Mercy Medical Center FY2016 Community Benefit Report Narrative#

2016

The Sisters of Mercy welcome all people of every creed, color, economic and social condition.

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

For the Health Services Cost Review Commission#

Mercy Medical Center
345 Saint Paul Place
Baltimore, Maryland 21201
www.mdmercy.com

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients:	Percentage of Patients who are Medicare Beneficiary:
184	13,680 Admissions and 5,000 Observation cases	21234,21215, 21222,21117, 21206,21218, 21224,21207, 21228,21229, 21221,21220, 21236,21217, 21093,21244, 21208,21136, 21230,21225, 21227,21213, 21212,21216, 21133,21239, 21209,21223, 21202,21214, 21211,21201, 21205,21231	Bon Secours, University of Maryland Midtown	Baltimore City: 11.9% Baltimore County: 11.4% Harford County: 14.7% Cecil County: 11.9% Source: Discharge Data	Medicaid Federal-2.4% Medicaid MCO-16.6% Source: Discharge Data	Medicare-25.5% Medicare Advantage-1.1% Source: Discharge Data

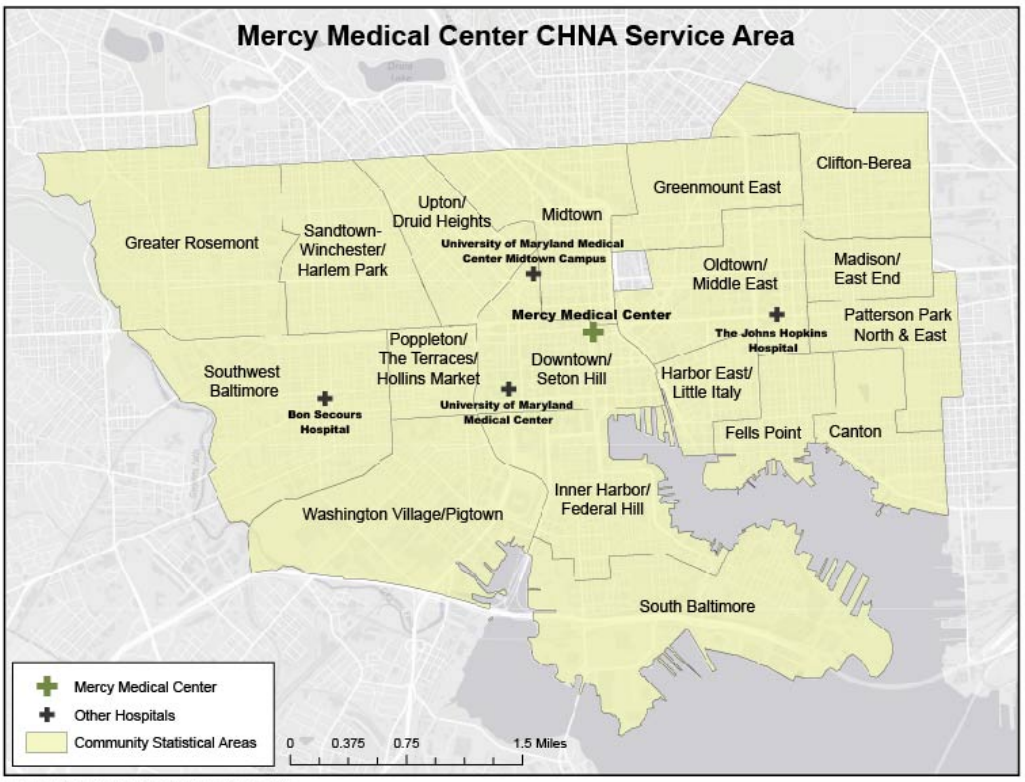
Mercy Medical Center, Inc. ("Mercy" or "MMC"), a non-profit corporation, which owns and operates a 184-licensed bed general acute-care teaching hospital affiliated with the University of Maryland School of Medicine. The MMC campus is located in the heart of Downtown Baltimore, Maryland. MMC is both a prominent community hospital, providing a broad range of primary and secondary acute-care services, as well as a preferred tertiary referral center in certain select specialties.

Mercy provides healthcare services to patients from a broad geographic area within the State of Maryland and beyond. As shown above, Mercy's primary service area consists of the majority of Baltimore City and portions of Baltimore and Anne Arundel Counties. Mercy's secondary service area generally surrounds the Primary Service Area and includes the remaining portions of Baltimore City, portions of Baltimore County and a portion of Anne Arundel County. These service areas accounted for approximately 63% of Mercy's total discharges in the 12 months ended June 30, 2016. The remaining 37% of discharges originate from outside Mercy's traditional service areas, including patients from outside of Maryland. Due to its downtown location near several other hospitals, including two large Academic Medical Centers and two other multi-hospital health systems, Mercy is not the dominant hospital provider in any of the ZIP codes comprising Mercy's traditional service area. Further, Mercy Medical Center generates more than sixty percent (61%) of its total revenue from regionally oriented, surgically focused specialty programs (Centers of Excellence) drawing patients from nearly every ZIP code across Maryland.

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

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

MERCY COMMUNITY BENEFIT SERVICE AREA



Baltimore Neighborhood Indicators Alliance, 2016

The Sisters of Mercy were originally founded in Dublin, Ireland to care for homeless, abused and neglected women and children. This timeless legacy influences Mercy's approach to focus special attention on certain target populations, such as infants, women, and the impoverished. When it comes to Community Health Needs and Community Benefit activities, Mercy has focused its resources on a smaller geographic area that represents downtown and inner-city neighborhoods in order to include medically underserved, low income, and minority populations. Mercy provides an array of specialized citywide support programs for targeted populations including: lower-income pregnant women, individuals experiencing homelessness, substance abusers, and support and coordination with Federally Qualified Health Centers to meet community health needs. Mercy also houses a citywide forensic examination program for victims of sexual assault and a family violence program.

Mercy defined its Community Benefit Service Area as part of its CHNA process for the 2013 tax year. During a series of meetings as part of the CHNA process for 2013, Mercy's Community Benefits Committee discussed the socioeconomic and health parameters that define Mercy's "community". Following a data driven process (*See: Mercy Medical Center 2013 CHNA & 2015 Community Benefit Report*), the committee appropriately decided that Mercy should focus its limited resources on Community Benefit activities to improve population health within 18 Community Statistical Areas (CSAs) that represent downtown and the inner-city neighborhoods east, west, and south of the city center. The Committee believes that this definition of Mercy's community, which represents a smaller

geographic area than the CBSA previously utilized by Mercy, will foster greater coordination, better strategic partnerships and improved measurement of outcomes, in particular with respect to the targeted populations including lower-income mothers and their babies and individuals experiencing homelessness. In addition, as part of the CHNA process for 2013 and 2016, Mercy representatives sought input regarding its proposed Community Benefit Service Area from community leaders, public health experts, and representatives of minority, low income, and medically underserved populations. The consensus feedback from these discussions validated and confirmed Mercy's Community Benefit Service Area Definition. In accordance with IRS regulations governing CHNAs, Mercy has defined its CHNA community to in order to include "medically underserved, low income or minority populations". Prior to 2013, Mercy's community benefit outreach was focused on a large geographic area within Baltimore City (15 ZIP codes) that as previously selected as Mercy's Community Benefit Service Area ("CBSA") based on the prevalence and concentration of emergency room visits.

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

Table II

Median Household Income within the CBSA	$38,772 (Baltimore City Total) *U.S. Census Data*
Percentage of households with incomes below the federal poverty guidelines within the CBSA	23.3% *Aggregated U.S. Census Data*
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	9.8% (Baltimore City Total) *U.S. Census Data, Small Area Estimate (2014).*
Percentage of Medicaid recipients by County within the CBSA.	Not available
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	See table(s) below
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	See table(s) below

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	See table(s) below
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	See table(s) below

QUANTATIVE ANALYSIS OF MERCY'S CBSA HEALTH PROFILE:

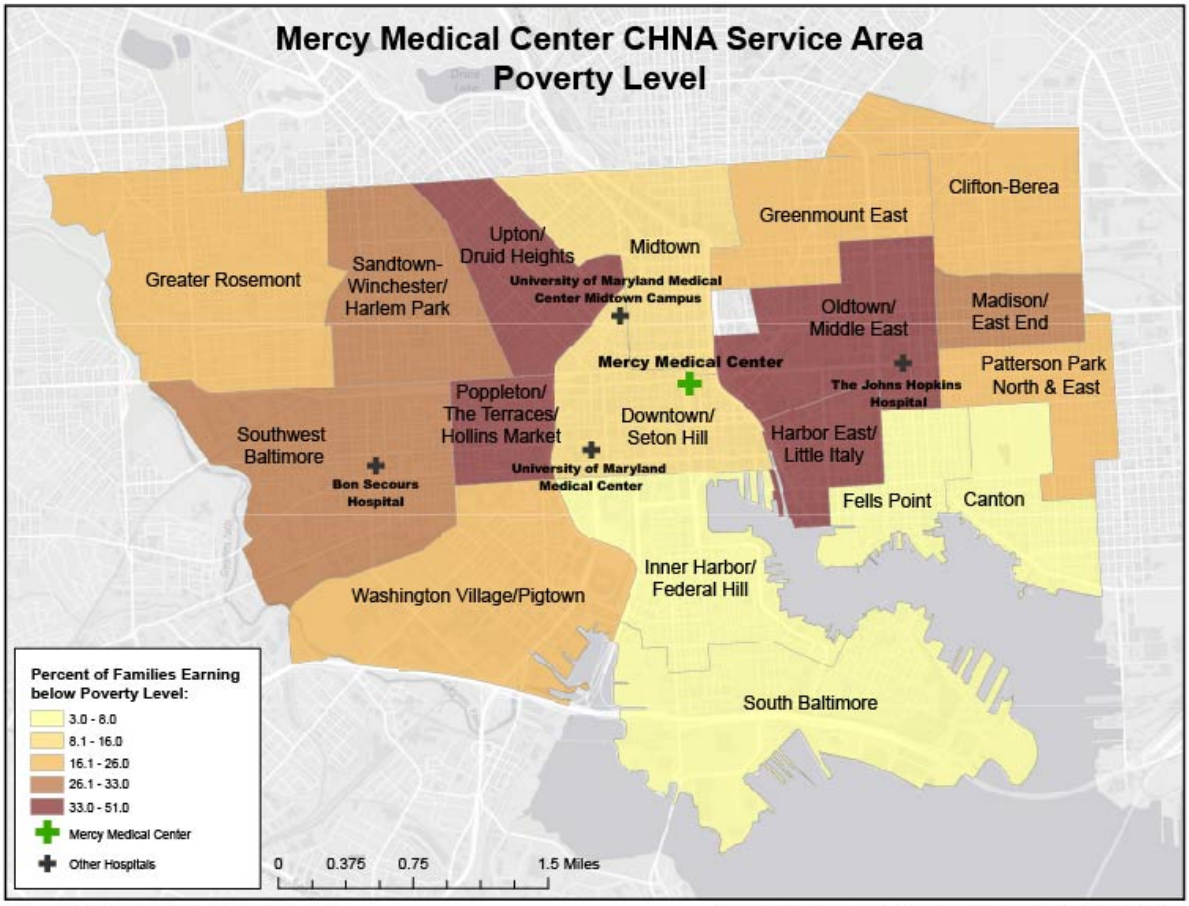
Quantitative Data

As part of the quantitative data gathering process for the 2016 CHNA, Mercy's Community Benefit Committee members worked collaboratively with The Baltimore Neighborhood Indicators Alliance-Jacob France Institute at the University of Baltimore (BNIA-JFI). BNIA-JFI is a nonprofit organization whose core mission is to provide open access to meaningful, reliable, and actionable data about, and for, the City of Baltimore and its communities. BNIA-JFI builds on and coordinates the related work of citywide nonprofit organizations, city and state government agencies, neighborhoods, foundations, businesses, and universities to support and strengthen the principle and practice of well informed decision making for change toward strong neighborhoods, improved quality of life, and a thriving city. BNIA-JFI is also a partner member of the National Neighborhood Indicators Partnership of the Urban Institute (NNIP). NNIP is a collaborative effort by the Urban Institute and nearly 40 local partners to further the development and use of neighborhood-level information systems in local policymaking and community building. BNIA-JFI provided to Mercy' Community Benefit Committee a broad array of neighborhood data indicators that provide all of the facts and circumstances present in Mercy's Community Benefit Service Area including barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral and environmental factors that influence health in the community.

Incorporated into BNIA-JFI's neighborhood-level socioeconomic datasets are individual Neighborhood Health Profiles completed by the Baltimore City Health Department and updated in March 2012. The Neighborhood Health Profiles examine at the underlying factors that affect health in each neighborhood—the social determinants of health. The social determinants of health are the conditions in which residents live, learn, work, and play, and include factors like access to healthy food, healthy housing, quality schools, and safe places to be active. The Neighborhood Health Profiles present health outcome information at the Community Statistical Area (CSA) level in Baltimore City in order to support community-level health improvement efforts to achieve the Healthy Baltimore 2015 plan, the City's comprehensive public health agenda to improve health outcomes in Baltimore. The Baltimore City's Office of Epidemiology utilized rigorous research methods and survey analysis techniques to aggregate all the data to the Community Statistical Area (CSA) level. The use of the most recently available Neighborhood Health Profile information from the Baltimore City Health Department ensures that the community health priorities of Mercy Medical Center remain aligned with the current health priorities of the City. Data sources include a variety of public and private sources such as: The U.S. Census, The American Community Survey, The Vital Statistics Administration at the Maryland Department of Health and Mental Hygiene, The National Center for Health Statistics, The Baltimore City Public Schools System, The Mayor's Office of Information Technology, The Baltimore City Housing Department, The Baltimore City Comptroller's Office, The Baltimore City Planning Department, The Baltimore City Real Property Management Database, The Baltimore City Liquor Board, The Baltimore City Health Department, Center for a Livable Future, and the Maryland Department of the Environment.

Key Findings

<u>Demographics: Income, Unemployment & Poverty</u>



Baltimore Neighborhood Indicators Alliance, 2016

Data Source: US Census, American Community Survey 2009-2013

The chart below details the Household Income, Unemployment & Poverty makeup of Mercy's CNHA Service Area. The percentage of Households earning less than $25,000 is dramatically higher than the citywide percentage. Conversely, there are far fewer Households earning more than $75,000 within Mercy's CNHA Service Area than Citywide. In certain neighborhoods including Greenmount East, Oldtown/Middle East, Poppleton/Hollins Market and Upton/Druid Heights, more than half of all Households earn less than $25,000. Similarly, the percentage of families earning below the poverty level is significantly higher within Mercy's CNHA Service Area than the City as a whole, which is already among the poorest jurisdictions in the State of Maryland. Unemployment within Mercy's CNHA Service Area is slightly higher than Citywide. Perhaps more than any other dataset included in this report, the chart below demonstrates Mercy's long-standing special commitment to serve the poor and underserved.

	Percentage of Population by Household Income	% of population 16+ that is	% of families earning

	<$25,000	$25-40,000	$40-60,000	$60-75,000	$75,000+	unemployed	below poverty level
Canton	9.3	7.8	13.0	12.0	57.9	4.0	3.1
Clifton-Berea	48.0	22.0	14.7	7.6	7.7	10.0	21.5
Downtown/Seton Hill	42.6	14.9	17.4	9.0	16.1	3.1	15.1
Fells Point	17.3	8.9	11.8	11.8	50.2	4.3	6.9
Greater Rosemont	46.8	18.2	15.5	8.1	11.4	15.5	25.2
Greenmount East	54.1	20.6	10.8	4.9	9.6	15.7	25.3
Harbor East/Little Italy	42.2	16.8	8.0	4.3	28.7	11.1	41.2
Inner Harbor/Federal Hill	20.0	4.1	14.0	7.1	54.7	4.2	7.7
Madison/East End	46.8	15.9	16.4	7.6	13.3	15.6	31.5
Midtown	38.2	14.8	16.2	9.0	21.7	6.6	10.8
Oldtown/Middle East	63.1	14.5	10.5	3.6	8.3	14.8	50.5
Patterson Park North and East	26.7	10.2	17.2	8.2	37.7	9.3	25.9
Poppleton/Hollins Market	62.4	12.5	10.1	5.0	10.0	11.4	44.8
Sandtown-Winchester/Harlem Park	48.9	18.3	16.3	9.2	7.4	14.0	31.6
South Baltimore	15.9	5.9	13.3	9.4	55.4	6.3	5.1
Southwest Baltimore	49.6	18.0	13.9	7.4	11.1	15.7	33.0
Upton/Druid Heights	65.6	10.5	10.8	7.4	5.7	14.6	50.6
Washington Village/Pigtown	30.6	12.7	21.2	10.5	25.1	9.4	24.4
Mercy Community Benefit Service Area Estimate	**41.0**	**14.1**	**14.3**	**8.0**	**22.7**	**10.3**	**23.3**
Baltimore City	**33.2**	**15.4**	**16.6**	**5.4**	**25.5**	**9.9**	**19.1**

Demographics: Race & Ethnicity

The chart below details the population and racial/ethnic makeup of Mercy's CNHA Service Area. Mercy's CNHA Service Area population (186,653) represents approximately 30% of Baltimore City's total population. The mix of white and black population in CNHA Service Area is roughly equivalent the citywide mix. Mercy's CNHA Service Area also includes two neighborhoods (Patterson Park North and East, Fells Point) with disproportionately high numbers of Hispanic/Latino residents compared to the City as a whole. Mercy's CNHA Service Area includes one neighborhood (Downtown/Seton Hill) with a significantly greater share of Asian residents. Access to government sponsored health insurance (Medicaid and subsidized private qualified health plans on Maryland's Health Exchange) and limited English proficiency may present barriers to some Hispanic/Latino residents within Mercy's CNHA Service Area seeking health care services.

CSA	Population 2010	Percent of Population by Race/Ethnicity					
		Black	White	Asian	Other	Two or More	Hispanic/ Latino
Canton	8100	4.0	86.0	3.4	0.4	1.3	5.0
Clifton-Berea	9874	96.3	1.1	0.3	0.3	1.1	1.0
Downtown/Seton Hill	6446	37.0	39.2	15.9	0.6	2.8	4.5
Fells Point	9039	7.8	69.8	4.6	0.7	2.0	15.1
Greater Rosemont	19259	96.6	0.7	0.2	0.3	1.3	1.0
Greenmount East	8184	95.8	1.6	0.2	0.3	1.1	0.9
Harbor East/Little Italy	5407	57.9	28.5	4.6	0.6	1.6	6.8
Inner Harbor/Federal Hill	12855	11.5	79.5	3.9	0.4	1.6	3.2
Madison/East End	7781	90.3	3.1	0.8	0.6	1.2	4.0
Midtown	15020	32.1	52.7	7.8	0.5	2.9	3.9
Oldtown/Middle East	10021	89.5	5.4	2.0	0.3	1.0	1.7
Patterson Park North and East	14549	38.0	36.0	1.9	1.2	1.8	21.1
Poppleton/The Terraces/Hollins Market	5086	82.9	12.7	1.0	0.4	1.4	1.7
Sandtown-Winchester/Harlem Park	14896	96.6	1.1	0.3	0.2	1.0	0.7
South Baltimore	6406	2.7	90.3	2.7	0.3	1.5	2.6
Southwest Baltimore	17885	75.8	16.8	1.1	0.6	2.1	3.6
Upton/Druid Heights	10342	92.4	3.9	0.6	0.4	1.4	1.4
Washington Village/Pigtown	5503	49.0	39.1	5.3	0.7	2.5	3.4
Mercy Community Benefit Service Area Estimate	**186653**	**61.6**	**28.9**	**2.7**	**0.5**	**1.6**	**4.6**
Baltimore City	**620961**	**63.8**	**28.3**	**2.3**	**0.5**	**1.7**	**4.2**

Demographics: Age & Gender:

The chart below details the Age & Gender makeup of Mercy's CNHA Service Area. In terms of both Age and Gender, there is little difference between Mercy's CNHA Service Area and Baltimore City as a whole. However, several neighborhoods within Mercy's CNHA Service Area included higher percentages of persons under age 18 than the Baltimore City as whole. Mercy's CNHA Service Area does not have a disproportionate share of residents over age 65 compared to Baltimore City more broadly.

CSA	Percentage of Population by Age (years)					Percentage of Population by Gender	
	Under 18	18-24	25-44	45-64	65 and up	Male	Female
Canton	7.1	10.5	53.0	18.5	10.9	49.5	50.5
Clifton-Berea	25.5	10.5	22.5	26.1	15.5	45.3	54.7
Downtown/Seton Hill	8.0	20.6	50.7	16.9	3.8	49.1	50.9
Fells Point	9.7	11.3	51.7	19.5	7.7	51.0	49.0
Greater Rosemont	26.1	11.0	22.3	27.6	12.9	45.6	54.4
Greenmount East	25.4	10.8	21.7	29.9	12.3	45.7	54.3
Harbor East/Little Italy	24.0	9.8	37.0	22.6	6.6	48.6	51.4
Inner Harbor/Federal Hill	9.5	13.3	47.2	19.4	10.6	50.8	49.2
Madison/East End	32.8	13.1	24.9	22.6	6.6	46.1	53.9
Midtown	6.0	22.6	39.3	19.4	12.7	48.6	51.4
Oldtown/Middle East	25.0	12.3	27.0	23.9	11.9	45.3	54.7
Patterson Park North and East	22.2	11.6	41.2	18.7	6.2	50.1	49.9
Poppleton/The Terraces/Hollins Market	25.5	10.5	28.7	25.9	9.3	47.2	52.8
Sandtown-Winchester/Harlem Park	25.8	11.5	23.9	26.9	11.8	45.7	54.3
South Baltimore	10.6	10.4	51.3	19.6	8.1	50.9	49.1
Southwest Baltimore	27.1	11.0	25.3	26.6	10.0	48.6	51.4
Upton/Druid Heights	29.1	12.1	24.3	24.3	10.1	44.7	55.3
Washington Village/Pigtown	21.0	11.3	37.6	22.0	8.1	49.8	50.2
Mercy Community Benefit Service Area Estimate	**20.4**	**12.6**	**33.5**	**23.2**	**10.2**	**47.8**	**52.2**
Baltimore City	**21.5**	**12.6**	**29.0**	**25.2**	**11.7**	**47.1**	**52.9**

Education:

The chart below details several key indicators related to education attainment, literacy, and truancy within Mercy's CNHA Service Area. Most indicators are consistent with the City as a whole. However, truancy levels worsen within Mercy's CNHA Service Area as students reach high school age. Like the rest of the City, there are large disparities in educational achievement within Mercy's CNHA Service Area from neighborhood to neighborhood. Areas with higher rates of poverty and minority population are less likely to enter kindergarten "ready to learn", achieve lower proficiency scores in reading and math, miss more days of school, and achieve fewer high school diplomas and college degrees.

CSA	% of Kindergarten Students "Fully Ready to Learn"	% of students reading at "proficient" or "advanced" levels		% of students missing 20 or more days of school			% of adults 25+ attaining educational levels*		
		3rd Grade	8th Grade	Elementary	Middle	High	HS or less	Some HS or Assoc. Degree	BS/BA or more
Canton	96.0	80.0	80.0	6.0	12.8	34.5	7.4	29.0	63.7
Clifton-Berea	79.0	54.7	47.4	16.2	16.4	43.4	27.4	65.4	7.2
Downtown/Seton Hill	75.0	55.6	57.9	14.0	14.9	40.8	8.8	27.4	63.8
Fells Point	88.7	77.5	81.0	6.8	8.7	27.4	11.0	25.6	63.4
Greater Rosemont	77.5	53.5	58.2	12.8	11.8	38.2	28.3	63.9	7.9
Greenmount East	80.3	60.4	51.4	14.5	14.6	44.3	24.6	69.7	5.7
Harbor East/Little Italy	40.3	71.7	64.6	20.6	14.0	36.2	27.0	41.5	31.5
Inner Harbor/Federal Hill	90.0	94.3	60.0	7.5	15.8	34.8	10.5	23.4	66.1
Madison/East End	61.0	59.9	47.7	16.3	17.1	50.4	39.7	55.1	5.2
Midtown	72.5	73.3	75.0	11.2	10.9	32.6	12.9	28.9	58.2
Oldtown/Middle East	77.2	57.8	57.0	16.4	15.7	46.0	36.1	51.5	12.4
Patterson Park North and East	66.3	65.0	64.7	10.4	15.0	41.5	25.5	40.3	34.2
Poppleton/The Terraces/Hollins	84.2	58.3	52.8	21.5	23.4	39.9	31.0	52.6	16.4
Sandtown-Winchester/Harlem Park	83.6	50.9	49.4	13.0	14.7	43.4	30.1	64.5	5.5
South Baltimore	90.5	86.2	82.4	11.3	16.4	27.3	12.2	29.9	58.0
Southwest Baltimore	69.1	49.2	54.7	16.7	17.4	44.3	31.4	59.1	9.5
Upton/Druid Heights	74.0	51.1	39.4	19.5	21.0	41.9	33.2	55.5	11.2
Washington Village/Pigtown	94.0	59.3	55.1	13.2	28.9	35.3	20.9	45.1	33.9
Mercy Community Benefit Service Area Estimate	**77.4**	**63.2**	**59.5**	**13.3**	**15.4**	**39.4**	**23.9**	**47.6**	**28.6**
Baltimore City	**77.6**	**64.9**	**62.0**	**13.1**	**13.3**	**35.6**	**19.8**	**53.4**	**26.8**

Physical, Built, and Social Environment:

The Baltimore City Health Department compiled data on the built and social environment affecting residents in the City in order to identify and track environmental factors that directly contribute to the health and well-being of residents. Scholarly research like the CDC's Adverse Childhood Experiences (ACE) study highlights the link between childhood trauma and later-life health. The CDC's ACE study found a strong correlation between adverse childhood experiences and poor health outcomes. The ACE Study suggests that children exposed to the "toxic stress" of violence, homelessness, abuse, and neglect are at a greater risk for illness and premature death as well as a lower quality of life. The chart below reveals that residents in Mercy's CNHA Service Area are disproportionately exposed to alcohol and liquor stores, juvenile arrests, domestic violence and gun violence. In addition to these adverse social conditions, the built environment presents similar challenges within our community.

CSA	Alcohol Store Density per 1,000 Residents	Tobacco Store Density per 1,000 Residents	Juvenile Arrests per 1,000 10-17 Year Olds	Domestic Violence Incidents Reported per 1,000 Res.	Non-Fatal Shootings per 10,000 Residents
Canton	4.3	23.5	81.5	39.6	0.0
Clifton-Berea	1.9	49.6	144.9	63.5	72.9
Downtown/Seton Hill	7.9	130.3	1005.6	76.8	90.0
Fells Point	4.1	50.9	27.5	39.9	5.5
Greater Rosemont	0.9	36.9	107.9	62.6	42.1
Greenmount East	1.6	49.7	116.6	72.9	68.4
Harbor East/Little Italy	2.8	-	116.9	75.5	22.2
Inner Harbor/Federal Hill	3.3	25.8	359.0	39.1	3.1
Madison/East End	1.7	50.1	108.3	75.4	50.1
Midtown	1.9	28.7	198.0	24.1	14.0
Oldtown/Middle East	0.8	-	145.6	65.7	42.9
Patterson Park North and East	1.2	50.1	72.8	60.2	18.6
Poppleton/The Terraces/Hollins Market	2.0	43.3	111.9	68.6	27.5
Sandtown-Winchester/Harlem Park	1.3	56.1	211.6	67.9	64.4
South Baltimore	2.0	18.7	69.9	38.2	3.1
Southwest Baltimore	2.2	51.4	132.7	77.2	41.4
Upton/Druid Heights	0.7	39.0	250.2	72.6	42.5
Washington Village/Pigtown	2.4	50.9	91.7	80.1	38.2
Mercy Community Benefit Service Area Estimate	**2.1**	**45.9**	**151.1**	**59.9**	**35.8**
Baltimore City	**11.5**	**21.8**	**79.2**	**54.2**	**2.3**

-data not available due to CSA shift

In addition, as shown in the charts below, Mercy's CNHA Service Area has more than twice the rate of vacant homes and lead paint violations as the rest of the City. Furthermore, an oversupply and over-

reliance on carry out restaurants and corner stores for food supply also highlights the existence of food deserts within our community.

CSA	Lead Paint Violations per 1,000 households (annually)	Energy Cutoffs per 1,000 households (annually)	Vacant Buildings per 1,000 housing units	Vacant Lots per 1,000 Housing Units
Canton	1.3	7.2	5.7	11.1
Clifton-Berea	63.6	61.2	250.7	129.7
Downtown/Seton Hill	0.9	4.1	99.3	46
Fells Point	3.3	5.7	12.3	21
Greater Rosemont	24.7	77	156.9	50.9
Greenmount East	64.6	59.9	326.9	272.1
Harbor East/Little Italy	-	-	20.6	-
Inner Harbor/Federal Hill	1.1	11.9	4.7	67.7
Madison/East End	90.3	89.8	206.6	46
Midtown	1.5	7.4	36.0	16.6
Oldtown/Middle East	-	-	346.7	-
Patterson Park North and East	24.9	32.2	37.9	216.6
Poppleton/The Terraces/Hollins Market	8.7	31.3	154.9	226.6
Sandtown-Winchester/Harlem Park	39.8	86.9	343.3	150.7
South Baltimore	1.4	8	3.9	49.4
Southwest Baltimore	43.5	79.6	270.8	109.1
Upton/Druid Heights	21.6	45.2	336.7	155.1
Washington Village/Pigtown	13.7	45.8	75.0	79.3
Mercy Community Benefit Service Area Estimate	**24.5**	**39.3**	**153.1**	**94.4**
Baltimore City	**11.8**	**39.1**	**80.3**	**59.3**

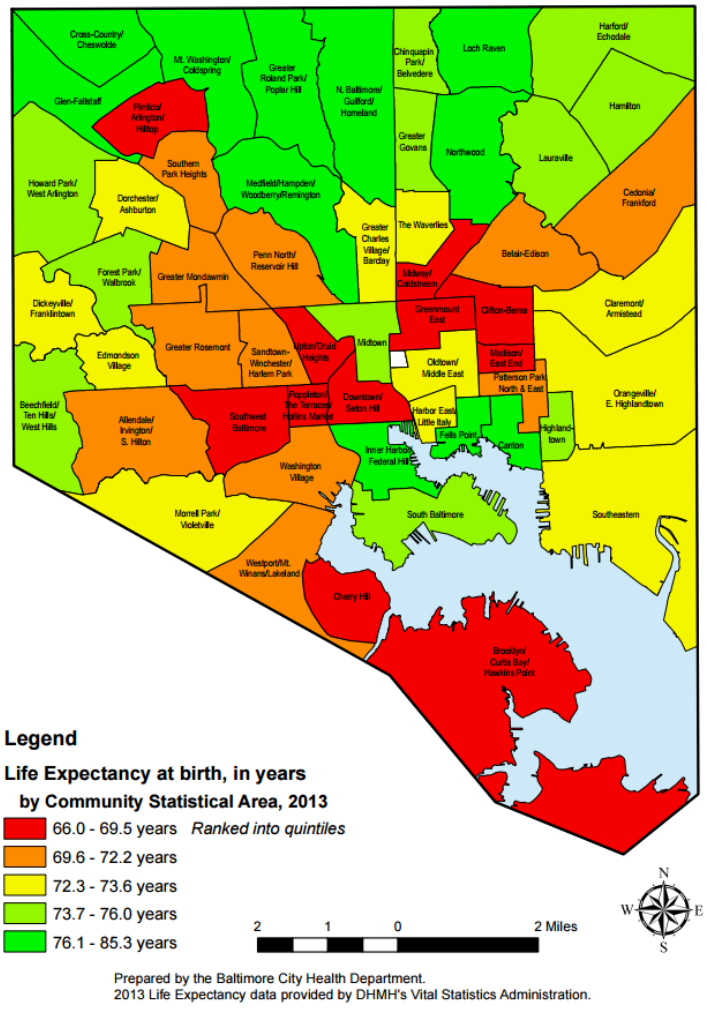
-data not available due to CSA shift

	Fast Food Restaurants per 1,000	Carry-out Restaurants per 1,000 Residents	Corner Stores per 1,000 Residents
Mercy Community Benefit Service Area Estimate	**3.1**	**22.1**	**15.2**
Baltimore City	**1.5**	**12.7**	**9.0**

Key Community Health Indicators

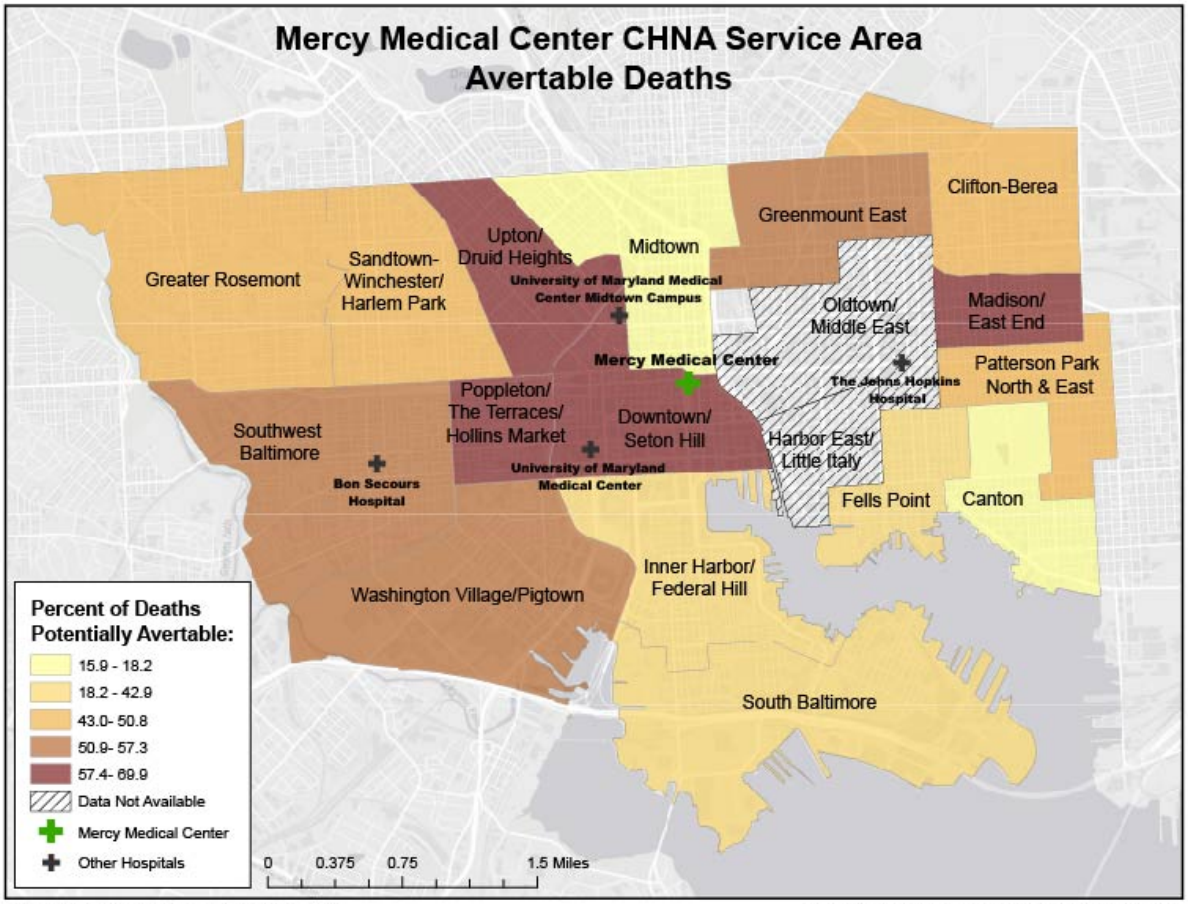
Life Expectancy, Premature Mortality, and Years of Potential Life Lost (YPLL):

In the citywide health profile, the Baltimore City Health Department used life expectancy estimates that reflected the mortality rates in Baltimore City: Life expectancy is a measure that summarizes health over the entire lifespan. Life expectancy at birth is the average number of years a newborn can expect to live, assuming she or he experiences the currently prevailing rates of death throughout her or his lifespan. The estimated citywide life expectancy at birth in Baltimore was 71.8 years. The mortality rate is the rate at which individuals in a population die, expressed in terms of deaths per 10,000 residents per year, and is age adjusted. Age-adjusted mortality reflects all deaths from all causes, taking into account differences in population size and age distribution. Years of potential life lost (YPLL) is a measure of the impact of premature mortality on a population. Premature mortality is death before the age of 75. YPLL is calculated by adding together the years of life that were not lived because people died before age 75. Both life expectancy and YPLL are heavily influenced by deaths in the first few decades of life. Infant deaths and juvenile deaths can heavily impact a community's life expectancy data and YPLL.



Prepared by the Baltimore City Health Department.
2013 Life Expectancy data provided by DHMH's Vital Statistics Administration.

As show in the map above, 7 of the 11 Community Statistical Areas within Baltimore City that are in the lowest quintile for Life Expectancy at Birth are located with the Mercy Community Benefit Service Area.



Baltimore Neighborhood Indicators Alliance, 2016

Data Source: Baltimore City Health Department, 2011

The following chart below reveals that significantly more people die prematurely from all causes in Mercy's CNHA Service Area than in the City as a whole. The Health Department calculated that 36.2% of all deaths in the City are avertable. Avertable deaths are defined as being deaths that could have been avoided if all Baltimore communities had the same opportunities for health. Specifically, the Health Department created a baseline by calculating the death rate in the five communities with the highest income in the City. The assumption is that the death rate in the five highest-income neighborhoods can be achieved by every other community. In the chart below, a positive percentage in the column labeled "% of deaths potentially avertable" reflects the percentage of deaths that could have been avoided if a particular CSA had the same death rate as the baseline rate from the five highest-income communities.

CSA	Age-adjusted Deaths per 10,000 Residents, All Causes	Total Annual YPLL per 10,000 Residents	% of Deaths Potentially Avertable
Canton	86.7	506.7	15.9
Clifton-Berea	141.9	2423.5	45.8
Downtown/Seton Hill	238.2	1511.9	69.9
Fells Point	110.6	806.9	35.0
Greater Rosemont	140.0	1902.1	46.7
Greenmount East	144.9	2241.6	54.1
Harbor East/Little Italy	-	-	-
Inner Harbor/Federal Hill	113.2	1431.0	42.9
Madison/East End	157.9	2264.0	64.0
Midtown	90.6	875.0	18.2
Oldtown/Middle East	-	-	-
Patterson Park North and East	128.9	1852.6	48.5
Poppleton/The Terraces/Hollins Market	171.7	2366.5	64.0
Sandtown-Winchester/Harlem Park	144.5	2323.1	50.8
South Baltimore	122.3	782.4	40.6
Southwest Baltimore	157.8	2250.4	57.3
Upton/Druid Heights	175.8	2494.5	63.2
Washington Village/Pigtown	145.9	1482.8	55.3
Mercy Community Benefit Service Area Estimate	**128.0**	**1636.3**	**46.6**
Baltimore City	**110.8**	**1377.4**	**36.2**

-Data not available due to CSA shift

While the overall death rates in Mercy's CNHA Service Area area higher than the city average, the data for the Downtown/Seton Hill community, Madison/East End, Poppleton, and Upton/Druid Heights merits further examination. The data indicates that residents in these areas dying far earlier than residents in higher income neighborhoods. One likely factor in the Downtown/Seton Hill data point (approx. 70% avertable death) could be the disproportionate concentration of homeless persons in the downtown area. Healthcare for the Homeless estimates that life expectancy for an individual experiencing homelessness at any point is only 48 years.

Top causes of premature deaths:

CSA	Adult Deaths per 10,000 Residents, by Cause of Death				
	Heart Disease	Cancer (All)	Lung Cancer	Stroke	HIV/AIDS
Canton	22.8	25.1	6.5	3.5	+
Clifton-Berea	30.7	31.3	7.9	7.3	7.2
Downtown/Seton Hill	71.0	47.2	16.1	11.7	10.4
Fells Point	28.3	25.9	9.8	4.9	+
Greater Rosemont	35.8	28.8	7.4	6.9	6.5
Greenmount East	37.4	26.3	7.7	6.9	8.2
Harbor East/Little Italy	-	-	-	-	-
Inner Harbor/Federal Hill	28.5	24.3	7.7	5.1	5.6
Madison/East End	35.2	28.6	9.3	8.4	5.9
Midtown	26.7	18.6	5.8	3.9	6.7
Oldtown/Middle East	-	-	-	-	-
Patterson Park North and East	32.2	22.9	5.8	4.3	9.3
Poppleton/The Terraces/Hollins Market	32.6	27.4	10.2	8.2	11.8
Sandtown-Winchester/Harlem Park	36.4	28.0	7.7	6.2	6.8
South Baltimore	35.0	33.3	12.1	2.9	+
Southwest Baltimore	42.3	32.7	11.5	5.9	5.8
Upton/Druid Heights	47.9	30.3	9.1	6.9	12.4
Washington Village/Pigtown	42.5	32.5	11.6	4.9	3.7
Mercy Community Benefit Service Area Estimate	**33.6**	**26.6**	**8.2**	**5.6**	**5.2**
Baltimore City	**28.5**	**23.1**	**6.9**	**5.2**	**3.9**

-Data not available due to CSA shift

+Rate not calculated, fewer than five deaths

Consistent with Mercy's 2013 CHNA, A significant output of Mercy's community health profile is the identification of the top causes of premature death within our specific community. **The top four causes of premature death in our 18 priority communities are heart disease, cancer, homicides, and HIV/AIDS.** These four categories contribute greatly to the years of potential life lost in each neighborhood. Of note, these four conditions are not necessarily the top causes of death in our community. For example, there are 5.2 strokes deaths per 10,000 residents in the City and 3.5 homicide deaths per 10,000 residents in the City. However, when calculating the years of potential life lost, the younger age of homicide victims prioritizes the impact of their premature death in our health profile.

CSA	Age-adjusted Deaths per 10,000 Residents by Cause of Death				
	Chronic Lower Respiratory Disease	Homicide	Drug-Induced Deaths	Diabetes	Septicemia
Canton	4.5	+	+	3.2	2.2
Clifton-Berea	2.3	8.5	6.5	3.7	4.4
Downtown/Seton Hill	8.2	3.4	4.0	5.5	6.2
Fells Point	6.7	1.4	4.0	2.7	3.5
Greater Rosemont	4.3	8.2	5.4	3.2	4.5
Greenmount East	3.7	6.7	6.7	5.9	4.0
Harbor East/Little Italy	-	-	-	-	-
Inner Harbor/Federal Hill	5.1	3.7	3.1	3.4	2.0
Madison/East End	6.2	10.6	6.3	5.1	4.7
Midtown	2.0	1.2	2.0	3.7	1.3
Oldtown/Middle East	-	-	-	-	-
Patterson Park North and East	3.0	6.1	3.9	4.1	4.8
Poppleton/The Terraces/Hollins Market	8.4	6.3	10.0	5.5	7.3
Sandtown-Winchester/Harlem Park	3.4	8.6	7.6	4.3	5.0
South Baltimore	8.3	+	2.6	3.9	2.1
Southwest Baltimore	4.5	6.3	7.8	5.3	5.0
Upton/Druid Heights	2.3	7.5	8.5	7.7	6.4
Washington Village/Pigtown	9.3	2.4	3.4	5.3	6.9
Mercy Community Benefit Service Area Estimate	**4.4**	**4.4**	**4.3**	**4.2**	**3.8**
Baltimore City	**3.9**	**3.5**	**3.7**	**3.5**	**3.5**

-Data not available due to CSA shift

+Rate not calculated, fewer than five deaths

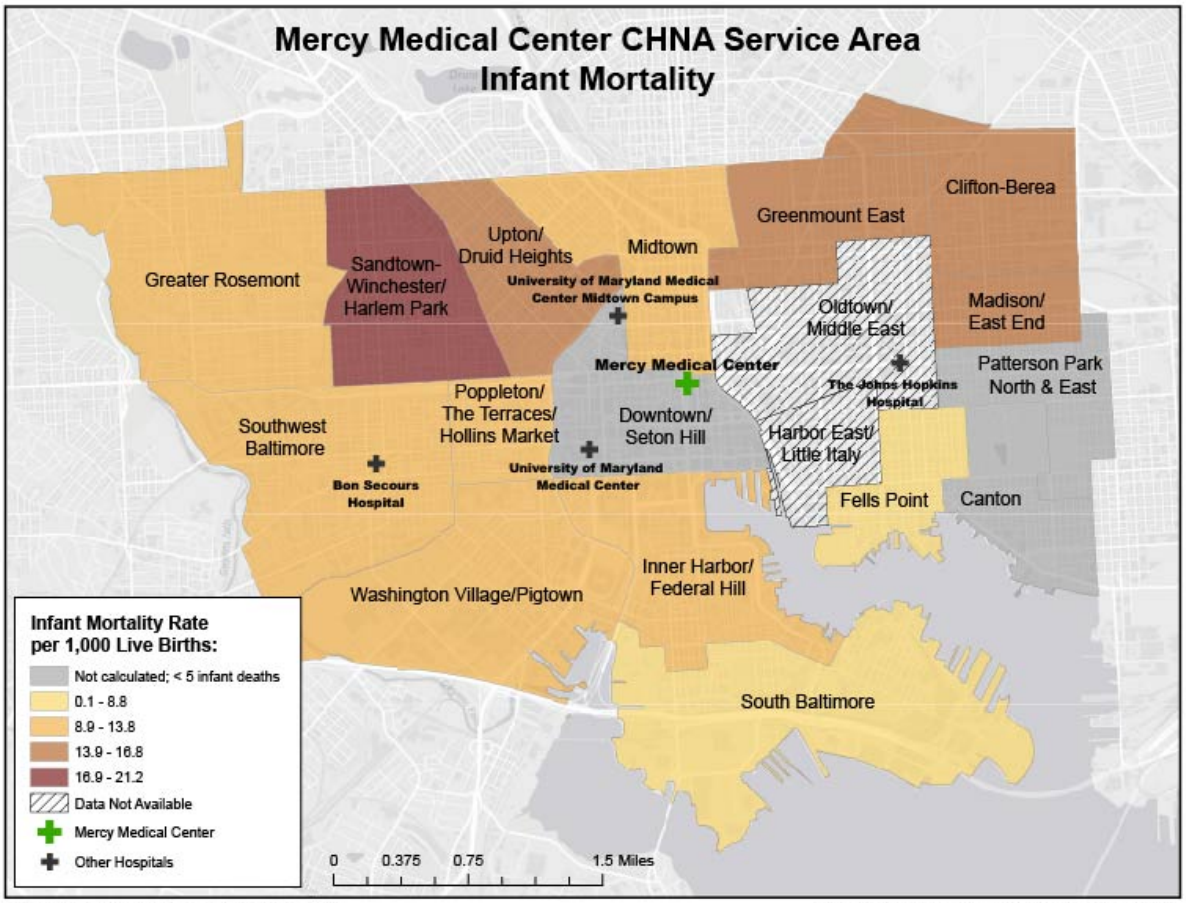
CSA	% of All Deaths, by Cause of Death				
	Heart Disease	Cancer (All)	Lung Cancer	Stroke	HIV/AIDS
Canton	27.0	27.0	7.2	4.5	+
Clifton-Berea	22.6	23.2	6.0	5.3	4.2
Downtown/Seton Hill	24.4	21.4	6.2	2.6	8.8
Fells Point	24.2	22.8	8.3	4.6	+
Greater Rosemont	26.6	20.4	5.3	5.1	4.3
Greenmount East	25.3	18.6	5.9	4.8	6.6
Harbor East/Little Italy	-	-	-	-	-
Inner Harbor/Federal Hill	23.7	20.6	6.3	4.1	6.5
Madison/East End	20.4	17.5	5.6	4.1	4.9
Midtown	30.3	20.7	6.5	4.4	6.5
Oldtown/Middle East	-	-	-	-	-
Patterson Park North and East	24.5	18.1	5.0	3.5	7.1
Poppleton/The Terraces/Hollins Market	17.4	16.0	6.4	4.7	8.0
Sandtown-Winchester/Harlem Park	25.5	19.6	5.4	4.3	4.4
South Baltimore	27.7	26.3	9.7	2.2	+
Southwest Baltimore	26.4	20.2	7.0	3.6	4.0
Upton/Druid Heights	26.5	17.4	5.5	3.6	7.4
Washington Village/Pigtown	26.6	21.8	8.9	3.8	3.4
Mercy Community Benefit Service Area Estimate	**25.1**	**20.7**	**6.5**	**4.1**	**4.7**
Baltimore City	**25.8**	**20.8**	**6.3**	**4.7**	**3.5**

-Data not available due to CSA shift

+Rate not calculated, fewer than five deaths

Maternal and Child Health Indicators:

As noted earlier, The Sisters of Mercy were originally founded in Dublin, Ireland to care for homeless, abused and neglected women and children. This influences Mercy's special attention to mothers and infants. Mercy is the largest birthing hospital in Baltimore delivering roughly 1-in-5 of all children born in Baltimore City each year. Mercy is the second largest hospital provider to low-income mothers insured by Medicaid in the state with nearly 2,000 Medicaid births annually (72% of mothers delivering at Mercy are Medicaid-insured). Additionally, Mercy has a long-standing practice partnering with Federally Qualified Health Centers to improve community health and to help manage high risk populations, including pregnant women. Mercy currently provides on-site Obstetric services and delivers babies for three FQHC's. Despite strong efforts among hospital and community providers as well as the successes of the City's B'more for Healthy Babies campaign, more must be done to improve the health outcomes for mothers, infants, and children in our City. Baltimore's City's rates of infant mortality, especially in poor neighborhoods, including those within Mercy's Community Benefit Service Area remain unacceptably high.



Baltimore Neighborhood Indicators Alliance, 2016

Data Source: Baltimore City Health Department, 2011

Despite reductions in the citywide teen birth rate in recent years, the rate of births to persons 15-19 years old remains 51% higher in Mercy's Community Benefit Service Area. With respect to the percentage of women receiving prenatal care in the first trimester, Mercy's Community Benefit Service Area is on par with the citywide average. However, the disparity within Mercy's community merits further attention. Only 50.2% of women in Madison/East End received prenatal care in the first trimester compared to 75% in both Canton and South Baltimore, even as the neighborhoods are in close proximity to each other. Furthermore, the data suggests that several areas within Mercy's Community Benefit Service Area are unfortunately confronted by high rates of smoking during pregnancy, pre-term births, low birth weights, and infant deaths.

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

-Data not available due to CSA shift

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

-Data not available due to CSA shift

+Rate not calculated, fewer than five deaths

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

   _X__Yes
   ____No

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

   If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).
   https://mdmercy.com/~/media/Mercy%20Site/Files/About%20Mercy/Policies%20and%20Corporate%20Documents/2016/2016CHNAonlyForUpload.ashx

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

   __X_Yes Enter date approved by governing body here: 06/ 08/16
   ____No

   If you answered yes to this question, provide the link to the document here.
   https://mdmercy.com/~/media/Mercy%20Site/Files/About%20Mercy/Policies%20and%20Corporate%20Documents/2016/2016CHNAImplementationStrategyForUpload.ashx

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

      _X_Yes
      ___No

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

Community Benefit Planning

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

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

i. Senior Leadership

1. _X_CEO
2. _X_CFO
3. _X_Other (please specify) Board Committee, Sr. VP for Institutional Advancement, VP for Corporate Affairs

Describe the role of Senior Leadership.

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

ii. Clinical Leadership

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

Describe the role of Clinical Leadership

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

iii. Community Benefit Operations

1. ___Individual (please specify FTE)
2. _X_Committee (please list members)
3. ___Department (please list staff)
4. ___Task Force (please list members)
5. ___Other (please describe)

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

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

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

Spreadsheet	_X__yes	_____no
Narrative	_X__yes	_____no

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

The Community Benefit Spreadsheet is prepared by staff in the Finance department and reviewed by Finance Management. All quantitative data is documented as to source.

The Community Benefit Narrative is prepared by a member of Senior Management and reviewed by Mercy's Community Benefit Steering Committee.

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

Spreadsheet	____X_yes	_____no
Narrative	__X_yes	_____no

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

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

b. *Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative*

activities with each partner (please add as many rows to the table as necessary to be complete)

Community Stakeholders				
Name	**Title**	**Organization**	**Background**	**Interview**
Andrew Gervase	President	**Sharp Leadenhall Planning Committee**	The Sharp Leadenhall Planning Committee is a community organization representing the historic Sharp Leadenhall neighborhood in South Baltimore.	2/26/2016
Hon. Eric Costello	Councilman	**Baltimore City Council**	Elected official representing a substantial portion of Mercy's Community Benefit Service Area.	2/8/2016
Olivia D. Farrow, Esq.	Deputy Commissioner	**Baltimore City Health Department**	The Baltimore City Health Department is the oldest, continuously-operating health department in the United States, BHCD has a wide-ranging area of responsibility, including acute communicable diseases, chronic disease prevention, emergency preparedness, HIV/STD, maternal-child health, school health, senior services and youth violence issues.	2/5/2016
Faye Royale-Larkins, RN, MPH	Chief Executive Officer	**Total Health Care, Inc.**	Total Health Care is one of Maryland's largest minority-run, nonprofit, federally qualified community health centers. For more than 45 years, Total Health Care has provided medical care in Baltimore.	2/16/2016
Kevin Lindamood	President and CEO	**Healthcare for the Homeless**	Health Care for the Homeless is an FQCA-deemed, free-standing 330(h) federally qualified health center accredited by the Joint Commission for both ambulatory and behavioral health care and certified as a Primary Care Medical Home (PCMH).	1/29/2016
James Macgill, Jr.	Consultant, Health Affinity Group	**Association of Baltimore Area Grantmakers**	As the region's premier resource on philanthropy dedicated to informing grantmakers and improving the community, The Association of Baltimore Area Grantmakers' membership includes more than 140 private and community foundations, corporations, donor advised funds, giving circles and public charities.	2/16/2016
Molly McGrath Tierney	Director	**Baltimore City Department of Social Services**	The Baltimore City Department of Social Services assists people in need by administering a wide range of public assistance programs. Primarily, BCDSS helps low-income people as well as families and children in crises.	2/17/2016
Gena O'Keefe, M.D.	Senior Associate with The Annie E. Casey Foundation	**B'More for Healthy Babies Initative & The Annie E. Casey Foundation**	The Annie E. Casey Foundation is devoted to developing a brighter future for millions of children at risk of poor educational, economic, social and health outcomes. The foundation makes grants that help cities and neighborhoods create more innovative, cost-effective responses to the issues that negatively affect children.	2/10/2016
Rev. Susan Tjornehoy	Senior Pastor	**Christ Lutheran Church**	Christ Lutheran Church is a metropolitan congregation of the Evangelical Lutheran Church in America. The congregation also offers extensive programs in education for persons of all ages; a nursery school and a year-round homeless shelter for forty women and children.	2/3/2016

Traci Kodeck	Interim CEO	**HealthCare Access Maryland**	HealthCare Access Maryland is a nonprofit agency that connects residents to public health care coverage and helps them navigate services effectively. HCAM connects uninsured and underinsured clients to health insurance, health care, and vital community resources. HCAM programs and services are designed to bridge gaps in services to pregnant and postpartum women, immigrants, people experiencing homelessness, youth in foster care, people with substance use disorders, individuals recently released from jail, and others.	2/5/2016

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

_____yes __X__no

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

_____yes __X__no

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

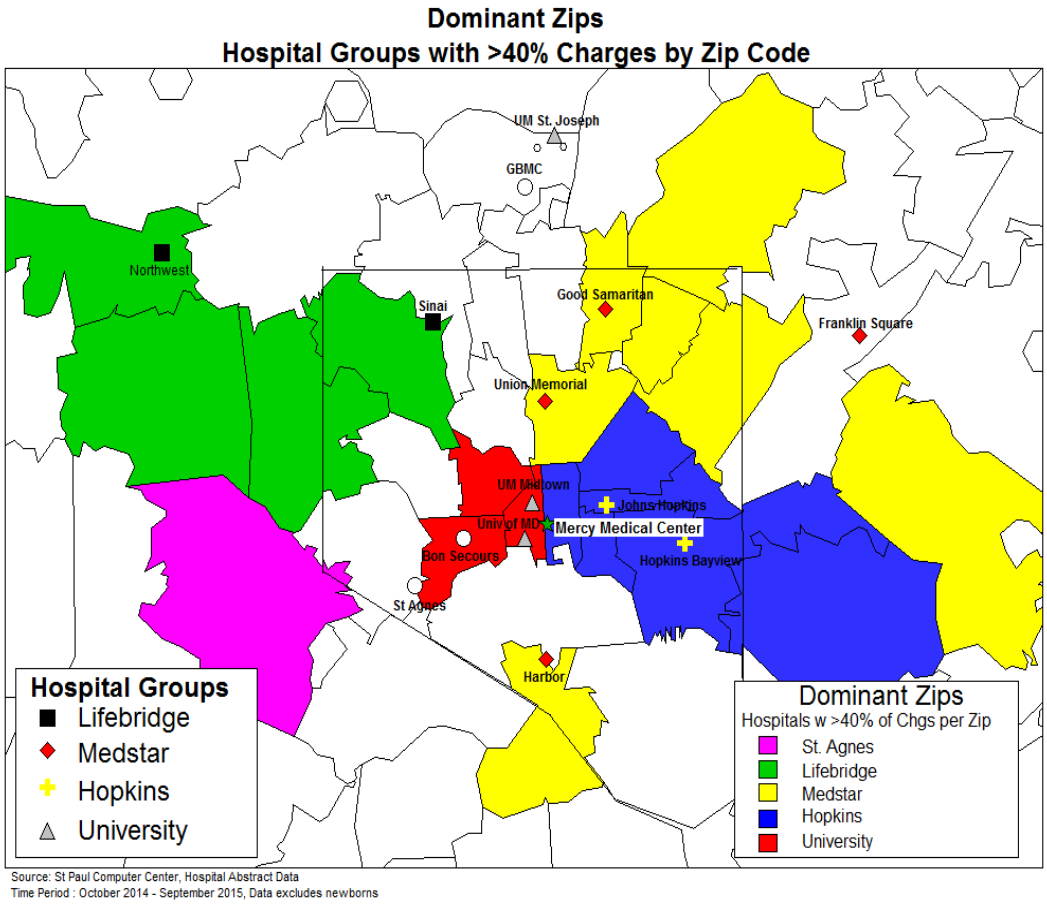
2. *Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an*

identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

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

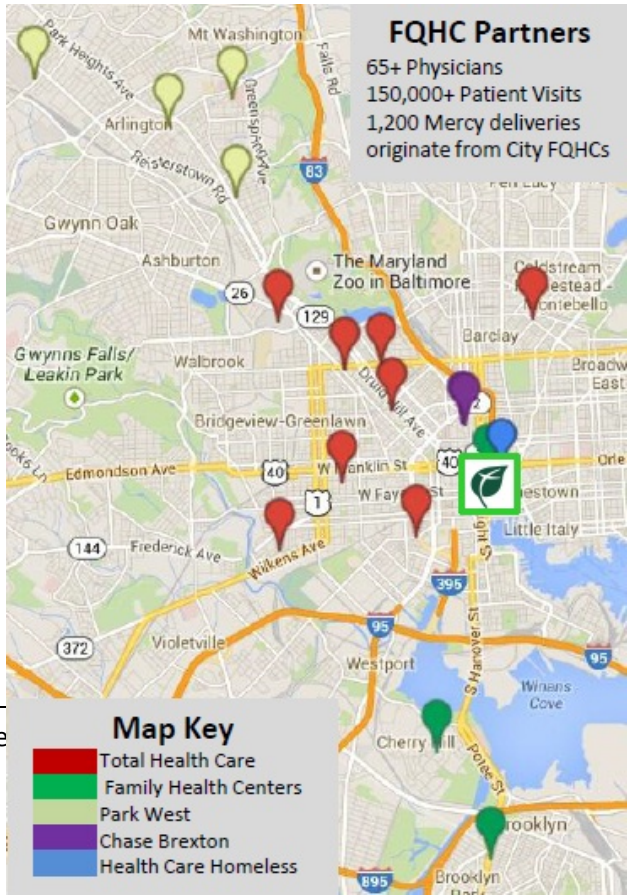
EXISTING HEALTH CARE FACILITIES & OTHER COMMUNITY RESOURCES

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



Baltimore City Hospitals: Johns Hopkins Hospital, LifeBridge Sinai Hospital, University of Maryland Medical Center, St. Agnes Hospital, John Hopkins Bayview Medical Center, Medstar Good Samaritan Hospital, MedStar Union Memorial Hospital, MedStar Harbor Hospital Center, University of Maryland Midtown Campus.

Federally Qualified Health Centers: In addition to hospitals, seven different federally qualified health centers (FQHCs) operate 15 different community health clinics inside or within walking distance of our community. A map of Federally Qualified Health Centers can be found at: http://phpa.dhmh.maryland.gov/opca/docs/Maryland%20MUAP_FQHC%208-4-14.pdf



SBIRT Sites: To address addiction and substance abuse, multiple providers have treatment centers and sites inside Mercy's community. This map gives a sense for the location of treatment centers and SBIRT sites (Screening, Brief Advice, Brief Intervention, Referral to Treatment, Brief Treatment) in the City. A concentration of these facilities is housed within our community: http://www.marylandsbirt.org/about/maryland-sbirt-sites/

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

Under the new All Payer Model Mercy continues improving quality, lowering costs and responding to population/community needs. Through Global Budget Revenue (GBR) incentives, Mercy has broadened its focus and reached further into the community to work towards Maryland's statewide population health goals.

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

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

VI. PHYSICIANS

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

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

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

inadequate insurance that many patients are referred to the Mercy orthopedic physicians from non-Mercy settings throughout the metropolitan area.

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

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

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

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

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

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

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

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

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

Category: Non-resident house staff and hospitalists

OB coverage subsidy of $1,630,007

PA support for charity services of $2,933,672

Category: Coverage of Emergency Department Call

Psychiatric coverage subsidy of $201,071

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

ED physician subsidy of $3,341,170

Physician Charity Care of $1,074,017

VII. APPENDICES

To Be Attached as Appendices:

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

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

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

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

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

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

APPENDIX V ATTACHMENT A:

Our Mission

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

Our Values

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

Our Vision

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

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

a.1**. Identified Need**: Improving access to care and the frequency of care for our homeless neighbors. This focus area was identified as part of the 2016 CHNA process.

b**. Name of the Initiative**: Healthcare for the Homeless (HCH). Health Care for the Homeless is an FQCA-deemed, freestanding 330(h) federally qualified health center accredited by the Joint Commission for both ambulatory and behavioral health care and certified as a Primary Care Medical Home (PCMH).

c. **Target population** - It is currently estimated that Baltimore City has a homeless population of 3000 individuals on any given day. Many reside in and around the Baltimore City Central Business District where Mercy Medical Center is located. The estimated life expectancy for individuals experiencing homelessness is only 48 years, according to Healthcare for the Homeless.

d. **Number of people reached**: HCH has provided 73,661 encounters for CY 2016, an increase of 8.6% over CY2015.

e. **Primary Objective**: Maintain support for Healthcare for the Homeless (HCH): Mercy provides primary medical and pediatric physicians, nurse practitioners, PA and social work providers to support the mission of primary care, preventative medicine and support services at the HCH site. The initiative supports a continuum of care for patients utilizing HCH and Mercy services. Effective preventative care for this high risk population reduces avoidable utilization. Mercy also supported HCH efforts to expand services with a new mobile clinic.

f. **Single or Multi-year plan**: Mercy is a founding partner of HCH, which was established in 1985. Mercy has supported HCH its founding and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: Mercy works closely with the Governance and Management of HCH to provide this support in addition to Baltimore City Office of Homeless Services and Behavioral Health System Baltimore.

h. **Impact/Outcomes**; While Mercy supports this critical initiative, it is difficult to "move the needle". We do believe that if Mercy were not a full partner in supporting this initiative many of the 73,000+ services noted above would not have been provided to this vulnerable population.

i. **Evaluation of Outcome** – As stated, HCH has provided 73,661 encounters for CY 2016, an increase of 8.6% over CY2015. Mercy will continue to monitor the needs expressed by Healthcare for the Homeless. Mercy also supported HCH efforts to expand services with a new mobile clinic.

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future.

k.A. **Total Expense** = $1,748,156

k.B. **Offsetting Grant** = $949,270

a.1. **Identified Need**: Access to Emergency Care for uninsured and underinsured patients aligns with our CHNA focus areas for Homeless population, FQHC Coordination, improving birth outcomes and pre-natal care, and support for addiction and victims of violence.

b. **Name of the Initiative**: Support for Emergency Room Physicians

c. **Target population** - 60,941 Baltimore residents lack health insurance coverage, according to U.S. Census small area estimates

d. **Number of people reached**: Of the 40,279 Emergency visits in FY2016, 59.5% were to uninsured or underinsured patients.

e. **Primary Objective**: Provide accessible emergency health care regardless of insurance status. Mercy provides subsidized support to the Emergency Department Physician practice to subsidize Medicaid and underinsured patients.

f. **Single or Multi-year plan**: Mercy has supported its Emergency Room physicians since its inception and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: St. Paul Place Specialists

h. **Impact/Outcomes**; Services noted above would not have been provided to this vulnerable population in need of emergency medical care.

i. **Evaluation of Outcome** –Mercy will continue to monitor the needs expressed to provide this critical service and works with community partners to reduce avoidable ED utilization.

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future.

k.A. **Total Expense** = $3,341,170

k.B. **Offsetting Grant** = none

a.1. **Identified Need**: Access to Emergency Psychiatric Care for uninsured and underinsured patients aligns with our 2016 CHNA focus areas for the Homeless population, FQHC Coordination, and support for addiction and victims of violence.

b. **Name of the Initiative**: Support for Emergency Room Psych Consultations

c. **Target population** - Fifty two percent (52%) of Mercy's high utilizers (all-payers) have a mental health or substance abuse diagnosis. Access to psychiatric consults is a critical need.

d. **Number of people reached**: 5,059 Emergency room patients sought services from Mercy with a psych diagnosis.

e. **Primary Objective**: Provide accessible psychiatric consults in the emergency health care regardless of insurance status. Mercy provides subsidized support to the Psychiatric Physicians to subsidize Medicaid and underinsured patients.

f. **Single or Multi-year plan**: Mercy has supported this program for many years and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: St. Paul Place Specialists

h. **Impact/Outcomes**; Services noted above would not have been provided to this vulnerable population.

i. **Evaluation of Outcome** –Mercy will continue to monitor the needs expressed to provide this critical service

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future.

k.A. **Total Expense** = $201,070

k.B. **Offsetting Grant** = none

a.1. **Identified Need**: Access to Primary Care for uninsured and underinsured patients through collaboration with a local Federally Qualified HealthCare organizations. This focus area was identified as part of the 2016 CHNA process.

b. **Name of the Initiative**: Support Family Health Centers of Baltimore

c. **Target population** - FQHC's are a critical access point for health care, especially primary care, obstetrics and pediatrics, for Medicaid-insured patients and those without health insurance coverage. In Baltimore City, there are currently 211,356 individuals enrolled in Medicaid Managed Care Organizations and 60,941 Baltimore residents lack health insurance coverage.

d. **Number of people reached**: Roughly 24,000 patient encounters were provided at Mercy's subsidized locations.

e. **Primary Objective**: Mercy provides subsidized support to Adult and Pediatric physician offices through the Family Health Centers of Baltimore (an FQHC). This helps to provide cost-efficient and accessible health care regardless of insurance status and arranges for sliding scale fees to assist the uninsured with physician and other expenses. Providing care in the community setting supports reductions in potentially avoidable hospital utilization.

f. **Single or Multi-year plan**: Mercy has supported this critical program for many years.

g. **Key Collaborators in Delivery**: Family Health Centers of Baltimore

h. **Impact/Outcomes**; Services noted above may not have been provided to this vulnerable population.

i. **Evaluation of Outcome** – Tracking of FQHC visits to Mercy specialists is not available. Access to primary care services for higher risk populations such as Medicaid-insured and the uninsured reduces avoidable utilization.

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future.

k.A. **Total Expense** = $1,794,871

k.B. **Offsetting Grant** = none

a.1. **Identified Need**: Access to Primary Care for uninsured and underinsured patients through collaboration with local Federally Qualified HealthCare organizations. This focus area was identified as part of the 2016 CHNA process.

b. **Name of the Initiative**: Support of local FQHCs through Board membership

c. **Target population** - FQHC's are a critical access point for health care, especially primary care, obstetrics and pediatrics, for Medicaid-insured patients and those without health insurance coverage. In Baltimore City, there are currently 211,356 individuals enrolled in Medicaid Managed Care Organizations and 60,941 Baltimore residents lack health insurance coverage.

d. **Number of people reached**: Mercy's support of these important programs touches all of the target population.

e. **Primary Objective**: Senior Mercy Executives volunteer to serve on the boards of several Baltimore City Federally Quality Health Centers to promote collaboration and FQHC stewardship and sustainability.

f. **Single or Multi-year plan**: Mercy has supported this critical program for several years and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: Family Health Centers of Baltimore, Total Healthcare, Healthcare for the Homeless

h. **Impact/Outcomes**; Supports closer collaboration with FQHC's to improve access to health care.

i. **Evaluation of Outcome** –N/A

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future.

k.A. **Total Expense** =$82,419

k.B. **Offsetting Grant** = none

a.1. **Identified Need**: Access to OB and NICU services for uninsured and underinsured patients aligns with strategies to improve birth outcomes and pre-natal care for expectant mothers as identified in our 2016 CHNA.

b. **Name of the Initiative**: Support of OB and NICU Physician extenders

c. **Target population** - Per the CHNA, Mercy's CBSA had 16.6 live births per 1,000 residents. Also there were 12.7% of births classified as low birth weight, which would indicate the need for NICU services.

d. **Number of people reached**: In 2016, 69.4% of Mercy's deliveries were to uninsured or Medicaid patients. Additionally, 74.6% of the NICU patients were uninsured or underinsured.

e. **Primary Objective**: Mercy provides support to physician practices through subsidies for PA and NP physician extenders in order to provide OB and NICU health care Services regardless of insurance status. The cost included as community benefit represents the uninsured and underinsured percentage of the cost of providing this service.

f. **Single or Multi-year plan**: Mercy has supported this critical program for several years and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: St. Paul Place Specialists Physician Practices, Baltimore City's B'more for Healthy Babies Program

h. **Impact/Outcomes**; Services noted above would not have been provided to this vulnerable population.

i. **Evaluation of Outcome –** In 2009, Baltimore City one of the highest mortality rate (IMR) in the City's history. The City's IMR has since fallen by 38%—from 13.5 deaths per 1,000 live births in 2009 to 8.4 in 2015. As the City's largest birthing hospital and obstetrical provider, Mercy's community benefit efforts and its work with multiple partners under the leadership of the Baltimore City Health Department contributed to this improved outcome among the targeted population.

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future

k.A. **Total Expense** = $1,704,017

k.B. **Offsetting Grant** = none

a.1. **Identified Need**: Access to OB and NICU services for uninsured and underinsured patients aligns with strategies to improve birth outcomes and pre-natal care for expectant mothers as identified in our 2016 CHNA.

b. **Name of the Initiative**: Support of OB and NICU Physician extenders

c. **Target population** - Per the CHNA, Mercy's CBSA had 16.6 live births per 1,000 residents. Also there were 12.7% of births classified as low birth weight, which would indicate the need for NICU services.

d. **Number of people reached**: In 2016, 69.4% of Mercy's deliveries were to uninsured or Medicaid patients. Additionally, 74.6 % of the NICU patients were uninsured or underinsured.

e. **Primary Objective**: Provide OB health care regardless of insurance status. Mercy provides support to these physician practices through subsidies for OB coverage.

f. **Single or Multi-year plan**: Mercy has supported this critical program for several years and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: St. Paul Place Specialists Physician Practices, Baltimore City's B'more for Healthy Babies Program

h. **Impact/Outcomes**; Services noted above would not have been provided to this vulnerable population.

i. **Evaluation of Outcome –** In 2009, Baltimore City one of the highest mortality rate (IMR) in the City's history. The City's IMR has since fallen by 38%—from 13.5 deaths per 1,000 live births in 2009 to 8.4 in 2015. As the City's largest birthing hospital and obstetrical provider, Mercy's community benefit efforts and its work with multiple partners under the leadership of the Baltimore City Health Department contributed to this improved outcome among the targeted population.

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future

k.A. **Total Expense** = $1,630,007

k.B. **Offsetting Grant** = none

a.1. **Identified Need**: Improve birth outcomes and pre-natal care for expectant mothers. Facilitate better care coordination with the City's Federally Qualified Health Centers. Provide narrowly tailored health education to segments of the population within our community. This focus area was identified as part of the 2016 CHNA process.

b. **Name of the Initiative**: Baby Basics Prenatal Health Literacy Program

c. **Target population** - In 2016, Mercy delivered 3,127 babies.

d. **Number of people reached**: In 2016, 3,052 Baby Basics Health Literacy Books provided in FY2016

e. **Primary Objective**: The Baby Basics Prenatal Health Literacy Program provides health education to expectant mothers at Federally Qualified Health Centers read, understand, and act upon pregnancy information. The program empowers underserved populations to be active participants and to effectively navigate the healthcare system. Patients participating in Baby Basics increase adherence to prenatal visits.

f. **Single or Multi-year plan**: Mercy has supported this critical program for several years and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: Total Health Care, Family Health Centers of Baltimore, Park West Health System, B'more for Healthy Babies

h. **Impact/Outcomes**; Services noted above would not have been provided to this vulnerable population.

i. **Evaluation of Outcome –** In 2009, Baltimore City one of the highest mortality rate (IMR) in the City's history. The City's IMR has since fallen by 38%—from 13.5 deaths per 1,000 live births in 2009 to 8.4 in 2015. As the City's largest birthing hospital and obstetrical provider, Mercy's community benefit efforts and its work with multiple partners under the leadership of the Baltimore City Health Department contributed to this improved outcome among the targeted population.

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future.

k.A. **Total Expense** = $45,786

k.B. **Offsetting Grant** = $17,914

a.1. **Identified Need**: Provide support to victims of violence and addiction. This focus area was identified as part of the 2016 CHNA.

b. **Name of the Initiative**: The Forensic Nurse Examiner (FNE) Program (formerly the SAFE Program)

c. **Target population** - The Baltimore City Police Department reported 287 sexual assaults to the FBI Uniform Crime Reporting system in 2015. Per the National Sexual Violence Resource Center, rape is the most under-reported crime.

d. **Number of people reached**: In 2016, 461 patients were provided forensic services

e. **Primary Objective**: The Forensic Nurse Examiner (FNE) Program (formerly the SAFE Program) provides care to victims of sexual, domestic, child, elder and institutional violence. The centerpiece of Mercy's program is a skilled team of Forensic Nurse Examiners (FNEs) who document the details of the assault, collect crucial time-sensitive evidence and perform medical exams, tests and treatments. In order to raise awareness and reduce violence, the program's leadership and certified nursing staff provide community education about domestic violence and sexual assault to law enforcement and the community. The FNE Program is the designated site for forensic patients in Baltimore City and the only comprehensive program of its kind in Maryland.

f. **Single or Multi-year plan**: Mercy has supported this critical program for many years and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: - Sex and Family Crimes Division of the Baltimore City Police Department - Family Crisis Center of Baltimore

h. **Impact/Outcomes**; Services noted above would not have been provided to this vulnerable population.

i. **Evaluation of Outcome** – Mercy evaluates the number of individuals served by this critical program.

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future

k.A. **Total Expense** = $631,053

k.B. **Offsetting Grant** =$251,170

a.1. **Identified Need**: Provide support to victims of violence and addiction. This focus area was identified as part of the 2016 CHNA.

b. **Name of the Initiative**: Mercy Family Violence Response Program

c. **Target population** - Per the CHNA, Mercy's CBSA had 59.9 Domestic Violence Incidents Reported per 1,0000 residents 2016

d. **Number of people reached**: In 2016, 687 patients were provided services

e. **Primary Objective**: The program services victims of child abuse and neglect, sexual assault and abuse, domestic violence and vulnerable adult abuse. Services include: crisis counseling intervention, safety planning, danger assessment, documentation, and community resource referral for patients of MMC and it's associated physicians.

f. **Single or Multi-year plan**: Mercy has supported this critical program for many years and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: -Domestic Violence Coordinating Council, Turn Around, House of Ruth

h. **Impact/Outcomes**; Services noted above would not have been provided to this vulnerable population.

i. **Evaluation of Outcome** – Mercy evaluates the number of individuals served by this critical program.

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future

k.A. **Total Expense** = $221,381

k.B. **Offsetting Grant** =$119,467

a.1. **Identified Need**: Provide support to victims of violence and addiction. This focus area was identified as part of the 2016 CHNA.

b. **Name of the Initiative**: Mercy Inpatient Detoxification Program

c. **Target population** - Per the CHNA, Mercy CBSA had 4.3 Drug-Induced Deaths per 10,000 residents

d. **Number of people reached**: In 2016, 1,002 patients were admitted to this service

e. **Primary Objective**: Mercy's Substance Abuse and Medical Detoxification Program Mercy offers one of two inpatient detoxification units in Baltimore City and provides physician subsidies for the professional component of these inpatient services. Of note, a number of diseases and medical conditions are over-represented in patients with substance abuse (e.g. Infectious Disease, Gastroenterology). Consultative and follow up care with appropriate specialists also are supported.

f. **Single or Multi-year plan**: Mercy has supported this critical program for many years and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: Baltimore City Police Department, Behavioral Health Systems Baltimore.

h. **Impact/Outcomes**; Services noted above would not have been provided to this vulnerable population.

i. **Evaluation of Outcome** – Mercy evaluates the number of individuals served by this critical program.

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future.

k.A. **Total Expense** = $603,461

k.B. **Offsetting Grant** =none

a.1. **Identified Need**: Provide support to victims of violence and addiction. This focus area was identified as part of the 2016 CHNA.

b. **Name of the Initiative**: Screening, Brief Intervention and Referral to Treatment (SBIRT)

c. **Target population** - In 2016, in Baltimore City there were XXX reported cases of addiction

d. **Number of people reached**: In 2016, 6,555 patients had intervention with a Peer Recovery Coach in ER. 952 referred to treatment

e. **Primary Objective**: Screening, Brief Intervention and Referral to Treatment (SBIRT) services: Mercy is one of three Hospital-based SBIRT sites in Baltimore City. SBIRT is a proven-effective public health approach to identifying and providing early intervention among individuals at risk for developing substance use and other behavioral health disorders.

f. **Single or Multi-year plan**: Mercy has supported this critical program for several years and expects to continue into the foreseeable future.

g. **Key Collaborators in Delivery**: Behavioral Health System Baltimore

h. **Impact/Outcomes**; Services noted above would not have been provided to this vulnerable population.

i. **Evaluation of Outcome** – Mercy evaluates the number of individuals served by this critical program.

j. **Continuation of the Initiative**; Mercy expects to continue this initiative into the foreseeable future.

k.A. **Total Expense** =$225,193

k.B. **Offsetting Grant** =$105,472

Mercy Medical Center **Appendix I**
HSCRC Community Benefit Report
FY 2016

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

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

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

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

Mercy Medical Center **Appendix II**
HSCRC Community Benefit Report
FY 2016

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

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

MERCY MEDICAL CENTER

POLICY AND PROCEDURE
PATIENT FINANCIAL SERVICES

FINANCIAL ASSISTANCE POLICY

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

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

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

Financial Assistance

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

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

Notification and Application

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

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

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

Eligibility & Benefits

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

Statutory and Regulatory Required Categories

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

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

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

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

    c. Low-income-household energy assistance program;

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

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

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

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

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

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

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

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

6. A homeless patient qualifies for Financial Assistance.

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

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

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

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

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

    b. Medical expenses; and/or

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

Defined Terms

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

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

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

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

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

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

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

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

Developed by: Justin Deibel
Edna Jacurak
Betty Bopst

APPROVED BY:

John Topper, SVP, CFO	Mary Crandall, Director PFS

Mercy
HEALTH SERVICES

PATIENT INFORMATION:
BILLING AND FINANCIAL ASSISTANCE POLICY

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

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

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

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

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

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

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

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

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

Update: 6/1/09

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

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

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

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

COMPLETE AND RETURN STUB

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

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

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

MEDICARE NUMBER	DATE RETIRED

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

EMPLOYER NAME	ADDRESS

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

DETACH HERE RETURN ABOVE STUB

PATIENT INFORMATION:
BILLING AND FINANCIAL ASSISTANCE POLICY

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

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

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

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

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

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

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

PAYMENT ON ACCOUNT

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

Our Mission

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

Our Values

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

Our Vision

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

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