates (7.9%). Howard County's median household income is $104,375.

- US $51,914
- Maryland $70,647
- Greater Baltimore $61,351
- Howard County $104,375

Source: Median household income, Greater Baltimore and Howard County compared to MD and U.S. (2006-2010 and 2009- 2012).

In general, the proportion of families and people living in poverty in Greater Baltimore is less compared to the Nation and comparable to Maryland. A noteworthy indicator is the proportion of single female household families living in poverty with children under 5 years (7.1%) which is significantly lower than Maryland (27.8%) and the Nation

(45.8%) . Howard County is even lower with 3.2% of families living in poverty. However, in the category of single female household families living in poverty with children under the age of 5 years, the figure is significantly higher at 20.6%. Source: U.S. Census Bureau American Community Survey 5-Year Estimates, 2010

Table 4. Poverty Status of Families and People in the Past 12 Months (2006–2010)

	U.S.	Maryland	GB Service Area	Howard Co.
Families	10.1%	5.7%	5.5%	3.2%
With related children under 18 years	15.7%	8.7%	8.1%	5.1%
With related children under 5 years	17.1%	9.2%	4.5%	4.9%
Married couple families	4.9	2.2%	2.9%	1.2%
With related children under 18 years	7.0	2.6%	3.8%	1.7%
With related children under 5 years	6.4	2.8%	2.3%	0.9%
Families with single female householder	28.9%	17.1%	13.1%	13.6%
With related children under 18 years	37.4%	22.7%	17.9%	17.8%
With related children under 5 years	45.8%	27.8%	7.1%	20.6%
All people	13.8%	8.6%	9.5%	4.9%
Under 18 years	19.2%	10.9%	10.6%	5.8%
18 years and over	12.1%	7.9%	9.2%	4.6%
65 years and over	9.5	7.9%	8.6%	5.5%

Source: U.S. Census Bureau American Community Survey 5-Year Estimates, 2010
U.S. Census Bureau, 2012

Education

Education is an important social determinant of health. It is well known that individuals who are less educated tend to have poorer health outcomes. High school graduation rates and educational attainment rates for higher education in the Greater Baltimore and Howard County communities are slightly higher than the state and nation. Approximately 89% of Greater Baltimore adults have a high school diploma or higher degree. Thirty-seven percent (37%) have a bachelor's degree or higher. In Howard County, 94.7% have a high school diploma or higher degree and 59% have a bachelor's degree. This is in comparison to Maryland (87.8%; 35.7%) and the Nation (85.0%; 27.9%). (Source**:** U.S. Census Bureau American Community Survey 5-Year Estimates, 2010)

Health Status Indicators

Health Care Access

Health insurance coverage can have a significant influence on health outcomes. According to the Maryland Behavioral Risk Factor Surveillance System (2012), the percentage of Greater Baltimore residents who have health insurance coverage (88.1%) is higher compared to Maryland (87.0%) and the Nation (81.7%). 91.9% of Howard County residents have health insurance coverage. In addition, the percentage of Greater Baltimore residents who have visited a doctor for a routine checkup within the past year (82.7%) is higher compared to Maryland (75.8%) and the Nation (66.9%). Approximately 15% of Greater Baltimore residents indicated

that there was a time in the past 12 months when they could not afford to see a doctor which is lower compared to the nation (17%) but higher in comparison to the state (13%). This indicator is favorable when compared to state and national rates but still reveals a significant proportion of the population who is struggling to access health care. Source: (Maryland Behavioral Risk Factor Surveillance System, 2012)

Mental Health

There is limited data available at the local level regarding mental health.

Based on the results of the Maryland Behavioral Risk Factor Surveillance System, a higher proportion of Greater Baltimore residents (16.3%) indicate they have been diagnosed with a depressive disorder compared to Maryland (13.6%). This rate is on par with national statistics.

The percentage of Greater Baltimore service area residents who are binge drinkers (16.6%) is favorable compared to Maryland (18.0%) and the Nation (18.3%). Binge drinking is defined as males having five or more drinks on one occasion or females having four or more drinks on one occasion. Howard County residents is also below averages for both Maryland and the Nation.

Table 5. Excessive Drinking (2011)

Alcohol Use in past 30 days:	U.S	Maryland	GB Service Area	Howard Co
	%	%	%	%
Binge Drinking: Had four (women)/five (men) or more drinks on an occasion	18.3	18.0	16.6	14.9%

Source: Maryland Behavioral Risk Factor Surveillance System, 2012

The tables below represent current living situations for adults in Maryland. Approximately 20% of the area's population live in situations other than independent living. More than 13% of residents in the CBSA are homeless.

Table 6. Living Situation – Adults – Where They are Living Now (2011)

	Baltimore County		Baltimore County				Howard County		Howard County			
			White / Caucasian		Black / African American				White / Caucasian		Black / African American	
	n	%	n	%	n	%	n	%	N	%	n	%
Independent	5,384	86.4	3,553	87.7	1,688	83.9	76	81.9	415	81.7	268	83.0
Community	422	6.8	242	6.0	172	8.5	92	10.7	56	11.0	31	9.6
Institutional	53	0.9	25	0.6	28	1.4	9	1.0	4	0.8	5	1.5
Homeless	284	4.6	172	4.2	96	4.8	32	3.7	20	3.9	11	3.4
Other	90	1.4	59	1.5	28	1.4	23	2.7	13	2.6	8	2.5

Source: Maryland Mental Hygiene Administration Outcomes Measurement System

b. In Table II, describe the population within the CBSA, including significant demographic characteristics and social determinants that are relevant to the needs of the community and ***include the source of the information in each response***. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, transportation, education and healthy environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its Area Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf), The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Table II

Median Household Income within the CBSA Anne Arundel: $84,409 Baltimore: $64,814 Howard: $104,375	US Census, 2012
Percentage of households with incomes below the federal poverty guidelines within the CBSA Anne Arundel: 5.9% Baltimore: 8.5% Howard: 4.4%	US Census; 2012
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml Anne Arundel County: 6.60% Baltimore County: 10.3% Howard County: 7.6% (Estimate: 142,235 individuals)	US Census, American FactFinder, 2013 American Community Survey
Percentage of Medicaid recipients by County within the CBSA. Anne Arundel County: 8% Baltimore County: 14% Howard County: 10%	US Census; American Fact Finder; 2013 Estimates
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx Anne Arundel County: 79.8 years (White: 80.1 yrs and Black: 77.3 yrs) Baltimore County: 79.2 years (White: 79.5 years and Black: 77.5 years) Howard County:82.3 years (White: 81.0 years and Black: 81.1 years)	Maryland Dept of Health and Mental Hygiene; Vital Statistics Administration Annual Report; 2012

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). Deaths per 100,000 residents (1); All Cause Mortality Maryland: 780.8 Anne Arundel: 819.8 Baltimore: 797.5 Howard: 676.0 Deaths Due to Suicide (2): US: 12.1% Maryland: 8.4% Anne Arundel: 9.6% Baltimore: 8.7% Howard: 8.9% Suicide Deaths per 100,000(3): US: 11.2% Maryland: 9.0% Anne Arundel: 9.4% Baltimore: 10.0% Howard County: 8.4%	(1) Dept. of Health and Mental Hygiene; Environmental Health Tracking; County Profiles (2) Centers for Disease Control and Prevention, National Center for Health Statistics, 2012, Maryland Department of Health and Mental Hygiene (3) SHIP, County Profiles, Demographic data, 2007 - 2013
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx Educational Attainment Percent high school graduate or higher Anne Arundel: 90.5% Baltimore: 89.4% Howard: 94.7% School Enrollment Preschool: Anne Arundel: 7.1% Baltimore: 6.7% Howard County: 6.5% Kindergarten: Anne Arundel: 5.4% Baltimore: 4.1% Howard: 5.3%	Sheppard Pratt's Community Benefit Secondary Data Profile; U.S. Census, 2012 Sheppard Pratt's Community Benefit Secondary Data Profile; U.S. Census, 2012

Elementary School: Anne Arundel: 37.4% Baltimore: 35.0% Howard: 39.5% High School: Anne Arundel: 20.5% Baltimore: 19.3% Howard: 22.3% College or graduate school: Anne Arundel: 29.7% Baltimore: 34.9% Howard: 26.4% <u>Divorce Rate by County:</u> Anne Arundel: 10.3% Baltimore: 9.9% Howard: 8.4% <u>Food Stamps/SNAP Program Benefits</u> Anne Arundel: 4.8% Baltimore: 7.6% Howard: 4.1%	

Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx Race and Ethnicity (1) Anne Arundel: African American Medicare Beneficiaries: 12.9% Hispanic Medicare Beneficiaries: 1.25% Non-Hispanic white Medicare Beneficiaries: 81.83% Other Medicare Beneficiaries: 2.99% Baltimore: African American Medicare Beneficiaries: 19.5% Hispanic Medicare Beneficiaries: 10.3% Non-Hispanic white Medicare Beneficiaries: 76.41% Other Medicare Beneficiaries: 3.06% Howard County African American Medicare Beneficiaries: 15.61% Hispanic Medicare Beneficiaries: 1.47% Non-Hispanic white Medicare Beneficiaries: 72.43% Other Medicare Beneficiaries: 10.49%	SHIP, County Profiles, Demographic data, 2012.
Race and Ethnicity(2) Anne Arundel: White: 76% Black/African American: 15.6% Asian: 3.5% Hispanic or Latino: 6.1% All Others: 2% Baltimore: White: 65 % Black/African American: 26.1% Asian: 5% Hispanic or Latino: 4.2% All Others: 1.7% Howard County White: 62.4% Black/African American: 17.8% Asian: 14.4% Hispanic or Latino: 5.9% All Others: 2.3%	US Census Bureau, 2012

Language Anne Arundel: English Only: 89.7% Language Other than English: 10.3% Spanish: 4.8% Speak English less than "very well": 7.5% Baltimore: English Only: 86.9% Language Other than English: 22.3% Spanish: 4.9% Speak English less than "very well": 9.1% Howard: English Only: 77.7% Language Other than English: 22.3% Spanish: 4.9% Speak English less than "very well": 16.2%	US Census Bureau, 2012
Other Mental Illness Hospitalization Statistics (2010) Anne Arundel: 2,914 hospitalizations By Gender: Male-56.2%; Female-43.8% By Race: White – 75.6% Black – 17.5% Baltimore: 7,306 hospitalizations By Gender: Male-54.4%; Female-45.6% By Race: White - 69.5% Black – 19.3% Howard: 1,191 hospitalizations By Gender: Male – 50.7%; Female – 49.3% By Race: White – 69% Black – 19.3%	Community Benefit – Secondary Data profile Maryland Department of Health and Mental Hygiene

Other: <u>Available Housing</u> for Individuals with Mental/Behavioral Health issues (2012) Anne Arundel: 11 Baltimore: 15 Howard: 16 <u>Out of Home Placements for Children</u> Anne Arundel: 320 children Baltimore: 798 children Howard: 107 children	Community Benefit –Secondary Data Profile (2013) State of Maryland Out-Of-Home Placement and Family Preservation Resource Plan; Governor's Office for Children; December 13, 2013

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. _03_/31__ /_2013_ (mm/dd/yy)

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

Please follow this link to Sheppard Pratt's Community Health Needs Assessment:

http://www.sheppardpratt.org
Navigate to the bottom of the page; next to Connect with Us, in the second column, click on CHNA Report.

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

_X__Yes _06_/ _04_/_2013_ (mm/dd/yy) Enter date approved by governing body here:
___No

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

http://www.sheppardpratt.org
Navigate to the bottom of the page; next to Connect with Us, in the second column, click on CHNA Implementation Plan.

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

_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.

Sheppard Pratt Health System's Community Benefit Needs Assessment was presented to and approved by the Board of Trustees on March 31, 2013. Subsequently, Community Benefit Programming was discussed as part of the Board's FY 2016 Strategic Planning Retreat. The program, including a 2nd Health Needs Assessment was targeted as part of the system's evolution as well and growth for the future. As such, the overall responsibility for the program was assigned to

the Vice President of Business Development with an executive level committee named to serve as the Community Benefit Operations Committee. The group is charged with identifying and implementing strategic community benefit programming as it best fits the needs of the targeted population. Additionally, the Community Benefit Operations Committee will be developing goals for the coming period.

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) VP Business Development, VP Human Resources

Describe the role of Senior Leadership.

Senior administrative leadership, along with senior clinical leadership, provide oversight for the implementation of community benefit programs as they serve as the Community Benefits Operations Committee. They provide input into each initiative as it relates to their area of expertise.

ii. Clinical Leadership

1. _X__Physicians (2), VP Medical Affairs and CEO
2. _X__Nurse, Chief Nursing Office
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

Senior clinical leadership, along with senior administrative leadership, provide oversight for the implementation of Community Benefit programs as they serve as the Community Benefits Operations Committee. They provide input into each initiative as it relates to their area of expertise.
.

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.

Bonnie Katz, VP, Business Development and Support Operations is responsible for the support operations for health system locations as well as business development activities. Additionally, Ms Katz is charged with the oversight of the Community Benefit strategic program design and program implementation including operations. She serves as the Chairperson of the Community Benefit Committee.

Steven S. Sharfstein, M.D., President and CEO serves as the health system's Chief Executive Officer and is responsible for directing and supervising the operations, administration, and maintenance of the Health System and all of its functions and facilities. He is ultimately responsible for development of long range and strategic plans as well as ultimately for the quality of patient care. As a member of the Community Benefit Committee, he provides guidance to ensure program alignment with health system mission to serve the most vulnerable in our community.

Robert Roca, M.D., Vice President, Medical Affairs is directly responsible for the organization's clinical vision and direction including patient care, advocacy, physician group administration and the quality improvement activities of the health system. As a member of the Community Benefit Committee, he offers insight into various collaborative possibilities as well as program clinical staffing.

Gerald Noll, VP and Chief Financial Officer is charged with the overall fiscal operations of the health system including in-depth analysis of financial policies and procedures. He ensures that the health system's financial system is accurate, efficient and in accordance with standard financial practices as well as government regulations. On the Community Benefit Committee, Mr. Noll acts as the fiscal consultant.

Ernestine Cosby, R.N., Vice President and Chief Nursing Officer oversees the health system's nursing department and all facets of its operations including patient care as well as clinical and staffing standards. As a member of the Community Benefit Committee, she provides input for any initiatives which involve nursing or other departments for which she provides leadership.

Cathy Doughty, Vice President, Human Resources determines and directs the health system's staffing with strategies to support a productive work force. She is charged with developing and implementing initiatives which support the health system's strategic direction. As a member of this committee, she provides insight into community benefit staff allocation.

Doloras Branch, Business Development Manager provides management support to multiple programs within the health system including its Community Benefit program activities. She provides community benefit program data collection, statistics and report development support to the Community Benefit Committee.

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

Spreadsheet	__X___yes	_____no
Narrative	__X___yes	_____no

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

The Health System's financial and accounting records are audited annually by KPMG, Inc. Community Benefit Report financial data is provided from the audited financial statements. Sheppard Pratt's Financial Office Analysts provide input into the development of the statistics and perform an internal review prior to submission to the Board of Trustees. Approval to release the report is provided by the Controller and Chief Financial Officer.

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

Spreadsheet	__X___yes	_____no
Narrative	__X___yes	_____no

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

__X__Other hospital organizations
__X__Local Health Department(s)
_____ Local health improvement coalitions (LHICs)
__X__Schools
_____ Behavioral health organizations
_____ Faith based community organizations
_____ 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**
Greater Baltimore Medical Center	Michael Myers	Director of Finance	Community Benefit Assessment
University of Maryland, St,. Joseph Medical Center	Susanne Decrane	Vice President Mission Integration	Community Benefit Assessment

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.

Table III Initiative I – Autism Specialty Pages within Virtual Resource Center

a. 1. Identified Need 2. Was this identified through the CHNA process?	According to the Centers for Disease Control and Prevention, "about 1 in 68 children have been identified with autism spectrum disorder (ASD)". In Maryland, the CDC has found the number to be slightly higher; 1 in 60 children have been diagnosed with the disorder (CDC Community Report on Autism 2014). Yes, this initiative was identified through the CHNA process.	
b. Hospital Initiative	Development of Autism Specialty Pages within the Virtual Resource Center	
c. Total Number of People within the Target Population	Maryland Autism and Developmental Disabilities Monitoring further clarifies the number of children with autism spectrum disorder to 468. This number includes those children who may not have ASD documented as part of their medical record.	
d. Total Number of People Reached by the Initiative Within the Target Population	1,194 page views	
e. Primary Object of the Initiative	To increase the community 's awareness and knowledge of mental and behavioral health issues by providing outreach, education , training and resources. The enhanced resource center provides autism-specific information, with links to support services, informative blogs, news articles, helpful sites to visit as well as service and advocacy organizations, a facts list and resources for parents.	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	The effort from Sheppard Pratt was invested in the previous fiscal year by Bonnie Katz, Jessica Kapustin, Chelsea Soobitsky, and the web development consultant. Ongoing content updates and provided by Chelsea Soobitsky and web development consultants.	
h. Impact/Outcome of Hospital Initiative?	The Autism Virtual Resource Center provided updated information on autism-specific services and supports 1,194 times in a confidential and private viewing thereby allowing the public to become better educated about autism in a convenient, confidential and informal manner.	
I. Evaluation of Outcomes	Outcomes were measured by the increasing number of page views experienced year to year. FY 2014 page views: 39 FY 2015 page views: 1,194	
j. Continuation of Initiative?	Yes, this initiative will continue into the next fiscal year with content being updated as required as new developments become evident.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative None in this fiscal year.	B. Direct Offsetting Revenue from Restricted Grants None.

Table III Initiative 2 – Community Education – Parent Lecture Series

a. 1. Identified Need 2. Was this identified through the CHNA process?	The Maryland SHIP 2012 Program Measures; Healthy Social Environments, Objective 7 aims to reduce child maltreatment to 4.8 children per 1,000 by 2014. The baseline was cited as 5 children suffering from maltreatment per 100,000 in 2010 as compared to a national baseline of 9 children suffering from maltreatment in 2008. Sheppard Pratt's program was developed in response to calls received in their centralized intake as well as requests through Sheppard Pratt's Crisis Walk In Program. Yes, this initiative was developed through the CHNA process.	
c. Hospital Initiative	Community Education – Parent Lecture Series or Events	
c. Total Number of People within the Target Population	Total Households with one or more people under 18 yrs in the family: Anne Arundel County: 67,988 Baltimore County: 99,112 Howard County: 38,727 Total Households with one or more people under 18 yrs: 205,827	
d. Total Number of People Reached by the Initiative Within the Target Population	Two hundred and thirty one individuals attended the following events 5 events during this report period. Four presentations were provided: "Why Does My Child Do That?"; "School Transitions"; "Child and Anxiety; and "Autism and ADHD". A film viewing followed by a Q&A panel focused on the images that saturate our lives as to unattainable beauty with its increasing effects on children, among others.	
e. Primary Object of the Initiative	To increase the community's awareness and knowledge of mental and behavioral health issues by providing outreach, education, training and resources, including free lectures on parenting and issues important for child and adolescent development.	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Sheppard Pratt: Bonnie Katz, Jessica Kapustin, Chelsea Soobitsky, Drew Pate, M.D., Desmond Kaplan, M.D., Susan Barrett	
h. Impact/Outcome of Hospital Initiative?	61 family representatives attended the parent lecture series. 170 individuals attended the film event.	
I. Evaluation of Outcomes	This initiative is intended as ongoing community education and enlightenment where attendees are able to speak with an health care professional in a normalized environment.	
j. Continuation of Initiative?	Yes, this effort will continue into FY 2016. For upcoming events, Sheppard Pratt will attempt collaborative efforts with local agencies in order to publicize the events and increase exposure to this valuable parent education series.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $10,176	B. Direct Offsetting Revenue from Restricted Grants None

Table III Initiative 3 – Positive Behavioral Intervention and Supports Program (PBIS)

a. 1. Identified Need 2. Was this identified through the CHNA process?	The need for violence prevention in our school systems is widely publicized through tragic events occurring throughout our country. In 2008, Maryland convened a Summit on School Safety Solutions in which prevention rather than punishment was a focus as well as helping students to learn alternatives to violence when confronted with a difficult situation. Professional development and PBIS were cited as a valuable stepping stones toward peaceful school environments. No.	
d. Hospital Initiative	Positive Behavioral Intervention and Supports Program	
c. Total Number of People within the Target Population	Number of Public Schools in Maryland: 1,448 Number of Non-Public Schools in Maryland: 1,425 Approximately 58,940 teachers (www.localschoolsdirectory.com)	
d. Total Number of People Reached by the Initiative Within the Target Population	1,040 schools trained in PBIS since the program's inception 1,600 Maryland school staff 62 schools within the current report period for Tier II training. 26 schools provided with universal team training 24 school systems involved in various levels of training	
e. Primary Object of the Initiative	To engage teachers and school system staff in professional educations to better prepare them to identify students with mental health needs. The PBIS network supports the implementation of Positive Behavioral Interventions and supports in state, local, and community agencies.	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Sheppard Pratt: Tim Truscello, Director Day School Programs Susan Barrett, PI and Director Education Grants Jerry Bloom, Coordinator, Education Grants Patty Hershfeldt, Ph.D., Asst Dirctor, Educationl Grants Others: Maryland State Department of Education: Kristina Kyles-Smith, Asst. State Sup[erintendent Bonnie Van Metre, M.Ed, Behavioral Specialist Johns Hopkins: Philip Leaf, Director, Center for the Prevention of Youth Violence Catherine Bradshaw, Ph.D., Director, Center for the Prevention of Youth Violence	
h. Impact/Outcome of Hospital Initiative?	Total of 1,040 Maryland Schools and 1,600 school staff have been trained in PBIS; 980 of those schools are actively implementing the PBIS model. In the 2014 to 2015 school year, 62 schools signed up for the pilot project Check In Check Out, Tier II which provides targeted intervention, designed for students who (s) are unresponsive to Tier I supports, (b) do not require more immediate individualized interventions and (c) are demonstrating need across multiple settings or contexts.	
I. Evaluation of Outcomes	Outcomes were measured based on student behaviors: Significant reduction in school-level suspensions among PBIS schools. Students in PBIS schools were 32% less likely to receive an office discipline referral.	
j. Continuation of Initiative?	Yes, this effort will continue into FY 2016.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $1,217,998	B. Direct Offsetting Revenue from Restricted Grants $1,217,998

Table III Initiative 4 – Life Space Crisis Intervention Program

a. 1. Identified Need 2. Was this identified through the CHNA process?	Sheppard Pratt provides special education services through Level I and II schools to education systems throughout Maryland. As part of this relationship, Sheppard Pratt education staff have gained insight as to the need for behavioral health training to assist teachers and other school staff to develop positive student relationships. No.	
e. Hospital Initiative	Life Space Crisis Intervention Program	
c. Total Number of People within the Target Population	Number of Public Schools in Maryland: 1,448 Number of Non-Public Schools in Maryland: 1,425 58,940 (www.localschooldirectory.com)	
d. Total Number of People Reached by the Initiative Within the Target Population	1,670 school staff and administrators	
e. Primary Object of the Initiative	To provide school staff with an intensive experiential training integrating evidenced-based practices related to prevention and integration, behavioral management and modification resulting in positive student relationships with school staff.	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Sheppard Pratt: Jim Truscello, Director Day School Programs Abby Potter, Coordinator Educational Development and Training	
h. Impact/Outcome of Hospital Initiative?	1,670 total school staff trained 6 Full Staff Trainings with 3 days of follow up consultation throughout the year 3 District-wide trainings 1-year long monthly consultation LSCI presentation were made at 4 Regional conferences with approximately The LSCI concepts were presented at a State Conference	
I. Evaluation of Outcomes	Evaluation of outcomes are currently in development.	
j. Continuation of Initiative?	Yes, this effort will continue into FY 2016.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $71,469.19	B. Direct Offsetting Revenue from Restricted Grants $71,469.19

Table III Initiative 5 – Therapy Referral Service

a. 1. Identified Need 2. Was this identified through the CHNA process?	As part of Sheppard Pratt's joint Health Needs Assessment, Mental Health/Suicide was reported to be the third most frequently selected health issue. Further, respondents indicated that the resources available for the treatment of mental health issues as being insufficient. The Maryland Behavioral Risk Factor Surveillance system reports a higher proportion of Greater Baltimore residents (16.3%) have been diagnosed with a depressive disorder compared to Maryland (13.6 percent) The Affordable Care Act has engulfed the health care delivery system with individuals seeking behavioral health services and without a resource to help them understand where and how to access their benefits. . No.	
b. Hospital Initiative	Therapy Referral Service	
c. Total Number of People within the Target Population	According to NIMH health statistics prevalence data, approximately 18.5% of the adult population could suffer from a mental health impairment For children the prevalence is estimated at 20% of the population. http://www.nimh.nih.gov/health/statistics/index.shtml. Further, SAMSHA data indicates that about 50% are actively seeking treatment. Applying the population estimates for the Community Benefit tri-county estimates provided (2009 American Community Survey 1 yr Estimates) yields a targeted population of 156,226 individuals possibly in need of psychiatric service information. (99,959 adults and 56,267 children).	
d. Total Number of People Reached by the Initiative Within the Target Population	5,093 callers inquired about service and how to access their healthbenefits 1,863 callers referred outside the Sheppard Pratt system as Sheppard Pratt could not accommodate their specific needs	
e. Primary Object of the Initiative	Provide mental health referral information to the public in a free, confidential manner that is personalized to the individual needs of the community member.	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Participating Hospital Staff include: Bonnie Katz, VP Business Development and Support Operations Harvey Weinstein, Therapy Referral Service Manager	
h. Impact/Outcome of Hospital Initiative?	5,093 individuals were given free access to clinically-trained staff who were able to assist caller by listening to their problems, making a preliminary assessment, and referring them to an appropriate clinical community resource.	
I. Evaluation of Outcomes	Outcomes not evaluated.	
j. Continuation of Initiative?	Yes, this effort will continue into FY 2016 as Sheppard Pratt will continue providing referral services to those in need.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $321,078.	B. Direct Offsetting Revenue from Restricted Grants None

Table III Initiative 6 – Crisis Services

a. 1. Identified Need 2. Was this identified through the CHNA process?	As outlined in Objective 34 of the Maryland State health Improvement Process (SHIP), crisis utilization of emergency rooms for those suffering from a behavioral health issue places a strain on the health care system. No.	
b. Hospital Initiative	Crisis Services through 1) Crisis Walk In Clinic, 2) Urgent Assessment and 3) Scheduled Crisis Intervention Program	
c. Total Number of People within the Target Population	In 2011, SHIP reported an average of 5,077 individuals seen in emergency rooms for behavioral health issues	
d. Total Number of People Reached by the Initiative Within the Target Population	4,575 individuals utilized the Crisis Walk In Clinic 592 individuals utilized the Urgent Assessment, Scheduled Crisis Intervention and Bridge programs 5,167 individuals served	
e. Primary Object of the Initiative	Provide an emergency room alternative focused on serving the needs of individuals in crisis and requiring immediate evaluation for safety or triage to the appropriate level of care.	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Sheppard Pratt Staff: Bonnie Katz, VP Business Development and Support Operations Benedicto Borja, M.D., Medical Director, Crisis Walk In Clinic Harvey Weinstein, Manager	
h. Impact/Outcome of Hospital Initiative?	5,167 individuals were provided with an urgent or emergency behavioral health assessment by an M.D. and receiving recommendations for the appropriate level of care. Of the 5,167 individuals served, 305 were in need of immediate care in a setting which required ambulance transport to insure their safety.	
I. Evaluation of Outcomes	Outcome evaluation is not collected on this program.	
j. Continuation of Initiative?	Yes, this effort will continue into FY 2016.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $237,771	B. Direct Offsetting Revenue from Restricted Grants None.

Table III Initiative 7 – Crisis Referral Outpatient Program

a. 1. Identified Need 2. Was this identified through the CHNA process?	As outlined in Objective 34 of the Maryland State Health Improvement Process (SHIP), crisis utilization of emergency rooms for those suffering from a behavioral health issue places a strain on the health care system. Additionally, those referred for stabilization in an outpatient partial hospital setting may not have immediate access to this type of stabilization immediately. No.	
b. Hospital Initiative	Crisis Referral Outpatient Program (adults only)	
c. Total Number of People within the Target Population	99,959	
d. Total Number of People Reached by the Initiative Within the Target Population	383	
e. Primary Object of the Initiative	To provide prompt stabilization of adults in crisis who are seeking outpatient attention for their active and untreated mental health problem and to link them with ongoing outpatient care once stabilized thereby preventing ongoing reliance on Emergency Rooms for episodic care.	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Sheppard Pratt Staff: Bonnie Katz, VP Business Development and Support Operations Benedicto Borja, M.D., Program Medical Director Efigenia Geli-Geocadin, M.D. Program Clinical Director	
h. Impact/Outcome of Hospital Initiative?	383 individuals suffering from a mental health crisis and kept out of inpatient care setting while being safely treated within a daily clinical care environment. This program bridges a critical gap between until patients can obtain an appointment with an outpatient psychiatrist.	
I. Evaluation of Outcomes	Outcomes not collected for this initiative.	
j. Continuation of Initiative?	Yes, this initiative will continue into FY 2016.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $208,146	B. Direct Offsetting Revenue from Restricted Grants None.

Table III Initiative 8 – Telepsychiatry

a. 1. Identified Need 2. Was this identified through the CHNA process?	Telepsychiatry services are provided in medically underserved counties of Maryland. No.	
b. Hospital Initiative	Telepsychiatry Program	
c. Total Number of People within the Target Population	Estimated 3,500 people live below the poverty level and may be seeking help for a mental health service within the rural counties where telepsychiatry is offered through health departments or Federal Qualified Health Centers.	
d. Total Number of People Reached by the Initiative Within the Target Population	1,012 active clients	
e. Primary Object of the Initiative	Increase access to psychiatry services through the medium of videoconferencing in areas with inadequate mental health resources. Decrease wait time for mental health services Provide services that will lessen the likelihood of an emergency room visit.	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Sheppard Pratt Staff: Bonnie Katz, VP, Business Development and Support Operations Desmond Kaplan, M.D., Telepsychiatry Medical Director Doloras Branch, Telepsychiatry Program Manager Atlantic Health Clinic: Deborah Wolfe Cecil County Health Department: Stephanie Garrity and Shelly Gulledge Choptank Community Health System: Jonathan Moss, M.D. Lower Shore Clinic: Tuesday Trott Mountain Laurel Health Center; Beth Little-Terry Three Lower Counties Clinic: Sue Gray West Cecil Health Center: Mark Rajkowski Wicomico County Health Department: Lori Brewster and Michelle Hardy Worcester County Health Department: Deborah Goeller	
h. Impact/Outcome of Hospital Initiative?	2,669 encounters were provided to 1,012 active clients including 457 initial evaluations; 2,212 medication management sessions 2,243 hours of service	
I. Evaluation of Outcomes	Client satisfaction is high with 90% reporting that their needs were met during the session and 95% reporting that they received good care. PHQ9 surveys reflects an average 3 point improvement between the 1st and 3rd visits.	
j. Continuation of Initiative?	Yes, this effort will continue into FY 2016 in order to provide services where clinical shortages have a negative impact on patient care.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $271,277.23	B. Direct Offsetting Revenue from Restricted Grants $87,999.43

Table III Initiative 9 – Telepsychiaty Integration with Maryland FQHCs
Care Integration

a. 1. Identified Need 2. Was this identified through the CHNA process?	The Health Services Resource Administration has identified multiple rural Maryland counties as medically underserved as well as health professional shortage areas. Specifically, some counties suffer from a lack of areas by mental health resource which leaves residents with un- or undertreated mental illness. No	
b. Hospital Initiative	Telepsychiaty Integration with Maryland FQHCs Care Integration in medical setting through telepsychiatry. This demonstration project is funded by CareFirst.	
c. Total Number of People within the Target Population	100 clients	
d. Total Number of People Reached by the Initiative Within the Target Population	126 active clients	
e. Primary Object of the Initiative	To provide co-location of behavioral health care utilizing videoconferencing within four Federally Qualified Health Centers located in rural Maryland settings	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Bonnie Katz, Vice President Business Development Desmond Kaplan, M.D., Telepsychiatry Medical Director Doloras Branch, Program Manager Choptank Community Health System: Jonathan Moss, M.D. Mountain Laurel Health Center; Beth Little-Terry Three Lower Counties Clinic: Sue Gray West Cecil Health Center: Mark Rajkowski	
h. Impact/Outcome of Hospital Initiative?	337 services were provided to 126 active clients. Client satisfaction is very high with 90% reporting their needs were met during the session and 95% reporting that they received good care. Additionally, PHQ9 data indicates an 18 point improvement when clients grade how difficult mental health problems have made it for them to do their work or to get along with others.	
I. Evaluation of Outcomes	This is a three year grant program funded until March 2017. CareFirst has been pleased with the program's progress to date.	
j. Continuation of Initiative?	Yes, this effort will continue into FY 2016.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $88,672	B. Direct Offsetting Revenue from Restricted Grants $87,999

Table III Initiative 10 – Professional Education Series

a. 1. Identified Need 2. Was this identified through the CHNA process?	As identified in Sheppard Pratt's Health Needs Assessment, there is a state-wide need for quality mental and behavioral health information, treatment and support. Sheppard Pratt has long been aware of this need. No	
b. Hospital Initiative	Professional Education Series including the Wednesday Lecture Series and other professional educational offering as needs are identified.	
c. Total Number of People within the Target Population	3,500	
d. Total Number of People Reached by the Initiative Within the Target Population	3,356	
e. Primary Object of the Initiative	To provide free and up-to-date mental health information to mental health, medical, human services and educational professionals.	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Steven Sharfstein, M.D., Chief Executive Officer Robert Roca, M.D., Chief Medical Officer Bonnie Katz, Vice President Business Development Jennifer Tornabene, Professional Education Manager	
h. Impact/Outcome of Hospital Initiative?	Health care and school professionals were provided with access to 98 accredited learning opportunities throughout the year. To support professionals treat suicidal patients, and hopefully to reduce the incident of suicide (SHIP initiative #8), 141 health care professionals were trained on the topic of "Cultural Competence in the Assessment and Treatment of Abused, Suicidal African American Women".	
I. Evaluation of Outcomes	Competencies for all attendees are graded prior to and after the session. As an example, for the session on the Assessment and Treatment of Abused and Suicidal African American Women, there was a 10% improvement in pre vs post case study testing and 85% of attendees felt that the session content would impact their practice.	
j. Continuation of Initiative?	Yes, this effort will continue into FY 2016.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $39,746	B. Direct Offsetting Revenue from Restricted Grants None.

Table III Initiative 11 – Services for Low-Income and Uninsured Individuals

a. 1. Identified Need 2. Was this identified through the CHNA process?	According to the 2012 US Census, approximately 18 percent or 294,204 of the Community Benefit Area (Anne Arundel, Baltimore and Howard Counties) are living on salaries below the poverty level. NIH estimates that approximately 18 percent may suffer from a mental illness: 52,956 people. No	
b. Hospital Initiative	Services for Low-Income and Uninsured Individuals	
c. Total Number of People within the Target Population	2,054 cases were uninsured or admitted with Medicaid coverage.	
d. Total Number of People Reached by the Initiative Within the Target Population	2,654 were provided with Financial Assistance 419 individuals were provided with assistance in accessing insurance and other support programs	
e. Primary Object of the Initiative	To provide treatment and support services to low income and uninsured individuals as available by connecting them with insurance coverage, financial assistance and support programs.	
f. Single or Multi-Year Initiative – Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Steven Sharfstein, M.D., Chief Executive Officer Robert Roca, M.D., Chief Medical Officer Bonnie Katz, Vice President Business Development Gerald Noll, Chief Financial Officer	
h. Impact/Outcome of Hospital Initiative?	$4,858,679 of uncompensated care was provided. 2,654 individuals provided with Financial Assistance of which 213 individuals were living in the Community Benefit tri-county area. 419 individuals were provided assistance with connecting for insurance coverage and other government support programs.	
I. Evaluation of Outcomes	Outcomes are not collected for this initiative.	
j. Continuation of Initiative?	Yes, this effort will continue into FY 2016.	
k. Total Cost of Initiative for Current Fiscal year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $4,858,679	B. Direct Offsetting Revenue from Restricted Grants None

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.

Sheppard Pratt plans to address two of the four needs identified through the 2013 Community Health Needs Assessment. It will focus its community benefit efforts on **Mental and Behavioral Health** and will incorporate **Access to Care** into its Mental & Behavioral Health strategies. As Sheppard Pratt is a behavioral health organization with a specialty psychiatric hospital, it will not focus on the following identified health needs: **Overweight/Obesity and Chronic Health Conditions** (Diabetes, Heart Disease, Cancer, Asthma). Sheppard Pratt partnered with neighboring acute care hospitals (Greater Baltimore Medical Center and Sheppard and University of Maryland St. Joseph Medical Center) to conduct the CHNA and encourages their efforts to address the other identified health needs.

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

Maryland Health Improvement Process (SHIP). As a specialty psychiatry hospital, Sheppard Pratt focuses its Community Benefit activities in the SHIP improvement areas of Healthy Social Environments; Chronic Diseases; and, Health Care Access.

Healthy Social Environments,

- Child Maltreatment
    - Sheppard Pratt's Parent Lectures provides parent education for those interested in learning more about what motivates their children and the best coping mechanisms for those times when growth and development do not go as planned.
- Reducing the Suicide Rate
    - Sheppard Pratt's offers a Therapy Referral Service which provides information for access to suicide hotlines as well as a list of other mental health support and treatment programs.
    - Sheppard Pratt's crisis response programming includes the Crisis Walk In Clinic, providing for timely suicide assessments.
    - Free professional education opportunities are provided the health care professionals through Sheppard Pratt. This year, one session was provided focusing on the topic of suicide.

Chronic Disease

- Reducing Emergency Room visits for Behavioral Health
    - Crisis Walk-In Clinic, Scheduled Crisis Intervention and Urgent Assessment Programs provide an alternative to an emergency room visit through a face-to-face evaluation those in need of an immediate safety evaluation as well as appropriate treatment and referral recommendations.

Healthcare Access

- Increasing the proportion of persons with health insurance:
  - Sheppard Pratt has hired an Entitlement Specialist who provides a resource for patients and families needing assistance in understanding how to access government support programs as well as application assistance if requested.

In other areas, Sheppard Pratt has supported State Health Care innovations through:

- Participation in medical health home concept by Sheppard Pratt's affiliate agencies;
- Increased efforts to promote smoke-free communities and new in FY 2016 with the addition of a Tobacco Dependence Coordinator;
- Offering flu shots to all clients; and,
- Institution of new mental health supports to observe certain patients before admitting.

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

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.

Sheppard Pratt is a specialty hospital with 90 percent of medical staff being Sheppard Pratt providers. The system is staffed at this level due to attrition, etc and has developed a method for distributing resources evenly across programs rather than assigning psychiatrists by program type. This method of allocation has allowed the health system to continue to serve patients in need of care without any gap in availability of specialist.

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.

The system subsidizes hospital–based physician salaries when they are negatively impacted by charity care or low reimbursement rates. This approach has been adopted in order to continue to offer mental health specialty services to the community as well as to insure full physician

coverage without any gaps in the availability of specialists**.** In FY 2015, the total subsidy was $854,949

Description of Financial Assistance Policy (FAP) and Process at Sheppard Pratt **Appendix I**

VII. 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)**

Sheppard Pratt first notifies each patient of the system's Financial Assistance though the provision of each patient with a Patient Handbook as part of the intake process upon admission. The Patient Handbook outlines policies, rules, and basic information about the Hospital including instructions on how to access financial assistance and charity care.

Financial Assistance Policy information is posted in the Admissions Suite as well as patient and family waiting areas informing interested parties that financial assistance is available. The policy is available in Spanish or an interpreter is brought in for other languages as needed**.** The Patient Information Sheet has been prepared in a culturally sensitive fashion, at a college reading level which reflects the community benefit service area's 65% college exposure rate. (2009 American Community Survey 1-yr estimates). All newly admitted clients are urged to speak with their therapist or other hospital staff to learn more about the hospital's Financial Assistance Policy. Upon admission, each patient is provided with a Patient and Family Handbook which includes the Financial Assistance Policy summary and contact information.

At the time of admission (intake), as much insurance, income and living situation information is gathered from the patient and collateral informants as the patient permits. Depending upon the patient's diagnosis and cognitive abilities, the patient may be unable to provide information or may not consent to a discussion with collateral informants. Hence, information may often be obtained only as the patient stabilizes. This stabilization process is different depending on diagnoses, ages, treatments et cetera. Therefore, a patient's need for financial assistance or other government benefit coordination is an ongoing process from the time of admission through to discharge. In this report period, Sheppard Pratt developed an Entitlement Specialist position and filled it with an individual uniquely qualified to discuss and assist patients and families with government entitlement program information and application assistance as needed. The Entitlement Specialist and assigned social workers also inform patients and families about Sheppard Pratt's Financial Assistance Program.

Finally, after discharge, Sheppard Pratt's patients are monitored for possible financial assistance application.

1) The Financial Assistance information is printed on the back of each self-pay statement.

2) Patient Accounting personnel act as financial advocates; and, as needed, may forward Financial Assistance paperwork for completion by all responsible parties.

3) Prior to transfer to a collection agency, accounts are reviewed again for possible financial assistance; and,

4) The collection agency also provides patients with Financial Assistance information and contact numbers.

Description of Sheppard Pratt's Financial Assistance Policy (FAP) Changes since ACA's Expansion Option effective January 1, 2014 **Appendix II**

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).**

Effective March 2014, the following changes were made to the Financial Assistance Policy:

1. Increased by fifty points the percentage of the Federal Poverty Guidelines to 250% necessary to qualify for Financial Assistant which established a more lenient baseline for income; and,

2. Extended the proactive portion of the Financial Assistance decision from 6 months to 12 months**.**

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

Sheppard Pratt A not-for-profit behavioral health system		Policy Number: HS-130.4 Page 1 of 2
Manual: Sheppard and Enoch Pratt Hospital Administrative Manual		Effective: 03/24/14
Section: 100 – Health System	Sub-section: 130 – Finance	Prepared by: Patricia Pinkerton
Title: Financial Assistance – Patient Financial Services		

POLICY:
Financial assistance will be provided to clients who are unable to pay for services rendered and who meet the criteria established in this policy regardless of race, color, creed, religion, gender, national origin, age, marital status, family status, handicap or other discriminatory factors.

PURPOSE:
To establish the eligibility criteria and process for application/approval of charitable assistance for Health System clients.

Use of client in this policy is intended to include all patients, students and residents.

PROCEDURE:

A. If a client states they are unable to pay out-of-pocket expenses, a determination will be made whether there is assistance available through other programs such as Medicaid. All other resources, including Medical Assistance, will first be applied before financial assistance will be awarded.

B. Financial Assistance requests (copy of application attached) should provide information regarding income, assets, expenses and verification of these items, as necessary.
- Financial assistance applications are required for most financial assistance requests.

C. Eligibility is usually determined based upon a two-part test which considers income and accumulated assets.
- Income—Income Schedule which is based upon 250% of the current Federal Poverty Guidelines (FPG's) as published in the Federal Register.
- Accumulated assets--$10,000 per individual, $25,000 per family.
- Applicants whose income and assets exceed the established eligibility guidelines but state they are unable to pay all or part of their account balance(s) may be further evaluated on a case-by-case basis. Eligibility for full or partial financial assistance will be determined after giving consideration to the client's total financial situation as well as a consideration of extenuating circumstances.

D. Income may include wages and salaries, Social Security, veteran's benefits, retirement benefits, unemployment and workers' compensation, trust payments, child support, alimony, public assistance, strike benefits, union funds, income from rent, interest, dividends, etc.

E. Approved financial assistance will be valid for twelve months from the date of application.

F. If only partial financial assistance is approved, a payment arrangement will be obtained on balances due. No interest, late fees or penalties will be assessed.

G. A determination letter is sent directly to the client or guarantor to inform them of the final disposition of the request.

H. Accounts meeting the criteria set forth in this policy will be written-off to financial assistance.

I. A summary of the Financial Assistance Policy will be posted in the Admissions areas, PFS and in the Patient Handbook. All billing statements include information regarding the availability of financial assistance.

This policy replaces previously issued Directive #120.11.

References:

Attachments:

Revision Dates:

Reviewed Dates:

12/05, 5/08, 10/11,12/13

Signatures:

Patricia Pinkerton:

Steven Sharfstein:

c. 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).**

Sheppard Pratt Health System - Patient Financial Policy

Sheppard Pratt Health System is dedicated to providing patients with the highest quality of care and service. To assist our patients, and to comply with Maryland State law, Sheppard Pratt offers the following information.

Hospital Financial Assistance

Under the Sheppard Pratt financial assistance policy, you may be entitled to receive financial assistance for the cost of medically necessary hospital services if you have a low income, do not have insurance, or your insurance does not cover your medically-necessary hospital care and you meet certain low income thresholds.

Sheppard Pratt's financial assistance eligibility is based on gross family income and family size of the patient and/or responsible person. Annual income criteria used will be 250% of the current federal poverty guidelines as established yearly in the Federal Register. Assets and liabilities will also be considered. Financial assistance may be awarded up to 100% of medical charges. If you wish to get more information about or apply for financial assistance, please call 410-938-3370 or toll free at 1-800-264-0949 Monday-Friday 8:00am to 3:00pm.

Patient Rights

Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill. If you believe you have been wrongly referred to a collection agency, you have the right to contact the Sheppard Pratt business office at 410-938-3370 or toll free at 1-800-264-0949.

You may be eligible for Maryland Medical Assistance. Medical Assistance is a program funded jointly by the State and Federal governments and it pays up to the full cost of health coverage for low-income individuals who meet certain criteria. In some cases, you may have to apply and be denied for this coverage prior to being eligible for Sheppard Pratt financial assistance.

For more information regarding the application process for Maryland Medical Assistance, please call your local Department of Social Services by phone 1-800-332-6347 or internet www.dhr.state.md.us. We can also help you at Sheppard Pratt by calling 410-938-3370.

Patient Obligations

For those patients with the ability to pay, it is their obligation to pay the hospital in a timely manner. Sheppard Pratt makes every effort to see that patient accounts are properly billed, and in-patients may expect to receive a uniform summary statement within 30 days of discharge. It is the patient's responsibility to provide correct insurance information.

If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under the hospital's financial assistance policy, or if you cannot afford to pay the bill in full, you should contact the business office at 410-938-3370.

If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. It is the obligation of the patient to assure the hospital obtains accurate and complete information. If your financial position changes, you have an obligation to contact the Sheppard Pratt business office to provide updated information.

Physicians who care for patients at Sheppard Pratt during an inpatient stay bill separately and their charges are not included on your hospital billing statement.

Sheppard Pratt Health System
Política Financiera de los Pacientes

Sheppard Pratt Health System esta dedicado a proveer a los pacientes la calidad más alta de cuidado y servicio. Para asistir a nuestros pacientes, y para cumplir con la ley del Estado Maryland, *Sheppard Pratt* ofrece la siguiente información.

Asistencia Financiera del Hospital

Bajo la política de ayuda financiera de *Sheppard Pratt*, usted puede tener derecho a recibir ayuda financiera para el costo de los servicios de hospitalización médicamente necesarios, si usted tiene un bajo ingreso, si no tiene seguro, o si su seguro no cubre sus necesidades médicas del cuidado de hospital y usted se encuentra con ciertas limitaciones de ingresos.

La elegibilidad para la asistencia financiera de *Sheppard Pratt* está basada en los ingresos totales de la familia y el numero de familiares del paciente y/o de la persona responsable. El criterio anual de ingreso usado será el 250% de las pautas de pobreza federales actuales conforme se hayan establecido cada año en el Registro Federal. El capital o patrimonio pasivo y el activo también serán considerados. La ayuda financiera puede ser concedida hasta el 100 % de costos médicos. Si usted desea conseguir más información, o cómo aplicar para ayuda financiera, por favor llamar al 410-938-3370 o llamar gratis al 1800-264-0949 de lunes a viernes de 8am a 3pm.

Derechos de los Pacientes

Aquellos pacientes que reúnen los criterios políticos de ayuda financieros descritos anteriormente pueden recibir la ayuda del hospital en el pago de su cuenta. Si usted cree que lo han referido equivocadamente a una agencia de recolección, usted tiene el derecho de contactar a la oficina de negocios del hospital *Sheppard Pratt* al 410-938-3370 o llamar al numero gratis 1800-264-0949.

Usted puede ser elegible para la Asistencia Médica de Maryland. La asistencia medica es un programa fundado conjuntamente con los gobiernos estatales y federales y estos pagan hasta el costo competo de la cobertura para individuos de ingresos bajos quiénes reúnen ciertos criterios. En algunos casos, usted puede aplicar y ser negado para este cubrimiento antes de ser elegible para la ayuda financiera del hospital *Sheppard Pratt.*

Para más información relacionada con el proceso de aplicación para la Asistencia Médica de Maryland, por favor llamar a su Departamento Local de Servicios Sociales al 1800-332-6347 o averiguar en la Internet al www.dhr.state.md.us. Nosotros también podemos ayudarle llamando al hospital *Sheppard Pratt* marcando el numero 410-938-3370.

Obligaciones del Paciente

Para aquellos pacientes con facilidad de pagar, es su obligación pagar al hospital a tiempo. El hospital *Sheppard Pratt* hace todo lo posible para que las cuentas de los pacientes sean correctamente facturadas, y los pacientes hospitalizados pueden recibir una factura detallada y completa 30 días después de que le han dado de alta. Es la responsabilidad del paciente de proporcionar la información de seguros correcta.

Si usted no tiene cubrimiento de seguro medico, nosotros esperamos que usted pague su cuenta a tiempo. Si usted cree que usted es elegible bajo la política de ayuda financiera, o si usted no puede pagar la cuenta completamente, usted podría contactar a la oficina de negocios al 410-938-3370.

Si usted deja de cumplir con la obligación financiera de su cuenta, usted puede ser enviado a una agencia de recolección. Es obligación del paciente asegurarse de que el hospital obtenga su información exacta y completa. Si su situación financiera cambia, usted tiene la obligación de contactar a la oficina de negocios del hospital *Sheppard Pratt* para proveer la información actualizada.

Los médicos que atienden a los pacientes durante una hospitalización, facturan por separado sus gastos y éstos costos no son incluidos en su factura de hospitalización.

Sheppard Pratt's Mission, Value Statement, Core Values and Guiding Principles – Attachment A **Appendix V**

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

Our Mission Statement: To improve the quality of life of individuals and families by compassionately serving their mental health, addiction, special education, and community support needs.

Our Values Statement: Since our founding in 1853, Sheppard Pratt Health System has remained loyal to our Quaker heritage. The Quaker testimonies of simplicity, peace, integrity, community, and equality drive not only our core values, but our guiding principles, as well.

Our Core Values:

- **To Meet a Need** - to work toward recovery of health and quality of life for people we serve
- **To Lead** - to continually seek and create more effective ways to serve individuals
- **To Care** - to employ the highest standards of professionalism, with compassion, at all times
- **To Respect** - to recognize and respond to the human dignity of every person

Our Guiding Principles:

- **Quality -** We will meet professional standards in our field and continuously improve all aspects of our work.
- **Empowerment** - We will encourage the autonomy of our consumers and staff using teamwork to achieve individualized goals.
- **Integrity** - We will conduct ourselves in an ethical, honest, and forthright manner.
- **Innovation -** We will use the expertise of our staff, as well as the latest scientific advancements, to create a system that is a model for others.
- **Community -** We will work to reduce stigma to increase access to mental health services and to increase awareness of the benefits of treatment.
- **Learning -** We will enhance professional knowledge and skills through inquiry, teaching, learning, and research.
- **Value -** We will assure that the cost of our services reflects their value and we will operate in a cost-efficient way.
- **Safety** - We will provide a safe environment for consumers, volunteers, staff, and visitors.
- **Diversity** - We will foster an environment that embraces the diversity of all of our constituents.
- **Charity** - We will meet our charitable responsibilities to serve the community and to honor the intent of our donors.
- **Caring** - We will provide all of our services with compassion and sensitivity.

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

- Increase life expectancy
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers - **Current strategies in place.**
- Reduce the % of youth using any kind of tobacco product – **Current strategies in place.**
- Increase the % vaccinated annually for seasonal influenza – **New strategies being implemented.**
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits – **New strategies in place.**
- Reduce hypertension related emergency department visits - – **New strategies in place.**
- Reduce the % of children who are considered obese - – **New strategies in place.**
- Increase the % of adults who are at a healthy weight - – **New strategies in place.**
- Reduce hospital ED visits from asthma -– **New strategies in place.**
- Reduce hospital ED visits related to behavioral health **– Current strategies in place.**
- Reduce Fall-related death rate **– Current strategies in place.**