Saint Agnes Hospital (21-0011)

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2016 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

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 regulatory 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 meeting aggressive quality targets, the Model requires the State to 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 in this new environment, 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 operations, activities, and investments 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 (LHICs) 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) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(3) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(4) Local Health Departments;
(5) County Health Rankings (http://www.countyhealthrankings.org);
(6) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(7) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(8) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(9) CDC Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);

(10) CDC Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)
(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 such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/)
(16) CRISP Reporting Services

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.

HSCRC Community Benefit 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).
    a. Bed Designation – The number of licensed Beds;
    b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
    c. Primary Service Area Zip Codes;
    d. List all other Maryland hospitals sharing your primary service area;

e. The percentage of the hospital's uninsured patients by county. (please provide the source for this data, i.e. review of hospital discharge data);
f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data, i.e. review of hospital discharge data, etc.).
g. The percentage of the Hospital's patients who are Medicare Beneficiaries. (Please provide the source for this data, i.e. review of hospital discharge data, etc.)

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area Zip Codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of Hospital's Uninsured Patients,:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
251 (not including bassinets)	18,354	21229, 21228, 21227, 21207, 21223, 21216, 21230	Sinai, BWMC, UMMC, Harbor, Mercy, UMMC Midtown, Bon Secours, JHH, Northwest, Howard County	Balt. City – 57.9% Balt. Cnty – 29.5% Howard Cnty – 3.7% Anne Arundel – 3.6% Other – 5.4% Source: Hospital discharge date	Balt. City – 61.8% Balt. Cnty – 29.5% Howard Cnty – 3.7% Anne Arundel – 2.9% Other – 2.0% Source: Hospital discharge date	Balt. City – 46.6% Balt. Cnty – 37.5% Howard Cnty – 7.5% Anne Arundel – 5.2% Other – 3.2% Source: Hospital discharge date

2. For purposes of reporting on your community benefit activities, please provide the following information:

a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):

(i) A list of the zip codes included in the organization's CBSA, and

(ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations reside.

(iii) Describe how the organization identified its CBSA, (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 community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/). 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)
Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)

Table II

Demographic Characteristic	Description	Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	West Baltimore – 21215, 21216, 21217 South Baltimore City – 21223, 21230 Brooklyn/Linthicum – 21090, 21225 Southwest Baltimore City – 21229 Woodlawn – 21207, 21244 Glen Burnie – 21060, 21061 Arbutus – 21227 Catonsville – 21228 Pasadena – 21122 South Carroll – 21104, 21163, 2184 Ellicott City – 21042, 21043, 21075 Saint Agnes uses a community health index score to identify areas where the most vulnerable populations reside. The more urban based communities of West Baltimore City 2.01, South Baltimore City 1.78, Brooklyn/Linthicum 1.58, Southwest Baltimore City 1.58 represent the greatest healthcare needs, each with overall indices exceeding 1.50.	The Saint Agnes CBSA represents zip codes that comprise 80% of Saint Agnes Hospital patient population. FY 16 community health index scores were provided by *Healthy Communities Institute*.
Median Household Income within the CBSA	Baltimore City - $41,988 Baltimore County - $64,624 Howard County - $108,503 Anne Arundel County - $85,685 Carroll County - $82,073	National Environmental Public Health Tracking Network – CDC (2013 data)
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Baltimore City – 22.7% Baltimore County – 9.5% Howard County - 5.3% Anne Arundel County – 7.3% Carroll County – 6.8%	National Environmental Public Health Tracking Network – CDC (2013 data)
For the counties within the CBSA, what is the percentage of uninsured for each county? 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	Baltimore City – 9.8% Baltimore County – 8.4% Howard County – 5.2% Anne Arundel County – 6.6% Carroll County – 5.5%	Small Area Health Insurance Estimates (SAHIE) – (U.S. Census 2014 data)

Percentage of Medicaid recipients by County within the CBSA.	Baltimore City – 33.4% Baltimore County – 18.4% Howard County – 11.1% Anne Arundel County – 13.0% Carroll County – 10.8%	Maryland Medicaid Enrollment Statistics (2016) & National Environmental Public Health Tracking Network – CDC
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	Male Life Expectancy Baltimore City – 67.8 Baltimore County – 75.5 Howard County – 79.8 Anne Arundel County – 759 Carroll County – 76.7 Female Life Expectancy Baltimore City –76.5 Baltimore County – 80.6 Howard County – 83 Anne Arundel County – 80.7 Carroll County – 81.4	http://www.worldlifeexpectancy.com/usa/maryland-life-expectancy-by-county
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Infant Mortality - White Baltimore City – 3.4 Baltimore County – 3.3 Howard County – 5.1 Anne Arundel County – 5.5 Carroll County – 4.0 Infant Mortality - Black Baltimore City –12.6 Baltimore County – 9.5 Howard County – N/A Anne Arundel County – 9.0 Carroll County – N/A	Maryland Department of Health and Mental Hygiene - Vital Statistics Administration (2012)
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	Please refer to Appendix 5 of our CHNA (*Service Area Health Risk Summary*). This assessment compares 35 community specific health indicators, against Central Maryland averages. The extent to which a community is at higher than average risk, for a specific indicator, the index score will exceed 1.00. The inverse is true for an index scores below 1.00, which indicates a comparatively lower level of health risk. The overall health index, which is an average of all community need indices, highlights those communities with the greatest healthcare needs in the Saint Agnes Hospital service area. This assessment has	Healthy Communities Institute.

	identified that the more urban based communities of West Baltimore City, South Baltimore City, Brooklyn/Linthicum and Southwest Baltimore City represent the greatest healthcare needs, each with overall indices exceeding 1.50. The suburban communities of Pasadena, Ellicott City and South Carroll have comparatively fewer healthcare needs, as determined by this assessment.	
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	<u>Baltimore City:</u> White 31.8% Black 63.4% Hispanic 2.7% Other 2.1% <u>Baltimore County:</u> White 68.3% Black 24.5% Hispanic 3.0% Other 4.2% <u>Anne Arundel:</u> White 78.0% Black 14.8% Hispanic 4.3% Other 2.9% <u>Howard County:</u> White 67.6% Black 16.7% Hispanic 4.9% Other 10.8% <u>Carroll County:</u> White 92.8% Black 3.7% Hispanic 1.8% Other 1.7%	The Environmental Public Health Tracking Site (2009)
Other		

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?

   _X__Yes
   ____No

   Provide date here. 06/24 /2016 (mm/dd/yy)

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

   http://www.stagnes.org/wp-content/uploads/2014/09/2016-CHNA.pdf

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 3?

   _X_Yes 06/24/2016__ (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.stagnes.org/wp-content/uploads/2014/09/2016-CHNA.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital? **(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b.)**

   a. Are Community Benefits planning and investments part of your hospital's internal strategic plan?

      _X_Yes
      ___No

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

Community Benefits are addressed in Saint Agnes Hospital's FY 2016 Integrated Strategic, Operating and Financial Plan (ISOFP) under the section *Call to Action: Healthcare the Leaves No One Behind.* In this section, Saint Agnes addresses its three strategic initiatives – Obesity, Cardiovascular Health, and Access to Primary Care Services – and specifies the anticipated outcomes for improving community health. It is worth noting that the CHNA referred to in the FY 2016 ISOFP relates to the CHNA conducted in 2013 since the Saint Agnes' new CHNA was not approved by the Board until June of 2016.

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. ___CFO
3. _X_Other (please specify) CMO, Chief Strategy Officer

Describe the role of Senior Leadership.

Senior leadership plays a role in design and execution of the CHNA as well as facilitates Board approval of the CHNA. Community Health Need goals are embedded in fiscal year goals for the Executive Team.

ii. Clinical Leadership

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

Describe the role of Clinical Leadership:

Saint Agnes has long standing relationships with members of the physician medical community and was fortunate to have the these individuals participate in the assessment process due to their strong knowledge of our community and the health industry, their specialized medical or public health expertise, or because they were able to represent the needs of the medically underserved, low-income, and minority populations, and those with chronic disease health needs.

iii. Population Health Leadership and Staff

1. ____ Population health VP or equivalent (please list)
2. _X__ Other population health staff (please list staff)

Those that have a role in population health at Saint Agnes include the following Senior Leadership positions and other staff:

Chief Executive Officer	Chair of Medicine	Chief of Emergency
Chief Nursing Officer	Chair of Surgery	Chief Medical Information Officer
Chief Medical Officer	Director, Care Management	Director, Managed Care and Government Relations
Chief Financial Officer	Director, Reimbursement	Director, Health Information Management

Describe the role of population health leaders and staff in the community benefit process.

As many of Saint Agnes' community benefit health initiatives are centered on chronic disease management and access to primary care, Saint Agnes must ensure these initiatives are at the fore front of the Hospital's population health priorities. Our Population Health Team is responsible for design and implementation of the initiatives.

iv. Community Benefit Operations
    1. ___Individual (please specify FTE)
    2. ___Committee (please list members)
    3. ___Department (please list staff)
    4. ___Task Force (please list members)
    5. _X_Other (please describe) Community Benefit evaluation is managed by a multi-disciplinary group that includes the following staff:

Chief Strategy Officer	Planning, coordination and facilitation
Director, Marketing and Communications	Communications, marketing/outreach
Vice President, Mission Integration	Catholic Identity Leadership
President, Saint Agnes Foundation	Community outreach/initiatives guidance and support
Director, Care Management	Care coordination/population health guidance and support
Director, Maryland Metabolic Institute	Chronic disease management/community outreach guidance and support
Director, Reimbursement & Compliance	Finance representative and HSCRC subject matter expert
Consulting Associate, Strategic Planning	Coordination and data gathering

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?)

A qualitative and quantitative review of information reported in both the CBR and schedule H of the IRS 990 is reviewed by Deloitte. There is no sign off of the review by Deloitte.

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
_____ Local health improvement coalitions (LHICs)
__X__ Schools
_____ Behavioral health organizations
__X__ Faith based community organizations
__X__ Social service organizations

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

Organization	Name of Key Collaborator	Title	Collaboration Description
American Diabetes Association – Maryland Area	David McShea Tracy Newsome	Executive Director Director, Community Health Strategies	Reviewed CHNA data analytics, provided input to CHNA priorities and

			discussed options to address needs related to education, prevention, and care related to diabetes.
Baltimore City Health Department	Sonia Sarkar Darcy Phelan-Emrick	Chief Policy and Engagement Officer Chief Epidemiologist	Reviewed CHNA data analytics, provided input to CHNA priorities and relationship to BCHD health improvement plan priorities. Discussed opportunities for further collaboration including CMMI Accountable Health Communities Grant and BCHD LHIC.
Baltimore Medical Systems, Inc.	Shirley Sutton	President/CEO	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed opportunities for Saint Agnes and BMS to advance clinical collaboration through BMS site located on Saint Agnes campus.
Catholic Charities	William McCarthy, Jr.	Executive Director	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed options to enhance collaboration through Catholic social services agencies to address social determinants of health.
Equity Matters	Michael P. Scott	Chief Equity	Reviewed CHNA

		Officer/President	data analytics, provided input to CHNA priorities and discussed options to improve collaboration between health care institutions and community-based organization to address disparities and social determinants of health.
Green & Healthy Homes	Ruth Ann Norton	President/CEO	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed impact of safe, affordable housing and the impact on health status and mechanisms to address housing needs, particularly for high need patients.
HealthCare Access Maryland	Traci Kodeck, MPH	Interim CEO	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed options to address needs related to community-based care management to address social determinants of health.
The Caroline Center	Patricia McLaughlin	Executive Director	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed options to address needs

			related to job training.
University of Maryland School of Nursing	Katherine Fornili Michelle R. Spencer	Asst. Professor, Department of Family & Community Health Clinical Instructor	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed health and social needs in West Baltimore City to improve health status for this community.
University of Maryland School of Social Work	Wendy E. Shaia Tanya L. Sharpe Stacey Stephens Frederick Strieder Lane Victorson	- Clinical Asst. Professor and Executive Director Associate Professor Director. B'More for Health Babies Clinical Associate Professor and Director, Family Connections Clinical Field Instructor, Neighborhood Fellows / Peace Corps Fellows	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed health and social needs in West Baltimore City, particularly related to the impact of social trauma and connection to chronic disease, behavioral health, and disparities in the health care system.
West Baltimore Health Enterprise Zone	Maha Sampath	Director Care	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed health and social needs in West Baltimore City based on the experience and successes of the West Baltimore Health Enterprise Zone.

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?

__X__yes ____no

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached example of how to report.

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

a. 1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.
2. Please indicate whether the need was identified through the most recent CHNA process.

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

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

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

e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results.

f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)

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

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

- What were the measurable results of the initiative?
- For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

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

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

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

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

While Saint Agnes Hospital will focus the majority of our efforts on the identified strategic programs outlined in the table below, we will review the complete set of needs identified in the CHNA for future collaboration. These areas, while important to the health of the community, will be met though either existing clinical programs or though collaboration with other health care organizations as needed. The unmet needs not addressed specifically by Saint Agnes Hospital, will continue to be addressed by key governmental agencies and existing community-based organizations. The Saint Agnes identified core

priorities target the intersection of the identified community needs and the organization's key strengths and mission.

1. 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 STATE HEALTH IMPROVEMENT PROCESS (SHIP)
   http://dhmh.maryland.gov/ship/SitePages/Home.aspx
   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.

Saint Agnes Hospital currently has one of the busiest Emergency Department (ED) in the state. Like many urban-based hospitals with significant ED volumes, a large proportion of the indigent and charity care provided by the hospital overall is generated through the ED. The increasing community need for indigent care coverage through the ED, coupled with declining physician reimbursement and greater malpractice exposure, has created greater "gaps" in the availability of specialist physicians to treat these patients. Consequently, mission-based hospitals like Saint Agnes, with an imperative to care for the poor and underserved, feel a duty to respond to fill in these gaps.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to 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.

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	There are gaps in care for a number of specialties including obstetrical, perinatal, neonatal, psychiatry and radiology that Saint Agnes must subsidize. Given Saint Agnes' urban, low income service area especially for emergency and obstetrical services, financial support of the specialties is critical to ensure these services are available to patients in the

	community.
Non-Resident House Staff and Hospitalists	Hospitalist and Intensivist coverage of medical/surgical patients is another service for which Saint Agnes provides physician subsidies. As primary care physicians become more focused on operating their own practices in the community, less of these physicians are available for house coverage of patients meaning hospitals must provide financial support to physicians able to provide this needed coverage to patients.
Coverage of Emergency Department Call	Subsidies are necessary for specialty care in the emergency department given Saint Agnes' number of uninsured patients and low reimbursement levels for its insured patients. On-call stipends are provided for the following surgical subspecialties: general, ENT, hand, neuro, orthopedic, pediatric, plastics, podiatry, urology, vascular, and thoracic.
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VII. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):
    a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's FAP. (label appendix I)

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

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

- provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
- includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
- besides English, in what language(s) is the Patient Information sheet available;
- discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).
c. Include a copy of your hospital's FAP (label appendix III).
d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

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

Attachment A

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

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

Table III A. Initiative II Cardiovascular Disease

Identified Need	Cardiovascular Disease
Hospital Initiative	Provides education and screening regarding cardiovascular disease throughout the community.
Primary Objective	Implementation Strategy: 1. Enhance and expand the foundation of education and screening services established with Saint Agnes's Red Dress Sunday and other initiatives to raise the community's awareness and knowledge of cardiovascular disease as well as an individual's own personal risk factors. 2. Support Baltimore City Health Department's Healthy Baltimore 2016 priority to promote heart health so as to reduce the impact of cardiovascular disease, the leading cause of death in Baltimore City. 3. Renovate acute care facilities of the Cardiovascular Institute to facilitate the adoption of a collaborative clinical practice model that better integrates all aspects of the multidisciplinary care team to improve patient outcomes. 4. Maintain Certificate of Ongoing Performance for primary and non-primary angioplasty programs to ensure that citizens of West Baltimore, particularly disenfranchised individuals continue to have access to interventional cardiovascular services. 5. Seek and secure grant opportunities that facilitate Saint Agnes's ability to enhance and expand cardiovascular education, screening, and treatment services.
Single or Multi-Year Initiative Time Period	This is a multi-year initiative intended to last the life of the 3-year CHNA that was conducted in 2013.
Key Partners in Development and/or Implementation	Screenings and education are done in cooperation with various organizations including senior centers, area churches and area schools. The Baltimore City Health Department will also be a key partner in reducing Baltimore's leading cause of death in the City. AstraZenaca is a key partner in the Hospital's Heart-to-Heart program
How were the outcomes evaluated?	Outcomes were evaluated through the various programs: 1. Heart-to-Heart program - In cooperation with AstraZenaca Health Foundation, this program provides a heart risk assessment and a 16-week healthy lifestyle intervention program for African-American women in medically underserved communities to reduce risk factors for cardiovascular disease.

Table III A. Initiative II Cardiovascular Disease

	Process and outcome measures for participants in this program are measured. 2. Red Dress Sunday –In cooperation with West Baltimore Care and several Medicaid MCOs, this program provides outreach and education on cardiovascular risk factors and improving heart health. The program targets residents in Saint Agnes' service area as well as residents living in the West Baltimore Health Enterprise Zone. The number of facilities hosting the event is measured. 3. Cardiovascular screening programs - Saint Agnes operates a number of community-based screenings in the area including Morrell Park Health Center, Security Square Mall, various senior centers and health fairs. Screenings performed are vascular, women's heart, hypertension, cholesterol and blood sugar screenings. The number of patients screened as well as those patients referred for additional follow up is measured. 4. Health Failure Center and CHF Nurse Navigators – One of Saint Agnes' chronic disease management programs focused on congestive heart failure provides OP treatment for the very frail patients suffering from this disease. In conjunction with our HFC clinic, RN nurse navigators work with these patients and support the team-based chronic disease model through coordination of care including patient appointments, medication monitoring and self-care compliance for patients at high-risk for potentially avoidable utilization (PAU). Metrics focused on CHF patients' participation in this program are tracked.
Outcomes (Include process and impact measures)	1. Heart-to-Heart program – All metrics for FY 16: a. Participants in the Heart-to-Heart program 27 vs a target of 38 b. Percentage of participants completing the program 100% vs. a target of 60.0% c. Percentage of participants with a statistically significant reduction in cholesterol level 51.9% vs. 50.0% d. The number of Health Champion facilities trained 19 vs. a target of 13 2. Red Dress Sunday – Metric for FY 16: a. The number of facilities hosting a Red Dress Sunday event 183 vs. a target of 185. 3. Cardiovascular Screenings – Metrics for FY 16. Targets to be established for FY 16. a. People participating in a Hypertension Screening program 2,978 vs. a target of 3,747 b. Percentage of people screened with a high risk of hypertension referred to a PCP 18.3% vs. a target of 20.5%. c. People participating in Lung Screening Program 353 vs. a target of 235. d. People participating in Heart Screening Programs 90 vs. a

Table III A. Initiative II Cardiovascular Disease

	target of 337 2. Heart Failure Center and CHF Nurse Navigators – All metrics for FY 16: a. Patients discharged with a diagnosis of CHF and referred to a RN Navigator 17.3% vs. a target of 80% b. Patients with a diagnosis of CHF being readmitted within 30 days 20.5% vs a target of 21.9% c. Eligible patients with a discharged diagnosis of CHF referred to the HFC 29.1% vs a target of 80.0% d. Referred patients attending an appointment at the HFC 81.7% vs. a target of 82.3%.	
Continuation of Initiative	Saint Agnes conducted a new Community Health Needs Assessment at the end of FY 2016. Cardiovascular Disease was identified as a top priority in the 2016 assessment. The CHNA conducted in FY 2016 comes with a new set of initiatives and a strategic plan which will implement starting in FY 2017.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $304,709	B. Direct offsetting revenue from Restricted Grants $112,083

Table III A. Initiative I Obesity and Related Conditions

Identified Need	Obesity and Related Chronic Conditions
Hospital Initiative	Provides education regarding obesity and healthy lifestyle behaviors throughout the community.
Primary Objective	The goal of the initiative is to educate people on the health risks associated with obesity. Numerous studies demonstrate a strong link between obesity and the risk for chronic health problems such as heart disease, type-2 diabetes, cancer, stroke, asthma and arthritis. Implementation Strategy: 1. In collaboration with strategic partners, seek opportunities to contract with area employers to offer programs to improve the health status of the community workforce. 2. Explore opportunities to enhance access to bariatric surgery program through the Maryland Medicaid program. 3. Seek opportunities to engage with area middle and secondary schools to provide educational sessions regarding obesity and healthy lifestyle behaviors. 4. Explore opportunities to provide environments that enhance access to physical activity for the community as part of the Gibbons Commons master plan. 5. Seek and secure grant opportunities that facilitate Saint Agnes's ability to enhance and expand obesity education, screening, and treatment services.
Single or Multi-Year Initiative Time Period	This is a multi-year initiative intended to last the life of the 3-year CHNA that was conducted in 2013.
Key Partners in Development and/or Implementation	Maryland Medicaid MCO's, area middle and secondary schools, area employers, and partners involved in the development of the Gibbons site. Additionally, Saint Agnes will continue to participate with the local health jurisdictions (including the Baltimore City Health Department) in the development of initiatives to promote this health need.
How were the outcomes evaluated?	Outcomes were evaluated through the following programs: 1. Pre-Diabetes Education Program - Outcomes were evaluated through Hospital participation with the Stulman Foundation Pre-Diabetes Education Program which is an education program to decrease the rate of pre-diabetes/diabetes for Saint Agnes' primary service area as well as residents in the West Baltimore

Table III A. Initiative I Obesity and Related Conditions

	Health Enterprise Zone. 2. Bariatric Surgery Program – Metrics focus on outreach, education and intervention for the community with unhealthy BMI especially the Medicaid population. 3. Outreach to Medicaid Population - The Saint Agnes Maryland Metabolic Institute focuses on diabetes education and prevention. Metrics focus on outreach and intervention of Medicaid patients at high risk for diabetes.	
Outcomes (Include process and impact measures)	1. Pre-Diabetes Education Program – All metrics for FY 16: a. People attending Pre-Diabetes Education programs 59 vs. a target of 40 b. Percent of people completing Pre-Diabetes Education program 66.1% vs. target of 50.0% c. Percent of program graduates decreasing their weight by at least 5% 23.1% vs a target of 75.0% 2. Bariatric Surgery Program – All metrics for FY 16: a. Bariatric surgeries performed 581 vs. target of 607 b. Percentage of bariatric surgery patients with Medicaid 13.6% vs. target of 14.2% c. Percentage of bariatric surgery patients who lower their BMI by at least 20% in 1 year 52.1% vs. target of 56.0% d. People attending bariatric seminars 1,254 vs. a target of 1,048	
Continuation of Initiative	Saint Agnes conducted a new Community Health Needs Assessment at the end of FY 2016. Obesity was identified as a top priority in the 2016 assessment. The CHNA conducted in FY 2016 comes with a new set of initiatives and a strategic plan which will implement starting in FY 2017.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $131,341	B. Direct offsetting revenue from Restricted Grants $8,333

Table III A. Initiative III Primary Care Access, Especially for the Poor and Vulnerable

Identified Need	Primary Care Access, Especially For the Poor and Vulnerable
Hospital Initiative	Facilitate access to primary care services for members of the community.
Primary Objective	Implementation Strategy: 1. In conjunction with strategic partner, Baltimore Medical Systems, Inc., facilitate access to primary care services via the Federally Qualified Health Center located on Saint Agnes campus through expansion of the FQHC facilities and enhanced collaborative linkages with Saint Agnes services. Metrics for this initiative will focus on access to care. 2. Establish a Health Enterprise Zone in West Baltimore through a collaborative partnership, the West Baltimore Primary Care Access Collaborative (WBPCAC). Support the mission of WBPCAC to create a sustainable, replicable system of care to reduce health disparities, improve access to health care, reduce costs, and expand primary care and community health workforce. Metrics for this initiative will focus on utilization of hospital services.
Single or Multi-Year Initiative Time Period	This is a multi-year initiative intended to last the life of the 3-year CHNA that was conducted in 2013.
Key Partners in Development and/or Implementation	Baltimore Medical Systems and their FQHC located on the campus of Saint Agnes, the members of the West Baltimore Primary Case Access Collaborative (WBPCAC), Seton Medical Group (offers primary and OB/GYN care to residents in Saint Agnes' primary service area), Esperanza Center (provides free primary and dental care services to immigrants in the metropolitan Baltimore region).
How were the outcomes evaluated?	Outcomes were evaluated through four programs: 1. BMS Partnership – Increase access to much needed primary and OB/GYN care in Southwest Baltimore through this on-campus FQHC. Saint Agnes currently employees the OB hospitalist group providing care to BMS patients. This OB hospitalist group provides coverage for BMS patient seen on the maternity ward of the Hospital as well as staff the prenatal clinic at BMS. Metrics focus on the number of patients treated through this BMS relationship 2. Seton Primary Care services – Increase access for those in most need of primary care services. Includes increasing visits for those treated in our on-campus primary care clinic. This clinic targets the underserved, high-risk patients that are not able to gain access to the BMS primary care clinic due to financial barriers or are not able to be seen in a timely fashion. This

Table III A. Initiative III Primary Care Access, Especially for the Poor and Vulnerable

	timely primary care follow-up allows for more effective care coordination for these high-risk patients. Metrics focused on expansion of care to Medicaid patients. 3. Collaborative partnership with West Baltimore Primary Care Access - Saint Agnes is one of the 16 founding partners in West Baltimore Care Collaborative which provides community outreach to reduce health disparities, improve health outcomes and reduce hospital emergency department utilization and costs for residents living in the West Baltimore Health Enterprise Zone. Outcomes measured through potentially avoidable utilization metrics of 30-day revisit and readmissions. 4. Breast Link Program - In cooperation with the Susan G. Komen Association of Maryland this program provides community outreach and education on breast health and preventative screenings for people residing in the West Baltimore Health Enterprise Zone. Metrics focused on patients receiving outreach education, screening and PCP appointments. 5. Palliative Care - Saint Agnes' Palliative care team help support seriously ill patients by matching medical treatments to informed patient and family goals. They also identify and coordinate resources and services to ensure a seamless care plan across a spectrum of settings (i.e., hospital, nursing home, hospice and home). Despite the intensity of spending for this patient population, quality of care for this group often is low, marked by poor communication, high burden of pain and other symptoms, low satisfaction, and treatments that run counter to what patients prefer. Effective palliative care programs can be successful in reducing excess resources in treating this patient population. Metrics for the initiative centered on the number of patients in the program and the efficacy of the program in being able to manage the intensity of the resources provided to these seriously ill patients.
Outcomes (Include process and impact measures)	1. BMS Partnership – All metrics for FY 16. a. BMS FHQC visits 37,921 vs. a target of 40,785 b. Total BMS FQHC new patients 4,421 vs. a target of 3,848 c. Prenatal visits at BMS 8,049 vs. a target of 8,763 2. Seton Primary Care Services – All metrics for FY 16. Targets to be established for FY 16. a. Percentage of Primary Care Medicaid visits to Saint Agnes Medical Group 8.8% vs. a target of 6.6%. 3. Collaborative partnership with West Baltimore Primary Care Access – All metrics for FY 16. a. Percentage of ED visits by HEZ residents 41.0% vs. a target 11.7%. b. Percentage of HEZ residents with 30-day readmissions 10.6% vs a target of 3.6%. 4. Breast Link Program – All metrics for FY 16: a. People attending education & outreach on breast health

Table III A. Initiative III Primary Care Access, Especially for the Poor and Vulnerable

	5,800 vs. a target of 6,580 b. Women in the Breast Link Program completing mammograms 57 vs. a target of 64 c. Women in the Breast Link Program attending a PCP appointment with a breast exam 147 vs. a target of 143. 5. Palliative Care Program – All metrics for FY 16: a. Total number of palliative care consults 1,068 vs. a target of 978. b. Percentage of palliative care patients with 30-day readmissions 3.2% vs. a target of 2.3% c. Percentage of palliative care patients discharged alive 82.4% vs. a target 80.9%.	
Continuation of Initiative	Saint Agnes conducted a new Community Health Needs Assessment at the end of FY 2016. This third priority in the FY 16 CHNA is a broader objective than that in FY 13 to increase access to primary care to Create Person-Centered Healthy Neighborhoods. The CHNA conducted in FY 2016 comes with a new set of initiatives and a strategic plan which will implement starting in FY 2017.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $5,039,000	B. Direct offsetting revenue from Restricted Grants $1,824,000

Appendix I

Communication of Saint Agnes Charity Care Policy – FY 2016

Saint Agnes Hospital, created by the Daughters of Charity in 1862, was originally created to provide nursing care to the poor. Since its inception, Saint Agnes continues to provide healthcare services to the indigent as part of its mission. Saint Agnes' provides free care to individuals below 250% of the Federal Poverty Line (FPL). Patients with income above 200% of the FPL but below 400% can receive financial assistance based on a sliding scale. In cases of unusual medical, financial or humanitarian burden, Saint Agnes can forgo the criteria established in the policy and offer charity care as is deemed appropriate. Additionally, as required by HSCRC regulation, Saint Agnes has adopted a financial hardship exemption that provides financial assistance to patients who incur medical debt for medically necessary services incurred by a family with income below 500% of the Federal Poverty Limit that exceeds 25% of the family income over a 12 month period.

Information regarding Saint Agnes' charity care policy is displayed at the following locations throughout the Hospital:

Diagnostic Imaging Registration
Main Entrance Information Desk
Surgery Registration Area
Seton Nuclear Cardiology Center
Breast Center
Cancer Center
Outpatient Rehab Services
Women's Health Center
Emergency Department Registration
Main Lobby/1st Floor Registration
Lab Outreach at BMS
Cashier's Office 1st Floor
Cardiac Rehab/Heart Failure Center
Anti-Coagulation Center
Seton Imaging Center
Diabetes Center

In addition, brochures and flyers are displayed and available to the public that describe the policy. St. Agnes also provides a copy of its *Patient Billing and Financial Assistance* Information Sheet to every inpatient treated per HSCRC regulations. The Information Sheet is published in both English and Spanish at a comprehension level suitable for our patient population. The Sheet summarizes the Hospital's charity care policy and also states Medicaid may be available to eligible patients. As part of the Corporate Responsibility Program (CRP), annual training for registration and billing personnel is conducted that includes knowledge of the organization's charity care policy. Finally, a public notice regarding the charity care policy is published annually in the *Baltimore Sun*.

St. Agnes has also adopted a hands-on approach to providing patients with a means of getting financial assistance for their healthcare. St. Agnes has a department within its Revenue Cycle division called Patient Financial Eligibility. The primary responsibility of this department is educating patients about financial assistance programs including public assistance and charity care. The department works with patients to evaluate their eligibility and income status for these financial assistance programs. In cases when eligibility status is favorable, the department assists the patients to obtain necessary documents and information to complete required applications.

Appendix II – Changes in FAP since the ACA's Health Care Coverage Expansion

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 III).

Ascension is committed to providing healthcare services to the disadvantaged and underserved communities where its health ministries are located. It is for this reason that the Health System moved to a standard, system-wide charity care and financial assistance policy starting in July of 2016. This new policy standardized the federal poverty levels (FPL) Ascension Health Ministries use to determine patients eligible for 100% charity care (up to 250% of the FPL) and discounted care (250% to 400% of the FPL). This expansion of the charity care and financial assistance thresholds means that Saint Agnes is able to provide assistance to a patient population that continues to be challenged with the cost of purchasing insurance even after healthcare insurance expansion.

Expansion of Medicaid benefits for individuals earning up to 138% of the federal poverty level has led to a decrease in patients applying for full charity. At the same time that these previously uninsured individuals are gaining insurance coverage, patients with commercial insurance including those provided with subsidies through the insurance exchange are experiencing an increase in deductibles and coinsurance that many do not have the financial means to pay. Many of these underinsured individuals qualify for sliding scale financial assistance under Saint Agnes' Charity Care policy but often do apply for assistance. Saint Agnes's Financial Assistance policy allows the Hospital to qualify individuals for presumptive charity and financial assistance by use of automated eligibility software. This software uses patient demographic information available to credit scoring agencies to estimate individuals' income and healthcare specific debt to assess their ability and propensity to pay. Saint Agnes has increased use of this automated eligibility software to identify patients eligible for financial assistance that do not proactively apply through the traditional charity application process.

Saint Agnes Healthcare, Inc. System Policy and Procedure Manual	**Page 1 of 20**	**SYS FI 05**
Subject: Charity Care/Financial Assistance	**Effective Date:** 2/05	
	Reviewed: **Revised:** 1/09, 05/09, 10/10, 9/12, 6/16	
Approvals: Final - President/CEO: _____ Date:_____ Concurrence:_____ Date_____ *(Policies become effective30 days after CEO signs.)*		

POLICY/PRINCIPLES

It is the policy of Saint Agnes Healthcare (the "Organization") to ensure a socially just practice for providing emergency or other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all emergency and other medically necessary services provided by the Organization, including employed physician services and behavioral health. This policy does not apply to payment arrangements for elective procedures or other care that is not emergency care or otherwise medically necessary.

3. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

SCOPE

This policy applies to all entities of the Saint Agnes HealthCare system.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- "**Amount Generally Billed**" or "**AGB**" means, with respect to emergency or other medically necessary care, the amount generally billed to individuals who have insurance covering such care.

- "**Community**" means patients residing in the following zip codes consistent with the Organization's Community Health Needs Assessment (CHNA):
    - Arbutus 21227
    - Brooklyn/Linthicum 21090, 21225
    - Catonsville 21228
    - Ellicott City 21042, 21043, 21075
    - Glen Burnie 21060, 21061
    - Pasadena 21122
    - South Baltimore City 21223, 21230
    - South Carroll County 21104, 21163, 21784
    - Southwest Baltimore City 21229
    - West Baltimore City 21215, 21216, 21217
- "**Emergency Care**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either:
    a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
    b. Serious impairment to bodily functions, or
    c. Serious dysfunction of any bodily organ or part.
- **"Hospital Markup"** means the markup included in hospital rates as calculated by the Health Services Cost Review Commission (uncompensated care in rates plus payer differential).
- "**Medically Necessary Care**" means care that is determined to be medically necessary following a determination of clinical merit by a licensed provider. In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- "**Organization**" means Saint Agnes Healthcare.
- "**Patient**" means those persons who receive emergency or medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

Financial assistance described in this section is limited to Patients that live in the Community:

1. Patients with income less than or equal to 250% of the Federal Poverty Level ("FPL"), will be eligible for 100% charity care write off on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any.

2. At a minimum, Patients with incomes above 250% of the FPL but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any. A Patient eligible for the sliding scale discount will not be charged more than the lesser of (1) charges minus hospital markup, (2) the calculated AGB charges. The sliding scale discount(s) can be found at Exhibit A.

3. The Organization will provide reduced-cost, medically necessary care to patients with family income below 500% of the FPL and medical debt that exceeds 25% of the family income. Eligible patients shall remain eligible for reduced cost, medically necessary care during the 12-month period beginning on the date on which the reduced-cost, medically necessary care was initially received. The patient and any immediate family member of the patient living in the same household may be eligible.

4. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring to determine eligibility notwithstanding an applicant's failure to complete a financial assistance application ("FAP Application").

5. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social service programs are deemed eligible for charity care, provided that the patient submits proof or enrollment within 30 days unless the patient or the patients representative requests an additional 30 days:
    a. Households with children in the free or reduced lunch program;
    b. Supplemental Nutritional Assistance Program (SNAP);
    c. Low-income household energy assistance Program;
    d. Women, Infants and Children (WIC);
    e. Other means-tested social services program deemed eligible for hospital free care by the Department of Health and Mental Hygiene and the HSCRC.

6. Eligibility for financial assistance must be determined for any balance for which the patient with financial need is responsible.

7. The process for Patients and families to appeal an Organization's decisions regarding eligibility for financial assistance is as follows:
    a. Patients will be notified of ineligibility of financial assistance through the hospital's financial assistance denial letter. Patients or families may appeal decisions regarding eligibility for financial assistance by contacting the Director of Patient Financial Services either via phone call or in writing mailed to 900 Caton Ave., Baltimore, Md. 21229.
    b. All appeals will be considered by Saint Agnes Healthcare's charity care and financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal.

Other Assistance for Patients Not Eligible for Financial Assistance (applicable to non-hospital services only)

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by Saint Agnes Healthcare.

1. Uninsured Patients receiving services at Seton Imaging, Lab Outreach or Professional Services who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.
2. Uninsured and insured Patients receiving services at Seton Imaging, Lab Outreach or Professional Services who are not eligible for financial assistance may receive a prompt pay discount. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.

Uninsured Discounts Available to Patients (applicable to hospital services only)

An uninsured patient receiving regulated hospital services will receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital. Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles the patient to a 1-percent discount.

Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged more than the lesser of (1) charges minus hospital markup, (2) the calculated AGB charges for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentage using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained by contacting Patient Financial Services at 667-234-2140.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process. The FAP Application and FAP Application Instructions are available online at stagnes.org or through request by calling Patient

Financial Assistance at 667-234-2140. FAP applications are also available at various Registration Locations throughout the hospital.

Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained by contacting Patient Financial Services at 667-234-2140.

Interpretation

This policy is intended to comply with 501(r), except where specifically indicated. This policy, together with all applicable procedures, shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

CONCURRENCE(S):

REFERENCE(S):

CROSS REFERENCE(S):

Exhibit A

Saint Agnes Healthcare

FINANCIAL ASSISTANCE SCALE

As of July 1, 2016

For Hospital Facility Services Only (Regulated)

Household Size	Charity Care				Financial Assistance Program					
	100%	to 200%	to 225%	to 250%	to 275%	to 300%	to 325%	to 350%	to 375%	to 400%
1	$11,490	$22,980	$25,850	$28,730	$31,600	$34,470	$37,340	$40,220	$43,090	$45,960
2	$15,510	$31,020	$34,900	$38,780	$42,650	$46,530	$50,410	$54,290	$58,160	$62,040
3	$19,530	$39,060	$43,940	$48,830	$53,710	$58,590	$63,470	$68,360	$73,240	$78,120
4	$23,550	$47,100	$52,990	$58,880	$64,760	$70,650	$76,540	$82,430	$88,310	$94,200
Saint Agnes Discount	100%	100%	100%	100%	75%	50%	25%	15%	12%	10.5%

For Professional Services (Deregulated)*

Household Size	Charity Care				Financial Assistance Program					
	100%	to 200%	to 225%	to 250%	to 275%	to 300%	to 325%	to 350%	to 375%	to 400%
1	$11,490	$22,980	$25,850	$28,730	$31,600	$34,470	$37,340	$40,220	$43,090	$45,960
2	$15,510	$31,020	$34,900	$38,780	$42,650	$46,530	$50,410	$54,290	$58,160	$62,040
3	$19,530	$39,060	$43,940	$48,830	$53,710	$58,590	$63,470	$68,360	$73,240	$78,120
4	$23,550	$47,100	$52,990	$58,880	$64,760	$70,650	$76,540	$82,430	$88,310	$94,200
Saint Agnes Discount	100%	100%	100%	100%	90%	80%	70%	60%	50%	46.1%

** Includes the following services:*

Seton Imaging

Lab Outreach

Seton Medical Group

Ascension Medical Group

Integrated Specialist Group

Radiologists Professional Services

Anesthesia Professional Services

Exhibit B

Saint Agnes Healthcare

AMOUNT GENERALLY BILLED CALCULATION

As of 3/31/16

Saint Agnes Healthcare calculates two AGB percentages – one for hospital facility charges and one for professional fees – both using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with IRS Reg. Sec. 1.501(r)-5(b)(3), 1.501(r)-5(b)(3)(ii)(B) and 1.501(r)-5(b)(3)(iii). The details of those calculations and AGB percentages are described below.

The AGB percentages for Saint Agnes Healthcare are as follows:

AGB for hospital facility charges: 93.3%
AGB for physicians' professional fees: 46.1%

These AGB percentages are calculated by dividing the sum of the amounts of all of the hospital facility's claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility (separately for facility charges and professional services) by the sum of the associated gross charges for those claims. The only claims that are utilized for purposes of determining the AGB are those that were allowed by a health insurer during the 12 month period prior to the AGB calculation (rather than those claims that relate to care provided during the prior 12 months).

Exhibit C

Saint Agnes Healthcare

LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY

As of July 1, 2016

Per Reg. Sec. 1.504(r)-4(b)(1)(iii)(F) and Notice 2015-46, this list specifies which providers of emergency and medically necessary care delivered in the hospital facility are covered by the Financial Assistance Policy (FAP). Elective procedures and other care that is not emergency care or otherwise medically necessary are not covered by the FAP for any providers

Providers covered by FAP	Providers not covered by FAP
Seton Medical Group Ascension Medical Group Integrated Specialist Group CEP America	ABDUR-RAHMAN,NAJLA MD ABERNATHY,THOMAS MD ACEBEY,MAURICIO MD ADDO M.D.,RICHARD O ADHIKARLA,ROHINI MD AFZAL,MUHAMMAD MD AHMED,AZRA MD AHUJA,GURMINDER MD AHUJA,NAVNEET K MD AKHTER,NABEEL M M.D. ALBUERNE,MARCELINO D MD AL-BUSTANI,SAIF S MD, DDS ALDRIDGE,DIONNE F LCSWC ALEX,BIJU K MD ALEXANDER,ZACHARY MD ALI,LIAQAT MD ALI,ZULFIQAR MD ALLEN,DANISHA MD ALONSO,ADOLFO M MD AMERI,MARIAM MD ANANDAKRISHNAN,RAVI K MD ANGLIN,DELROY MD ANSARI,MOHSIN MD ANTELMAN,ROBERT MD ANTHONY,JAMES D MD ANTONIADES,SPIRO B MD APOSTOLIDES,GEORGE Y MD APOSTOLO,PAUL M MD AREGAWI,ABIY MD

	ARSHAD,R MD ARWINDEKAR,ARUNA MD AWAN,HASAN A MD AWAN,MATEEN A MD AZIZ,SHAHID MD BAAKO,MICHAEL MD BACON,JOHN R MD BAHOUTH,MONA N MD BAJAJ,BHAVANDEEP MD BAJAJ,HARJIT S MD BALLO,MICHAEL MD BAMC/JONES MW, BANEGURA,ALLEN T MD BANERJEE,CHANDRALEK MD BARBOUR,WALID K MD BARNES,BENJAMIN T MD BARONE,MICHAEL A MD BASKARAN,DEEPAK MD BASKARAN,SAMBANDAM MD BASSI,ASHWANI K MD BASTACKY,DAVID C DMD BECK,CLAUDIA MD BEHRENS,MARY T MD BELTRAN,JUAN A MD BERGER,LESLY MD BERGER,NATHAN G MD BETHI,SIDDHARTH MD BEZIRDJIAN,LAWRENCE C MD BHARGAVA,NALINI MD BHASIN,SUSHMA MD BHATIA,PRIMALJYOT MD BIRCHESS,DAMIAN E MD BLAM,OREN G MD BLANK,MICHAEL DDS BLUEBOND-LANGNER,RACHEL MD BLUMBERG,ALBERT L MD BODDETI,ANURADHA MD BOEHLER,CHERYL PA-C BOENDER,DEBRA R DPM BORGIE,RODERICK MD BOWLIN,DENEEN MD BOWSER,LESTER MD BOYD,CHRISTINA M MD

	BRAMLETTE,JAMES MD BRIGGS,MICHELLE L CRNP BROUILLET,GEORGE MD BROWN,JACQUELINE A MD BROWN-KARAPELOU,MARIA K MD BUICK,MELISSA MD BUNDESEN., III,WILLIAM LCSW CABRERA,MICHELLE MD CAHILL,EDWARD H MD CAMPBELL,CATHERINE MD CAO,QI MD CAREY,RICHARD MD CARPENTER,MYLA MD CARR, III,THOMAS MD CARTER,MIHAELA M.D. CHAIKEN,MARC L MD CHANDER,CHERUVARI S MD CHANG,HENRY MD CHARLES,LYSA M MD CHATTERJEE,CHANDANA MD CHEIKH,ELIE MD CHEIKH,EYAD MD CHEN,WENGEN MD CHEUNG,AMY M MD CHOPRA,ASHOK MD CHOUDHRY,SHABBIR A MD CHOWDARY-MUPPURI,VINUTHA MD CHRIST,JOHN J CRNA CLARK,PAUL DO COHEN,BERNARD MD COHEN,BONNIE E MD COHEN,NERI MD COLANDREA,JEAN MD COLLINS,KALONJI MD COMMERFORD,CHRISTINE MD COOMBS,VICKIE RN COOPER,JANET MD CROSSON,JANE E MD CROWLEY,HELENA M MD DAMIEN,GLORIA MD DANG,KOMAL K MD DATLA,RAVI MD DAVALOS,JULIO MD

	DAVIDSON,SASHA MD DEBORJA,LILIA L MD DEJARNETTE,JUDITH MD DEOL,DILRAJ MD DESAI,KARTIK J MD DESAI,KIRTIKANT I MD DEY,RUBY MD DIAS,MICHAEL MD DICKERT,BRITTANY CRNP DICKSTEIN,RIAN MD DIDOLKAR,MUKUND S MD DIETRICH,RICHARD L MD DILSIZIAN,VASKEN MD DIXON,RENEE MD DIXON,TEKEEMA A MD DODGE,KARIN MD DODOO,RAPHAEL MD DOHERTY,BRENDAN MD DOVE,JOSEPH DPM DOVER,GEORGE J MD DROSSNER,MICHAEL N MD DUKE,PATRICIA CRNP DUNCAN,CONRAD J MD DUNCAN,MICHELLE E MD DUONG,BICH T MD DZIUBA,SYLWESTER MD EGERTON,WALTER E MD EGLSEDER,WALTER A MD EISENBERG,JOSEPH PhD ELMAN,MICHAEL J MD ENELOW,THOMAS MD ERAS,JENNIFER L MD ERSHLER,RACHEL MD ESCOBAR,EDUARDO MD ESSIEN-LEWIS,IME DO ETTER,JONATHAN R MD EVANS,JAMES R MD FADAHUNSI,NWAMAKA MD FATTERPAKER,ANIL MD FENIG,DAVID MD FERNANDEZ,RODOLFO E MD FERNANDOPULLE, GREGORY MD FILDERMAN,PETER S MD

	FITCH-ALEXANDER,LINDSAY V MD FLOYD,DEBORA M LCPC FLYNN,LAUREN LCSW-C FOLGUERAS,ALBERT J MD GALITA,OLIVER C MD GALLAGER,LAURENCE R MD GAMBEL,JEFFREY MD GARG,PRADEEP MD GARNETT,MICHELLE L MD GARY,NADER G MD GASKINS,RICHELLE MD GATDULA,CRISTETA L MD GAYED,BISHOY A MD GAYED,KELLY CRNP GEBREWOLD,HIRUT A MD GEORGIA,JEFFREY MD GERSH,STEVEN DPM GERSTENBLITH,JAY MD GHEBA,MOHAMMED R MD GHOSH,MAYURIKA MD GIBSON,MICHAEL S MD GLUBO,STEVEN M DPM GOBRIAL,EVEIT E MD GOLDMAN,MICHAEL H MD GOLDMAN,MICHAEL S MD GOR,NEELAM D MD GRAHAM,CHARLES R MD GRANT,CARRON R DPM GRATZ,EDWARD S MD GREEN-SU,FRANCES M MD GREENWELL,ROBERT C MD GROCHMAL,JAY C MD GROSS,SHARON C MD GROSSO,NICHOLAS MD GRUNEBERG,SHERRI L MD HANSEN,CHRISTIAN H MD HAROUN,RAYMOND I MD HAWKES,NATHAN M.D. HAYWARD,GERALD MD HECTOR,ROGER M.D. HEMP,SALLIE A LCSW HESS,CHRISTINE LCSW HICKEN,WILLIAM J MD

	HILL,SHARON E PA-C HILL,TERRI MD HOCHULI,STEPHAN U MD HOLTON, III,LUTHER MD HOMAYOUNI,NAVID MD HOPKINS,CESCILI MD HORMOZI,DARAB MD HUANG,JAMES L MD HUDES,RICHARD MD HUGHES,HELEN K. MD IFECHUKWU,CHINYERE PA-C IM,DWIGHT D MD IMIRU,ABEBE MD JACOB,ASHOK C MD JACOBS,JERALYN M.D. JAGOE,JENNIFER MD JANI,NIRAJ D MD JENSEN,ATIF K MD JOHNSON,DALE MD JOHNSON,GLEN E MD JOHNSON,KELLY MD JONES,VALERIE A MD JULKA,SURJIT S MD KACHROO,SONAL MD KALRA,KAVITA B MD KAMARA,KELVINDA CRNP-F KANNO,METTASSEBIA MD KANTER,MITCHEL A MD KANTER,WILLIAM R MD KASHYAP,SMRITI MD KEEN M.D.,STACEY KHALID,MIAN MD KHURANA,ARUNA Y MD KIM,CHRISTOPHER MD KIM,EMERY MD KIM,SOON JA MD KIM,SUNGJOO B MD KIM,YOUNG J MD KINNARD,RICHARD MD KLEBANOW,KENNETH M MD KLEINMAN,BENJAMIN DPM KONITS,PHILIP H MD KOPACK,ANGELA M MD

	KOPPER,JAMES A MD KRATZ,KATHERINE MD KRIZAN,DEANA LCSW-C KUMAR,RAMESH MD KUMOLUYI,OLUWAFOYINSAYOMI F MD KUNKLE,CYNELLE MD KUPPUSAMY,TAMIL S MD LAFFERMAN,JEFFREY MD LALA,PADMA M MD LANCELOTTA,CHARLES J MD LANDIS,JEFFREY T MD LANDRUM,B. MARK MD LANDRUM,DIANNE J MD LANDSMAN,JENNIFER MD LANE,ANNE D MD LANGER,KENNETH F MD LANTZ,JENNIFER MS, CCC/A LATIMORE,PIERRETTE CNM LEBLANC,DIANA M.D. LEDER,HENRY MD LEE,KATRINA PA-C LEITZEL,AMY L CNM LEMMA,SIRAK H MD LENOX-KRIMMEL,JANE SW LEVIN,BRIAN M MD LI,QING PA-C LIEPINSH,DMITRY MD LIN,ANNIE Z MD LITZENDORF,MARIA E MD LIU,JIA MD LONG,ADRIAN E MD LONG,ANDREW MD LONG,JACK M LCSW LOTLIKAR,JEFFREY P MD LOWDER,GERARD M MD LOWE,STEPHEN R MD LUMPKINS,KIMBERLY M. M.D. MACHIRAN,NORBERTO M MD MACIEJEWSKI,SHARON PT MADDEN,JOSHUA S MD MAKONNEN,ZELALEM MD MALLALIEU,JARED DO MALONEY,PATRICK MD

	MAMO,GEORGE J MD MANDIR,ALLEN S MD MARKO,JAMIE MD MARKWELL,JAMES K MD MARSHALL,VAUGHN MD MATHEW,ALEYAMMA MD MATIVO,CHRISTINE S MD MATSUNAGA,MARK T MD MAUNG,TIN O MD MAVROPHILIPOS,DIMITRIOS MD MAVROPHILIPOS,ZACHARIAS MD MAYO,LINDA D OTS MCCLELLAND,PAUL A MD MCCORMACK,SHARON J MD MCEWAN,MICHELE M MD MCGRATH,BRIDGET PA-C MCRILL,CONNIE M MD MEDWIN,IRINA MD MEHBOOB,MOHAMMED MD MEININGER,GLENN R MD MEKONEN,EYASU MD MELLER-AZRIELI,FIONA F MD MICHAUD,PAUL MD MIDDLETON,JEFFREY G MD MILLER,JOSEPH H MD MILLER,KAREN MD MILLER,PAUL R MD MILLER,STEVEN D M.D. MILLER,STEVEN D MD MINAHAN,ROBERT E M.D., JR MIRANDA,JOSILANE M MD MISHRA,TANUJA MD MITCHELL,JASON W MD MITCHERLING,JOHN J DDS MITCHERLING,WILLIAM W DDS MODI,KULWANT S MD MOESLEIN,FRED M MD MOGHBELI,HOMAYOON MD MOHAMED,ASIF A MD MOORE,GIGI CNM MOORE,JAMES T MD MORE, III,PAUL CRNA MORGAN,ATHOL W MD

	MORIARTY,SUSAN MD MUDON,MARLA PA-C MUELLER,JAMES LCSW MUMTAZ,M. ANWAR MD MUNTER,FLETCHER MD MURPHY,ANNE MD MUSARA,MUBAYIWA C MD MYDLARZ,WOJCIECH MD MYERS,RACHEL J PA-C NAKAZAWA,HIROSHI MD NANAVATI,ASHWIN L MD NARAYEN,GEETANJALI MD NARAYEN,VIJAY MD NEGUSSE,YODIT MD NELSON III,SIDNEY MD NEUBAUER,KATHRYN MD NEUNER,GEOFFREY MD NGUYEN,MARILYN MD NGWU,OGUNDU MD NICOL,THERESA MD NUCKOLS,JOSEPH MD O'CONNOR,MEGHAN P MD OLLAYOS,CURTIS MD OMITOWOJU,IFEOLUWA Y MD OPPONG,JOSEPH MD ORZACH,HARRIS E MD OTTAVIANO,YVONNE MD OTTO,DAVID I MD OTTO,JAMES MD OUELLETTE,SUSAN CRNP OWUSU-ANTWI,KOFI MD OWUSU-SAKYI,JOSEPHINE MD PARIKH,JYOTIN MD PARK,CHARLES MD PASS,CAROLYN J MD PASUMARTHY,ANITA MD PATAKI,ANDREW M MD PATEL,ALPEN MD PATEL,CHIRAG Y MD PATEL,JANKI MD PATEL,KRUTI N MD PATEL,MINESH R MD PERRY,JAMIE J M.D.

	PERVAIZ,KHURRAM MD PETERS-GILL,SHILLENA MD PETIT,LISA MD PICKETT,CICELY M MD PIEPRZAK,MARY A MD PIZARRO-DUPUY,NOEMI PA-C PLOTZ,ZACHARY MD POLSKY,MORRIS B MD POON,THAW MD POULTON,SCOTT C MD PRIETO,SALVADOR PA-C PULLMAN,RUDOLF MD PURDY,ANGEL MD QUINLAN,PAMELA M DO RAJA,GEETHA MD RAMANATHAN JR,MURUGAPPAN M MD RANKIN,ROBERT MD RASHKIN,JASON MD RAVEKES,WILLIAM MD RAVENDHRAN,NATARAJAN MD RECKORD,MARGARET M RN REDDY,ANURADHA MD REED,ANN MD REGMI,MANOJ MD REHMAN,MALIK A MD REILLY,CHRISTINE MD REINER,BARRY J MD REISINGER,ALAN MD RICHARD, III,HOWARD M MD RICHARDSON,LEONARD A MD RINGEL,RICHARD E MD ROBERTSON,KAISER MD ROBERTSON,LAURA MD ROBINSON,STACEY L LCSW-C RODGERS,ANDREW S. MD ROSS,JEROME MD ROSS,ROBERT W MD ROTH,JOHN DPM ROTH,MELINDA-ANN MD RUSSELL,JONATHON O MD RYU,HYUNG MD SAIEDY,SAMER MD SAINI,ANJALI MD

	SAINI,RUMNEET K MD SALAS,LOUIS MD SALAZAR,ANDRES E MD SALENGER,RAWN V MD SALIM,MUBADDA MD SALVO,EUGENE C MD SANARIZ,JOSE RICO CRNA SANDERS,BRIANA MD SANDERSON,SEAN O M.D. SANGHAVI,MILAN MD SANTOS,MARIA L MD SARDANA,NEERAJ MD SATTIN,SANDRA MD SAVAGE,ANGELA Y DPM SCHEERER,MICHAEL T MD SCHNEE,CHARLES MD SCHWARTZBAUER,GARY M.D. SCHWENGEL,DEBORAH A MD SCOTT,KATHLEEN M PA-C SCOTT,LAURA MD SEIBEL,JEFFREY L MD SEKAR,PRIYA MD SHABAZZ,BAYINNAH MD SHAH,RAJESH M MD SHAH,SANJAY P MD SHAIKH,NAOMI N MD SHAMS-PIRZADEH,ABDOLLAH MD SHAPIRO ,BRUCE K SHAW,COREY DO SHEKITKA,KRIS M MD SHETH,NIKHIL MD SHIN,JOHN MD SHIN,LAWRENCE MD SHITTA-BEY,ABIOLA MD SHORTS,ALISON MSCCC-SLP SHUBIN,CHARLES I MD SIEGEL,ELIOT L MD SILVERSTEIN,SCOTT MD SINGH,DEVINDER MD SINGH,KULDEEP MD SINNO,FADY MD SISBARRO,MEGAN M PA-C SKLAR,GEOFFREY MD

	SLEPIAN,IAN MD SLOANE,DANA MD SMITH,WARREN J MD SO,MATILDA H MD SOILEAU-BURKE,MONIQUE J MD SPEVAK,PHILIP J MD ST.MARTIN,DORIAN S MD STAIMAN,VICTORIA MD STANDIFORD,JOHN WILLARD W MD STERN,MELVIN S MD STEVENS,HOLLY PRN OT STONE,PHILLIP W MD STRAUCH,ERIC MD SUBASIC,WENDY J PA-C SUFFREDINI,DANTE A MD SULTAN,BABAR MD SUSEL,RICHARD M MD SUSSMAN,ALICIA MD SWANTON,EDWARD MD SWEHLA,BRIAN P MD SWETT,JEFFREY T DO SYDNEY,SAM V MD SYDNEY,STEPHANIE L PA-C TAHERKHANI,SARA MD TAMAYO,ANGELA MD TANSINDA,JAMES MD TAO,LYNN MD TAVASSOLIE,HOSSEIN MD TESHOME,TATEK S MD TESTANI,ROBERT B DDS THATTASSERY,EMIL MD THOMAS,RADCLIFFE MD THOMPSON III,WILLIAM R MD TIGNOR,APRIL MD TORRES,VIRMA V M.D. TRAMBADIA,MITESH MD TSCHUDY,MEGAN MD TUCHMAN,DAVID N MD TURAKHIA,BIPIN K MD TUUR-SAUNDERS,SYLVANA MD TWANMOH,JOSEPH R MD TWIGG,AARON MD UDOCHI,NJIDEKA MD

	VALLECILLO,JORGE MD VAN DEN BROEK,JEFFREY W DO VANGEERTRUYDEN,PETER H MD VASANTHAKUMAR,MUTHUKRISHNAN MD VASWANI,SURENDER K MD VERNON,NATALIA T MD VOIGT,ROGER W MD VOLIKAS,LAZAROS T MD WAELTERMANN,JOANNE M MD WALKER,MARK A MD WALKER,SHETARRA MD WALLACE,MICHAEL MD WARD,FRANCISCO A DO WARD,KRISTIN CRNA WARDEN,MARJORIE K MD WASKOW,LARRY PA-C WELLS,BRUCE C MD WEXLER,JEFFREY L MD WHEELER,CARL CRNP WHITE,PATRICK W MD WICKRAMARATNE,KANTHI MD WILLIAMS,SAMUEL R MD WILLIAMSON,SAMANTHA L MD WILSON,CANDACE L MD WINIKOFF,STEPHEN E MD WOLFF,JORDAN H MD WOLLNEY,DANA E MD WOOD,DAVID DPM WOODARD,EBONI MD WRIGHT,DAKARA R MD WYNN,HENRY PA-C YADAV,RAJ N MD YAUNCHES,DIANE M CNM YIM,KENNETH MD YOON,TIMOTHY S MD ZAIM,BULENT R MD ZHANG,DOU ALVIN MD-PHD ZHEUTLIN,LYNNE M MD ZHU,WEIMIN MD ZULU,SAMANA H M.D. ZUNIGA,LUIS M MD

SAINT AGNES HOSPITAL

Summary of Financial Assistance Policy

Saint Agnes Hospital has a commitment to and respect for each person's dignity with a special concern for those who struggle with barriers to access healthcare services. Saint Agnes Hospital has an equal commitment to manage its healthcare resources as a service to the entire community. In furtherance of these principles, Saint Agnes Hospital provides financial assistance for certain individuals who receive emergency or other medically necessary care from Saint Agnes Hospital. This summary provides a brief overview of Saint Agnes Hospital's Financial Assistance Policy.

We offer a number of financial assistance programs to help qualified patients honor the uninsured portion of your bill.

Who Is Eligible?

You may be able to get financial assistance. Financial assistance is generally determined by your total household income as compared to the Federal Poverty Level. If your income is less than or equal to 250% of the Federal Poverty Level, you will receive a 100% charity care write-off on the portion of the charges for which you are responsible. If your income is above 250% of the Federal Poverty Level but does not exceed 400% of the Federal Poverty Level, you may receive discounted rates on a sliding scale. If your income is between 400% and 500% of the Federal Poverty Level and you request assistance, a payment plan will be made available to you. Patients who are eligible for financial assistance will not be charged more for eligible care than the lesser of (1) amounts generally billed to patients with insurance coverage, or (2) charges minus the hospital's mark-up.

Please call 1-667-234-2140 for more information or visit our website @http://www.stagnes.org/patients-visitors/financial-assistance.

You may be eligible for Maryland Medical Assistance. Medical Assistance is a program that will pay for your health coverage. If you wish to apply with the State please call 1-855-642-8572 or apply online @ www.marylandhealthconnection.gov or you can call 1-667-234-3314 or 1-667-234-2188 and we can assist.

What Services Are Covered?

The Financial Assistance Policy applies to emergency and other medically necessary care. These terms are defined in the Financial Assistance Policy. Elective services and physician charges to both hospital inpatients and outpatients are billed separately and are not generally covered by the Financial Assistance Policy.

How Can I Apply?

To apply for financial assistance, you typically will complete a written application and provide supporting documentation, as described in the Financial Assistance Policy and the Financial Assistance Policy application.

How Can I Get Help with an Application?

For help with a Financial Assistance Policy application, you may contact a Financial Counselor at Saint Agnes Hospital at 1-667-234-2140 or visit our website at http://www.stagnes.org/patients-visitors/financial-assistance.

How Can I Get More Information?

Copies of the Financial Assistance Policy and Financial Assistance Policy application form are available at http://www.stagnes.org/patients-visitors/financial-assistance and at Patient Financial Services Offices at Saint Agnes Hospital. Free copies of the Financial Assistance Policy and Financial Assistance Policy application also can be obtained by mail by calling 1-667-234-2140.

What If I Am Not Eligible?

If you do not qualify for financial assistance under the Financial Assistance Policy, you may ask Saint Agnes Hospital to reconsider the denial of free or reduced cost care and you may qualify for other types of assistance including a payment plan. For more information, please contact a Financial Counselor by calling 1-667-234-2140 or Customer Service @ 1-667-234-2175.

Translations of the Financial Assistance Policy, the Financial Assistance Policy application, and this plain language summary are available in the following languages upon request:

Arabic
Chinese
French
Gujarati
Italian
Korean
Persian
Russian
Spanish
Tagalog
Urdu
Vietnamese

SAINT AGNES HOSPITAL

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Please call 1-667-234-2140 for more information or visit our website @http://www.stagnes.org/patients-visitors/financial-assistance.

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What If I Am Not Eligible?

If you do not qualify for financial assistance under the Financial Assistance Policy, you may ask Saint Agnes Hospital to reconsider the denial of free or reduced cost care and you may qualify for other types of assistance including a payment plan. For more information, please contact a Financial Counselor by calling 1-667-234-2140 or Customer Service @ 1-667-234-2175.

Translations of the Financial Assistance Policy, the Financial Assistance Policy application, and this plain language summary are available in the following languages upon request:

Arabic
Chinese
French
Gujarati
Italian
Korean
Persian
Russian
Spanish
Tagalog
Urdu
Vietnamese

Appendix V

Saint Agnes Hospital Mission, Vision and Core Values

Built on a Mission of Service

Saint Agnes Hospital was founded in 1862 by the Daughters of Charity to meet the health needs of the poor. As a Catholic health care ministry and member of Ascension Health, Saint Agnes Hospital is dedicated to the art of healing to sustain and improve the lives of the individuals and communities we serve.

Our Mission

Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable.

Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities.

We are advocates for a compassionate and just society through our actions and our words.

Our Vision

Patients are our passion. Our physicians and associates are our pride. Healing is our joy.

We will be widely known for the way our physicians, nurses and associates combine sophisticated medical technology with spirituality and compassion. Shoulder-to-shoulder, we stand united in our community to care for those in need. We will be a leader in service excellence.

Our Core Values

- **Reverence:** Respect and compassion for the dignity of another
- **Integrity:** Trust through personal leadership in words and actions
- **Wisdom:** Integrates excellence and stewardship into performance improvement
- **Creativity:** Promotes innovation and meets change with vitality and enthusiasm
- **Dedication:** Affirms the hope and joy of our ministry
- **Service:** Provides service that is truly responsive to the needs of others