COMMUNITY BENEFIT NARRATIVE SHEPPARD PRATT

FY2017 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.

As provided by federal regulation (26 CFR §1.501(r)—3(b)(6)) and for purposes of this report, a **COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)** report is a written document that has been adopted for the hospital facility by the organization's governing body (or an authorized body of the governing body), and includes:

(A) A definition of the community served by the hospital facility and a description of how the community was determined;

(B) A description of the process and methods used to conduct the CHNA;

(C) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant; and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and

(F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

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 & Roadmaps (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;
(15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/); and
(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 address health needs identified by the CHNA.

Required by federal regulations, the **IMPLEMENTATION STRATEGY** is a written plan that is adopted by the hospital organization's governing body or by an authorized body thereof, and:

With respect to each significant health need identified through the CHNA, either—
(i) Describes how the hospital facility plans to address the health need; or
(ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address it.

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 total number of licensed beds
   b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
   c. Primary Service Area (PSA) zip codes;
   d. Listing of all other Maryland hospitals sharing your PSA;

e. The percentage of the hospital's uninsured patients by county. (Please provide the source for this data, e.g., "review of hospital discharge data");

f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data (e.g., "review of hospital discharge data.")

g. The percentage of the hospital's patients who are Medicare beneficiaries. (Please provide the source for this data (e.g., "review of hospital discharge data.")

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 the Hospital's Patients who are Uninsured:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
Psychiatry Towson: 322 Ellicott City: 92	8,674 Source: FY'17 Hospital Inpatient Admissions Data	21234 21204 21222 21122 21215 21228 21401 21061 21403 21212 21225 21221 21229 21206 21244 21093 21227 21136 21207 21236 21030 21045 21117 21037 21044 21060 21216 21224 21133 21144 21208	Howard County General Hospital; 21044 Johns Hopkins Bayview; 21224 MedStar Franklin Square Medical Center; 21237 MedStar Union Memorial Hospital; 21218 Northwest Hospital Center; 21133 Sinai Hospital; 21215 University of Maryland Baltimore Washington Medical	2% Source: FY'17 Hospital Inpatient Admissions Data	43% Source: FY'17 Hospital Inpatient Admissions Data	13% Source: FY'17 Hospital Inpatient Admissions Data

		21220 21218 21043 21239 21075 21213 21217 21237 21146 21214 21286 21012 21114 21113 21040 21409 21014 21157 21042 21202 21001 21209 21784 21015 21211	Center , 21061 University of Maryland St. Joseph's Medical Center; 21204 (this list represents hospitals w/psych beds physically located in our PSA)			

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 (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.

      (iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., 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).

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/Pages/home.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 Chart Book 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 (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.	Because Sheppard Pratt is a specialty hospital and therefore draws patients from a larger geographic area, the CBSA was defined by the counties from which the greatest number of patients originate. While the market areas for the Towson and Ellicott City hospitals overlap, each has areas from which they have a greater concentration of patients. Baltimore County, Baltimore City, Howard County and Anne Arundel County comprise the Sheppard Pratt CBSA. The Towson campus has a higher concentration of patients from Baltimore City and County, while Ellicott City has a greater concentration of patients from Anne Arundel and Howard Counties. Anne Arundel zip codes: The following zip codes, sorted by county, represent 60% of the inpatient admissions: **Anne Arundel** 21122 21401 21061 21403 21037 21060 21144 21146 21012 21114 21113 21409 **Baltimore County** 21234 21204 21222 21228 21221	Sheppard Pratt CHNAs, Towson & Ellicott City Campuses 2016 http://www.zipcodestogo.com/ZIP-Codes-by-County.htm

	21244 21093 21227 21136 21207 21236 21030 21117 21133 21208 21220 21237 21286 **Baltimore City** 21215 21212 21225 21229 21206 21216 21224 21218 21239 21213 21217 21214 21202 21209 21211 **Howard County** 21045 21044 21043 21075 21042 The following zip codes comprise the geographic areas where the most vulnerable populations reside, (as measured by at least 10% of the population living below the poverty level) within the	

	CBSA: Anne Arundel County 20765 21144 21226 Baltimore County 21031 21040 21052 21105 21204 21207 21220 21221 21222 21227 21244 Baltimore City 21201 21202 21205 21206 21210 21211 21212 21213 21215 21216 21217 21218 21223 21224 21225 21229 21230 21231 21239 Howard County 20701 20763 21163	
Median Household Income within the CBSA	Anne Arundel: $89,031 Baltimore: $66,940 Howard: $110,113 Baltimore City: $41,819	U.S. Census Bureau, American Community Survey. 2010-14. Source geography: Tract. (see CHNA p. 13)
Percentage of households in the CBSA with household income below the federal poverty guidelines	Anne Arundel: 5.9% Baltimore: 9.06% Howard: 5.1% Baltimore City: 24.217%	Same as above (see CHNA p. 13)

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	Anne Arundel: 7% Baltimore: 8% Howard: 5% Baltimore City: 10%	www.countyhealthrankings.org/
Percentage of Medicaid recipients by County within the CBSA.	Anne Arundel: 9.8% Baltimore: 11.4% Howard: 7.7% Baltimore City: 24.6%	Us Census: American Fact Finder; 2016 American Community Survey 1-Year Estimates
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/Pages/Home.aspx	Anne Arundel: 79.8 yrs (White: 79.9 yrs. and Black: 78.2 yrs) Baltimore County: 79.4 yrs (White: 79.5 yrs. and Black: 78.4 yrs) Howard: 83.0 yrs (White:82.8 yrs. and Black: 81.8 yrs) Baltimore City: 74.1 yrs (White: 76.8 yrs. and Black: 72.3 yrs)	Maryland Dept of Health & Mental Hygiene; Vital Statistics Annual Report; 2014
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx	Deaths per 100,000 residents (1); All Causes Mortality Maryland: 764.5 Anne Arundel: 735.5 Baltimore: 965.4 Howard: 522.5 Baltimore City: 977.7 Suicide Deaths per 100,000(2): US: 13.0 Maryland: 10.1 Anne Arundel: 10.4 Baltimore: 10.0 Howard: 8.4 Baltimore City: 8.1	(1) DHMH; Environmental Health Tracking; County Profiles 2014 (2) CDC National Vital Statistics System and SHIP, County Profiles, Demographic data, 2007-2013

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://ship.md.networkofcare.org/ph/county-indicators.aspx	Educational Attainment Percent high school graduate or higher Anne Arundel: 91.1% Baltimore: 90.2% Howard: 95.2% Baltimore City: 80.9% School Enrollment *Preschool: Anne Arundel: 6.8% Baltimore: 6.7% Howard County: 6.3% Baltimore City: 6.9% *Kindergarten: Anne Arundel: 5.5% Baltimore: 4.6% Howard: 5.0% Baltimore City: 5.3% *Elementary School: Anne Arundel: 37.1% Baltimore: 35.7% Howard: 38.0% Baltimore City: 34.0% *High School: Anne Arundel: 20.2% Baltimore: 18.1% Howard: 22.1% Baltimore City: 17% *College or graduate school: Anne Arundel: 30.4% Baltimore: 35.0% Howard: 28.5% Baltimore City: 36.8% Food Stamps/SNAP Program Benefits Anne Arundel: 5.6% Baltimore: 8.6% Howard: 4.4% Baltimore City: 22.3%	Educational Attainment American Community Survey Data 2010-2014 CHNA p. 12 School enrollment: American Factfinder 2011-2-15 American Community Survey 5-year estimates S1401 Http://statisticalatlas.com/county/maryland
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://ship.md.networkofcare.org/ph/county-indicators.aspx	Race and Ethnicity (1) Anne Arundel: African American Medicare Beneficiaries: 13.1% Hispanic Medicare Beneficiaries: 1.56% Non-Hispanic white Medicare Beneficiaries: 82.19% Other Medicare Beneficiaries:	(1) SHIP, County Profiles, Demographic data, 2013. (2) American Community Survey 2015 Data USA ACS 2014 (3) https://statisticalatlas.com/county/Maryl

	3.38% Baltimore County: African American Medicare Beneficiaries: 20.19% Hispanic Medicare Beneficiaries: 1.09% Non-Hispanic white Medicare Beneficiaries: 75.28% Other Medicare Beneficiaries: 3.44% Howard County African American Medicare Beneficiaries: 15.92% Hispanic Medicare Beneficiaries: 1.56% Non-Hispanic white Medicare Beneficiaries: 70.97% Other Medicare Beneficiaries: 11.55% Baltimore City: African American Medicare Beneficiaries: 56.27% Hispanic Medicare Beneficiaries: not available Non-Hispanic white Medicare Beneficiaries: 40.76% Other Medicare Beneficiaries: 2.02% Race and Ethnicity(2) Anne Arundel: White: 69.4% Black/African American: 16% Asian: 4% Hispanic or Latino: 7.3% All Others: 3.3% Baltimore County: White: 58.7 % Black/African American: 27.4% Asian: 6.1% Hispanic or Latino: 5.2% All Others: 2.5% Howard County White: 54.1% Black/African American: 17.8% Asian: 17.6%	and/Howard-County/Languages https://statisticalatlas.com/county/Maryland/Baltimore-City/Languages https://statisticalatlas.com/county/Maryland/Baltimore-County/Languages https://statisticalatlas.com/county/Maryland/Anne-Arundel-County/Languages

	Hispanic or Latino: 6.5% All Others: 4.0% <u>Baltimore City:</u> White: 28.2% Black/African American: 61.2% Asian: 2.7% Hispanic or Latino: 4.8% All Others: 3.0% <u>Language (3)</u> <u>% of Population by Household Language Spoken</u> <u>Anne Arundel:</u> English: 93.6% Language Other than English: 6.4% Spanish: 5.1% Korean 0.7% Tagalog: 0.63% <u>Baltimore:</u> English: 94.3% Language Other than English: 5.7% Spanish: 3.6% African: 1.2% Russian: 0.9% <u>Howard:</u> English: 89.2 % Language Other than English: 10.8% Spanish: 4.9% Korean: 3.3% Chinese: 2.6% <u>Baltimore City:</u> English Only: 94.9% Language Other than English: 5.1% Spanish: 3.7% French: 0.7% African: 0.7%	

Other	Mental Illness Statistics Depression & Anxiety Disorder Prevalence Towson Facility Service Area Baltimore County % Depressive Disorder 13.9% ; Anxiety disorder 14.4% Baltimore City % Depressive Disorder 10.4% ; Anxiety Disorder 10.4% Ellicott City Service Area Anne Arundel County % Depressive Disorder 9.4% ; Anxiety disorder 9.3% Howard County % Depressive Disorder 4.9% ; Anxiety Disorder 4.8% Maryland % Depressive Disorder 10.1%; Anxiety Disorder 10.0% Baltimore County and Baltimore City had the second and third highest concentration of depressive disorders in the state (13.9 and 10.4 respectively). The percentage of these residents with either depressive or anxiety disorders is approximately 3 times higher than some other places such as nearby Howard County. Ellicott City Service Area Anne Arundel county and especially Howard County had a much lower percentage of residents with a major depressive disorder than the state. The percentage of Howard County residents with either Depressive or Anxiety disorders is approximately 50% less than the state as a whole. In both the Towson & Ellicott	Community Benefit – Secondary Data profile Maryland Department of Health and Mental Hygiene

	City service areas, the percent of residents with serious mental illness in the previous year was somewhat similar to the Maryland average, with Baltimore city residents slightly more likely to have a serious mental illness in the past year.	

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Within the past three fiscal years, has your hospital conducted a Community Health Needs Assessment that conforms to the IRS requirements detailed on pages 1-2 of these Instructions?

_X___Yes Provide date approved by the hospital's governing body or an authorized body thereof here: 06/07 /16 (mm/dd/yy)

____No

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).

https://www.sheppardpratt.org/about/chna

This is a link to both the Towson and Ellicott City 2016 Community Health Needs Assessments.

2. Has your hospital adopted an implementation strategy that conforms to the IRS requirements detailed on pages 3-4?

__X_Yes Enter date approved by governing body/authorized body thereof here: __/ 11/15/16 (mm/dd/yy)

___No

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

https://www.sheppardpratt.org/about/chna
This is a link to both the Towson and Ellicott City 2016 implementation strategies.

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

__X_Yes
___No

If yes, please provide a specific description of how CB planning fits into the hospital's strategic plan. If this is a publicly available document, please provide a link here and indicate which sections apply to CB planning.

Sheppard Pratt Health System's first Community Benefit Needs Assessment (CHNA) was presented to and approved by the Board of Trustees on March 31, 2013. Subsequently, Community Benefit Programming was discussed as part of the Board's FY 2016 Strategic Planning Retreat. The program included the review of two new CHNAs, one developed for our Towson campus and one for our Ellicott City campus. Both CHNAs, which were completed and approved by the Board on June 7, 2016, were targeted as part of the system's evolution as well as growth for the future. The overall responsibility for the program was assigned to the Senior Vice President of Strategy and Business Development with an executive level committee named to serve as the Community Benefit Operations Committee. The group was charged with identifying and implementing strategic community benefit programming as it best fits the needs of the targeted population. An Implementation Plan was developed for each of the two CHNAs.

b. What stakeholders within the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. _X__CEO
2. __X_CFO
3. __X_Other (please specify) Senior VP of Strategy & Business Development; VP of Human Resources

Describe the role of Senior Leadership.

Senior administrative leadership, along with senior clinical leadership, provide oversight for the implementation of community benefit programs. They provide input into each initiative as it relates to their area of expertise. This year Senior Leadership along with Clinical Leadership developed the Implementation Plans for each of the two CHNAs.

ii. Clinical Leadership

1. _X__Physician (VP of Medical Affairs)
2. _X__Nurse (VP & Chief Nursing Officer)
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

Senior clinical leadership, along with senior administrative leadership, provide oversight for the implementation of Community Benefit programs. They provide input into each initiative as it relates to their area of expertise. This year Clinical Leadership along with Senior Leadership developed the Implementation Plans for each of the two CHNAs.

iii. Population Health Leadership and Staff

1. ___X_ Population health VP or equivalent (please list)
    a. Dr. Robert Roca, VP & Chief Medical Officer
    b. Bonnie B. Katz, Senior VP, Strategy & Business Development
2. ___X_ Other population health staff (please list staff)
    a. Lynn Flanigan, Community Programs Coordinator
    b. Ernestine Cosby, VP & Chief Nursing Officer

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

Our population health efforts continued to evolve during this period. The lead individuals involved in thinking about population health are our Vice President of Medical Affairs (Dr. Robert Roca), our Senior Vice President for Strategy and Business Development (Bonnie Katz), our Vice President and Chief Nursing Officer (Ernestine Cosby), and Community Programs coordinator (Lynn Flanagan).

Much of the effort in FY 2017 was focused on the implementation of a collaborative care project with GBMC, to increase access to behavioral health services in Baltimore County. We began providing behavioral health services in 9 primary care medical homes (PCMHs) operated by GBMC Primary Care Associates. Services began in the 10th site at the beginning of FY 2018. This integrated care model will help to create more capacity for mental health services in alliance with somatic care providers, will help to reduce the stigma that is often associated with seeking mental health treatment, and will help to reduce ED visits related to mental health conditions. In addition we created a new observation unit, the Behavioral Observation Service, which is intended to reduce hospital ED referrals for patients presenting for co-occurring (mental health and addictions care) as well as inpatient admissions for such care. After being medically stabilized in observation status, the patient can be evaluated to determine most appropriate level of care.

iv. Community Benefit Operations

1. ___the Title of Individual(s) (please specify FTE)
2. __X_Committee (please list members)
3. ___Department (please list staff)
4. ___Task Force (please list members)
5. ___Other (please describe)

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

Bonnie Katz, Senior VP, Strategy & Business Development is responsible for health system business development and operations initiatives. A part of her responsibilities includes Community Benefit strategic program design and implementation, including public health-related initiatives and program operations. She serves as the Chairperson of the Community Benefits Committee.

Harsh Trivedi, M.D., President and CEO is responsible for directing and supervising all facets of the health system including the operations, administration, and maintenance of all health system functions and facilities. Ultimately Dr. Trivedi is also responsible for development of long range and strategic plans, including community benefit planning. As a member of the Community Benefits Committee, he provides guidance to ensure program alignment with health system mission to serve the most vulnerable in the community served by Sheppard Pratt.

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

Ray Dziesinski, VP and Chief Financial Officer manages the health system's fiscal operations including analysis of financial policies and procedures. He ensures that the health system's financial system is accurate, efficient and in accordance with standard financial practices as well as government regulations. On the Community Benefits Committee, Mr. Dziesinski acts as the fiscal consultant.

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

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

Spreadsheet _X____yes _____no

Narrative __X__yes _____no

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

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

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

Spreadsheet ___X__yes _____no

Narrative __X___yes _____no

If no, please explain why.

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

_____Yes ____X___No

If yes, please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

The hospital does not currently have a Strategic Transformation Plan.

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

_____Faith based community organizations

_____Social service organizations

_____Post-acute care facilities

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct a CHNA. Provide a brief description of collaborative activities indicating the roles and responsibilities of each partner and indicating the approximate time period during which collaborative activities occurred (please add as many rows to the table as necessary to be complete).

Organization	Name of Key Collaborator	Title	Collaboration Description

Sheppard Pratt did not specifically collaborate with any "core partners" in conducting the most recent CHNAs. However, there were many participants in our qualitative research process, representing local health care providers, health departments, and social service organizations to name a few, from both the Towson and Ellicott City service areas. A list of these participants can be found on pages 30-31 of the Towson CHNA report and on pp. 28-29 of the Ellicott City CHNA report.

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

_____yes __X___no

If the response to the question above is yes, please list the counties for which a member of the hospital organization co-chairs the LHIC.

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

_____yes __X___no

If the response to the question above is yes, please list the counties in which a member of the hospital organization attends meetings or is a member of the LHIC.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Please use Table III to provide a clear and concise description of the primary need identified for inclusion in this report, 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.

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

a. 1. Identified need: This may have been identified through a CHNA, a documented request from a public health agency or community group, or other generally accepted practice for developing community benefit programs. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include a description of the collaborative process used to identify common priority areas and alignment with other public and private organizations.

   2. Please indicate how the community's need for the initiative was identified.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based community health improvement initiatives may be found on the CDC's website using the following links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/), or from the County Health Rankings and Roadmaps website, here: http://tinyurl.com/mmea7nw.
   (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 or other negative health factor 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,

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. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.

h. Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.

   Describe here the measure(s)/health indicator(s) that the hospital will use to evaluate the initiative's impact. The hospital shall evaluate the initiative's impact by reporting (in item "i. Evaluation of Outcome"):

   (i) Statistical evidence of measurable improvement in health status of the target population. If the hospital is unable to provide statistical evidence of measurable improvement in health status of the target population, then it may substitute:

(ii) Statistical evidence of measureable improvement in the health status of individuals served by the initiative. If the hospital is unable to provide statistical evidence of measureable improvement in the health status of individuals served by the initiative, then it may substitute:

(iii) The number of people served by the initiative.

Please include short-term, mid-term, and long-term population health targets for each measure/health indicator. These should be monitored and tracked by the hospital organization, preferably in collaboration with appropriate community partners.

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? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)

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? If not, why? 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, and grants associated with the fiscal year being reported.
B. Of the total costs associated with the initiative, what amount, if any, was provided through a restricted grant or donation?

A. 1. Identified Need A. 2. How was the need identified:	1. **Access to Information on Autism for the General Community and for Families Dealing with Autistic Children** (Applies to both Towson & Ellicott City campuses.) 2. According to the Centers for Disease Control and Prevention, "about 1 in 68 children have been identified with autism spectrum disorder (ASD)". In Maryland, the CDC has found the number to be slightly higher; 1 in 60 children have been diagnosed with the disorder (CDC Community Report on Autism 2014). This need was identified in the 2013 CHNA. The Health System had historically received numerous telephone and email inquiries asking for information on autism.
B: Name of hospital initiative	**Provision of Autism Specialty Pages within Sheppard Pratt's Virtual Resource Center**
C: Total number of people within target population	According to the American FactFinder 2011 to 2015 5 Year Population Estimates, in the combined Towson and Ellicott City CBSAs, the 2015 total population under age 18 is 660,491. Applying the CDC's autism rate for Maryland, it is estimated that approximately 11,008 children have been diagnosed with an Autism Spectrum Disorder in our CBSA.
D: Total number of people reached by the initiative	In FY 2017, there were 1,303 people reached, as measured by the number of views of the Autism page.

E: Primary objective of initiative:	To increase the community's awareness and knowledge of mental and behavioral health issues by providing outreach, education, training and resources. The enhanced resource center provides autism-specific information, with links to support services, informative blogs, news articles, helpful sites to visit as well as service and advocacy organizations, a facts list, and resources for parents.
F: Single or multi-year plan:	Multi-Year – Sheppard Pratt continues to be supportive of the community's need for resources addressing the concerns of families dealing with and autism spectrum disorder.
G: Key collaborators in delivery:	Development of this initiative was invested in the previous 2 fiscal years by Bonnie Katz, Jessica Kapustin, Chelsea Soobitsky, and the web development consultant. Ongoing content updates continue to be provided by Jessica Kapustin and Kristina Schiller, with input obtained from the web site, doctors, family members as well as web development consultants.
H: Impact of hospital initiative:	The impact of the initiative is measured by evaluating the number of page views with the goal of increasing the number of views experienced each year.
I: Evaluation of outcome	Outcomes were measured by the increasing number of

	page views experienced year to year. FY 2014 page views: 39 FY 2015 page views: 1,194 FY 2016 page views: 1,168 FY 2017 page views: 1,303 In the most recent year, we experienced an 11.5% increase in the number of page views.	
J: Continuation of initiative:	This initiative will be continued, due to the prevalence of this disorder and the fact that the number of viewers has continued to increase over the 4 years since the page was originally created.	
K: Expense:	a. Costs associated with this initiative. None in this fiscal year.	b. Direct offsetting revenue from Restricted Grants or Donations ? N/A

A. 1. Identified Need: A. 2. How was the need identified:	1. **Community Education – Parent Lecture Series or Events** (Applies to both Towson & Ellicott City campuses.) 2. Sheppard Pratt's program was developed in response to input from community members as well as and comments received through the web site, Admissions, and Sheppard Pratt's Crisis Walk In Program. The Maryland SHIP 2012 Program Measures; Healthy Social Environments, Objective 7 aims to reduce child maltreatment to 4.8 children per 1,000 by 2014. The baseline was cited as 5.0 children suffering from maltreatment per 1,000 children in 2010 as compared to a national baseline of 9 per 1,000 in 2008. Current data (2015) shows that the statewide rate is still 5.0 per 1,000. In addition, as shown below, the maltreatment rates in most of the counties in Sheppard Pratt's CBSAs are significantly higher than the statewide rate: Baltimore City: 20.5/1,000 Baltimore County: 8.5/1,000 Anne Arundel County: 6.0/1,000 Howard County: 2.3/1,000
B: Name of hospital initiative	**Community Education – Parent Lecture Series or Events**
C: Total number of people within target population	Target population includes the Towson CBSA (Baltimore City and Baltimore County)and the Ellicott City CBSA (Howard and Anne Arundel Counties). The Under Age 18 population in the Towson CBSA is 310,310 and the Under Age 18 population in the Ellicott City CBSA is 199,725. Applying the statewide maltreatment estimate to the Sheppard Pratt CBSAs, shows that over 2,550 children could be suffering from maltreatment. This number is even higher if the county specific maltreatment rates are applied.

D: Total number of people reached by the initiative	There were 150 people who attended this lecture.	
E: Primary objective of initiative:	To increase the community's awareness and knowledge of mental and behavioral health issues by providing outreach, education, training and resources, including free lectures on parenting and issues important for child and adolescent development.	
F: Single or multi-year plan:	Multi Year	
G: Key collaborators in delivery:	Sheppard Pratt: Jessica Kapustin, Kim Gordon, M.D., Kathleen Gallagher, Deanna Miller, Kristina Schilling	
H: Impact of hospital initiative:	Impact of the initiative is measured by the number of people who attended the lecture.	
I: Evaluation of outcome	This initiative is intended as ongoing community education and enlightenment where attendees are able to speak with a health care professional in a normalized environment. This year Dr. Kim Gordon provided a session entitled "Help! I'm the Parent of an Anxious Child!" at the Sheppard Pratt Conference Center . Attendance at this event was 150, which was more than double the attendance at last year's two parent lectures combined.	
J: Continuation of initiative:	This effort will continue into 2018.	
K: Expense:	a. Costs associated with this initiative. $80	b. Direct offsetting revenue from Restricted Grants or Donations? N/A

A. 1. Identified Need: A. 2. How was the need identified:	1. **Violence Prevention in our School Systems** (Applies to both Towson & Ellicott City campuses.) 2. The identified need for violence prevention in our school systems is widely publicized through tragic events occurring throughout our country. In 2008, Maryland convened a Summit on School Safety Solutions in which prevention rather than punishment was a focus as well as helping students to learn alternatives to violence when confronted with a difficult situation. Professional development and the Positive Behavioral Intervention and Supports Program were cited as a valuable stepping stones toward peaceful school environments.
B: Name of hospital initiative	**Positive Behavioral Intervention and Supports Program (PBIS)**
C: Total number of people within target population	Including both public and private schools, there are 2,240 schools serving an estimated 1,027,313 children. (Maryland Public School Education Bug; Private & Public School Directories)
D: Total number of people reached by the initiative	In FY '17 222 training sessions were held throughout the state and these sessions were attended by more than 2,700 people.
E: Primary objective of initiative:	To engage teachers and school system staff in professional education sessions in order to better prepare them to identify students with mental health needs. The PBIS network supports the implementation of Positive Behavioral Interventions and Supports in state, local, and community agencies.
F: Single or multi-year plan:	Multi-year plan.

G: Key collaborators in delivery:	Sheppard Pratt: Jim Truscello, Director Day School Programs Susan Barrett, PI and Director Education Grants Jerry Bloom, Coordinator, Education Grants Patty Hershfeldt, Ph.D., Asst Dirctor, Educationl Grants Others: Maryland State Department of Education: Kristina Kyles-Smith, Asst. State Superintendent Bonnie Van Metre, M.Ed, Behavioral Specialist Johns Hopkins: Philip Leaf, Director, Center for the Prevention of Youth Violence Catherine Bradshaw, Ph.D., Director, Center for the Prevention of Youth Violence	
H: Impact of hospital initiative:	The impact of this initiative is measured by the number of schools trained in the PBIS program, the number of individuals who have attended various PBIS trainings, and the number of schools actively implementing the model.	
I: Evaluation of outcome	In 2017 there were 222 training sessions held and they were attended by approximately 2,700 people. To date, 1,100 Maryland schools have been trained in PBIS (almost 50% of all schools), with 855 of those schools actively implementing the model.	
J: Continuation of initiative:	Yes, this initiative will continue into FY 2018.	
K: Expense:	a. Costs associated with this initiative. $2,260,966.70	b. Direct offsetting revenue from Restricted Grants or Donations? $2,260,966.70

A. 1. Identified Need: A. 2. How was the need identified:	1. **Behavioral health training in school systems for teachers and other school staff**. (Applies to both Towson & Ellicott City campuses.) 2. As a key provider of special education services to education systems throughout Maryland, Sheppard Pratt education staff have gained insight as to the need for behavioral health training to assist teachers and other staff in developing positive student relationships.
B: Name of hospital initiative	**Life Space Crisis Intervention (LSCI) Training Program**
C: Total number of people within target population	There are approximately 995 schools located in the 4 counties where training was conducted this year. (Baltimore, Howard, Anne Arundel, and Prince George's Counties)
D: Total number of people reached by the initiative	3,000 people were trained in FY 2017
E: Primary objective of initiative:	To provide school staff with an intensive experiential training, integrating evidenced-based practices related to prevention and integration, behavioral management and modification, resulting in positive student relationships with school staff.
F: Single or multi-year plan:	Multi Year
G: Key collaborators in delivery:	Sheppard Pratt: Jim Truscello, Director Day School Programs Abby Potter, Coordinator Educational Development and Training
H: Impact of hospital initiative:	Sheppard Pratt has partnered with Baltimore County and University of

	Maryland to collect data on the effectiveness of Life Space Crisis Intervention. Training for professionals working in comprehensive school programs. This 3 year study will produce outcomes by the end of 2017. Currently, Sheppard Pratt gauges outcomes by the number of staff trained and the number of schools requesting training.	
I: Evaluation of outcome	Approximately 3,000 school staff received this training in FY 2017. These trainings occurred in Howard, Prince George's, Baltimore, and Anne Arundel counties.	
J: Continuation of initiative:	Yes, this initiative will continue into FY 2018.	
K: Expense:	a. Costs associated with this initiative. $37,658.88	b. Direct offsetting revenue from Restricted Grants or Donations? N/A

A. 1. Identified Need: A. 2. How was the need identified:	1**. Reduction of stigma related to the understanding and treatment of mental illness and related conditions.** (Applies to both Towson & Ellicott City campuses.) 2. Suicide is highly correlated with mental health& substance abuse disorders. The State Health Improvement Process (SHIP) indicated that in Maryland, approximately 500 lives are lost each year to this preventable cause of death. Theoretically, fewer lives would be lost if the stigma against treatment were removed. Stigma reduction was one of the most consistently recognized needs across all respondent groups in both of our 2016 CHNAs. (Towson & Ellicott City)
B: Name of hospital initiative	**Stigma Reduction**
C: Total number of people within target population	The total target population is 2,282,182. This includes the Towson CBSA population (Baltimore City and Baltimore County) and the Ellicott City CBSA population (Howard and Anne Arundel Counties).
D: Total number of people reached by the initiative	A survey of attitudes toward mental illness was conducted in late FY 2017 to establish a baseline for the development of future anti-stigma education campaigns. There were 374 surveys completed with an 87% completion rate.
E: Primary objective of initiative:	To reduce the stigmas for individuals seeking treatment for mental illnesses and substance abuse.
F: Single or multi-year plan:	Multi Year.
G: Key collaborators in delivery:	Jessica Kapustin

	Kristina Schiller	
H: Impact of hospital initiative:	A reduction in stigma associated with seeking mental health and substance abuse treatment as measured by future surveys.	
I: Evaluation of outcome	No outcomes to be evaluated at this time. The school systems with which we work are actively engaged in outcomes development.	
J: Continuation of initiative:	This initiative will be continued in FY 2018.	
K: Expense:	a. Costs associated with this initiative. None	b. Direct offsetting revenue from Restricted Grants or Donations? None

A. 1. Identified Need: A. 2. How was the need identified:	1. **Availability of Outpt. Services for General Psychiatric Conditions** (Applies to Ellicott City campus.) 2. The research conducted in the development of the 2016 CHNA for Sheppard Pratt Ellicott City revealed that although many individuals have private health insurance, there are fewer providers who accept Medicaid/Medicare. Child and Geriatric Psychiatry were highlighted as some of the greater areas of need among lower income households.
B: Name of hospital initiative	**Outpatient Services for General Psychiatric conditions and All Age Groups** This initiative was identified in the CHNA Implementation Plan for Sheppard Pratt Health System – Ellicott City.
C: Total number of people within target population	The Ellicott City CBSA population is 836,769, of which 202,070 are under the age of 18, and 105,873 are ages 65 and over.
D: Total number of people reached by the initiative	The program started mid-year and 18 children are being followed at Way Station's Howard County mental health clinic through telemedicine at this time.
E: Primary objective of initiative:	To expand the availability of outpatient mental health services for general psychiatric conditions, particularly the for the child and geriatric populations with public insurance. In FY'17 we began to provide child psychiatry time at no charge to Way Station's Howard County mental health clinic to help them meet the need for urgent crisis assessment of children. This service is provided via the medium of telemedicine from our Towson location to Howard County.

F: Single or multi-year plan:	Multi Year.	
G: Key collaborators in delivery:	Bonnie Katz Katie Wilburn Benedicto Borja, M.D. Way Station of Howard County: Cortina Darden	
H: Impact of hospital initiative:	Impact will be measured based on the number of services provided.	
I: Evaluation of outcome	We began this initiative in September of 2016 and provided a total of 60.25 hours of service to 18 patients at Way Station in FY '17.	
J: Continuation of initiative:	This initiative will be continued in 2018 and we will continue to explore opportunities to further expand outpatient services in collaboration with partners throughout Howard County.	
K: Expense:	a. Costs associated with this initiative. $9,037.50	b. Direct offsetting revenue from Restricted Grants or Donations? N/A

A. 1. Identified Need: A. 2. How was the need identified:	1. **Provision of telepsychiatry services to those in medically underserved counties in Maryland, where recruitment and retention of clinical staff is difficult, resulting in unreasonably long wait times for services.** 2. The HSRA has identified most of the Eastern Shore counties as mental health Health Professional Shortage Areas (HPSAs), including the three counties targeted in this initiative.
B: Name of hospital initiative	**Telepsychiatry Program**
C: Total number of people within target population	The targeted community identified in this initiative includes populations of Cecil, Wicomico, and Worcester counties, which totals 256,292.
D: Total number of people reached by the initiative	In FY 2017 there were 713 active clients.
E: Primary objective of initiative:	The primary objective s are to increase access to psychiatry services through the medium of video conferencing in areas with inadequate mental health resources; decrease wait time for mental health services; and provide services that will lessen the likelihood of an emergency room visit.
F: Single or multi-year plan:	Multi Year
G: Key collaborators in delivery:	Sheppard Pratt Staff: Bonnie Katz, Senior VP, Strategy & Business Development Benedicto Borja, M.D., Telepsychiatry Medical Director Doloras Branch, Telepsychiatry Program Manager Katie Wilburn, Telepsychiatry Practice Administrator

	Atlantic Health Clinic: Kim Parce Cecil County Health Department: Shelly Gulledge Lower Shore Clinic: Kristine Garlitz Wicomico County Health Department: Michelle Hardy Worcester County Health Department: Mike Trader	
H: Impact of hospital initiative:	The impact of the initiative is measured by the number of active clients, the number of encounters provided, and the hours of service.	
I: Evaluation of outcome	In FY 2017, 1,661 encounters were provided to 713 active clients. The encounters included 403 initial evaluations and 1,258 medication management sessions for a total of 1,503.75 hours of clinical service. (Note: these numbers exclude the Telepsychiatry Medical Demonstration project reported separately).	
J: Continuation of initiative:	Yes, this effort will continue into FY 2018 in order to provide services in areas where clinical shortages exist.	
K: Expense:	a. Costs associated with this initiative. $160,588.59	b. Direct offsetting revenue from Restricted Grants or Donations? None

A. 1. Identified Need: A. 2. How was the need identified:	1. **Reduce the utilization of hospital emergency rooms for those suffering from a behavioral health crisis or emergency. (Applies to the Towson campus.)** 2. As identified in the Maryland State Health Improvement Process (SHIP), Objective 34, crisis utilization of ERs for those with behavioral health crises places a strain on the health care system.
B: Name of hospital initiative	**Crisis Services**
C: Total number of people within target population	According to the Maryland Hospital Association's Behavioral Health Task Force's Environmental Scan, September 2016 release (revised January 2017), there were 52,271 behavioral health ED visits in CY 2015, from Sheppard Pratt's combined CBSAs.
D: Total number of people reached by the initiative	4,723 Total 4,212 in the Crisis Walk In Clinic 511 in the Crisis Response Outpatient Program
E: Primary objective of initiative:	Service the needs of individuals in a mental health crisis, in settings other than hospital Emergency Rooms.
F: Single or multi-year plan:	Multi Year.
G: Key collaborators in delivery:	Sheppard Pratt staff: Bonnie Katz, Senior VP, Strategy & Business Development Benedicto Borja, M.D., Medical Director, Crisis Walk In Clinic
H: Impact of hospital initiative:	Impact will be evaluated by the number of individuals

	served by our Crisis Walk In Clinic (CWIC) and our Crisis Response Outpatient Program (CROP)	
I: Evaluation of outcome	In FY 2017, 4,723 individuals were provided with an urgent or emergency behavioral health assessment by an M.D., were evaluated for safety, and triaged to the appropriate level of care, including referral to a Crisis Outpatient Program.	
J: Continuation of initiative:	Yes, this initiative will be continued in FY 2018, as the need is ongoing.	
K: Expense:	a. Costs associated with this initiative. $1,592,276.60	b. Direct offsetting revenue from Restricted Grants or Donations? $730,460.05

A. 1. Identified Need: A. 2. How was the need identified:	1. **A resource for individuals seeking behavioral health services to help them understand where and how to access their benefits**. (Applies to both Towson & Ellicott City campuses.) 2. As part of Sheppard Pratt's joint Health Needs Assessment in 2013, Mental Health/Suicide was reported to be the third most frequently selected health issue. Further, respondents indicated that the resources available for the treatment of mental health issues as being insufficient. The Maryland Behavioral Risk Factor Surveillance system reported a higher proportion of Greater Baltimore residents (16.3%) have been diagnosed with a depressive disorder compared to Maryland (13.6 percent). The Affordable Care Act has engulfed the health care delivery system with individuals seeking behavioral health services and without a resource to help them understand where and how to access their benefits. This service fills that needs gap.
B: Name of hospital initiative	**Therapy Referral Service**
C: Total number of people within target population	The total target population is 2,282,182. This includes the Towson CBSA population (Baltimore City and Baltimore County) and the Ellicott City CBSA population (Howard and Anne Arundel Counties).
D: Total number of people reached by the initiative	In FY 2017, free access to the service database was provided to 12,181 callers. Of those callers, 2,160 were provided with referrals or appointments.
E: Primary objective of initiative:	Provide mental health referral information to the public in a free, confidential manner that is personalized to the individual needs of the community member.

F: Single or multi-year plan:	Multi Year	
G: Key collaborators in delivery:	Participating hospital staff include: Bonnie Katz, Senior VP, Strategy & Business Development Robert Roca, M.D., MPH, VP, Chief Medical Officer	
H: Impact of hospital initiative:	Impact of the initiative is tracked by the number of callers served.	
I: Evaluation of outcome	In FY 2017, free access to the service database was provided by clinically trained staff to 12,181 callers. Staff evaluates the caller's issue and makes a preliminary assessment before providing a list of the appropriate clinical resources in the community. Of the callers served, 2,160 were provided with referrals or appointments.	
J: Continuation of initiative:	Yes, this initiative will continue into FY 2018 as Sheppard Pratt will continue providing referral services to those in need.	
K: Expense:	a. Costs associated with this initiative. $451,698.99	b. Direct offsetting revenue from Restricted Grants or Donations? N/A

A. 1. Identified Need: A. 2. How was the need identified:	1**. Access to mental health services for low income and uninsured individuals in the CBA**. (Applies to Towson & Ellicott City campuses.) 2. According to the US Census, approximately 11%, or 272,212 of the Community Benefit Area (Baltimore City, Anne Arundel, Baltimore, and Howard Counties) are living below the poverty level. NIH estimates that approximately 18% , or 48,998 of these individuals may suffer from a mental illness.
B: Name of hospital initiative	**Services for Low Income & Uninsured Individuals**
C: Total number of people within target population	The target population is the low income and uninsured population of the two CBSAs. As stated earlier, the Population of CBSAs living below the poverty level is estimated at 272,212. In addition, the US Census Bureau estimates that the uninsured population under the age of 65 in the combined CBSAs is 149,287.
D: Total number of people reached by the initiative	Uncompensated care was provided to 1,504 individuals.
E: Primary objective of initiative:	To provide treatment and support services to low income and uninsured individuals as available by connecting them with insurance coverage, financial assistance and support programs.
F: Single or multi-year plan:	Multi Year.
G: Key collaborators in delivery:	Harsh Trivedi, M.D., Chief Executive Officer Robert Roca, M.D. , Chief Medical Officer Bonnie Katz, Senior VP, Strategy & Business Development Gerald Noll, Treasurer Ray Dziesinski, Chief Financial Officer

H: Impact of hospital initiative:	Outcomes are evaluated by the number of patients served.	
I: Evaluation of outcome	$ 5,473,873 of uncompensated care was provided in FY 2017. This care was delivered to 1,504 individuals, of whom, 985 resided in either the Towson or Ellicott City CBSA. In addition, 531 individuals were provided assistance with connecting for insurance coverage and other government support programs.	
J: Continuation of initiative:	This initiative will continue in FY 2018.	
K: Expense:	a. Costs associated with this initiative. $5,473,873	b. Direct offsetting revenue from Restricted Grants or Donations? None

A. 1. Identified Need: A. 2. How was the need identified:	1. **Statewide need for quality mental and behavioral health information, treatment, and support.** (Applies to both Towson & Ellicott City campuses.) 2. This need was identified in Sheppard Pratt's 2013 Community Health Needs Assessment.
B: Name of hospital initiative	**Professional Education Series including the Wednesday Lecture Series and other professional Educational offerings as needs are identified.**
C: Total number of people within target population	The target population is the mental health professionals located in the Towson and Ellicott City CBSAs.
D: Total number of people reached by the initiative	There were 3,138 members of the community who attended our Professional Education Series in FY 2017.
E: Primary objective of initiative:	To provide the latest mental health information to mental health, medical, human service and educational professionals, at no charge. Our goal is to provide education that advances clinician knowledge, enhances competence, practice of performance, and where possible, improves outcomes for patients with psychiatric disorders.
F: Single or multi-year plan:	Multi Year
G: Key collaborators in delivery:	Harsh Trivedi, M.D., Chief Executive Officer Robert Roca, M.D., Chief Medical Officer

	Bonnie Katz, Senior VP, Strategy and Business Development Jennifer Tornabene, Professional Education Manager	
H: Impact of hospital initiative:	Competencies for all attendees at all sessions are graded prior to and after the session so that the impact on clinical practice can be evaluated.	
I: Evaluation of outcome	Attendees at all sessions are graded prior to and after the session so that the impact on clinical practice can be evaluated. For example, a session entitled "Anxiety & Stress Related Disorders in Children & Adolescents" was held on November 2, 2016. Attendee pre and post case study testing demonstrated a 5% improvement and 82% of attendees felt the session content would impact their practice. Attendee comments included: "Will increase screening effectiveness for anxiety"; "Better understanding of presenting behaviors in children. Better understanding of treatment options, specifically in medication."	
J: Continuation of initiative:	Sheppard Pratt will continue educational efforts in FY 2018.	
K: Expense:	a. Costs associated with this initiative. $41,162	b. Direct offsetting revenue from Restricted Grants or Donations? N/A

A. 1. Identified Need: A. 2. How was the need identified:	1. **Inadequate mental health resources in multiple medically underserved rural Maryland counties.** 2. This need was identified by the CareFirst Foundation who awarded the grant to Sheppard Pratt for this project. The entire populations of the 4 counties in the initiative reside in mental health Health Professional Shortage Areas (HPSAs).
B: Name of hospital initiative	**Care Integration with Maryland FQHCs**
C: Total number of people within target population	The target population includes the populations of Cecil, Wicomico, Caroline, and Garrett counties, which totals 266,791.
D: Total number of people reached by the initiative	In FY 2017 there were 388 active clients.
E: Primary objective of initiative:	To provide co-location of behavioral health care utilizing videoconferencing within four Federally Qualified Health Centers located in rural Maryland settings.
F: Single or multi-year plan:	Multi Year; Began in FY 2015 and ending in FY 2017
G: Key collaborators in delivery:	Bonnie Katz, Vice President Business Development Benedicto Borja, M.D., Telepsychiatry Medical Director Doloras Branch, Program Manager

	Katie Wilburn, Telepsychiatry Program Administrator Choptank Community Health System: Jonathan Moss, M.D. Mountain Laurel Health Center: Charles Wilt Three Lower Counties Clinic: Sue Gray West Cecil Health Center: John Ness	
H: Impact of hospital initiative:	Outcomes are evaluated by the number of clients served and services provided, patient satisfaction with service, and clinical improvement as measured by PHQ9 data.	
I: Evaluation of outcome	Outcomes are evaluated by the number of services provided, patient satisfaction with service, and clinical improvement as measured by PHQ9 data. In FY 2017, 930 services were provided to 388 active clients with 981.25 hours of clinical service. This represents a 17.1% increase in visits, a 13.4% increase in clients, and a 16.1% increase in clinical service hours over the previous year. There were 130 Evaluations and 800 Follow ups provided. Satisfaction with the program remains high with 88.7% reporting their needs were met during the session and 88.6% reporting that they received good care and increase of 1.5% and 6.2% respectively, over the previous year. Client reporting on how difficult their mental health problems have made it for them to do their work or get along with others reveals a 24 percentage point improvement between 1st and 3rd sessions during this fiscal year, which is a 9 percentage point improvement over last fiscal year.	
J: Continuation of initiative:	This initiative ended in FY 2017.	
K: Expense:	a. Costs associated with this initiative. $128,201.87	b. Direct offsetting revenue from Restricted Grants or Donations? $141,337.50

A. 1. Identified Need: A. 2. How was the need identified:	1. **Access to mental health services delivered on an integrated care basis.** (Applies to both Towson and Ellicott City campuses.) 2. Primary research conducted for our 2016 CHNAs for both the Towson and Ellicott City campuses identified a lack of communication and coordination between medical and behavioral health care service providers. It also identified a stigma on the part of some medical service providers that results in the inappropriate identification and referral of patients who need behavioral health care.
B: Name of hospital initiative	**Behavioral Health Integrated Care**
C: Total number of people within target population	The target population is the 77,000 lives enrolled in the 10 GBMC Primary Care Medical Homes.
D: Total number of people reached by the initiative	There were 738 people reached by the initiative in FY 2017.
E: Primary objective of initiative:	To deliver integrated care in a collaborative care model with Primary Care Associates of GBMC in order to broaden access to care and support the integration of somatic and behavioral care. A secondary objective would be to reduce stigma on the part of medical providers and to reduce stigma related to the understanding and treatment of mental illness and related conditions.
F: Single or multi-year plan:	Multi Year
G: Key collaborators in delivery:	Robert Roca, M.D. Primary Care Associates of GBMC Lynn Flanigan Robin Motter-Mast, DO Kolmac Clinic

H: Impact of hospital initiative:	The impact of this initiative will be measured by the number of primary care sites staffed, the number of visits provided, and the number of individuals served.	
I: Evaluation of outcome	There were 708 behavioral health care visits and 343 consulting psychiatrist visits provided in 9 sites in FY 2017. Service began in the 10th location in August of 2017 and will be included in next year's report.	
J: Continuation of initiative:	This initiative will be continued in FY 2018.	
K: Expense:	a. Costs associated with this initiative. $581,231.06	b. No Direct offsetting revenue from Restricted Grants or Donations? none this year

A. 1. Identified Need: A. 2. How was the need identified:	1**. Smoking Cessation Initiatives** (Applies to both the Towson and Ellicott City campuses.) 2. Americans with mental illness have a 70% greater likelihood of smoking than the general population according to the Centers for Disease Control and Prevention. People with serious mental illness die, on average, 25 years earlier than those without mental illness. Smoking is the main preventable contributing factor to this problem.
B: Name of hospital initiative	**Smoking Cessation Program**
C: Total number of people within target population	The target population for FY 2017 was all patients admitted to the adult and co-occurring inpatient units on our Towson & Ellicott City campuses, and the 3 Adult Day Hospitals on the Towson campus (Adult, Co-occurring, and Sullivan), who reported as having smoked within the last 30 days. Total admissions to these programs was 5,597. Of this total, 2,621 (47%) were smokers.
D: Total number of people reached by the initiative	Of the 2,621 identified smokers, 1,736 (66%) received some type of treatment (group therapy and/or individual counseling). In addition, the identified smokers were offered nicotine replacement therapy (NRT), of which almost 80% accepted and used it.
E: Primary objective of initiative:	To provide people with the tools they need to successfully quit smoking as part of their recovery process. By integrating smoking cessation treatment into ongoing treatment, we are able to more effectively help our patients quit and remain smoke-free.
F: Single or multi-year plan:	Multi Year
G: Key collaborators in delivery:	Robert Roca, M.D. Rachel Smolowitz, Ph.D.
H: Impact of hospital initiative:	The impact of this initiative will be measured by the number of patients who are screened for tobacco and nicotine use; the number of patients who receive smoking cessation counseling; and the number of

	patients who receive smoking cessation treatment.	
I: Evaluation of outcome	At the beginning of FY 2017 43% of patients who smoke received individual counseling, yet by the end of FY 2017 that figure had increased to 70 percent. In year 1 of the program, approximately 1,250 patients received some type of smoking cessation treatment. In FY 2017 that number increased to 1,736, and increase of 38.8%.	
J: Continuation of initiative:	This initiative will be continued in FY 2018.	
K: Expense: $92,958.41	a. Costs associated with this initiative. $92,958.41	b. Direct offsetting revenue from Restricted Grants or Donations? $84,999.00

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples: the fact that another nearby hospital is focusing on that identified community need, or that the hospital does not have adequate resources to address it.) This information may be copied directly from the section of the CHNA that refers to community health needs identified but unmet.

Towson CHNA

The 2016 CHNA for the Towson campus identified 29 community health needs, all related to mental health or substance abuse issues. As a result of the ranking methodology deployed by the Community Benefits Operations Committee, six initiatives were prioritized as the new initiatives on which to focus over the three year period. Of the six, the hospital began to work on two of them in FY 2017. These initiatives were reported in Table III. The next set of nine initiatives were determined to have high need and benefit to the community as well as high feasibility potential. However, given finite resources and capacity within Sheppard Pratt to implement them, there are no plans to introduce these initiatives at this time, but they will continue to be considered over time. The remaining 14 recommendations were ranked as either low need (due to availability of comparable services) or lower feasibility in terms of the ability to successfully implement or operationalize the solution. For these initiatives, we will continue to consider more viable options to meet these identified needs over time.

Ellicott City CHNA

The 2016 CHNA for the Ellicott City campus identified 25 community health needs. As a result of the ranking methodology deployed, six initiatives were prioritized as the new initiatives on which to focus over the three year period. Of the six, the hospital began to work on two of them in FY 2017. These initiatives were reported in Table III. Of the remaining 19 recommendations, four were determined to be low need and those recommendations will not be pursued. With respect to the remaining 15 recommendations, because of limited resources and the intensity of focus on the development of the Elkridge campus, we will not pursue these other identified needs at this time but will incorporate some of them into multi-year planning for the expanded campus in Elkridge.

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

Maryland Health Improvement Process (SHIP). As a specialty psychiatric-only hospital, Sheppard Pratt Health System is limited as to its Community Benefit impact within SHIP designated improvement areas. The areas of impact, as shown below, include Healthy Communities, Quality Preventive Care; Health Care Access, and Healthy Living.

Healthy Communities

Child Maltreatment

- Sheppard Pratt sponsored a Parent Lecture to provide parent education for those interested in anxiety in children

Reducing the Suicide Rate

- Sheppard Pratt's Therapy Referral Service continues to provide information on access to suicide hotlines as well as numerous mental health support and treatment programs

- Sheppard Pratt's crisis programming provides suicide assessments and immediate safety plans when needed.

Health Care Professionals are given access to free professional education opportunities through Sheppard Pratt. This year, selected sessions focused on topics related to both Child Maltreatment and Suicide. Titles included "Suicide Prevention in Health Care Systems" and "Anxiety & Stress Related Disorders in Children & Adolescents."

Reduce Fall-related death rate

- Fall prevention is a patient safety goal throughout the hospital and it has been given particular attention on the Geriatric units. There are currently fall prevention protocols in place on these units.

Quality Preventive Care

Reducing Hospital ED Visits Related to Mental Health Conditions and/or Addictions

- Crisis Response Programs include: 1) Crisis Walk-In Clinic, 2) Crisis Response Outpatient Program; 3) Scheduled Crisis Intervention ; 4) Urgent Assessment Programs; and 5) Behavioral Observation Service. All provide emergency room alternatives through a face-to-face evaluation. As clinically indicated, immediate safety evaluations are provided as well as appropriate treatment and referral recommendations.

Increase the % Vaccinated Annually for Seasonal Influenza

- Flu vaccines are offered to all clients, including children, during the flu season.

Healthcare Access

Increasing the proportion of persons with health insurance

- Sheppard Pratt's Entitlement Specialist and all Social Workers provide patients and families with resources and assistance to access government support programs. This includes application assistance if requested.

Participation in medical health home concept through Sheppard Pratt's affiliate agencies

- Residential and Psychiatric Rehabilitation Program members receive some basic primary care through their mental health program

Healthy Living

Reduce the % of Adults who are current smokers

- Continued efforts to promote smoke-free communities and the implementation of our Smoking Cessation program, including provision of the services of a Tobacco Dependence Coordinator.

Reduce the % of Children Who are Considered Obese

- Childhood obesity has been a focus of our prescribing physicians in our inpatient, residential and school programs. We have been part of research studies that validate correlation of certain pharmaceutical weight gains and weight gain/metabolic syndrome. This is an ongoing area of focus in terms of prescribing activities.

PHYSICIANS

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

Sheppard Pratt is a specialty hospital. Ninety percent of Sheppard Pratt's medical staff are Sheppard Pratt-employed psychiatrists. The system is staffed at this level due to attrition, etc., and has developed a method for distributing

resources evenly across programs rather than assigning psychiatrists by program type. This method of allocation has allowed the health system to continue to serve patients in need of care without any gap in availability of specialist.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please 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	The health system subsidizes hospital-based physician salaries when they are negatively impacted by charity care or low reimbursement rates. This approach has been adopted in order to continue to offer mental health specialty services to the community as well as to insure full physician coverage without any gaps in the availability of psychiatric specialists.
Non-Resident House Staff and Hospitalists	
Coverage of Emergency Department Call	Sheppard Pratt does not have an Emergency Department, but does provide a Crisis Walk-in Service which functions as an emergency room diversion.
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	In order to satisfy variable demand, we are required to recruit and compensate at a level that exceeds productivity standards so that we have availability for seven day coverage, on call coverage, sufficient for census surges and to satisfy EMTALA, meaningful use requirements and conditions of participation.

Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):

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

    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;
    - 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.

Appendix I

Sheppard Pratt first notifies each patient of the system's Financial Assistance though the provision of each patient with a Patient Handbook as part of the intake process upon admission. The Patient Handbook outlines policies, rules, and basic information about the Hospital including instructions on how to access financial assistance and charity care.
Financial Assistance Policy information is posted in the Admissions Suite as well as patient and family waiting areas informing interested parties that financial assistance is available. The policy is available in Spanish or an interpreter is brought in for other languages as needed**.** The Patient Information Sheet (in both English and Spanish) has been prepared in a culturally sensitive fashion, at a college reading level which reflects the community benefit service area's 65% college exposure rate. (2009 American Community Survey 1-yr estimates). All newly admitted clients are urged to speak with their therapist or other hospital staff to learn more about the hospital's Financial Assistance Policy. Upon admission, each patient is provided with a Patient and Family Handbook which includes the Financial Assistance Policy summary and contact information. At the time of admission (intake), as much insurance, income and living situation information is

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

1) The Financial Assistance information is printed on the back of each self-pay statement.
2) Patient Accounting personnel act as financial advocates; and, as needed, may forward Financial Assistance paperwork for completion by all responsible parties.
3) Prior to transfer to a collection agency, accounts are reviewed again for possible financial assistance; and,
4) The collection agency also provides patients with Financial Assistance information and contact numbers.

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).

Appendix II

Changes made effective March 2014 have continued; these changes include the following adjustments to the Financial Assistance Policy:

1. Increased by fifty points the percentage of the Federal Poverty Guidelines to 250% necessary to qualify for Financial Assistance which established a more lenient baseline for income; and,
2. Extended the proactive portion of the Financial Assistance decision from 6 months to 12 Months.

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

Appendix III

POLICY:

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

PURPOSE:

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

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

PROCEDURE:

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

B. Financial Assistance requests (copy of application attached) should provide information regarding income, assets, expenses and verification of these items, as necessary.

- Financial assistance applications are required for most financial assistance requests.

C. Eligibility is usually determined based upon a two-part test which considers income and accumulated assets.

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

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

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

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

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

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

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

This policy replaces previously issued Directive #120.11.

References:

Attachments:

Revision Dates:

Reviewed Dates:
12/05, 5/08, 10/11,12/13

Signatures:
Patricia Pinkerton:
Steven Sharfstein:

References:

Attachments:

Revision Dates:
2/14

Reviewed Dates:
12/05, 5/08, 10/11, 3/14

Signatures:
Patricia Pinkerton: 3/20/14
Steven Sharfstein: 3/24/14

References:

Attachments:

Revision Dates:
2/14

Reviewed Dates:
12/05, 5/08, 10/11, 3/14

Signatures:
Patricia Pinkerton: 3/20/14
Steven Sharfstein: 3/24/14

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).

Appendix IV

Sheppard Pratt Health System

Politica Financiera De Los Pacientes

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

Asistencia Financiera del Hospital
Bajo la política de ayuda financiera de *Sheppard Pratt*, usted puede tener derecho a recibir ayuda financiera para el costo de los servicios de hospitalización médicamente necesarios, si usted tiene un bajo ingreso, si no tiene seguro, o si su seguro no cubre sus necesidades médicas del cuidado de hospital y usted se encuentra con ciertas limitaciones de ingresos. La elegibilidad para la asistencia financiera de *Sheppard Pratt* está basada en los ingresos totales de la familia y el numero de familiares del paciente y/o de la persona responsable. El criterio anual de ingreso usado será el 250% de las pautas de pobreza federales actuales conforme se hayan establecido cada año en el Registro Federal. El capital o patrimonio pasivo y el activo también serán considerados. La ayuda financiera puede ser concedida hasta el 100 % de costos médicos. Si usted desea conseguir más información, o cómo aplicar para ayuda financiera, por favor llamar al 410-938-3370 o llamar gratis al 1800-264-0949 de lunes a viernes de 8am a 3pm.

Derechos de los Pacientes
Aquellos pacientes que reúnen los criterios políticos de ayuda financieros descritos anteriormente pueden recibir la ayuda del hospital en el pago de su cuenta. Si usted cree que lo han referido equivocadamente a una agencia de recolección, usted tiene el derecho de contactar a la oficina de negocios del hospital *Sheppard Pratt* al 410-938-3370 o llamar al numero gratis 1800-264-0949.
Usted puede ser elegible para la Asistencia Médica de Maryland. La asistencia medica es un programa fundado conjuntamente con los gobiernos estatales y federales y estos pagan hasta el costo competo de la cobertura para individuos de ingresos bajos quiénes reúnen ciertos criterios. En algunos casos, usted puede aplicar y ser negado para este cubrimiento antes de ser elegible para la ayuda financiera del hospital *Sheppard Pratt.*
Para más información relacionada con el proceso de aplicación para la Asistencia Médica de Maryland, por favor llamar a su Departamento Local de Servicios Sociales al 1800-332-6347 o averiguar en la Internet al www.dhr.state.md.us. Nosotros también podemos ayudarle llamando al hospital *Sheppard Pratt* marcando el numero 410-938-3370.

Obligaciones del Paciente
Para aquellos pacientes con facilidad de pagar, es su obligación pagar al hospital a tiempo. El hospital *Sheppard Pratt* hace todo lo posible para que las cuentas de los pacientes sean correctamente facturadas, y los pacientes hospitalizados pueden recibir una factura detallada y completa 30 días después de que le han dado de alta. Es la responsabilidad del paciente de proporcionar la información de seguros correcta.
Si usted no tiene cubrimiento de seguro medico, nosotros esperamos que usted pague su cuenta a tiempo. Si usted cree que usted es elegible bajo la política de ayuda financiera, o si usted no puede pagar la cuenta completamente, usted podría contactar a la oficina de negocios al 410-938-3370.

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

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

Sheppard Pratt Health System

Patient Financial Policy

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

Hospital Financial Assistance
Under the Sheppard Pratt financial assistance policy, you may be entitled to receive financial assistance for the cost of medically necessary hospital services if you have a low income, do not have insurance, or your insurance does not cover your medically-necessary hospital care and you meet certain low income thresholds.
Sheppard Pratt's financial assistance eligibility is based on gross family income and family size of the patient and/or responsible person. Annual income criteria used will be 250% of the current federal poverty guidelines as established yearly in the Federal Register. Assets and liabilities will also be considered. Financial assistance may be awarded up to 100% of medical charges. If you wish to get more information about or apply for financial assistance, please call 410-938-3370 or toll free at 1-800-264-0949 Monday-Friday 8:00am to 3:00pm.

Patient Rights
Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill. If you believe you have been wrongly referred to a collection agency, you have the right to contact the Sheppard Pratt business office at 410-938-3370 or toll free at 1-800-264-0949.
You may be eligible for Maryland Medical Assistance. Medical Assistance is a program funded jointly by the State and Federal governments and it pays up to the full cost of health coverage for low-income individuals who meet certain criteria. In some cases, you may have to apply and be denied for this coverage prior to being eligible for Sheppard Pratt financial assistance.
For more information regarding the application process for Maryland Medical Assistance, please call your local Department of Social Services by phone 1-800-332-6347 or internet www.dhr.state.md.us. We can also help you at Sheppard Pratt by calling 410-938-3370.

Patient Obligations
For those patients with the ability to pay, it is their obligation to pay the hospital in a timely manner. Sheppard Pratt makes every effort to see that patient accounts are properly billed, and in-patients may expect to receive a uniform summary statement within 30 days of discharge. It is the patient's responsibility to provide correct insurance information. If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under the hospital's financial assistance policy, or if you cannot afford to pay the bill in full, you should contact the business office at 410-938-3370.

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

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

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

Appendix V

Mission & Values

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

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

Our Core Values:

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

Our Guiding Principles:

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

- **Charity** - We will meet our charitable responsibilities to serve the community and to honor the intent of our donors.
- **Caring** - We will provide all of our services with compassion and sensitivity.

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